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02- DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
373 BOARD OF REGISTRATION IN MEDICINE

Chapter 26: Medical Liability Demonstration Project (the "Project"- Radiology Specialty Practice Parameters and Risk Management Protocols).

SUMMARY: This chapter implements 24 M.R.S.A. c. 21, sub-c IX by defining the eligibility requirements for enrollment of Maine licensed allopathic physicians practicing in the medical specialty of Radiology in the Medical Liability Demonstration Project. It describes the procedure for enrollment and for termination of enrollment in the Medical Liability Demonstration Project. Further, it sets forth the practice parameters and risk management protocols adopted by the Maine Board of Registration in Medicine, based on the recommendations of the Radiology Medical Specialty Advisory Committee established by 24 M.R.S.A. §2972 (Supp. 1990) as amended by Public Law (1991) Chapter 319.

SECTION 1: Participation in the Medical Liability Demonstration Project as a specialist in the medical practice of Radiology.

A. Eligibility to Participate: A physician may be enrolled by the Board of Registration in Medicine as a participating radiological physician in the Medical Liability Demonstration Project if:

(1) He/she has been granted a license to practice medicine and surgery in Maine by the Maine Board of Registration in Medicine and the license so granted is in good standing at the time of enrollment to participate in the project and he/she remains registered as qualifying, pursuant to 32 M.R.S.A. §3280 (1988 & Supp. 1990) and Chapter 1, Section 13 of the Board's rules, for the active practice of medicine and surgery within Maine. In addition,

(a) The physician is credentialed to practice radiology in one or more hospital(s) located in Maine; and,
(b) A majority of the physician's practice is in diagnostic radiology and occurs in such Maine hospital(s); and
(c) The physician is eligible for certification or is certified by the American Board of Radiology, the American Board of Diagnostic Radiology, or the American Osteopathic Board of Radiology.

(2) The physician makes application to the Board on a form provided by the Board and is thereafter approved for participation by the Board based on satisfactory evidence of eligibility.

B. Procedure for Enrollment in the Medical Liability Demonstration Project:

(1) Not later than December 1, 1991, the Board of Registration in Medicine will mail to every physician whom it believes to be engaged in the practice of Radiology in Maine a copy of this chapter of its rules and an application form for enrollment as a participant in the Medical Liability Demonstration Project.

(2) Until December 31, 1996, any physician who believes himself/herself eligible for enrollment and participation in the Medical Liability Demonstration Project pursuant to this chapter may request from the Board a copy of these rules and an enrollment application form.

(3) Between December 15, 1991 and December 31, 1991, the Board of Registration in Medicine and the Board of Osteopathic Examination & Registration will determine if 50% of all physicians qualifying for enrollment and participation under this chapter have applied. If not, all applicants will be promptly notified and the Medical Liability Demonstration Project, with respect to the specialty medical practice of Radiology will not take place. If the two Boards jointly determine that more than 50% of the eligible physicians have applied for enrollment prior to December 15, 1991, all physicians who have properly applied and who have been found eligible will be notified by their respective licensing board of their enrollment in the Medical Liability Demonstration Project commencing January 1, 1992.

(4) At any time until the sooner of: (1) a determination that fewer than 50% of eligible physicians have applied for enrollment prior to December 15, 1991 or (2) the termination of the Medical Liability Demonstration Project on December 31, 1996, any physician licensed by the Board of Registration in Medicine may request and submit enrollment application forms and, if determined by the Board to be eligible for participation, he/she shall be enrolled in the Medical Liability Demonstration Project.

C. Declination to participate; withdrawal from participation:

(1) Enrollment to participate in the Medical Liability Demonstration Project is entirely voluntary and is in no way a requirement for or condition of licensure to practice medicine and surgery in Maine. Physicians declining to enroll as participants need do nothing if

and when informed by the Board of their right to apply for enrollment. The Board shall, however, deem it a courtesy to be informed in writing of a physician's choice not to enroll.

(2) Physicians who have applied to be enrolled as participants and/or who have for sometime been participants in the Medical Liability Demonstration Project may, at any time, withdraw from enrollment by letter request for withdrawal from enrollment sent to the Board offices at State House Station "137, Augusta, ME 04333.

SECTION 2: Practice Parameters and Risk Management Protocols for the specialty practice of Radiology:

A. Pursuant to 24 M.R.S.A. §2973 (Supp. 1990), the Board of Registration in Medicine jointly with the Board of Osteopathic Examination & Registration finds the practice parameters and risk management protocols included in Appendix 1 of this Chapter to be consistent with appropriate standards of medical care and levels of quality in the practice of Radiology in Maine.

B. The Board of Registration in Medicine and Board of Osteopathic Examination & Registration have jointly adopted the practice parameters and risk management protocols for the practice of Radiology.

BASIS STATEMENT: The practice parameters and risk management protocols for the practice of Radiology in Maine are based on recommendations to the Board of Registration in Medicine and the Board of Osteopathic Examination & Registration by the Medical Specialty Advisory Committee on Radiology which was formed pursuant to 24 M.R.S.A. §2972 (Supp. 1990) as amended by Public Law (1991), Chapter 319. The Advisory Committee based its recommendations on studies of medical literature, consultation with experts, analysis of medical malpractice liability claims data, recommended standards of national specialty societies in the field of Radiology, and other sources deemed valid by the committee. In adopting these practice parameters and risk management protocols, it is the desire of the Maine Boards of Registration in Medicine and Osteopathic Examination and Registration that physicians engaged in the practice of Radiology in Maine will conform their care of patients to these standards whenever medically appropriate and thereby reduce risk to patients and the cost of defense of claims of negligent substandard care. The Medical Liability Demonstration Project in regard to the specialty practice of Radiology will evaluate the economic and risk benefit effect of the adoption of these standards and their acceptance by practitioners of Radiology in

Maine between January 1, 1992 and December 31, 1996, as provided by statute.

AUTHORITY TO ADOPT RULES: 32 M.R.S.A. §3269 (1988 & Supp. 1990) and 32 M.R.S.A. §2562 (1988); to adopt medical specialty practice parameters and risk management protocols: 24 M.R.S.A. §2973 (Supp. 1990).

EFFECTIVE DATE: December 1, 1991:

AGENCY COMMENTS AND RESPONSES TO COMMENTS ON PROPOSED RULES: Medical Liability Demonstration Project-Radiology Specialty Practice Parameters and Risk Management Protocols.

During the period allowed for public comment, the Board of Registration in Medicine received only one written comment on the proposed rule and it received no requests to hold a public hearing for comment on the proposed rule. The one written request was from a practicing Maine physician specialist in radiology who felt certain technical language used in Appendix I of the proposed rules was ambiguous or contradictory to usage of the same terms in federal regulations and in professional literature. The commentor proposed less ambiguous language and more precisely descriptive language. On advice of its Radiology Medical Specialty Advisory Committee, the Board found that the commentor's suggestions improved the comprehensibility of the rule and largely incorporated the commentor's suggestions in the finally adopted rule.

1. INTRODUCTION: The Medical Specialty Advisory Committee on Radiology has developed the following Practice Parameters/Risk Management Protocols for use by participating radiological practitioners in the State of Maine.

   In so doing, the definition of Practice Parameters of the American Medical Association has been adopted and applies to all the parameters and guidelines set forth here:

   > Practice parameters are strategies of patient management, developed to assist physicians in clinical decision-making. Practice parameters include standards, guidelines, and other patient management strategies. Standards are accepted principles for patient management. Guidelines are recommendations for patient management which identify a particular management strategy or a range of management strategies. Other strategies for patient management include practice policies and practice options.

   It is the opinion of the committee that these practice parameters, so defined and developed, define principles of practice which should generally produce high quality radiological care. The radiologist may exceed an existing standard as determined by the individual patient and available resources. The standards should not be deemed inclusive of all proper methods of care or exclusive of other methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the propriety of any specific procedure or course of conduct must be made by the radiologist in light of all circumstances presented by the individual situation. Adherence to these standards will not assure successful outcome in every situation. It is prudent to document the rationale for any deviation from these standards in the patient's radiology record.

   Four practice parameters have been adopted as of the effective date of these rules, as follows:

   1. Screening Mammography
   2. Antepartum Ultrasound
   3. Outpatient Angiography
   4. Performance of Adult Barium Enema Examination.

2. STANDARD: PERFORMANCE OF SCREENING MAMMOGRAPHY

Periodic mammography screening of asymptomatic women has been shown to reduce breast cancer mortality. Screening mammography is one area in which diagnostic radiology services can contribute positively to improve overall patient care. The principles for mammography do not basically differ from those applicable to other radiological examinations. Key points to be considered are the criteria for credentialing professionals, equipment specifications, monitoring and maintenance schedules, standards for image quality, standardized image evaluation procedures, meticulous record keeping and periodic review of data for outcomes of the mammography services when feasible.

A. Definition: "Screening mammography" means an effort to detect unsuspected breast cancer at an early stage in asymptomatic women.

(1) Intent: separate women into groups with low and high probability of breast cancer.

(a) Most screened women can be assured no significant abnormalities exist.
(b) The remainder of the screened women will be informed that abnormality exists which must be investigated further.

(2) Exam: ordinarily limited to craniocaudal and mediolateral oblique views of each breast.

(a) Supplementary views may be needed but should not be done routinely.

(3) If breast physical examination is not available at screening site, women should be informed that physical examination is a complementary and necessary procedure.

B. Goal: Produce the optimum, reproducible quality image at the minimum radiation dose necessary to give adequate image information.

C. Indication: (1) asymptomatic women at least 40 years of age; (2) Women younger than 40 years who present with high risk factors.

D. Frequency: (1) every one to two years between 40 and 49 years of age, with same frequency if screening initiated prior to 40 years; (2) every year after 50 years of age.

E. Qualifications of Personnel

(1) Physician:

(a) Certification or eligibility for certification by the American Board of Radiology or American Osteopathic Board of Radiology, and
(b) Interpret mammograms on a regular basis. Physician should interpret or review minimum of 480 mammograms per year, recognizing that this number may not be achievable in low population areas, and
(c) Continuing Medical Education: initially should have 40 hours of CME credits in Mammography, and thereafter 15 hours CME credits every three (3) years.

(2) Radiological Physicist:

(a) Certification by American Board of Radiology in Radiological Physics or American Board of Medical Physics in Diagnostic Radiological Physics recommended.

(3) Radiological Technologist:

(a) State licensure required, and
(b) Perform mammography on a regular basis, and
(c) Be competent in breast positioning and compression, and knowledgeable concerning technical factors, radiation safety, radiation protection, and quality control, and
(d) Should receive continual supervision on image quality from interpreting physician.

F. Equipment Requirements

(1) Designed especially for mammography with a compression device and removable grid.

(2) Precise Specifications

(a) Low energy beam to produce high subject contrast, and
(b) Compression device to improve contrast, minimize radiographic scatter, produce uniform density, and reduce dose and subject motion, and

(c) Film-screen mammography focal spot size 0.3 mm preferable, and
(d) Focal-object distance should be 50 cm or more, and
(e) A dedicated film processor with developer time and temperature setup specifically for the film being used is preferable for film-screen mammography.

G. Radiation Dose: The average glandular dose will be measured at least annually.

(1) For examination of a 4.5 cm thick, compressed breast, consisting of 50% glandular and 50% adipose tissue, the dose will be no more than 0.35 Rad per exposure.

H. Quality Control Program: Documented QC program with procedure manuals and logs.

(1) Technologists' Checks: darkroom cleanliness, processor quality control, screen cleanliness, view boxes and viewing conditions, phantom images, visual check list, repeat analysis, analysis of fixer retention in film, darkroom fog, screen-film, darkroom fog, screen-film contact, compression.

(2) Physicists' Checks: cassette holder assembly evaluation, collimation assessment, focal spot size measurement, Kvp accuracy/reproducibility, beam quality assessment (half value layer measurement), automatic exposure control (AEC) System performance assessment, uniformity of screen, breast entrance exposure and average glandular does.

(3) Professional Quality Assurance Program

(a) Systems for reviewing outcome data will be established. Included will be:

(i) disposition of positive mammograms,
(ii) correlations of surgical biopsy results with mammogram reports whenever possible.

It is understood that in some practice situations it will not be possible to obtain follow-up information on all positive mammograms.

I. Mammography Report: Definitive diagnosis is usually not rendered, although in some instances a highly suspicious abnormality may be identified which will warrant a recommendation for biopsy.

(1) The report should include:

(a) Description of any abnormalities detected and their location, and
(b) Recommendations for subsequent follow-up studies when appropriate, and
(c) Comparison to prior mammograms when practical.

(2) Render report as soon as reasonably possible.

(3) All reports in high probability category should be communicated to the referring physician or his designated representative in such a manner that receipt of the report is assured and documented.

J. Film Retention: Original mammograms shall be retained by a facility or made available to the patient or her designee for a period of at least five (5) years.

K. Self-Referral: Direct access by individuals is permissible without requiring physician referral in advance.

(1) Facilities must have well-developed notification procedures for the patient and her physician, or procedures for referral to a licensed physician who has agreed to accept such patients.

(a) Self-referred (i.e., those women who have no referring physician) patients should be notified of the results of the screening by mail.
(b) Reports in high probability category should be communicated to the patient by certified mail; and,

(i) should indicate need for further consultation with a physician; and,
(ii) follow-up contact with patient or the physician should be made to determine compliance with follow-up care.

L. Free Standing and Mobile Settings

(1) Screening mammography may take place in non-traditional radiology settings where there may not be a physician in attendance.

(2) Mammography offered must follow all of the

previously mentioned guidelines with strict adherence to documented protocols.

3. STANDARD: ANTEPARTUM ULTRASOUND

A. Introduction: These guidelines have been developed for use by practitioners performing obstetrical ultrasound studies. In some cases, specialized and/or additional studies may be necessary. While it is not possible to detect all structural congenital anomalies with diagnostic ultrasound, adherence to the following guidelines will maximize the possibility of detecting many fetal abnormalities. A limited examination is acceptable in clinical emergencies but any limited examinations should be documented as such in the medical record.

B. Equipment: The following ultrasound probes are recommended:

(1) Transabdominal scanning: 3 to 5 mHz transducer (probe). For obese patients, 2 to 2.25 mHz transducers may be used;

(2) Transvaginal scanning: 5 mHz or higher transducer.

C. Method: Real time scanning with as low a power setting as possible to obtain the necessary diagnostic information is to be used.

D. Documentation: A record of the examination including a permanent record of the ultrasound images and written report are to be included in the patient's medical record. Any limitation or exclusion of images should be documented in the written report or supplement.

(1) Images to be recorded are outlined in F below as the minimum to be included as part of the record. In cases where an abnormality is suspected, additional images should be recorded if the images more clearly demonstrate the area of suspicion.

(2) Images should be labelled with patient name, date, and site examination. Orientation of the scan may be included if this more clearly demonstrates an abnormal or normal area.

E. Communication

(1) A written report of the findings should be available to the referring physician within a reasonable time period. This period of time is defined under the

following principles with the realization that certain findings may require immediate clinical attention.

(a) Any results which mandate immediate intervention or treatment by the responsible physician necessitate direct and immediate verbal communication between the radiologist and the responsible physician.

(b) Findings of a less urgent nature may be communicated by indirect means such as mail, recorded messages, computer printouts, or FAX. In every instance, the time taken to transfer information shall not unreasonably delay treatment of a condition suspected by antepartum obstetrical ultrasound.

(2) Any limitations of the examination should be described with follow-up studies suggested when appropriate.

F. Examination protocols

(1) First trimester (The following parameters should be included as a minimum to be analyzed and recorded as part of a standard antepartum obstetrical ultrasound examination. Any abnormalities should be included on the recorded filmed images and be included in the radiology report.)

(a) Gestational sac analysis (to be used when no fetal pole is visualized)

(i) location of sac within uterus
(ii) measurement of sac for estimate of mean sac diameter
(iii) the presence or absence of a yolk sac

(b) Embryo/fetal pole analysis

(i) crown/rump length measurement to be used when visualized for fetal gestational age until the biparietal diameter can be accurately measured
(ii) biparietal diameter to be used for fetal gestational age in late stages of first trimester when accurate measurement is possible.
(iii) number of embryos present

(c) Fetal viability documentation- The viability of

the fetus should be confirmed by real time observation of fetal heart motion. (In general, heart motion can be seen at 7 weeks with transabdominal scanning at 6 weeks with transvaginal scanning.)

(d) Uterine/adnexal analysis includes documenting the following:

(i) uterine wall abnormalities
(ii) cervical abnormalities
(iii) adnexal abnormalities

(2) Second and third trimesters

(a) Fetal viability documentation - Real time observation of fetal cardiac activity and/or fetal motion is necessary for confirmation of viability. Abnormalities of fetal heart rate/rhythm are to be reported.
(b) Fetal presentation/lie - Images and report to document fetal position.
(c) Fetal number - if a multiple gestation is present, the following information should be documented:

(i) amniotic membranes (if present)
(ii) number and location of placenta (-ae)
(iii) fetal size comparison
(iv) fetal gender (if visualized)

(d) Estimate of amniotic fluid volume (increased, decreased, or normal) should be reported.
(e) Analysis of fetal anatomy includes, but should not be limited to, the following:

(i) Abnormalities should be documented on filmed images and reported in the radiology report.
(ii) Analysis of the following regions will detect many structural congenital abnormalities but additional or specialized studies may be necessary. Areas include:
1. cerebral ventricles
2. posterior fossa
3. fetal spine
4. heart
5. stomach
6. renal regions
7. umbilical cord insertion
8. abdominal wall

9. bladder, and
10. limbs.

(f) Analysis of the placenta includes the following:

(i) location and position relative to the internal cervical os
(ii) appearance

(g) Analysis of the umbilical cord includes the following:

(i) establishing the presence of a three vessel cord if stage of development allows (i.e. early second trimester examinations may be limited as small cord size might not allow for visualization)

(h) Uterine/adnexal evaluation includes documenting the following:

(i) uterine wall abnormalities
(ii) cervical abnormalities
(iii) adnexal abnormalities

G. Assessment of gestational age - In general the most accurate age is based on the earliest study. Gestational age determination from subsequent ultrasound examinations should be compared to the initial ultrasound gestational age.

(1) First trimester gestational age is to be determined by:

(a) mean gestational sac diameter (when no fetal pole is visualized)
(b) crown/rump length (when fetal pole is visualized)
(c) biparietal diameter (when accurate measurement is possible in later stages of first trimester)

(2) Second trimester gestational age assessment includes:

(a) age is calculated by head circumference measurement/biparietal diameter and femur length using standard tables.

(3) Third trimester gestational age assessment includes:

(a) age is calculated by measurement of biparietal diameter/head circumference, femur length and abdominal circumference using standard tables.

H. Growth parameters -- For analysis of appropriate fetal growth, the following growth parameters are to be measured and compared to standard tables and, when available, earlier ultrasound examinations.

(1) Second trimester growth parameters including:

(a) biparietal diameter
(b) head circumference
(c) femur length

(2) Third trimester growth parameters measured and compared to standard tables including:

(a) estimate of fetal weight
(b) analysis of abdominal circumference (comparison with head circumference and/or standard tables may allow the detection of growth retardation).
(c) biparietal diameter
(d) head circumference
(e) femur length

4. STANDARD: OUTPATIENT ANGIOGRAPHY.

A. Output angiography is now considered safe and feasible for many patients if appropriate precautions are taken. This represents significant cost savings as well as greater convenience for patients and health care providers.

(1) Definition of Outpatient Angiographic Procedures. The following procedures can be considered for outpatient angiographic study:

Abdominal aortography
Peripheral [runoff] arteriography
Thoracic aortogrpahy
Renal and mesenteric arteriography
Head and Neck arteriography
Selective extremity arteriography
Pulmonary arteriography
Selective catheter venographic studies (i.e., renal venography, gonadal venography, and testicular vein embolization)
Other angiographic studies may be considered for

outpatient procedures if deemed medically appropriate

(2) Patient Selection. Patients considered as candidates for outpatient angiographic procedures should meet the following criteria:

(a) A medical history should be available, including indications for procedure, list of current medication, allergies, and prior relevant surgical procedures.
(b) The patient must have arrangements made for transportation home, preferably with a family member or a neighbor, rather than by taxi or in the company of someone unfamiliar with the patient. Due to medications administered during the procedures, it is necessary that the patient not transport himself/herself home, and
(c) The patient or family member should be able to arrange for the patient's care after the procedure; i.e., due to sedation used during the angiographic procedure, the patient should not be left unattended. If the patient lives alone, it is preferable for a family member or neighbor to attend the patient for at least 8 hours after the time of discharge, and
(d) The patient's mental status should be intact; confused or impaired patients should be strongly considered for an inpatient procedure unless careful arrangements can be made for close observation post-procedure.

B. Relative Contra-Indicatons to Outpatient Angiography

Patients with any of the following are considered at increased risk for outpatient angiography and an inpatient procedure may be indicated:

(1) Poorly controlled hypertension (i.e., diastolic pressure greater than 100 mm/Hg) as these patients have a higher incidence of hematoma and bleeding complications at groin puncture sites.

(2) Abnormal renal function because of the potential for further deterioration of renal function after exposure to contrast media.

(3) Abnormal coagulation parameters, electrolyte abnormalities or significant anemias.

(4) Advanced age (greater than 75 years) because of the potential for increased complications. Older patients may be considered appropriate candidates for outpatient angiographic procedures, but only after careful scrutiny of the other criteria. If there are no other significant organ system abnormalities and the patient has a responsible adult available for observed care post-procedure, outpatient angiography may be appropriate.

(5) When observation by a resporsible adult cannot be satisfactorily arranged post-discharge from the outpatient procedure.

(6) Travel time greater than one hour from the outpatient angiographic facility; these patients may be studied on an outpatient basis but should be encouraged to arrange an overnight stay close to the facility or nearby hospital to allow for prompt management of delayed complications should they occur.

(7) Diabetics are not necessarily excluded from outpatient procedures; however, caution should be taken to insure that their renal function is normal, that they are satisfactorily hydrated prior to and post-procedure, and that appropriate arrangements for insulin management are made prior to the procedure.

C. Patient Care

The following are offered as minimal guidelines for patient care related to outpatient angiographic procedures. Regardless of the setting, all angiographic procedures should conform to usual and accepted techniques.

(1) Pre-procedure Care

(a) The clinical history should be reviewed by the physician to insure that the indications for the study are appropriate. Prior angiographic and other pertinent radiographic studies should be reviewed. In patients undergoing peripheral vascular evaluation, initial assessment with non-invasive studies with recording of ankle and brachial pressures is recommended.

(b) List of current medications should be available; the patients should be encouraged to bring their medications with them.

(c) Appropriately documented informed consent should be obtained.

(d) Initial assessment should include recording of vital signs, assessment of peripheral pulses and review of laboratory parameters.

(e) Laboratory evaluation may be appropriate as medically indicated and this may include hemoglobin, hematocrit, creatinine, electrolytes and coagulation parameters.

D. Procedure Care

(1) All arteriographic patients who are at high risk should have cardiac monitoring throughout the procedure.

(2) All arteriographic patients should have intravenous access maintained throughout the procedure for administration of medications and fluid resuscitation.

E. Post-procedure Care

(1) Patients with arterial catheterization should be monitored for a minimum of four hours after the procedure. All patients should have post-procedure monitoring of vital signs, assessment of puncture site and distal pulses. Patients undergoing head and neck arteriography also should have monitoring of neurologic function. Monitoring should be increased to six hours in patients with hypertension, or those with a hematoma post-procedure.

(2) Assessment prior to discharge should include evaluation of puncture site, distal pulses and vital signs. Vital signs and pulses should be unchanged from the time of admission; any significant change precludes discharge. The patient should be evaluated by the angiographer or designated nurse/technologist prior to discharge. The patient should be ambulated and the puncture site checked for bleeding and hematoma prior to discharge.

(3) A physician should be available to handle patient problems or questions for 24 hours post-procedure.

(4) Access to inpatient care should be available for patients who have unexpected complications or require further procedures at the completion of the angiographic study.

F. Communication

(1) Any results which mandate immediate intervention or treatment by the responsible physician necessitate direct and immediate verbal communication between the radiologist and the responsible physician. This should be documented.

(2) Reporting of less urgent findings may be communicated by indirect means such as mail, recorded messages, computer print outs or FAX. In every instance the time it takes to transfer information shall not unreasonably delay the treatment of a condition specifically diagnosed on the angiogram. The report should be documented in the X-ray record.

G. Indications for Admission

The decision to admit a patient after an outpatient angiographic procedure is at the discretion of the physician. The following should be considered as indications for admission.

(1) Complication resulting from the angiographic procedure including any significant change in pulse in the affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-procedure; or

(2) Significant findings on diagnostic angiography warranting further therapy that would necessitate inpatient admission is also a reasonable indication for admission; or

(3) Admission at the time of the study is encouraged if problems are suspected or arise.

H. The Angiographic Facility

(1) The highest possible quality imaging equipment should be available for all outpatient angiography procedures. This should include high resolution image intensifier, television chain and standard arteriographic filming capabilities to include rapid serial films of at least 14 inches in diameter. Digital subtraction capabilities are highly desirable as they allow decreased contrast volumes and less cardiovascular disturbances during angiography.

(2) There must be adequate facilities for cardiac monitoring and for cardiac resuscitation.

(3) Every angiographic facility should have the appropriately trained personnel to provide proper patient care and operation of the equipment.

I. Quality Improvement

Outpatient procedures should be monitored as part of the overall quality improvement program of the facility. Incidence of complications and unexpected admissions should be recorded and periodically reviewed for the opportunity to improve care. The incidence of delayed admission (i.e., admissions that become necessary after discharge from the outpatient facility) should be less than 2% for problems or complications related to angiography. This data should be collected in a manner which complies with statutory and regulatory peer review procedures in order to protect the confidentiality of the peer review data.

5. STANDARD: PERFORMANCE OF ADULT BARIUM ENEMA EXAMINATIONS.

A. INTRODUCTION: Examination of the colon by barium enema procedure of proven efficacy. The goal of the radiologic examination is to establish the presence and nature of disease by producing the optimum quality study at the minimum radiation dose necessary. The following standard is for performance of the barium enema in adult patients.

B. INDICATIONS: The indications for barium enema examination include, but are not limited to, suspected neoplasms, diverticular disease and inflammatory bowel disease. However, the barium enema may be helpful in diagnosing almost all disease states intrinsically or extrinsically affecting the colon. History and symptoms serving as indications for the barium enema examination include abdominal pain, diarrhea, constipation, bleeding, anemia, abdominal masses, intestinal obstruction, fever or sepsis, polyposis syndromes, and a personal or familial history of colon neoplasm, and history of previous neoplasm.

C. PHYSICIAN QUALIFICATIONS: Examinations must be performed by or under the direct supervision of a licensed physician at the site. The physician should have the following qualifications:

(1) The physician shall have spent a minimum of three months in documented formal training in the performance and interpretation of gastrointestinal fluoroscopy in an approved residency training program, and

(2) The physician shall have documented training and understanding of the physics of diagnostic radiology, and the equipment needed to produce the images. This should include conventional plain film radiology, tomography, fluoroscopy, film-screen combinations, conventional and digital image processing, and the processing and development of films. In addition, the physician must be familiar with the principles of radiation protection, the hazards of radiation exposure to both patient and radiographic personnel, and the monitoring requirements.

Certification by the American Board of Radiology or American Osteopathic Board of Radiology is considered proof of adequate physician training.

D. RADIOLOGICAL TECHNOLOGISTS: Full state licensure is required. Qualifications for technologists performing gastrointestinal radiography should be in compliance with existing operating procedures or manuals at the imaging facility and in compliance with the current ACR policy statement that fluoroscopy by a technologist is limited to a positioning or localizing procedure.

E. EQUIPMENT AND QUALITY CONTROL

(1) Examinations should be performed with fluoroscopic image intensification and radiographic equipment meeting all applicable federal and state radiation standards.

(2) Each imaging facility should have documented policies and operations for monitoring and evaluating the effective management, safety, and operation of imaging equipment. The quality control program should be designed to minimize patient, personnel and public radiation risks and maximize the quality of the diagnostic information.

(3) At least annually, equipment performance should be monitored and a quantitative dose determinations should be conducted by a qualified medical radiation physicist.

(4) There should be review of the standards for equipment and radiation safety that are currently recognized by such national organizations as the National Council on Radiation Protection (NCRP), the National Electrical Manufacturers Association

(NEMA), the American Association of Physicists n Medicine (AAPM), the American College of Medical Physicists (ACMP) or other appropriate federal and state regulatory bodies.

F. COLON PREPARATION: The preparation should consist of any effective combination of dietary restriction, hydration, osmotic laxatives, contact laxatives and cleansing enemas. This should result in a colon which is free of fecal material and excess fluid. In certain clinical situations, preparation may be limited or omitted.

G. EXAMINATION PRELIMINARIES

(1) An appropriate medical history should be available.

(2) The barium enema tip should be inserted by a physician; or a radiological technologist, or a professional nurse trained in enema tip insertion. A retention cuff may be used. It should be inflated carefully.

H. EXAMINATION TECHNIQUE: The following examination descriptions may be modified by the physician to produce examinations of equal or greater quality. The physician should modify any or all parts of the examination as warranted by clinical circumstances and the condition of the patient.

(1) Single-contrast examination: The following is presented as an example of the single-contrast examination.

(a) Barium suspension of approximately 15-20% weight/volume.
(b) Kilovoltage of 100 KVP or greater (depending on the patient's size) during filming.
(c) Manual or mechanical compression of all accessible segments of the colon during fluoroscopy.
(d) Spot films should demonstrate all segments of the colon in profile which are not routinely visualized on overhead films.
(e) Overhead films to include frontal and oblique views of the entire filled colon, an angled-beam view of the sigmoid colon, and a lateral view of the rectum.
(f) A post-evacuation film is recommended.
(g) The quality controls specific to this study are:

(i) Each accessible segment of the colon is seen in compression during fluoroscopy, and
(ii) Each segment of the entire colon is seen without overlap, and
(iii) Radiographic technique should attempt to penetrate all segments of the barium filled colon.

(2) Double-contrast Examination. The following is presented as an example of the double-contrast examination:

(a) High density (80% weight/volume or greater) barium suspension commercially prepared specifically for this examination.
(b) Kilovoltage of 90 KVP or greater (depending on the patient's size).
(c) Barium suspension and room air (or carbon dioxide) are introduced under fluoroscopic control to achieve adequate coating and distention of the entire colon. Intravenous or intramuscular glucagon may be administered to facilitate bowel distention and patient comfort.
(d) The colon should be examined flouroscopically during the course of the examination.
(e) Some combination of films should be taken to attempt to demonstrate all of the segments of the colon in double-contrast. A suggested list of possible views would include the following:

(i) Spot films of the rectum, sigmoid colon, flexures and cecum in double-contrast.
(ii) Large format films including prone and supine views the entire colon, an angled view of the sigmoid colon and a lateral view of the rectum.
(iii) Both lateral decubitus views of the entire colon using a horizontal beam (a wedge filter is recommended.)

(f) The quality controls specific to the double-contrast study are:

(i) Complete barium coating of the entire colon has been achieved, and
(ii) The colon is well distended with gas, and
(iii) An attempt is made to see each segment of the colon in double-contrast on at least two films taken in different positions.

I. BARIUM ENEMA QUALITY CONTROLS. The following quality controls should be applied to all barium enema examinations:

(1) When examinations are completed, patients should be held in the fluoroscopic area until films have been checked by the physician.

(2) Poorly exposed or positioned films should be repeated as necessary.

(3) An attempt should be made to resolve questionable radiologic findings before the patient leaves. Repeated fluoroscopy of the patient should be performed as necessary.

(4) Where sufficient follow-up information can be obtained, the following is suggested for a quality control program:

(a) Correlate radiological, endoscopic and pathologic findings where available.

J. QUALITY IMPROVEMENT

(1) Procedures should be systematically monitored and evaluated as part of the overall quality improvement of the facility. Monitoring should include the evaluation of the accuracy of radiologic interpretations as well as the appropriateness of the examination.

(2) Incidence of complications and adverse events should be recorded and periodically reviewed in order to identify opportunities to improve patient care. The data should be collected in a manner which complies with statutory and regulatory peer review procedures in order to protect the confidentiality of the peer review data.

K. BARIUM ENEMA REPORT: The report should describe the nature, number and location of or extent of lesions in the colon. Any limitations of the radiologic examination should be described and additional studies should be suggested when appropriate.

L. COMMUNICATION WITH REFERRING PHYSICIAN:

(1) Any results which mandate immediate intervention or

treatment by the responsible physician necessitate direct and immediate verbal communication between the radiologist and the responsible physician. This should be documented.

(2) Findings of less urgent nature may be communicated by indirect means such as mail, recorded messages, computer printouts or FAX. In every instance the time it takes to transfer information shall not unreasonably delay the treatment of a condition diagnosed on the barium enema exam.

VERMONT

VERMONT STATUTES ANNOTATED

Title 12

1993

CUMULATIVE POCKET SUPPLEMENT

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professional" in the fifth sentence and substituted "chair" for "chairman" following "preside as" in the sixth sentence.

Subsection (b): Substituted "$50.00, with the superior court clerk" for "$25.00, with the court administrator" following "fee of".

Subsection (c): Substituted "superior court clerk" for "court administrator" preceding "shall, within 30" and "lay persons" for "laymen" following "list of 12" in the first sentence, inserted "or superior court clerk" following "administrator" in the second sentence, substituted "presiding judge" for "court administrator" following "decided by the" in the third sentence, and "susperior court clerk" for "court administrator" near the beginning of the fifth sentence and added the sixth sentence.

Subsection (d): Inserted "by the state" following "compensated" in the first sentence.

Effective date of 1991 (Adj. Sess.) amendment. See note set out preceding § 7001 of this title.

§ 7003. Procedures of arbitration panel; practice guidelines

(a) The claim shall be submitted to the arbitration panel in an informal manner and under such procedural rules as may be laid down by the supreme court, provided that strict adherence to the technical rules of procedure and evidence applicable in the case of jury trials shall not be required. Discovery shall be governed by the Vermont Rules of Civil Procedure. All testimony shall be under oath, and the right to subpoena witnesses and evidence shall obtain as in all proceedings conducted in the superior court. The right of cross-examination shall obtain as to all witnesses and parties, and such cross-examination shall be conducted in an orderly, dignified manner, subject to the control of the judicial referee. All parties shall be entitled, individually or through counsel, to make opening and closing statements. A transcript of the hearings shall be kept by a court reporter. The judicial referee shall retain custody of any exhibits admitted as evidence.

(b) Practice guidelines duly established by professional organizations of health care providers, by licensed hospitals, or by quality assurance programs recognized by state law shall be admissible as evidence on the question of whether the respondent met or failed to meet the applicable standard of care.—Added 1975, No. 248 (Adj. Sess.), § 1; amended 1991, No 160 (Adj. Sess.), § 46.

HISTORY

1991 (Adj. Sess.) amendment. Added "practice guidelines" following "panel" in the section catchline, designated the existing provisions of the section as subsec. (a) and added subsec. (b).

Effective date of 1991 (Adj. Sess.) amendment. See note set out preceding § 7001 of this title.

Herb Olcon of VT Legislative Council says guidelines are voluntary.

OVERVIEW

See also ATR

Cookbook Medicine

A new federal health agency to establish guidelines for the practice of medicine started out with high hopes that it can help lower the nation's health care bill. But big savings seem unlikely.

BY JULIE KOSTERLITZ

Organized medicine reacted dyspeptically 13 years ago when Congress created a federal agency to monitor new trends in medical technology and knowledge and to set guidelines for appropriate practice.

To the American Medical Association (AMA), the move "opened up the specter of the feds saying what's medically appropriate," said John R. Ball, executive vice president of the American College of Physicians, who had worked for a Public Health Service precursor to the monitoring agency.

Doctors have long had a name for such outside intervention: cookbook medicine. Asking doctors to practice according to a formula, particularly ones promulgated by government functionaries, they felt, was akin to asking Julia Child to consult Betty Crocker.

Medical specialty societies for years have voluntarily convened experts to pronounce on the state of the art in their field. The American Academy of Pediatrics had pioneered the idea as early as the 1930s. But letting the government into the act was another matter.

As luck would have it, the AMA and the medical devices industry, which also objected to federal oversight, found an important kindred spirit: the Reagan Administration, which came into office in 1981 believing it had a mandate to restrain government's heavy hand.

In short order, the nuisance was abated. The Center for Health Care Technology Assessment, which never had more than $4 million dollars in its budget, was out of business by its third birthday.

But now, in a remarkable turnabout, Congress, the Bush Administration and yes, even the AMA, are simmering on the same burner when it comes to support for the Agency for Health Care Policy and Research (AHCPR), established by Congress in 1989 to determine "how diseases, disorders and other health conditions can most effectively and appropriately be diagnosed and treated."

What caused organized medicine's conversion?

The answer is complicated. At its core are the forces that drive other profound changes in the health care arena: an explosion of technology and a simultaneous explosion in the cost of care.

Public and private-sector payers now insist on knowing what they're buying, and have hired platoons of their own experts to scrutinize doctors' bills and records to make sure the care they're buying is necessary.

The medical community itself has had a change of heart and has changed its tactics. It has seen itself second-guessed by a proliferation of insurance company and government reviewers using seemingly arbitrary and sometimes secret criteria for withholding payment.

If treatment guidelines and standards are being developed by organizations other than doctors' groups anyway, it seemed the choice was either to get on board and have a say in their development, or be flattened on the tracks.

"This is [organized medicine's] last chance," said John M. Eisenberg, interim chairman of medicine at the University of Pennsylvania Medical School and a member of Congress's Physician Payment Review Commission. "If it doesn't participate voluntarily, [it will be subjected to] more-draconian measures."

By 1989, a new government agency to conduct research and convene experts, indeed, seemed preferable to some of the more heavy-handed cost cutting measures that Congress was considering in the area of doctors' medicare reimbursements.

But overcoming the medical community's opposition was only a first step. Now, the federal oversight agency must cope with inflated and conflicting expectations of doctors, researchers, lawmakers and the payers of medical bills.

"One of the problems is that each of the different communities looks at [the development of guidelines] and sees something else. It's almost a Rorschach test," said Samuel O. Thier, president of the National Academy of Sciences's Institute of Medicine, which is advising the assessment agency.

In particular, many observers worry that Members of Congress are expecting the agency to come up with guidelines that will eradicate all unnecessary medical care and save medicare billions of dollars. That's not going to happen, they say flatly.

The assessment agency must grapple with a great deal of uncertainty about the comparative value and effectiveness of alternative medical treatments and procedures. Even when experts reach consensus on a guideline, observers predict, it is likely to be so broad it won't really affect anyone except the few doctors who are clearly operating outside the accepted norms.

Moreover, evolving developments in medical practice and technology present a moving target. Some procedures may become obsolete before they have been fully studied. Others, which initially appear ineffective, may produce better results as practitioners gain experience in using them.

Getting the word out to doctors, getting them to accept the agency's findings and getting them to voluntarily alter their everyday practices pose major challenges. And even if guidelines help eradicate inappropriate care, they may also induce doctors to perform more of the procedures that are found to be effective—thus potentially driving up some costs.

Another possible problem is that, no matter what the guidelines recommend, patients may demand something other than what experts consider the optimal treatment.

But that doesn't mean that the agency's quest isn't worthwhile. "I think there are very few people who have thought about it who don't think this is an incredibly long-overdue activity," said Gail R. Wilensky, administrator of the Health Care Financing Administration (HCFA), which runs the medicare and medicaid programs.

Richard A. Bloom

Samuel O. Thier, head of the National Academy of Sciences's Institute of Medicine Medical practice guidelines stir expectations that resemble "a Rorschach test."

AN UNCERTAIN SCIENCE

As the pace of technological change accelerated in the late 1970s, medical specialty groups scrambled to keep their members up to date. And, as health care costs soared, private and public insurers frantically sought ways to control their costs. Both groups tried to find ways to define what constituted appropriate care.

The result was a proliferation of guidelines and quality measures. Based on different criteria, some contradicted others. All were hard to keep track of and there was no way to make sure doctors knew about them or followed them.

Review standards developed by payer groups, which didn't always bear the imprimatur of recognized experts, were treated as suspect by doctors who saw them as arbitrary attempts to delay or deny compensation. And payers often mistrusted the specialty groups' guidelines, which they considered self-serving.

The situation cried out for order, but it took a while to persuade Congress to act. In the mid-1980s, a handful of medical researchers began publishing findings that led to the harsh conclusion that medicine wasn't nearly as much of a science as many had believed. Moreover, the researchers argued, a large chunk of the medical care being paid for by the nation was unnecessary.

David M. Eddy, director of the Center for Health Policy at Duke University, and John Billings, an independent consultant, decried the lack of study of health care results in a 1988 article in the journal *Health Affairs*.

"For many important practices, the existing evidence is of such poor quality that it is virtually impossible to determine even what effect the practice has on patients, much less whether that effect is preferable to the outcomes that would have occurred with other options," Eddy and Billings wrote. "Our current ability to analyze that information is primitive."

They concluded: "We simply do not know the appropriate standard of care for some medical practices. The care that is currently being delivered might or might not be appropriate. The standards we use to evaluate actual practice may or may not be the correct ones."

Other research showed that accepted standards of medicine vary a great deal from place to place, even among nearby cities. A study led by John E. Wennberg, professor of epidemiology in the department of family medicine at Dartmouth Medical School, published in *The New England Journal of Medicine* in 1989, found a much higher rate of hospitalization of medicare patients in Boston than in New Haven.

Wennberg argued that the variation in hospital care did not appear to result from a greater amount of sickness in Boston, nor did it have much impact on overall mortality rates, which were roughly the same for the medicare-aged populations in both cities.

Hospitalization decisions, Wennberg said, seemed guided by a range of nonscientific factors. Greater hospital use in Boston, for example, correlated not with higher levels of illness, but with a greater availability of hospital beds.

Extensive research by RAND Corp., published in 1987 and 1988, cited excessive performance of certain types of surgery. "If rates of inappropriate use similar to those we found in the four procedures we studied held for all procedures," project leader Robert H. Brook said, "it is not inconceivable that reducing unnecessary care could trim $50 billion a year from the nation's medical bill."

Such statements captured the imagination of Members of Congress and executive branch health officials concerned about controlling medicare costs without incurring the political wrath of the elderly. By the late 1980s, many of them could quote these studies by heart.

Somewhere along the line, an assertion of uncertain origin—that perhaps 25 per cent of all care delivered in this country was most likely unnecessary—gained currency in federal health policy circles. The prospect of painlessly trimming hun-

J. Jarrett Clinton directs health care review unit
"More literature and less substance than expected"

dreds of billions of dollars from the nation's health bill was tantalizing.

To achieve such a goal, it was apparent that money would be needed for additional research, to coordinate scientific literature reviews, to shepherd expert opinion to a consensus on good medical practice and to get the findings out to the doctors. Who better to pay for it than the federal government?

Even before the Reagan Administration left office, Wilensky's predecessor at HCFA, William L. Roper, was a believer. He pushed the agency to collect data from its vast medical claims and physician peer review organizations and to check for variations in practice patterns and treatment results.

"Federal health agencies will no longer focus only on financing services, conducting biomedical research, implementing laws and administering bureaucratic rules," Roper wrote in the *New England Journal of Medicine* in November 1988. "[They] will also be involved in the collection of data and the distribution of information about health care itself."

Congress did not require much persuading. Although some backers tried to dampen expectations of huge cost savings, the idea of investing millions to save billions was enormously appealing to its Members.

Even the AMA decided that the time had come for federal assessment of the appropriateness of medical procedures. In 1989, as Congress considered establishing limits to medicare's overall payments to doctors, AMA lobbyists argued for an alternative approach: research on medical effectiveness and the development of appropriate practice guidelines.

If the development of such standards was entrusted to HCFA, it was feared that doctors would dismiss the process as a cost cutting exercise by government bill payers, rather than see it as a neutral effort to benefit from medical expertise.

The answer was to create a new office, which almost was named the Agency for Health Care Research and Policy, until Senate aides noticed during a late-night drafting session that the acronym might sound undignified.

HIGH EXPECTATIONS

Established within the Health and Human Services Department (HHS) as one of eight subunits of the Public Health Service, the Agency for Health Care Policy and Research faces a tall challenge: improving the effectiveness of the nation's medical care.

That may sound grandiose and vague, but Congress spelled out several specific ways that it was to tackle its job. And it has provided much more money—$117 million this year—than it did in the early 1980s for the short-lived Center for Health Care Technology Assessment.

In return, the AHCPR was ordered to show quick results by coming up with three medical practice guidelines by Jan. 1, 1991. (The deadline was missed, but the agency says that first standards are now complete and under review.)

One task is to examine the perplexing problem of the wide variations in health care practices around the country. Another is to convene groups of experts from a wide variety of backgrounds to develop guidelines for the treatment of selected health conditions. A third assignment is to find effective ways to disseminate its research findings and guidelines.

In addressing its mission, the agency was ordered to give priority to the study of medical conditions and technology relevant to medicare and medicaid patients. The AHCPR also must concentrate on topics that affect large numbers of people or result in major health care costs.

Already, the agency has convened seven panels to come up with guidelines for dealing with cataracts, prostate disease, depression, acute or chronic pain, sickle-cell disease, bedsores and urinary incontinence.

Unlike the guidelines developed by medical specialty societies, the agency is making an effort to reflect the views not just of specialists, but those of general practitioners, nurses, other "allied health" practitioners, such as physical therapists, and health care consumers.

But developing federal guidelines won't be easy. The agency has asked the Institute of Medicine for advice on how to proceed. The institute's response, which some wags have dubbed "Guidelines for Guidelines," dispels the notion that setting guidelines "is a relatively simple or straightforward undertaking" or that "there is one right way to develop guidelines."

In addition to literature reviews and testimony from medical experts, the agency seeks to base its assessments on the patient's perspective of the effectiveness of a given health care procedure. It seeks to determine not just whether surgery repairs an organ or removes an obstruction, but also whether it helps or hurts a patient's ability to walk, for example, or experience less pain.

This is already proving tough. "The key issue is that there is more literature than anybody expected, and less in it of scientific substance than expected," said J. Jarrett Clinton, a career public health service officer who is the agency's acting administrator. "And there are probably many more options for patients and physicians to discuss than many thought."

A CRITICAL AUDIENCE

After it comes up with guidelines, Clinton's agency, which is expected to get a permanent director in the near future, will face an even tougher task: persuading doctors to accept them as authoritative and useful, and to incorporate them into the way they care for patients.

There are nearly 500,000 practicing physicians in the United States, each with an individualized style, based on training, experience and temperament. And although organized medicine has now endorsed the concept of practice guidelines, it doesn't mean that rank-and-file physicians will.

"One thing that gets physicians so upset is that they feel their competency is being challenged and they resent that a great deal," said Rep. J. Roy Rowland, D-Ga., a family practitioner and a member of the Energy and Commerce Subcommittee on Health and the Environment.

Supporters of the AHCPR hope that the quality of the agency's work, the credibility of its panels and the breadth of its support in the medical community will

help. "As physicians become more aware of the potential benefits of the guidelines, they [will be] increasingly inclined to use them," said John T. Kelly, director of the AMA's office of quality assurance.

But James L. Reinertsen, president of Park Nicollet Medical Center, a large multi-specialty clinic in suburban Minneapolis, rattles off a host of reasons why rank-and-file physicians are likely to resist guidelines.

Doctors, he said, will rebel against rules used as the basis for reward or punishment and will home in instantly on their flaws. Practicing physicians also tend to be skeptical of experts. "Doctors on the front lines tend to view academics who haven't spent a night on call for 30 years with a certain cynicism," Reinertsen said.

Perhaps more important is the gap between what makes sense on paper and what makes sense in the real world of practice. Reinertsen cites his clinic's experience trying to implement cancer specialists' guidelines on mammography, which he said would require them to quintuple the equipment on hand. "Nobody's calculating the impact on the system," he said.

Clinton says his agency plans pilot tests of its guidelines in the hopes of forestalling such problems.

Another uncertainty is how the courts will treat federal treatment guidelines in medical malpractice cases. Supporters of guidelines hope they will be viewed as an acceptable standard of care that will prove helpful in the courtroom to physicians who have followed them.

"If a court says the guidelines are irrelevant" it could put a quick end to their spread, said Peter P. Budetti, director of the Center for Health Policy Research at George Washington University. "You can't expect doctors to be torn between guidelines and the standards set in the tort system."

Although the AHCPR has no way to compel doctors to use its guidelines, both medicare and private health insurers are likely to use the standards in making payment decisions. Reimbursement may be denied for care deemed inappropriate, that is, falling outside the guidelines.

Indeed, HCFA now has a large project under way that will eventually make possible the computerized review of medicare patients' charts to determine whether appropriate practice guidelines have been followed. Unusual patterns of care by physicians would be identified and the physicians' medicare files would be kicked out for further review, HCFA officials said.

At first blush, such an idea sounds like a physicians' nightmare worse than cookbook medicine: computer cookbook medicine. But HCFA chief Wilensky says she thinks doctors will prefer it to the system now in place, which relies on the competence and subjectivity of hundreds of nurse and doctor reviewers.

"I think there's a lot of indication that this will be perceived as an improvement," she said. Moreover, in the near term, the computer reviews will result in few payment denials, she said. Instead, they mostly will be fed back to the physicians for educational purposes.

SAVINGS UNLIKELY

Supporters of medical guidelines worry, however, that members of Congress and employers who are worried about how to pay the nation's rising health care bill, are counting on the standards to save a lot of money, and soon. As an example, they point to what they regard as the grossly unrealistic deadline Congress set for the AHCPR's first rules.

Richard A. Bloom

The American Medical Association's John T. Kelly "Physicians will be inclined to use guidelines."

Asked about skyrocketing health care costs last November, HHS Secretary Louis W. Sullivan said that evaluating medical procedures to "find out which ones work would allow us to eliminate and certainly not pay for those that are not effective. That will certainly help us significantly."

As the HCFA computer experiment illustrates, however, there's an inherent tension between the attitudes of physicians and the expectations of those who pay the doctor bills.

If practice guidelines are too restrictive, they risk ignoring the very real variations that make each patient different and risk unduly impinging on the professional judgment of doctors. "What every doctor is keenly aware of is that [individual] patients differ from a clinical point of view," as do the medical choices that they make, Kelly said.

Guidelines will have to reflect the fact that "proper medical management requires the flexibility to individualize" treatment, the AMA spokesman said.

Philip Caper, a professor of public policy at Dartmouth Medical School and chairman of the Codman Research Group Inc. in Lyme, N.H., cautioned that the quest for broadly accepted standards may prove frustrating.

"Either you have to have such overwhelmingly persuasive scientific evidence, which is scarce, or you have to have a consensus," he said. When there is strong consensus, he argued, a guideline is redundant. If consensus is weak, "you'll come up with protocols so broad they will have little influence on the mainstream of doctors."

Caper said the major problem in medicine is not the "one guy who's off-the-wall," but the vast uncertainty that exists as to what constitutes good practice in mainstream medicine.

In fact, the differences in doctors' styles of practice that result in vastly different rates of hospitalization and costs, he said, can be extremely subtle and would probably not be altered by most guidelines.

There are other reasons why guidelines probably won't save money. If they weed out unnecessary care, they may also help popularize effective procedures and increase patient demand.

In addition, there is no reason to believe that patients, for personal reasons, will not request more-extensive treatment than guidelines recommend.

Most experts agree that as long as some procedures aren't clearly ineffective—and most seem to fall into a gray area—it will be hard to deny them to patients.

Those who are looking for cost savings from medical practice guidelines very likely will be disappointed. "The expectations are the wrong ones," Caper said. "It's a useful exercise and will result in better information, but I don't think it has anything to do with cost containment at all. It will not save a nickel." ■

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State of the Art: Maine

Practice Guidelines May Reduce Liability

In MAINE, a five-year experiment to reduce medical liability now offers doctors a way to lower malpractice premiums. The project has introduced practice protocols aimed at reducing physicians' dependence on defensive medicine. Authorized by legislators in literally their last act of the 1990 session, the new guidelines are an effort by doctors and lay people alike to select standards for care ranging from preadmission testing to caesarean section procedures during delivery.

For physicians who elect to join the project, the protocols provide a defense against malpractice actions by patients, but may not be the basis for a suit. (This protection is known as an "affirmative defense.") Some doctors maintain that malpractice suits have little to do with the actual quality of care provided, and several studies bear these providers out.

To prevent such suits, the project uses explicit standards to link treatment to liability, explained Gordon Smith, counsel for the Maine Medical Association (MMA). John Makin, a physician and chairman of the committee that developed the obstetrics and gynecology guidelines agreed: "It eliminates second guessing by outside experts."

In developing the protocols, the state's medical and osteopathic boards jointly convened specialty panels to propose and adopt standards by rule. Four specialty groups—obstetrics and gynecology, anesthesiology, radiology and emergency medicine—assembled 22 practice protocols. Health care consumers also participated in the panels, and patient-physician communication plays a role in every standard.

The groups' efforts were directed at procedures or conditions the members identified as being likely to promote defensive medicine practices or lead to tort liability. Rather than drafting the guidelines from scratch, the groups looked at national practice standards and adapted them to Maine.

According to Dan Meyer, a member of the evaluation study group, this process led to choosing common practices rather than best practice standards that might be less familiar to all practitioners. New standards may be adopted by the medical and osteopathic boards as the experiment progresses.

As each group chose guidelines for its specialty area, practicing physicians

> ***"[The protocols] eliminate second guessing by outside experts."***

were alerted to the proposed standards. Specialists who chose to join the experiment were required to declare their intent to do so by late last fall. For a specialty to become eligible for the project's tort protections, half of the doctors in the specialty were required to participate. Specialties that were unable to meet this benchmark would have been dropped from the experiment. NOT

Unlike VERMONT and MINNESOTA, which now require the use of practice parameters, the success of Maine's project hinges on voluntary participation. According to Meyer, this approach offered physicians a greater degree of involvement early on in the process.

As a result, doctors who supported the guidelines worked hard to bring their colleagues on board as well. When liability protection began on January 1, 1992 almost 90 percent of the eligible specialists had signed on.

Though support for the experiment has solidified, the legislation authorizing it met with some resistance. Sen. Paul Gauvreau, a key sponsor, noted that the law passed after "robust legal debate" and added he hopes the inevitable test case comes early. Trial lawyers opposed the law as possibly unconstitutional, and the state's largest malpractice insurer warned its subscribers of the project's uncertain legal ramifications.

In response, the state's specialty societies, as well as national specialty colleges, worked to counteract the insurer's warnings. That the guidelines themselves were based on existing practice parameters aided their cause. "[The groups] put known standards into law, doing away with the battle of experts," MMA's Smith argued.

Though a full evaluation is several years in the offing, observers expect that practice changes, such as fewer orders for neck X-rays, may be evident before the year is out. Both the U.S. General Accounting Office and the Rand Corporation have expressed interest evaluating the project at some future date.

In addition to protecting physicians, the protocols offer hospitals a basis for updating their equipment and practices. Small, rural hospitals, say many observers, stand to gain the most.

"So many [doctors in these hospitals] cry wolf, that risk managers get blase," commented Richard Flowerdew, an anesthesiologist and chairman of that specialty's protocol group. The guidelines, he argued, may help staff physicians substantiate their requests. • *KL*

NEWS YOU CAN USE

Medicine by the book

A gusher of guidelines for doctors can educate patients, too

Even the smartest physicians with the best of intentions don't always make the right choices. About 20 percent of hysterectomies and coronary bypass, back and prostate surgery, as well as dozens of other medical procedures, are done unnecessarily, often before trying more conservative measures. And no one tracks the people who *should* go under the knife but don't.

A major drive to curtail these miscalculations is underway. The concept is deceptively simple: For a given medical condition, the various treatment options and the consequences of each are considered; a team of experts then creates a recipe for treating the condition – a "practice guideline" that clinicians and surgeons can consult. The idea has caught fire in the past couple of years, driven largely by the belief that inappropriate medicine is adding billions to the nation's burgeoning healthcare bill. Since 1989, some 200 to 300 guidelines have emanated from a potpourri of medical groups, government bodies, health maintenance organizations and think tanks. This spring, the federal government served notice that it stands foursquare behind the idea. The Agency for Health Care Policy and Research, part of the U.S. Public Health Service, released the first three of 12 guidelines planned this year, with four more to follow in 1993 (table, Page 70).

Patient empowerment. The results will be widely disseminated, and not just to doctors: Consumers can and should get them, too. While the guidelines are written for physicians and other healthcare professionals, their value as well-informed overviews will be immediately clear. "I think most doctors prefer patients who are informed," says James Todd, executive vice president of the American Medical Association. "A guideline can help patients see what the choices are and work with their doctor to make a decision."

A decision in which the patient is a more equal partner is likelier to produce better care. The government's first three reports address problems that are extraordinarily widespread but that the medical community, in the government's view, addresses inadequately: urinary incontinence, which affects some 10 million Americans; pain control after surgery or trauma, and bedsores, which afflict some 1 in 3 nursing-home patients. The guidelines assert, for example, that half of surgery patients get too little pain relief afterward. And surveys show that as few as 1 in 10 people with urinary incontinence get proper medical attention.

The release of the federal guidelines has turned up the heat on professional organizations to do likewise. A few groups, notably the American College of Cardiology and the American Heart Association, have long been generating guidelines. Now they're getting company. The American Academy of Neurolo-

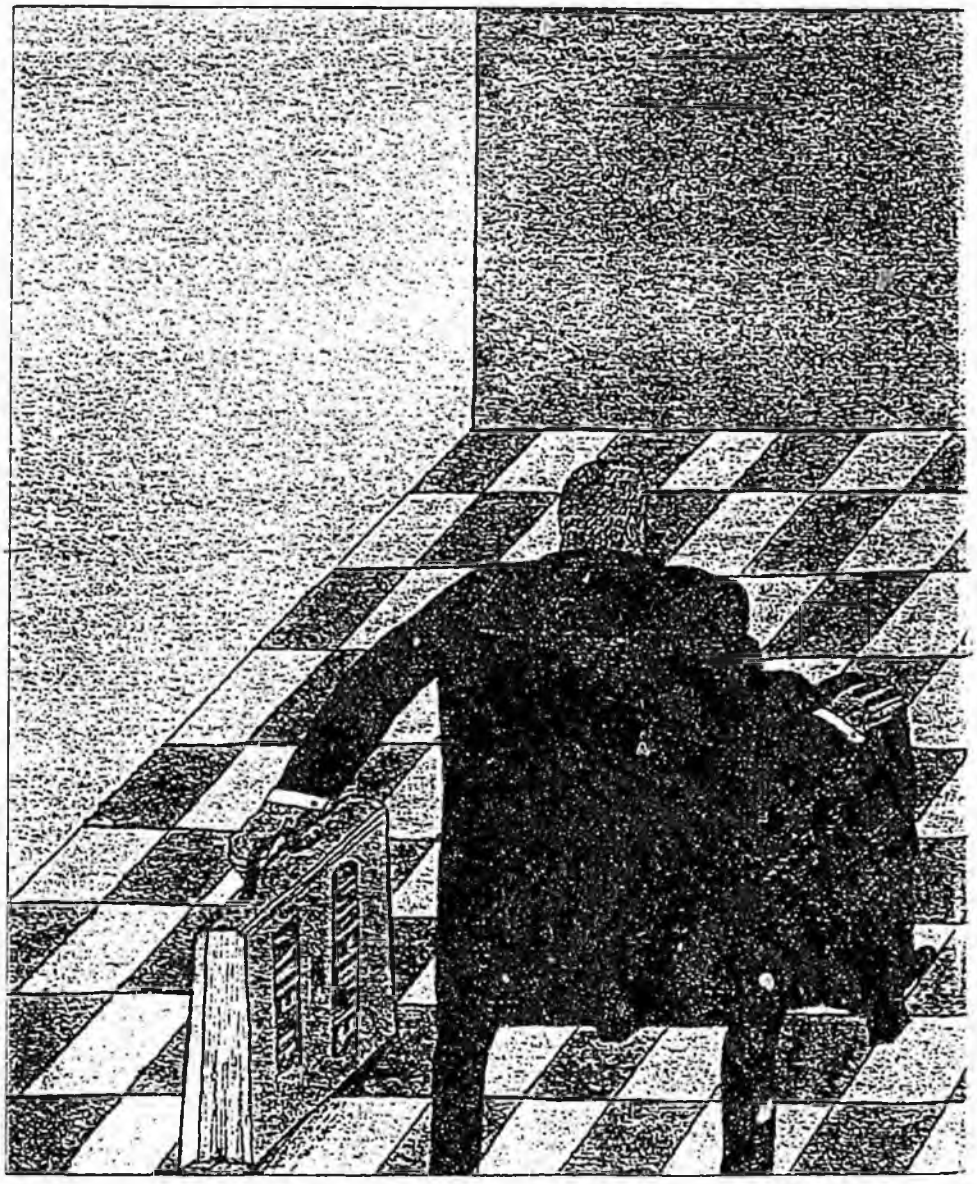


ILLUSTRATION BY DEVIS GREBU FOR USN&WR

gy plans to release five guidelines in 1992 and 11 more by the end of 1994; the American Academy of Allergy and Immunology and the American Academy of Dermatology each will release at least five this year. And the AMA has joined forces with the Rand Corp. and a consortium of 65 other medical groups, including the American Hospital Association, to develop and disseminate dozens of "practice parameters," as the AMA prefers to call them, over the next five years.

A Maine test. Many physician groups hope that guidelines will help bring down malpractice-insurance premiums. The state of Maine is testing the notion. Some 400 Maine physicians last January began following treatment guidelines, modified from those issued by medical groups, for 23 medical procedures from barium enemas to Caesarean sections. Researchers will track, over a five-year period, whether the guidelines lower the rate of inappropriate procedures.

'I think most doctors prefer patients who are informed. A guideline can help patients work with their doctor to make a decision.'

James Todd, executive vice president
American Medical Association

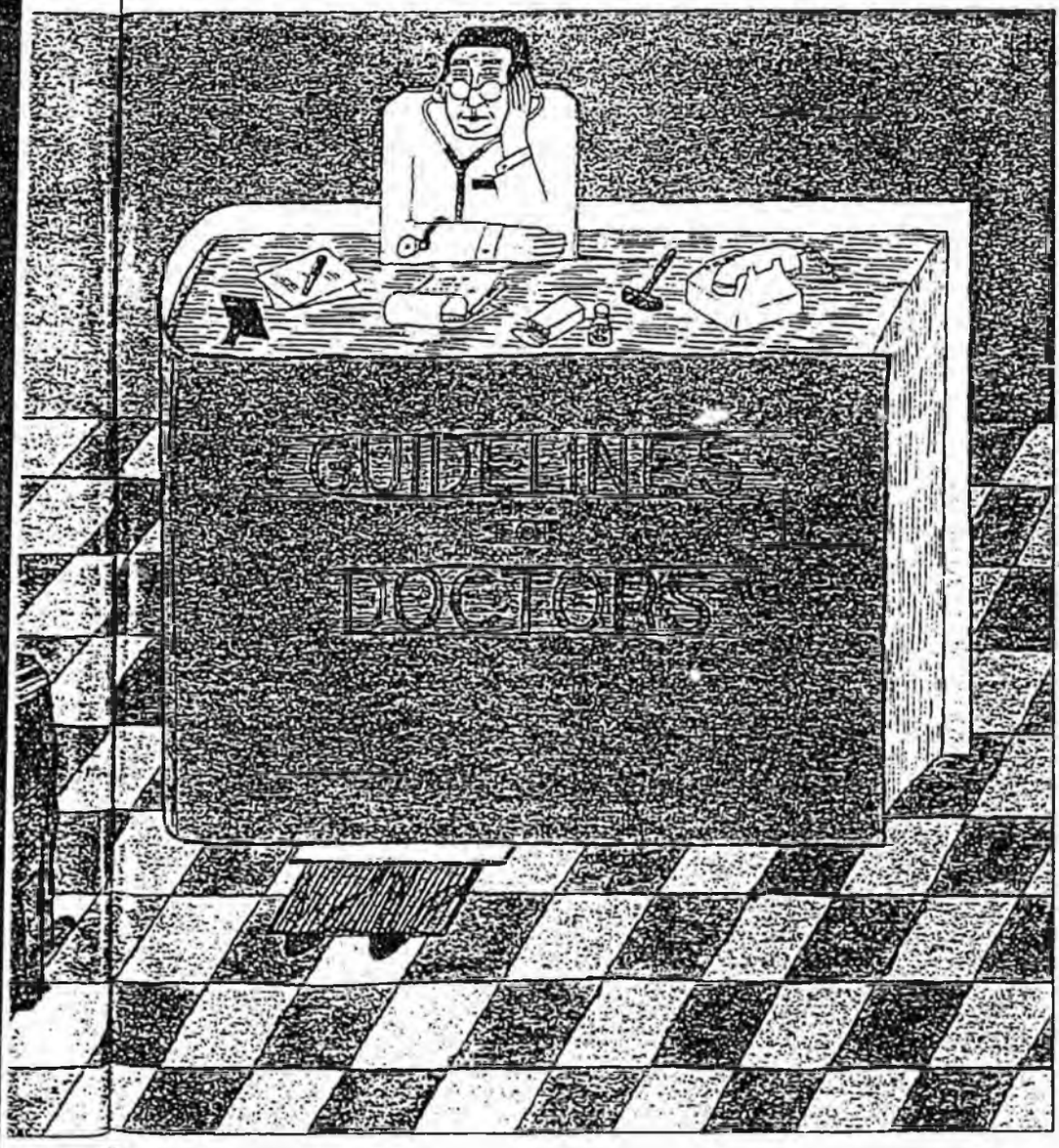
"I think most of us recognize that this is the wave of the future. I, for one, welcome it," says Parker Harris, a Bangor obstetrician and gynecologist who admits that he doesn't always know what's best and believes a clearly written guideline aids both doctor and patient. Over several years, he helped put together Maine's hysterectomy guideline, much of it drawn from his own experience. Thirteen years ago, for example, Harris told patient Anne Heitmann, now 35, that she was a prime candidate for a hysterectomy. She had endometriosis, a painful condition in which tissue from the lining of the uterus migrates and grows on other organs in the abdomen. But Heitmann wanted to have children and asked Harris if she couldn't avoid the surgery. He agreed to help her try, treating her conservatively with drugs and surgery that didn't destroy her ability to have children. And although he did remove one ovary, he also delivered Christopher, now 10, and Nicholas, now 8. "We went over the options with him at every turn. I'm not sorry I waited," says Heitmann, who finally had a hysterectomy in March. Says Harris: "Treating her taught me a lot about the value of waiting."

Works in progress. Like Heitmann, millions of Americans stand to benefit if medical decision making is made more rational. But guidelines development is an evolving science. Sometimes thousands of studies must be reviewed and a consensus crafted after a year or more of debate and drafts. The goal is a document that rises above the cacophonic mix of authoritative and pedestrian studies that skitter across physicians' desktops. Some, like the flowchart guidelines from the Harvard Community Health Plan, are relatively succinct at 10 to 20 pages. Others are book length and exhaustive. The Rand Corp.'s manuals of 100-plus pages on coronary bypass surgery and angioplasty, for example, weigh more than 1,000 different surgical criteria.

The language in a guideline can be quite technical – but surprisingly often, it isn't. Even when it is, plowing through medicalese will be worthwhile if your doctors seem undecided or less than confident over which way to go. Not every condition warrants a guideline, though. There are few options when removing a small patch of skin cancer, for example, and thus no need to consult a guideline. On the other hand, a woman diagnosed with breast cancer would have a strong incentive to get the just published guideline from the American College of Surgeons on breast-conserving lumpectomy as an alternative to mastectomy.

Some doctors pejoratively refer to guidelines as "cookbook medicine." But no one expects doctors to mindlessly follow step-by-step instructions, and consumers shouldn't want them to. Even thorough guidelines can't take exceptional patients, or those with multiple illnesses, into account. And the significant role that cost can play is one that guidelines are not designed to weigh.

People diagnosed with a serious dis-



ease or told they should have surgery need to zero in on the right treatment as quickly as possible. The first step should be to ask the doctor whether he is consulting a guideline or knows of one. A yes should be followed by a request for a copy to look over together with the doctor. Or you can order your own, absorb it and discuss it during a later visit. Many HMOs have developed their own guidelines in-house rather than rely on an outside group. HMO patients should ask whether such guidelines exist.

Easy reading. The forthcoming federal guidelines will arm consumers with especially valuable information on common and vexing conditions, from lower-back problems to ear infections in children and prostate troubles. Along with the detailed guidelines for doctors, the Agency for Health Care Policy has printed simplified versions as consumer pamphlets, obtainable from an 800 number as shown below. The 10-page pamphlets will accompany all of the agency's future guidelines.

The pamphlets are a mixed blessing.

GUIDELINES FOR THE ASKING

More than 200 guidelines help physicians evaluate different conditions and decide on various procedures. But anyone, not just doctors, can get guidelines for personal use. Here are some of the major ones, with information on obtaining them.

CANCER

BREAST CANCER SURGERY (lumpectomy as an alternative to mastectomy)
Issued: July 1992
Key points: Women with a localized cancer that is found early and is still small are the best candidates for this minimal surgery.
Source: American Cancer Society (free)

CERVICAL CANCER
Issued: December 1989
Key points: A cancer must be sized and its severity "staged." The aggressiveness of treatment, primarily with surgery and radiation, depends on these factors.
Source: American College of Obstetricians and Gynecologists (free)

CHRONIC CONDITIONS

ASTHMA
Issued: June 1991
Key points: Progressively stronger drugs in precise combinations are advised as the symptoms of this chronic illness grow worse. A 44-page booklet includes steps to diagnosis and flowcharts of drug treatment options for mild, moderate and severe asthma.
Source: National Asthma Education Program, National Heart, Lung and Blood Institute (free)

DIABETES (diagnosis and treatment for insulin-dependent and non-insulin-dependent types)
Issued: 1988; update due January 1993
Key points: Different insulin products and regimens can have radically different effects on blood-sugar control. Therapy must be carefully individualized. Two 150-page manuals present treatment goals and the options for achieving them.
Source: American Diabetes Association ($19.95)

HEART

ANGIOGRAPHY (X-ray procedure that locates and identifies coronary artery blockages)
Issued: October 1987
Key points: The procedure is definitely indicated for patients with severe angina, or chest pain, but not for those with mild "stable" angina. It should not be used as a first-step screening tool for coronary artery disease.
Source: American College of Cardiology (free)

ANGIOPLASTY (procedure to clean out blocked coronary arteries with balloon-tipped probe)
Issued: 1991
Key points: Advisable if clotbusters fail to dissolve blockage after heart attack, or in lieu of bypass when one artery is blocked. Should not be done if a relatively small part of the heart is threatened and patient has no symptoms. A 150-page manual includes a rating scale for appropriateness.
Source: Rand Corp. ($15)

CARDIAC PACEMAKERS
Issued: July 1991
Key points: Most serious heart-rhythm disturbances require implanting a pacemaker even if there are no symptoms. A full diagnostic work-up is needed to clearly establish and identify the problem.
Source: American College of Cardiology (free)

CHOLESTEROL
Issued: January 1992
Key points: The level of blood cholesterol should be considered along with other risk factors such as smoking, family history and lifestyle in determining the best treatment to minimize heart disease. Drugs and diet are among the treatment options.
Source: Harvard Community Health Plan Inc. ($5)

WHERE TO GET THEM

■ **Agency for Health Care Policy and Research**
AHCPR Publications Clearinghouse
PO Box 8547
Silver Spring, MD 20907
(800) 358-9295

■ **American Academy of Neurology**
2221 University Avenue, S.E.
Minneapolis, MN 55414
(612) 623-8115

■ **American Academy of Ophthalmology**
Order Department
PO Box 7424
San Francisco, CA 94120
(415) 561-8500

■ **American Academy of Orthopaedic Surgeons**
Customer Services
222 S. Prospect Avenue
Park Ridge, IL 60068

■ **American Cancer Society**
Department CRS
PO Box 49749
Atlanta, GA 30359
(800) 227-2345

■ **American College of Cardiology**
ACC Griffith Resource Library
9111 Old Georgetown Road
Bethesda, MD 20814
(301) 897-5400

■ **American College of Emergency Physicians**
Sales and Service Center
PO Box 619911
Dallas, TX 75261
(214) 550-0911

■ **American College of Gastroenterology**
c/o Dr. James Achord
2500 N. State Street
Jackson, MI 39216
(601) 984-4540

■ **American College of Obstetricians and Gynecologists**
ACOG Resource Center
409 12th Street, S.W.
Washington, DC 20024

■ **American College of Physicians**
6th and Race Streets
Philadelphia, PA 19106

■ **American Diabetes Association**
1660 Duke Street
Alexandria, VA 22314
(800) 232-3472, (703) 549-1500

■ **American Psychiatric Association**
Office of Research
1400 K Street, N.W.
Washington, DC 20005

■ **American Urological Association**
Health Policy Dept.
1120 N. Charles Street
Baltimore, MD 21201
(410) 727-1100

■ **Centers for Disease Control**
Mail Stop A-23
1600 Clifton Road, N.E.
Atlanta, GA 30333

■ **Harvard Community Health Plan**
c/o Dr. Lawrence Gottlieb
10 Brookline Place
Brookline, MA 02146

■ **National Asthma Education Program**
NHLBI Information Center
PO Box 30105
Bethesda, MD 20824
(301) 951-3260

■ **Rand Corp.**
Library Distribution Services
PO Box 2138
Santa Monica, CA 90407
Telephone credit-card orders:
(310) 393-0411, ext. 6686

The basic information on the pros and cons of various treatment options is useful but thin. Neither the pain nor urinary-incontinence pamphlets cite drugs by name, for instance. Consumers eager for advice that could help them make a treatment decision should ask as well for the "quick reference" guides that doctors get. These are short versions—20 to 25 pages—of the complete guidelines, and while technical in parts, should be decipherable to most readers. The pain guideline booklet, for example, discusses recommended dosages of painkillers—invaluable to a patient about to have major surgery. There is also a quick reference guide to easing acute pain in children who are undergoing surgery.

Guidelines won't cure all the ills of American medicine, nor will they guarantee delivery of the best possible care. Some people may prefer to leave the decisions up to their doctor. But more Americans, like Anne Heitmann, want to know the options and be involved in the decision. If it helps the system work a little better, that's a side benefit. ■

BY STEVEN FINDLAY

CORONARY BYPASS SURGERY
Issued: March 1991
Key points: The surgery is advisable if at least three arteries are more than 50 percent blocked, causing significant pain and threatening an imminent heart attack. It is not indicated when one artery is blocked and there are no symptoms.
Source: American College of Cardiology (free)

HEART ATTACK
Issued: August 1990
Key points: Clotbusters like TPA and streptokinase should be administered as quickly as possible to patients under 70 who have had a heart attack within the past six hours. Angioplasty is generally recommended for previous stroke sufferers and others ineligible for clotbusters.
Source: American College of Cardiology (free)

PAIN

CHEST PAIN
Issued: 1990
Key points: Severe, crushing pain that radiates to the jaw, neck, shoulder or arm is very likely a heart attack. A battery of tests to confirm the diagnosis should be performed quickly. Other chest pain, especially if coughing is involved, also warrants a thorough medical work-up.
Source: American College of Emergency Physicians ($5)

PAIN FROM SURGERY OR INJURY
Issued: March 1992
Key points: Doctors should treat post-surgical pain and pain from injury or accidents more aggressively; addiction to opiate painkillers like morphine is rare.
Source: Agency for Health Care Policy and Research (free)

PELVIC PAIN IN WOMEN
Issued: September 1989
Key points: There are many possible causes, such as infections, cysts, appendicitis, gastrointestinal illnesses and cancer. Key tests and symptoms that permit diagnosis are listed along with treatment options, including hysterectomy.
Source: Harvard Community Health Plan, Inc. ($5)

CARPAL TUNNEL SYNDROME
(numbness, pain or tingling in the thumb or fingers)
Issued: July 1991
Key points: Drugs and physical therapy should be tried before surgery except when severe numbness in the hand indicates possible nerve damage.
Source: American Academy of Orthopaedic Surgeons (free)

HERNIATED DISK, LOWER BACK
Issued: July 1991
Key points: Surgery is generally a last resort. It should be done only when prolonged use of alternatives such as back exercises, physical therapy and drugs has failed to ease the pain and the patient's quality of life is severely affected. A regimen of prolonged bed rest is unnecessary.
Source: American Academy of Orthopaedic Surgeons (free)

MISCELLANEOUS

BEDSORES
Issued: May 1992
Key points: Simple measures, such as keeping the skin moist and shifting bedridden patients regularly, can prevent this common affliction of elderly people, especially those in nursing homes.
Source: Agency for Health Care Policy and Research (free)

INFERTILITY
Issued: March 1992
Key points: Both partners need to go through a battery of tests, administered in a certain logical sequence for best results and to spare patients the need for repeat testing.
Source: Harvard Community Health Plan Inc. ($5)

URINARY INCONTINENCE
Issued: March 1992
Key points: Surgery is advised only if drugs and pelvic-muscle exercises fail.
Source: Agency for Health Care Policy and Research (free)

USN&WR—Basic data: Directory of Practice Parameters, 1992 Edition, American Medical Association; Practice Parameters Update, American Medical Association, May 1992; Agency for Health Care Policy and Research, Rockville, Md.; Standards of Medical Care: The Comparative Guide to Medical Practice Guidelines and Outcomes Research, 1992 Edition, R&R Publishing Inc., Washington, D.C.; individual medical groups

A 1992-93 GUIDELINE CALENDAR

The following guidelines are due out by the end of 1993. The organizations will put your name on a list to get a guideline when it is released.

SUMMER 1992

CATARACTS
Agency for Health Care Policy and Research

ESTROGEN REPLACEMENT THERAPY
(for menopausal symptoms) American College of Physicians

PROSTATE ENLARGEMENT
Agency for Health Care Policy and Research

FALL 1992

DEPRESSION
(diagnosis and nonhospital treatment by family doctors) Agency for Health Care Policy and Research

FEVER IN CHILDREN
American College of Emergency Physicians

GLAUCOMA
American Academy of Ophthalmology

HEART FAILURE
(from coronary vascular disease) Agency for Health Care Policy and Research

HIV INFECTION
(evaluation and early treatment) Agency for Health Care Policy and Research

IMPOTENCE
American Urological Association

OTITIS MEDIA
(ear inflammation or infection in children) Agency for Health Care Policy and Research

PAIN
(cancer related) Agency for Health Care Policy and Research

PARKINSON'S DISEASE
American Academy of Neurology

SEIZURES
American College of Emergency Physicians

SICKLE CELL DISEASE
Agency for Health Care Policy and Research

STROKE
(rehabilitation) Agency for Health Care Policy and Research

WINTER 1992-93

EATING DISORDERS
American Psychiatric Association

GALLSTONES
American College of Physicians

HEADACHE
(chronic or migraine) American Academy of Neurology

PROSTATE CANCER
American Urological Association

SPRING 1993

ANGIOPLASTY
American College of Cardiology

CATARACT SURGERY
Rand Corp.

DEPRESSION
(in adults, treated by psychiatrists and psychologists) American Psychiatric Association

SUMMER 1993

ALZHEIMER'S DISEASE
(screening) Agency for Health Care Policy and Research

MAMMOGRAPHY
Agency for Health Care Policy and Research

PEPTIC ULCERS
American College of Gastroenterology

FALL 1993

LOWER-BACK PROBLEMS
Agency for Health Care Policy and Research

SCHIZOPHRENIA
American Psychiatric Association

SUBSTANCE ABUSE
American Psychiatric Association

URINARY-TRACT INFECTIONS
American Urological Association

LEGISLATIVE REFERENCE LIBRARY

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3808
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 400
Juneau, Alaska 99801-2105

Copies of minutes listed below were originally included in this file. The minutes are available on the legislative computer database. In order to save space copies of minutes have not been left in the files.

Mary Pagenkopf

11/22/93 11:00 am House Labor & Commerce

HB
292
File 2

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM February 2, 1994

SUBJECT: Civil actions - (HB 292( ) "R" VERSION))

TO: Representative Bill Hudson

FROM: Michael F. Ford
Legislative Counsel

The enclosed draft reflects changes agreed to by the committee at this point. There are three issues contained in this version of the draft that I wanted to bring the attention of the committee.

First, by adding the phrase "was discovered or should have been discovered by the exercise of reasonable diligence" to Sec. 09.10.065(a)(1) (in Sec. 4) I believe the committee has adopted existing law applicable to determining when the clock starts for purposes of application of statutes of limitation. In legal terms this date is also known as the date when a cause of action "accrues." Yurioff v. American Honda Motor Co., 803 P.2d 386 (Alaska 1990). The significance of this relates to another section of the draft section 6. In sec. 6, the current two year statute of limitation for a tort suit is re-enacted as Sec. 09.10.075. This two year limit that requires a tort suit be brought two years from the date of accrual, or two years from when a person knows or should know that the person has a claim. In short, there are two almost identical provisions relating to accrual of an action, one contained in Sec. 4 and another in Sec. 6. This may lead to confusion and unnecessary litigation over the enactment of similar provisions of law applicable to the same lawsuit. One solution to this situation is to change Sec. 09.10.065 in a manner that leaves Sec. 09.10.075 as the applicable statute of limitation. This would create one two year statute for all tort suits, except when a shorter period is imposed under another provision of law.

This brings me to the second issue, again concerning sec. 4. In sec. 4, Sec. 09.10.065(a)(1) appears to allow two years to bring a negligence action against a health care provider. The key point here is that the committee amended this provision to allow a person two years from when the injury is discovered or should have been discovered to bring suit. It appears that this rolling two year period would be cut off by the provisions of sec. 3. Under Sec. 09.10.052(a)(3), in sec. 3, a person has six years from the date "of the last act alleged to have caused the person injury,

death, or property damage" to bring suit. Under this provision, I believe that a person negligently injured by a health care professional would have only six years from the date of injury to bring a lawsuit, not two years from the date the person discovers or should have discovered the injury as contemplated in sec. 4. In short, if the committee wishes to retain the rolling two year discovery limit for actions against a health care provider, then it is necessary to amend Sec. 09.10.052 in sec. 3, to ensure this occurs.

Third, in sec. 7 (AS 09.17.010(c)), sec. 9 (AS 09.17.020(c)), and sec. 25 (AS 09.55.-580(h)), I have deleted the requirement that a person be convicted of the offense and substituted language regarding attempting, committing, or fleeing the commission of the class A or unclassified felony. Requiring that the person bringing the action be a "victim of that offense" raises a question concerning a person who was "fleeing" from the crime. It is unclear whether a person injured by a person fleeing a class A or unclassified felony would also qualify as an exception to the cap on noneconomic damages. For example, assume that a person commits a class A felony and then flees the crime by car. While heading down G street the offender injures a pedestrian. Was the pedestrian a "victim of the offense" as required under this language? The problem is also illustrated by looking at the language in AS 09.17.030 (in sec. 10). If the language in sec. 10 were used, the benefits of the law would apply to the pedestrian in the example because the amended language requires that the act of fleeing the class A felony relate to the pedestrian's injury, not that the pedestrian be a victim of the class A felony.

If you have further questions please contact me.

MFF:gc:pl
94-077.glc

Enclosure

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

M E M O R A N D U M February 7, 1994

SUBJECT: Sectional Summary of CSHB 292 (L&C)

TO: Representative Bill Hudson

FROM: Michael F. Ford
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Findings and Purpose.

Section 2. Requires the state medical board to develop medical practice parameters. The parameters are required to be designed to avoid malpractice claims, to consider consumer needs, and to eliminate the practice of defensive medicine.

Section 3. Limits the time within which a person may bring an action for personal injury, death or property damage to six years from the date a newly manufactured product was first used for its intended purpose, of substantial completion of certain construction, or the date of the last act alleged to have caused the injury, death, or damage. Establishes certain exceptions to the six-year limit.

Section 4. Provides that if a person bringing an action for professional negligence against a health care provider is less than six years old on the date of injury, the person has until their eighth birthday to bring suit, except when a longer period is allowed under AS 09.10.075. Provides for certain exceptions to the time limit for fraud or intentional concealment.

Section 5. Conforming amendment for section 6.

Section 6. Limits the time within which a person can bring an action for personal injury, death or property damage to two years after accrual of the action. Eliminates the exception for minority contained in AS 09.10.140(a) that would otherwise apply to the time limit for bringing a personal injury action.

Section 7. Adds wrongful death as a type of action subject to the limit contained in AS 09.17.010. Adds loss of consortium as a type of damage that may be recovered. Imposes a cap of $500,000 on all claims arising out of a single injury or death, as opposed to each claim based on a separate incident or injury. Repeals an exception to the cap on noneconomic damages for disfigurement or severe physical impairment. Adds an exception to the cap on noneconomic damages for certain crime victims.

Section 8. Requires that a person must show clear and convincing evidence of malice or conscious acts showing deliberate disregard of another person by the person from whom the punitive damages are sought, in order to receive punitive damages.

Section 9. Limits the amount awarded as punitive damages to not more than three times the amount of compensatory damages or $200,000, whichever is greater.

Section 10. Prohibits a person from recovering damages if the person suffers the damages while committing, attempting to commit, or fleeing from a felony, and the action substantially contributed to the injury or death.

Section 11. Requires that a verdict be itemized when damages are awarded for either personal injury and death. Requires reduction of an amount awarded for past or future gross earnings, by the amount of federal and state income tax that would be paid.

Section 12. Allows any party to require future damages be paid by periodic payment instead of as a lump-sum. Requires that a judgment amount paid to an attorney under a contingent fee agreement be reduced to present value and paid as a lump sum.

Section 13. Requires that a judgment paid by periodic payments must be secured.

Section 14. Requires that a judgment ordering payment of future damages by periodic payment, include increases in future payments for anticipated inflation.

Section 15. Provides that a claimant may only recover damages that exceed amounts received from collateral sources, with certain exceptions. Allows the claimant and a person defending a claim to introduce certain evidence regarding collateral sources. Requires that evidence of a collateral source is only admissible after the fact finder has rendered an award, with certain exceptions. Prohibits a person who provides a collateral benefit from bringing an action based on the provision of the benefit.

Section 16. Requires that fault be allocated to each person responsible for damages, regardless of whether the person is a party.

Section 17. Provides that an assessment of fault under AS 09.17.080 against a person who is not a party may not be used to impose civil liability on that person.

Section 18. Allows a person to release another person from civil liability. Provides for reduction of the claim against others by the amount of the release. This section corrects a problem created by the tort reform initiative enacted in 1987.

Section 19. Changes the penalty imposed under AS 09.30.065 to actual costs and attorney fees.

Section 20. Ties the rate of interest on judgments to an amount three percent above the federal reserve rate in effect on January 2 of the year in which the judgment is entered.

Section 21. Prohibits the award of prejudgment interest on future damages or punitive damages.

Section 22. Conforming amendment for section 26.

Section 23. Changes the word "pecuniary" to "economic."

Section 24. Limits an award of damages for wrongful death to the limits under AS 09.17.010 and AS 09.55.580(g).

Section 25. Limits the amount awarded in pecuniary damages for wrongful death to $10,000 if the deceased is not survived by a spouse, child, or dependent. Provides an exception for damages awarded to a crime victim.

Section 26. Prohibit the award of attorney fees in a civil action for personal injury, death, or property damage, unless authorized by statute or by agreement of the parties.

Section 27. Limits the civil liability of a hospital for an act or omission of a health care provider who is not an employee of the hospital.

Section 28. Requires that court pleadings be signed, that an allegation in a pleading be well grounded in fact and warranted by existing law. Requires sanctions be imposed for violating the statute.

Section 29. Repealers.

Section 30. Court rule change section.

Section 31. Court rule change section.

Section 32. Court rule change section.

Section 33. Court rule change section.

Section 34. Court rule change section.

Section 35. Requires the state division of insurance to prepare a report on the civil justice system.

Section 36. Requires the state medical board to adopt medical practice parameters by January 1, 1997.

Section 37. Severability clause.

Section 38. Applicability section.

Section 39. Effective date.

MFF:pl
94-106.plm

WALTER J. HICKEL, GOVERNOR

PLEASE REPLY TO:

☐ 1031 WEST 4TH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501-1994
PHONE: (907) 269-5100
FAX: (907) 276-3697

☐ KEY BANK BUILDING
100 CUSHMAN ST., SUITE 400
FAIRBANKS, ALASKA 99701-4679
PHONE: (907) 451-2811
FAX: (907) 451-2846

☐ P.O. BOX 110300 - STATE CAPITOL
JUNEAU, ALASKA 99811-0300
PHONE: (907) 465-3600
FAX: (907) 465-6735

■ Juneau-Annex
Phone: (907) 465-3603
Fax: (907) 465-2539

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

March 8, 1994

The Honorable Brian Porter
Alaska House of Representatives
State Capitol, Room 516
Juneau, AK 99801-1182

Re: HB 292, tort reform

Dear Representative Porter:

You have asked for our legal opinion on HB 292, otherwise known as the tort reform bill. We have spent considerable time analyzing the legal and constitutional issues raised by the proposed legislation. Our comments below address the most recent version of the bill, CSHB 292 (L&C).

We understand that the House Judiciary Committee, which you chair, and the House Labor and Commerce Committee have invited and received input on this bill from many sources. We appreciate your efforts to consider a variety of viewpoints, as this is a complicated piece of legislation that will have significant impacts. Please do not hesitate to contact us if we can provide further assistance with this bill.

SECTION 3: STATUTE OF REPOSE

Section 3 proposes to enact a "statute of repose" in a new AS 09.10.052. The Alaska Supreme Court has observed:

> A statute of repose differs from a statute of limitation in that the former may bar a cause of action before it accrues, because the statute begins to run from a specific date unrelated to the date of injury. A cause of action thus precluded is *damnum absque injuria*, a loss without a remedy. In contrast, a statute of limitation begins to run when the plaintiff's cause of action accrues or is

discovered. It operates to prevent a plaintiff from sleeping on his or her rights.

Turner Construction Company, Inc. v. Scales, 752 P.2d 467, 469 n. 2 (Alaska 1988).

The statute of repose in this bill would bar personal injury, death, or property damage claims brought more than six years after the earlier of one of three events. In the product liability context, the six years would run from the date a newly manufactured product was first used for its intended purpose. Proposed AS 09.10.052(a)(1). Where construction is alleged to have caused injury, death, or property damage, the statute is triggered by the date the construction is substantially completed, which is defined as when it can be occupied or used in the manner for which it is intended. Proposed AS 09.10.052(a)(2) and (d). Finally, for all other tort cases, the six years would run from the last act alleged to have caused the personal injury, death, or property damage. Proposed AS 09.10.052(a)(3).

The statute does not apply to a tort that was caused intentionally or resulted from gross negligence, fraud, fraudulent misrepresentation, or breach of an express warranty or guarantee, or if there is intentional concealment of facts that would give notice of a potential claim. Proposed AS 09.10.052(b)(1) and (2). Additionally, the six year period would be tolled during any time that a foreign body without therapeutic or diagnostic purpose or effect remains undiscovered in the body of an injured person, where the action is based on the presence of that foreign body. Proposed AS 09.10.052(c). If another provision of law imposes a shorter period of time for filing suit, the statute of repose will not apply. Proposed AS 09.10.052(b)(3).

The statute of repose would put an outer limit on when claims may be brought, regardless of when the cause of action accrues. For example, in the context of a products liability or defective building case, an action for an injury that occurs more than six years after the product is first used or the building is substantially completed would be barred, regardless of how soon after the injury the claimant brought suit. If the injury occurred within the six-year window, the claimant would have to sue within two years under the tort statute of limitations, or before the six-year deadline, whichever is sooner.

For other types of cases, the implications of the statute of repose are more subtle. The two-year statute of limitations runs from the "accrual" of the cause of action. See AS 09.10.070 and proposed 09.10.075 in section 6 of the bill. In many cases, the cause of action will accrue on the date of injury or the "last

act alleged to have caused the personal injury, death, or property damage," so the clock will start to run for purposes of the statute of limitations and the statute of repose at the same time. In those cases, the two-year statute of limitations will govern. See proposed AS 09.10.052(b)(3). However, there are circumstances in which a cause of action may not accrue when the "last act" occurs. Under Alaska law, a cause of action does not accrue until a person discovers or reasonably should have discovered the existence of all elements of their claim. Cameron v. State, 822 P.2d 1362, 1366 (Alaska 1991). Until a claimant reasonably discovers that she has a claim, her cause of action does not accrue and the statute of limitations does not begin to run. The statute of repose will have the effect of cutting off those claims that have not accrued (reasonably been discovered) within six years of the last act alleged to have caused damage, and may shorten the usual two-year time frame for filing suit for those who discover their claims within the six-year window.

Constitutional Problems.

For a number of reasons discussed below, we believe that the Alaska Supreme Court would probably find the proposed statute of repose invalid under several alternative provisions of the Alaska Constitution, including art. 1, § 1 (equal protection); art. 1, § 7 (due process); art. 1, § 15 (obligation of contracts); and art. 1, § 16 (right to jury trial). Proposed AS 09.10.052 may also be subject to invalidation, at least in part, because of conflicts with federal law pertaining to warranties.

While courts in some states have upheld the constitutionality of statutes of repose, courts in other states have found them unconstitutional.[1] See, generally, 25 A.L.R. 4th 641, "*Validity and Construction of Statute Terminating Right of Action for Product-Caused Injury at Fixed Period After Manufacture, Sale, or Delivery.*"[2]

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[1] The Alaska Supreme Court has stricken a six-year statute of repose that was not as broad as the one proposed in this bill, on constitutional grounds. Turner Construction Co., Inc. v. Scales, 752 P.2d 467, 469 n. 2 (Alaska 1988). Because of differences in this bill and in the tort liability picture today, we undertake an independent analysis of the statute of repose proposed in this bill.

[2] Aside from what the courts have done, apparently some legislatures have had second thoughts after adopting laws of this kind. The Florida legislature completely repealed its statute of

(continued...)

Equal Protection.

Cases from other jurisdictions are not particularly helpful in gauging how the Alaska Supreme Court would rule on the constitutionality of this section. The Alaska court applies a different standard to determine whether a law is constitutional under the equal protection clause of the Alaska Constitution than other courts use to analyze their corresponding equal protection clauses. See Wise, *Northern Lights -- Equal Protection Analysis in Alaska*, 3 Alaska Law Review 1 (1986). Since the Alaska Supreme Court overturned an earlier statute of repose (AS 09.10.055) on equal protection grounds under art. 1, § 1 of the Alaska Constitution, the primary analysis of the validity of Section 3 should logically center on the equal protection clause.

The first question the court considers in an equal protection case is whether the constitutional claimant asserts a fundamental constitutional right or the statute uses a suspect classification. State v. Erickson, 574 P.2d 1, 12 (Alaska 1978). If the answer to either question is "yes," then the statute is invalid under the Alaska Constitution absent a compelling state interest. Id.

In Turner Construction Company, Inc. v. Scales, 752 P.2d 467 (Alaska 1988), the court held that the subject statute of repose classified defendants based on their occupation or the nature of the work they perform, while it classified plaintiffs based on the time their injury occurred. The court held that neither classification was a "suspect class" that would trigger the "compelling state interest" standard. Id. at 470 - 71. The court nevertheless found that the right to redress wrongs through the judicial process is "significant." The court therefore analyzed the constitutional claims under the "fair and substantial relationship test" of the Alaska Constitution. Id. at 471.

The court next examined the statutory purpose to determine whether it was a legitimate exercise of the state's police power. The court concluded that encouraging construction and avoiding stale claims by shielding certain defendants from potential future liability were legitimate governmental purposes. Id. The means used by the statute were reviewed to determine

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[2] (...continued)
repose after only a few years. See FSA 95.031(2). The Kansas legislature radically amended its statute in 1991 to revive cases based on disease caused by toxic products, and to allow suits in cases where the plaintiff could prove that the injury occurred during the useful life of the product. See KSA 60-3303.

whether they substantially furthered the purpose articulated by the legislature. In doing so, the Turner decision emphasized, the court did not and will not hypothesize facts which would sustain otherwise questionable legislation. Id. (citing Isakson v. Rickey, 550 P.2d 359, 362 (Alaska 1976)).

As the final step in the analysis, the state's interest in the means employed by the enactment must be balanced against the nature of the constitutional right involved. State v. Erickson, 574 P.2d at 12.

The court has not wavered in its determination to decide for itself whether an enactment of the legislature actually accomplishes the legislature's stated purpose. In other words, the court will not simply accept the legislature's pronouncement that a given set of circumstances exists or that the facts giving rise to a social problem being addressed by a bill are as the legislature claims them to be. These are called "legislative facts" and the court will delve into them in depth to make up its own mind on the validity of the enactment.

In State v. Erickson, the court said:

> Legislative facts come into play when the court is faced with the task of deciding the constitutionality of a statute, statutory interpretation or the extension or restriction of a common law rule upon grounds of policy. These policy decisions, as in the case at hand, often hinge on social, political, economic, or scientific facts, most of which no longer fall within the classification of irrefutable. Cases involving such decisions cannot be decided adequately without some view of the court of the policy considerations and background upon which the validity of a particular statute or rule is grounded.

Id. at 5.

In that regard, the court has required a showing of "hard facts" to justify the purpose and objective of a regulation. The court has refused to accept the unsupported word of a public official to uphold a regulation. Breeze v. Smith, 501 P.2d 159 (Alaska 1972).

In other words, before an Alaskan court will uphold the proposed statute of repose based on the findings and purpose in Section 1, it will conduct an evidentiary hearing to determine whether the legislature's findings are factually accurate. The

findings and purpose statement in support of the proposed statute of repose is as follows:

> • the level of malpractice insurance premiums discourage various professionals from initiating or continuing their practice or offering needed services to the public;
>
> • society as a whole cannot afford the price of lawsuits years after construction, manufacture, delivery of services, and other actions;
>
> • the widespread use of "claims made" insurance policies makes it impossible to adequately and economically insure against actions for an unlimited period of time;
>
> • it is extremely difficult to defend against a claim that has become stale after information and witnesses have disappeared;
>
> • society on the whole is better served with a statute of repose even though a few limited injuries may go without compensation;
>
> • the purpose of the Act is to create a more equitable distribution of the cost and risk of injury;
>
> • the purpose of the Act is to reduce costs associated with the civil justice system while insuring that adequate and appropriate compensation for persons injured through the fault of others is available.

We predict that the supreme court would, as it did in Turner Construction, find that these legislative purposes address valid police power objectives. We doubt, however, that the court would go the next step and uphold proposed AS 09.10.052, because it is conceivable that the court would not find that the means chosen by the legislature actually, as a practical matter, further those goals. As to the last step in the analysis, we do not believe that the court would determine that the state interest in the chosen means outweighs the significant interest that Alaskan citizens have in obtaining compensation for physical injuries, property damage, and death brought about by defective products and poorly constructed buildings. Further, we believe that the proposed statute of repose establishes distinctions between classes of

people in a way that is not justifiable under the equal protection clause.

The Goal of Reducing Insurance Premiums.

The first relevant finding of fact is in Section 1(a)(2) where the legislature states its determination that the cost of malpractice insurance premiums discourages physicians, architects, engineers, attorneys, and other professionals from initiating or continuing their practice or offering needed services to the public. In a court hearing, those attacking the constitutionality of the statute of repose would likely attack this finding on two levels: (1) that there is no shortage of professionals in Alaska caused by high malpractice premiums; and (2) that implementation of the statute of repose would not actually lower malpractice insurance premiums in Alaska.

Whatever the court finds on whether malpractice insurance premiums are actually preventing professionals from providing or offering needed services to the public, it is questionable whether the court would find that the statute of repose would actually reduce the level of malpractice insurance premiums in Alaska. There are at least two reasons for being skeptical on this point: first, studies have shown that insurance premiums tend to be governed by factors such as the insurance companies' return on their investments and other money management practices. This explains why, for example, automobile insurance rates (which are unrelated to the perceived increase in product liability or malpractice litigation) have increased at approximately the same rate as malpractice insurance rates during the last fifteen or twenty years despite the perceived "explosion" in products liability and professional malpractice liability. States that have adopted statutes of repose or other tort reform measures have not seen corresponding drops in malpractice insurance rates. See VanKirk, *The Evolution of Useful Life Statutes in the Products Liability Reform Effort*, Duke L.J. 1689, 1712 - 13 (1989).

Second, it is questionable what effect an Alaskan statute of repose would have on Alaskan insurance premiums that are set on a national basis. Alaska is a minuscule part of the national insurance market. Only one-fifth of one percent of all United States citizens lives in Alaska. The changes to the tort system that a statute of repose would bring about would eliminate some tort claims, but certainly not all of them. Mathematically, therefore, any impact on the national insurance market could be a fraction of an already infinitesimal percentage.

Unless those parties seeking to uphold the validity of proposed AS 09.10.052 are able to introduce concrete evidence that it would actually lower Alaskan insurance rates to a degree that actually results in more doctors or architects practicing in Alaska, the court will not be likely to uphold the law. Cutting off the citizens' existing remedy for injuries caused by products or structures over six years old is a radical way to try to increase the number of professional practitioners in the state. The literature on the subject suggests that this particular means will not serve the end sought by the legislation. If the literature is correct, we predict that the court will not uphold the statute of repose because it does not accomplish what it sets out to accomplish.

The next relevant finding is found in Section 1(a)(3) of the bill. This section essentially contains three findings: that society as a whole cannot afford the price of lawsuits years after construction, manufacture, and delivery of services; that the widespread use of "claims made" insurance policies makes it impossible to adequately and economically insure against actions for an unlimited period of time; and that it is extremely difficult to defend against a claim that has become stale after information and witnesses have disappeared. Again, each of these findings must be evaluated to see first, whether they are true; and second, whether proposed AS 09.10.052 would, as a practical matter, solve the problems.

Societal Considerations.

On the finding that "society as a whole cannot afford the price of lawsuits years after construction, manufacture and delivery of services," the court would be compelled to weigh the costs to society of the current tort system against the costs to society if the statute of repose were implemented. A number of considerations are present. First, the court would necessarily inquire as to whether the statute would actually reduce the "price of lawsuits" which is, to the professionals and manufacturers involved, the "price of insurance." As discussed above, it is questionable whether proposed AS 09.10.052 would reduce the price of insurance.

Second, there are a number of costs that society must bear if the statute of repose is implemented. These costs must be balanced against the benefit to society if the court were to find that the statute actually reduces the price of lawsuits. The first cost to society is that, instead of the wrongdoer paying for injuries inflicted by the wrongdoer's negligence, many injured people, if denied the opportunity to obtain compensation for injuries they suffer through no fault of their own, could wind up

on Medicaid and welfare for the rest of their lives. Instead of being supported by the wrongdoer, who can afford to spread the risk by purchasing insurance and passing those insurance costs along to customers as a price of doing business, the injured parties will, if they cannot work, be supported by Alaskan taxpayers. Since a significant number of the product manufacturers and insurers who would benefit from the statute of repose are located outside of Alaska, it is difficult see how the Alaska Supreme Court would perceive this shift of risk to the Alaskan taxpayers to be a benefit to Alaskan society.

It is unclear whether proposed AS 09.10.052 is intended to apply to actions brought by the state or its political subdivisions. Actions brought in the name of the state or a municipality have a special six-year statute of limitations. See AS 09.10.120. In Alascom, Inc. v. North Slope Borough, 659 P.2d 1175 (Alaska 1983), the Alaska Supreme Court held that this six-year statute applies to actions brought by a state or political subdivision rather than shorter periods provided by another statute. Under this reasoning, proposed AS 09.10.052 may not limit actions by the state or political subdivisions in which a longer statute of limitations arguably applies; however, if a court concluded otherwise, the result could have serious consequences for state and local governments.

The State of Alaska itself is the owner of literally billions of dollars worth of public buildings and facilities. If proposed AS 09.10.052 applies equally to public entities as owners, it would cut off the state's, municipalities', and school districts' ability to recover their losses in the case of negligently designed buildings and facilities with latent defects. For example, the Anchorage School District was recently able to recover millions of dollars in connection with asbestos removal. Under the proposed statute of repose, the school district's ability to collect on its losses would have been cut off six years after building completion, and the taxpayers would have picked up the tab.

In another instance, a rural school roof recently collapsed under a snow load due to what was determined to be a latent design defect. Again, if the costs cannot be recovered from the negligent designer, who is required to have insurance under the design contract, the taxpayers may wind up carrying the load.

This scenario can actually put a double burden on a public agency constructing a building. Public construction contracts uniformly require the contractor to carry insurance, including E&O coverage. That means that the public agency pays for the risk of loss due to design defect when the agency pays for the

construction of the facility. Since the school roof designer (in the above example) included the cost of insurance in its contract bid, the designer did not carry the risk of loss under the present risk-sharing arrangement -- the school district did, because it indirectly paid for the designer's insurance. But if a statute of repose shifts the risk to the taxpayers after the sixth year, the public, in effect, may wind up bearing the risk twice. For these and the other reasons mentioned, it is unlikely that the court would find that the statute serves the legislative purpose of providing a benefit to Alaskan society.

Furthermore, it is unclear whether this proposed statute of repose is intended to apply to statutorily created causes of action[3]; if so, it would have detrimental effects. Specifically, application of proposed AS 09.10.052 to hazardous waste cases would be particularly devastating since the results of such environmental pollution are often not known or felt until decades after the disposal of the waste. For example, in the famous Love Canal case, waste disposed up until the 1930s percolated out of its burial site in the 1970s, resulting in contamination of drinking water and residential homes. In Alaska, abandoned wastes from oil field operations in the Kenai Peninsula during the 1960s have caused contamination of private residences and drinking water wells that was not discovered until the 1980s. Under such a statute of repose, injured property owners would be unable to recover for decreased property values or cleanup costs if the initial disposal of the waste occurred more than six years before the discovery of the waste.

Application of proposed AS 09.10.052 to Alaska's hazardous substance strict liability statute (AS 46.03.822) would impose tremendous costs on property owners as well as the state. Current property owners would be barred from recovering state-mandated cleanup costs from prior owners and operators who may have disposed of hazardous substances on the property over six years before the substances are discovered. Such a rule would also result in the state bearing a greater share of cleanup costs when the strict six-year rule prevents recovery of such costs from the culpable prior polluters. At a minimum, proposed AS 09.10.052 and AS 09.10.070 (in section 5 of the bill) should be clarified to ensure that the statute of repose would not apply to these statutory causes of action.

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[3] See above discussion concerning the Alascom case. It is also unclear whether the proviso being added to AS 09.10.070 in section 5 of the bill, "Except as otherwise provided by law," is intended to make statutory actions for personal injury, death, or property damage subject to the statute of repose in AS 09.10.052.

Public Policy.

Besides imposing the risk of loss on the person who profits from the sale of a product and who is in the best position to spread the risk around, it should be acknowledged that strict products liability encourages the safe design of products. One need look no further than the case of the Ford Pinto with the exploding gasoline tank to see that some companies are willing to sell defective products if it is in their economic interest to do so. Abolition of strict products liability after six years (or any other period of time) would not deter the mind-set that led to the design and sale of the Pinto. Product designers are sophisticated, and there is significant pressure on them to reduce costs in order to boost profits for the corporation. With a six year "home free" provision written into the law, some designers may succumb to the pressure to design products capable of causing great physical harm in a manner that makes them operate safely for only the minimum six year period, and then fail because inferior methods or materials were used in order to save money.

In the case of products like the Chevrolet pickup trucks with the "saddle bag" gasoline tanks, a major debate is currently underway concerning whether General Motors should issue a recall to correct the perceived safety defect. In determining the overall benefit to society that a statute of repose might bring about, the court would likely consider whether the statute would promote the safety and well being of Alaskan citizens. One probable effect of AS 09.10.052 would be to further discourage companies such as General Motors from recalling dangerously designed products, such as the pickup trucks with "saddle bag" gasoline tanks. This is because such companies would consider themselves "home free" after six years of the product being on the market. They would have no incentive, therefore, to recall the product in Alaska in order to make it safe because no matter how dangerous the trucks are, GM would have no exposure under Alaskan law for further liability after the trucks were more than six years old. The court must weigh these considerations in determining whether society as a whole would benefit from the statute of repose, as the legislative findings contend.

We doubt that the court would find Alaskan society as a whole would benefit from the elimination of this public safety feature of product liability law. Again, if Alaskans who suffer serious physical injury are not able to recover from the negligent product manufacturers who reside outside of Alaska, and if they cannot work because of their injuries, they could well wind up being supported by Alaskan taxpayers.

Availability of Insurance.

Section 1(a)(3) asserts that the widespread use of "claims made" insurance policies makes it impossible to adequately and economically insure against actions for an unlimited period of time. Again, the main question for the court is whether the statute of repose would make "long tail" insurance policies more available than they are. As discussed above, to the extent these decisions are made by the insurance industry on the national level and Alaska is an infinitesimal segment of the insurance market, it is highly unlikely that the proposed statute of repose would serve the stated purpose.[4]

Fairness of Defending Older Claims.

Section 1(a)(3) asserts that it is difficult to defend against a claim that has become stale after information and witnesses have disappeared. Several commentators have noted that this is really not the case. Manufacturers and designers document their work. Practice shows that they retain those documents. There is no evidence that products liability cases based on older products have a higher rate of favorable verdicts for plaintiffs or unfavorable verdicts for defendants. See VanKirk, *The Evolution of Useful Life Statutes in the Products Liability Reform Effort*, Duke L.J. 1689, 1712 - 13 (1989).

The Remaining Findings and Purposes.

The remaining findings of fact and stated purposes of the bill that are relevant to the statute of repose are essentially subsumed in the above discussion. Section 1(a)(4) declares that, on the whole, society is better served with a statute of repose

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[4] It is interesting that this tort reform bill, which would provide direct financial benefits to the insurance industry, should be based upon this particular finding. Twenty states, including the State of Alaska, have sued a number of major insurers and re-insurers for conspiring to make "long tail" coverage unavailable in the mid-1980s. The case is pending in the U.S. District Court in the Northern District of California. See In re Insurance Anti-trust Litigation, C-88-1688 (MDL-767). The states recently won a significant victory in the United States Supreme Court, and the case is back in the District Court for trial. It is ironic that the insurance industry would financially benefit from legislation adopted on the ground that "long tail" coverage is not available, when significant evidence exists that many insurance and re-insurance companies illegally conspired to eliminate it.

even though in a few limited instances injuries may go without compensation. Section 1(b)(1) states that the purpose is to enact further reforms that create a more equitable distribution of the cost and risk of injury. Finally, Section 1(b)(2) states that a purpose of the Act is to reduce costs associated with the civil justice system while ensuring that adequate and appropriate compensation for persons injured through the fault of others is available. For the reasons set forth in the discussion of Sections 1(a)(2), (3), and (4) above, it is doubtful that the court would find that proposed AS 09.10.052 would, as a practical matter, further these objectives. Again, we do not suggest that the court would not find these objectives to be laudable and legitimate legislative purposes, but we do not believe that the court would find that the means -- the proposed statute of repose -- materially advances the cause.

The Nature of the Rights Abridged and Discriminatory Effects.

As the last step in Alaskan equal protection analysis, the court balances the state's interest in the particular enactment against the nature of the rights abridged. This has been described as a "sliding scale" under which the state bears a correspondingly heavier burden to prove that its legislation serves the state's interests as the nature of the interest becomes more important. Wise, *Northern Lights -- Equal Protection Analysis in Alaska*, 3 Alaska Law Review 1 (1986).

In Turner Construction, the court noted that "the interest in redressing wrongs through the judicial process is a significant one." 752 P.2d at 471. And in Hanebuth v. Bell Helicopter International, 694 P.2d 143, 147 (Alaska 1984), the court said, "It is profoundly unfair to deprive a litigant of his right to bring a lawsuit before he has any reasonable opportunity to do so." Since the court has identified the interests of injured plaintiffs to be "significant rights," and the court has said that it is "profoundly unfair" to deprive a litigant of the right to bring suit, we presume that the court will place a fairly heavy burden on the state to justify the statute of repose.

This is especially true in view of the fact that the statute would, in practice, create distinctions between groups of people without any apparent rational basis for doing so. The distinctions between groups can happen in subtle ways, but if the bill has a discriminatory effect, the court will scrutinize it closely.

The proposed statute of repose might perversely deny compensation to certain people for their good behavior, while allowing others who are less responsible for their own well being

to sue and recover damages. For example, evidence has been developed that cigarette smoking exacerbates and speeds up the disease process caused by asbestos. Suppose two workers were exposed to the same asbestos-related project at the same time; one smoked cigarettes and the other did not. Assume the cigarette smoker came down with cancer in time to file suit against the asbestos manufacturer under the statute of repose. Because the non-smoker had healthier lungs, and was therefore more resistant to the effects of the asbestos, the non-smoker did not come down with cancer for several more years, at which time he found that the statute of repose barred his lawsuit. We doubt that the court would see this outcome as either fair or rational. The same analysis might apply to other dangerous products such as the cancer-causing drug DES; sterility-causing intra-uterine devices; PCBs; dioxins; and silicon gel breast implants. Alaskans with strong immune systems might be denied compensation under the statute of repose while those with weaker immune systems might succumb to the disease process in time to sue.

The statute might also, in practice, draw impermissible distinctions between Alaskans based on wealth. Wealthy people probably own a higher percentage of new cars and other products, while less wealthy people tend to own older-model used cars and other used products. In the case of the Ford Pinto, or the Chevrolet pickup truck with "saddle bag" gas tanks, the defect that injures people is the same on the day that the vehicle leaves the factory as it is seven or eight years later. Of all the people seriously burned or killed in Ford Pintos or Chevrolet pickup trucks, those injured within the first few years of the product's life, before the statute of repose deadline, are likely to be the relatively more wealthy. Those likely to be injured after the product has been in use for several years, and after the deadline has passed are likely to be relatively less wealthy. The statute of repose would allow a relatively greater proportion of claims to be made by those of relatively greater wealth while cutting off the rights of those of lesser wealth, even though the risk of injury from the defective gasoline tanks is exactly the same regardless of the age of the vehicle. While "poverty" has not generally been held to be a "suspect classification" which would trigger the "strict scrutiny test," the courts are not inclined to allow distinctions based on financial ability to go unnoticed when assessing the constitutionality of a statute under the equal protection clause. See Tribe, *American Constitutional Law (2nd)*, § 16-36 through § 16-37, citing Edwards v. California, 314 U.S. 160 (1941). Because this bill draws a potential distinction between classes of people based on wealth, we believe the court would place an increased burden on the state to prove that the overall benefits outweigh the burdens.

Arbitrariness.

Aside from the potential equal protection problem raised by the financial condition of the plaintiff, proposed AS 09.10.052 might be found to be excessively arbitrary in the way that it establishes the six-year statute of repose. An arbitrary classification can violate both the due process and the equal protection clauses of the constitution. In Lankford v. Sullivan, Long & Hagerty, 416 S.2d 996 (Alabama 1982), a ten-year statute of repose was struck down as arbitrary and therefore unconstitutional.

The proposed statute of repose in this bill would certainly have arbitrary consequences in some cases. Take, for example, the case of two different individuals who purchase 1987 Chevrolet pickup trucks. Both trucks are manufactured on the same day in June 1987. One is bought and first used in June 1987 by Buyer #1, and the other is bought and first used by Buyer #2 in August 1987. Both trucks are essentially identical, and both have the same defectively designed gasoline tanks. Both trucks are involved in broadside collisions on July 4, 1993. Both Buyers #1 and 2 are burned to death when their trucks leak gasoline and catch fire. Under proposed AS 09.10.052, the estate of Buyer #2 can recover against General Motors, but Buyer #1's estate cannot, even though the cause of their deaths is exactly the same. Since the clock begins to run under proposed AS 09.10.052 on the date of purchase, Buyer #1's family is left with nothing, even though the death may have been the fault of the manufacturer. We doubt that the Alaska Supreme Court would view this as a rational outcome, but that is the effect this statute of repose could have.

Rationality.

For the above reasons, we doubt that the Alaska Supreme Court would be any more inclined to approve proposed AS 09.10.052 than it was to uphold the statute of repose in Turner Construction. In Hanebuth v. Bell Helicopter International, the Alaska Supreme Court quoted with approval language from Eisenmann v. Cantor Brothers, Inc., 567 F. Supp. 1347, 1352 (N.D. Ill. 1983), in which that court said it would be "absurd" to foreclose a cause of action even before it arose. As the courts have noted, "we would have the anomaly of an action being barred before the cause of action even arose! Mr. Bumble ('the law is a ass, a idiot') would have prevailed once again." Hanebuth, 694 P.2d at 147.

Other courts, including the New Hampshire Supreme Court, have referred to *Alice in Wonderland* when describing laws like this:

> [E]xcept in Topsy Turvy Land, you can't die before you are conceived, or be divorced before ever you marry, or harvest a crop never planted, or burn down a house never built, or miss a train running on a non-existent railroad. For substantially the same reasons, it has always heretofore been accepted, as a sort of logical 'axiom,' that a statute of limitations does not begin to run against a cause of action before that cause of action exists, *i.e.* before a judicial remedy is available to a plaintiff.

Heath v. Sears, Roebuck and Company, 464 A.2d 288, 295 (New Hampshire 1983).

Fiscal Note.

The fiscal impact of proposed AS 09.10.052 might be substantial in some unanticipated ways. As noted above, Alaska has spent vast amounts of public money, in the billions of dollars, on public works including highways, airports, buildings, and other facilities. Alaska municipalities and school districts likewise have enormous amounts at stake.

The statute of repose could jeopardize the public's right to recoup money when a structure or facility fails, or a person is otherwise injured, because of a latent defect after six years. But people who are injured by these latent defects (whether in buildings, on the public highways, or at other facilities) will nevertheless continue to sue public entities, because they own the property. The public entity will not, however, have any right of indemnity against the negligent builder or designer in such cases where six years have elapsed, unless an exception to the statute of repose applies.[5]

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[5] Proposed AS 09.10.052(b) creates exceptions to the general six year time bar; the statute of repose would not apply if the personal injury, death, or property damage were the result of, among other things, breach of an express warranty or guarantee. Proposed AS 09.10.052(b)(1). Sophisticated property owners may be able to avoid the harsh effects of the statute of repose in the future to some extent in their contract negotiations with builders and designers. However, if the statute of repose went into effect July 1, 1994, as provided in Section 39 of the bill, and applied to buildings already completed or under construction, the ability of owners to protect themselves by contracting for an express warranty or guarantee may be nil.

The statute of repose will also fiscally impact the state to the extent that state taxpayers will become the sole support for some percentage of Alaskans who are too seriously injured to earn a living or care for themselves, but who are not allowed to recover from the party that injured them.

Consumer Protection and Warranties.

Proposed AS 09.10.052 would also adversely impact the rights of Alaskan consumers with respect to losses caused by consumer products. This section might also serve to limit the rights of Alaskan consumers and businesses under warranties, although to the extent that it limits consumer warranties, it is probably superseded by (and therefore invalid under) the Magnuson-Moss Act, 15 U.S.C. §§ 2301-2312, and art. 1, § 15 of the Alaska Constitution which forbids legislation impairing the obligation of contracts. In any event, the statute of repose can have negative consequences for Alaskan consumers and businesses who suffer physical or financial injury resulting from poorly designed products or buildings more than six years after the products were first used or the buildings were substantially completed.

Conclusion.

For the above reasons, we do not believe that the statute of repose proposed in Section 3 of this bill would be enforceable in Alaska.

SECTION 4: LIMITATION ON ACTIONS AGAINST HEALTH CARE PROVIDERS

Section 4 would create a new AS 09.10.065 regarding the statute of limitations for malpractice actions against health care providers. The statute would require all such lawsuits involving children who are injured when they are less than six years old to be filed before the child's eighth birthday. This would eliminate the tolling of the statute of limitations during the child's minority that currently is authorized by AS 09.10.040(a). The time limit of proposed AS 09.10.065(a) would not apply where fraud causes the failure to timely bring an action on behalf of an injured minor, or facts that would give notice of a potential action have been intentionally concealed. Proposed AS 09.10.065(c). Additionally, this statute of limitations would not apply if proposed AS 09.10.075, discussed below, would provide

a longer period of time for filing suit. Proposed AS 09.10.065(b).[6]

The legislative statement of findings and purpose discussed above with respect to Section 3 also apply to Section 4 of the bill. As with the proposed statute of repose, we believe the court would not be inclined to uphold the new statute of limitations in proposed AS 09.10.065 without a showing that the provisions of that statute of limitations would in reality, and not just in theory, reduce the level of malpractice insurance premiums in Alaska or reduce the price of lawsuits. As was stated above, the court is likely to view the rights of individual Alaskans as substantial. A party attempting to use this statute as a defense would therefore bear a heavy burden to show that the provisions of proposed AS 09.10.065 that limit lawsuits against health care providers actually make serious in-roads against the cost of malpractice insurance.

The impact of a new statute of limitations on Alaska malpractice insurance premiums is questionable.[7] We believe that the court would also consider the actual ability of physicians or other health care providers to purchase insurance and to pass along the cost of insurance to those paying for the health care. All of these considerations would necessarily be included in any determination by the court of whether the statute of limitations proposed in AS 09.10.065 creates a more "equitable distribution of the cost and risk of injury" as claimed in Section 1(b)(1) of the bill.

While the constitutionality of the statute of limitations in proposed AS 09.10.065 may be a closer question than the statute of repose in proposed AS 09.10.052 (because there may be fewer irrational distinctions between potential claimants), we are

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[6] It is unclear how this statute and proposed AS 09.10.052, the statute of repose, would mesh. The statute of repose declares an outside limit of six years in which to bring tort actions, yet this statute of limitations would allow some injured children as much as eight years in which to file a medical malpractice action. The legislature should clarify how the two statutes are meant to relate.

[7] We note that a significant percentage of Alaskan health care providers procure insurance through a single source, which does business in only two states. It is possible, although we make no prediction, that these Alaskan physicians may experience a rate reduction or smaller rate increase if HB 292 becomes law.

nevertheless not confident that the new statute of limitations would survive constitutional scrutiny.[8]

SECTION 6: LIMITATION ON ACTIONS INVOLVING INJURY TO PERSON OR PROPERTY

Section 6 of the bill creates a new statute of limitations in proposed AS 09.10.075, expressly for tort actions. The statutory time limit for bringing an action for personal injury, wrongful death, or property damage would be two years from the accrual of the action. Proposed AS 09.10.075(a).[9] This standard incorporates the concept of the "discovery rule" that is judicially recognized in Alaska case law. Cameron v. State, 822 P.2d 1362, 1366 (Alaska 1991)(cause of action does not accrue until claimant discovers or reasonably should have discovered existence of elements of cause of action).[10]

This statute of limitations in proposed AS 09.10.075 abrogates the tolling provisions of AS 09.10.140(a) for minors, but leaves them in place for incompetent persons in personal injury, wrongful death, or property damage cases. Constitutional problems arise when the legislature limits the ability of a person who is not legally able to enter into contracts to use the courts for the protection of rights.

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[8] We also note that the statute of limitations in Section 4 of this bill appears to present some potential conflicts with the Health Care Reform measure proposed by Governor Hickel. The Governor's bills, SB 270 and HB 414, mandate pre-complaint arbitration procedures; if that legislation were enacted, the interplay between mandatory arbitration and the statute of limitations should be clarified.

[9] The current general tort statute of limitations is two years. AS 09.10.070. However, there is a six-year statute of limitations for certain actions involving destruction and taking of property. See AS 09.10.050. Because proposed AS 09.10.075 would cover "property damage" suits, the legislature should clarify how this proposed statute and existing AS 09.10.050 are to be construed.

[10] As mentioned in the discussion of section 3 above, the proposed statute of repose would set an outer limit of six years from the last act alleged to have caused the personal injury, death, or property damage for the discovery of a claim and filing of an action. This would set a six-year ceiling that does not exist under the discovery rule today.

In Bush v. Reid, 516 P.2d 1215 (Alaska 1973), the Alaska Supreme Court struck down a statute that prevented a parolee from suing during the time he was on parole. In that decision, the court noted that only the tolling provisions of AS 09.10.140 prevented former AS 11.05.070 (which disabled prisoners from maintaining suit until discharged from the criminal sentence) from amounting to "the baldest of takings" in violation of the Due Process Clause.

We believe that the rationale of Bush might well be found applicable to minors. This section eliminates the tolling provision in the case of minors who, because of their age, are not legally entitled to enter contracts or bring suit on their own. Elimination of the safeguard to their rights could well be found a taking under the Due Process Clause, or have an impermissible, unequal impact on groups of people in violation of the Equal Protection Clause. We therefore doubt that Section 6 will survive constitutional scrutiny.

SECTION 7: NONECONOMIC DAMAGES CAP

Section 7 proposes to make several changes to AS 09.17.010. That statute currently lists the type of noneconomic damages that may be recovered in personal injury actions, and establishes a noneconomic damages cap of $500,000 for each claim based on a separate incident or injury. The cap does not apply to damages for disfigurement or severe physical impairment, terms that are not defined in the present law.

The bill would expressly make AS 09.17.010 applicable to wrongful death actions, in addition to personal injury claims. Although the Alaska Supreme Court has not had occasion to determine whether wrongful death actions are already implicitly covered by AS 09.17.010, it has reached that conclusion as to a companion section of the tort reform law, AS 09.17.040. See Beck v. Department of Transportation & Public Facilities, 837 P.2d 105, 117 (Alaska 1992).

Additionally, the bill identifies loss of consortium as a recognized type of noneconomic damages claim. The existing damages cap of $500,000 would be the ceiling for all claims arising out of a single injury or death. The current version of the bill eliminates the exception to the cap for disfigurement or severe physical impairment.[11] AS 09.17.010(c). Instead, the only

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[11] We note that the House Labor & Commerce Committee wrote a letter of intent, indicating its desire that the House Judiciary

(continued...)

circumstances in which more than $500,000 in noneconomic losses could be awarded would be where the defendant had committed or attempted to commit a class A or unclassified felony, the plaintiff was a victim of that offense, and the action is based on that offense. Notably, this new provision does not require that the defendant be convicted of the offense. For the sake of future statutory interpretation, the legislature should clarify what burden of proof applies to this exception.

SECTION 8: PUNITIVE DAMAGES STANDARD

AS 09.17.020 presently provides that the burden of proof for punitive damages is clear and convincing evidence. However, the statute does not specify the level or type of evidence necessary to support an award of punitive damages. Section 8 of the bill would require clear and convincing evidence of "malice or conscious acts showing deliberate disregard of another person by the person from whom the punitive damages are sought." Proposed AS 09.17.020.

This standard generally comports with existing Alaska jurisprudence. The Alaska Supreme Court has found that punitive damages are not favored in law and therefore are to be allowed "only with caution and within narrow limits." Alaska Placer Co. v. Lee, 553 P.2d 54, 61 (Alaska 1976). Consequently, the court has limited punitive damages

> to cases where the wrongdoer's conduct could fairly be categorized as "outrageous, such as acts done with malice or bad motives or reckless indifference to the interests of another." Malice may be inferred if the acts exhibit "a callous disregard for the rights of others." However, "where there is no evidence that gives rise to an inference of actual malice or conduct sufficiently outrageous to be deemed equivalent to actual malice," the trial court need not, and indeed should not, submit the issue of punitive damages to the jury.

State Farm Mutual Automobile Insurance Co. v. Weiford, 831 P.2d 1264, 1266 (Alaska 1992) (citations omitted).

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[11] (...continued)
Committee consider adopting "an amendment that: 1) defines the phrase 'disfigurement or severe physical impairment'; and 2) restores the exclusion or establishes a more 'realistic cap' on these types of injuries, per the commitment of the Chair of the Judiciary Committee." House Journal, p. 2280 (Feb. 7, 1994).

It should be noted that the proposed statutory standard may be higher than the test quoted above, as it appears to eliminate "reckless indifference to the rights of others" as a basis for a punitive damages award. We see no legal difficulties with this section.[12]

SECTION 9: PUNITIVE DAMAGES CAP

Section 9 adds two new subsections to AS 09.17.020 regarding punitive damages. The first would place a cap on punitive damage awards of either $200,000 or three times the amount of compensatory damages awarded. Proposed AS 09.17.020(b). The Alaska Supreme Court has declined on several occasions to judicially adopt a fixed ratio between punitive and compensatory damages, most recently in Cameron v. Beard, ___ P.2d ___, Op. No. 4032 (Alaska, December 3, 1993).

> This court has refused to prescribe a definite ratio between compensatory and punitive damages. Ben Lomond, Inc. v. Campbell, 691 P.2d 1042, 1048 (Alaska 1984). Though comparing punitive and actual damage awards is one way to determine if punitive damages are excessive, other factors, such as the magnitude and flagrancy of the offense, the importance of the policy violated, and the defendant's wealth, are equally important to the determination.

Clary Ins. Agency v. Doyle, 620 P.2d 194, 205 (Alaska 1980). The Alaska Supreme Court's refusal to apply a ratio test in reviewing punitive damage awards raises some doubt as to how the proposed cap would fare in a court challenge.

The second new subsection would make an exception to the proposed punitive damages cap in cases where the defendant committed or attempted to commit a class A or unclassified felony, the plaintiff is a victim of that offense, and the action is based on that offense. Proposed AS 09.17.020(c). This is similar to the proposed exception to the ceiling on noneconomic damages in AS 09.17.010(c). As in proposed AS 09.17.010(c), this subsection does not specify the applicable burden of proof; the legislature should clarify its intent in this regard.

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[12] Because Section 9, discussed below, creates new subsections (b) and (c) to AS 09.17.010, the text of Section 8 should be designated as (a).

SECTION 10: CRIMINAL CONDUCT BARS RECOVERY OF DAMAGES

AS 09.17.030 was enacted in 1986 in response to public outcry. Individuals engaged in felonious[13] conduct could file lawsuits and seek monetary awards as a result of situations that resulted in personal injury or death brought about or affected by their own criminal wrongdoing. The present statute precludes recovery by a person who suffers personal injury or death if three elements are present: (1) the injury or death occurred while the person was engaged in the commission of a felony, (2) the person has been convicted of the felony (either through a guilty plea or a plea of nolo contendere), and (3) the felony substantially contributed to the injury or death. The current law specifically states that this section does not affect a right of action under 42 U.S.C. § 1983.[14]

Section 10 of the bill amends the language of the first two elements of AS 09.17.030. Rather than being limited to situations where the claimant was actually "engaged in the commission of a felony," the statute would be expanded to apply where the claimant was attempting to commit a felony or fleeing from the commission of a felony. Proposed AS 09.17.030. The bill removes the second element that requires that the claimant be convicted of the felonious conduct.

The existing statute was recently examined by our Supreme Court in Sun v. State, 830 P.2d 772 (Alaska 1992). In Sun, a personal injury complaint was filed against the state and state troopers alleging that the troopers used excessive force by

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[13] A felony is defined as a criminal offense for which an individual may be sentenced to a term of imprisonment of more than one year. See AS 12.55.125 and 12.55.135.

[14] Although AS 09.17.030 does not bar claims brought under 42 U.S.C. § 1983, the Alaska Supreme Court in Lord v. Fogcutter Bar, 813 P. 2d 660 (Alaska 1991), dismissed a § 1983 claim brought by a convicted felon on public policy grounds. Lord, a patron in the Fogcutter Bar, alleged that the bar served him alcohol while he was intoxicated, in violation of AS 04.21.020. As a result of his excessive consumption of alcohol, he claims that he subsequently kidnapped, raped, and assaulted a woman with whom he left the bar. Lord based his complaint upon alleged violations of the dram shop statute and his federal civil rights. The court recognized that even though the dram shop statute does give rise to some claims by individuals who are injured while intoxicated, the statute does not provide a convicted felon, such as Lord, with a cause of action for any damage sustained during the commission of the felony.

shooting the plaintiff a number of times while attempting to apprehend him. The plaintiff claimed that AS 09.17.030 violated the due process clause of the Alaska constitution by, in effect, nullifying Alaska's statutes on the use of excessive or deadly force. The court found that because the law "did not change the substantive law of arrest, and because significant sanctions remain for violations of the substantive law of arrest," AS 09.17.030 did not deprive Sun of due process under the Alaska Constitution" Id. at 775. We do not believe that the proposed changes will have any constitutional ramifications.

SECTION 11: DAMAGE AWARDS FOR LOST EARNINGS TO BE REDUCED FOR TAXES

"The general principle underlying the assessment of damages in tort cases is that an injured person is entitled to be replaced as nearly as possible in the position he would have occupied had it not been for the defendant's tort." Beaulieu v. Elliott, 434 P.2d 665, 670-71 (Alaska 1967). AS 09.17.040(a) presently provides the guidelines that a court or jury must follow when damages are awarded for personal injury.

Damages may be awarded to a plaintiff for past and future economic[15] loss as well as for past and future noneconomic[16] loss. AS 09.17.040(a). Punitive damages may also be awarded if the court or jury finds that the conduct that caused the plaintiff's injury was malicious and outrageous. Id. See Section 8 discussion, supra.

The first change proposed by Section 11 broadens the types of cases in which itemization of damages must occur to include cases where there has been a death, in addition to personal injury cases.

Section 11 also proposes to add a new second subsection to AS 09.17.040(a) that requires all awards for past or future gross earnings to be reduced by the amount of federal or state

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[15] Awards for economic damages compensate plaintiffs for past, as well as future, losses and include, but are not limited to, wages that the party would have been able to earn, medical bills, and the impairment of earning capacity.

[16] Noneconomic damage awards are awarded for past and future losses and compensate plaintiffs for pain, suffering, inconvenience, physical impairment, disfigurement, loss of enjoyment of life, and other nonpecuniary damage. See AS 09.17.010(a).

taxes that would have been paid, under the tax rates in effect on the date of the injury or death.[17] Proposed AS 09.17.040(a)(2).

The Alaska Supreme Court has considered tax issues related to damage awards. The leading case in this area mandates that an award for past wage loss should include a deduction for income taxes that would have been paid. This is partly based upon the fact that the tax laws applicable to the income plaintiff would have earned in the past are ascertainable. Beaulieu v. Elliott, 434 P.2d at 673. In that respect, the proposed language of paragraph (a)(2) that applies to past wage compensation is merely a codification of existing Alaska law. But the balance of the proposed language in section (a)(2), that applies to awards for future gross earnings, deviates from established Alaska case law. Id.

The Alaska court has repeatedly held that future income taxes are not to be considered when awarding damages for impairment of future earning capacity. Ehredt v. Dehavilland Aircraft Co. of Canada, 705 P.2d 446, 453 (Alaska 1985); City of Kotzebue v. McLean, 702 P.2d 1309, 1317 (Alaska 1985); State v.Harris, 662 P.2d 946, 948 (Alaska 1983); Yukon Equipment Inc. v. Gordon, 660 P.2d 428, 434-35 (Alaska 1983). When considering and reconsidering this issue, the court has reiterated its holding in Beaulieu, stating that "Income tax rates, provisions relating to deductions and exemptions, and other aspects of income tax laws and regulations are so subject to change in the future that...a court cannot predict with sufficient certainty just what amounts of money a plaintiff would be obliged to pay in federal and state income taxes on income that he would have earned in the future had it not been for a defendant's tortious conduct." Yukon, 660 P.2d at 434.

The rationale given for deducting taxes from gross earnings is that the prevailing party's award will more accurately reflect actual after-tax losses and is not "inflated" by the amount that would have been paid out in taxes. Future gross earnings would have been taxed if received in the normal course of the plaintiff's work history if he had not been injured, whereas they are not subject to federal income tax when part of a personal

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[17] The IRS does not tax personal injury awards. 26 U.S.C. § 104(a) provides that ". . . gross income does not include the amount of any damages received (whether by suit or agreement and whether as lump sums or as periodic payments) on account of personal injuries or sickness." (Emphasis added.)

injury award.[18] On the other hand, reduction of an award for future gross earnings under proposed AS 09.17.040(a)(2) will give defendants a benefit not previously afforded by the courts.

SECTION 12: FUTURE DAMAGES PAID THROUGH PERIODIC PAYMENTS

Historically, when a plaintiff is compensated for future damages, the award is paid in a lump sum to be used as the need arises, even if the expense is one that will not present itself for a number of years. For example, if a victim is severely injured, the damages are often based upon medical and other expenses that will be incurred over a lifetime. A periodic payment scheme is sometimes fashioned to provide for the payment of these damages by some formula so that the funds will become available as they are needed, rather than at the time of the judgment.

Section 12 amends AS 09.17.040(d) in two ways. Presently, subsection (d) allows only the injured party to request the court to order that the amount of any award for future damages be paid by periodic payments, rather than by a lump sum payment. The proposed language first seeks to amend the statute so that any party to the case, including the party against whom a judgment has been rendered, may request a periodic payment schedule. Since the proposed language limits the periodic payment scheme to awards for future damages only, the injured party theoretically would receive the intended compensation in the same manner as it would have been obtained but for the injury or death in question.

Periodic payment provisions vary throughout the United States. The scheme may be mandatory, or discretionary, depending upon the statutory provision that applies. As in Alaska, periodic payment provisions apply only to future damage amounts. In some states, such a payment scheme is often not triggered unless the award reaches a threshold amount. (The amount ranges from $50,000 to $500,000. In most of the states that have a threshold amount, it is in the $100,000 to $250,000 range.)

It has been suggested that an injured party's ability to actually receive the full amount of the award is threatened by this change, as the defendant might refuse to pay the amount owed over

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[18] It should be noted, however, that when awarded, future economic damages are statutorily reduced to present value and the burden is on the plaintiff to invest the award in such a manner so that the award is augmented to beat inflation and compensate for lost future wage increases. AS 09.17.040(b).

the years or might become insolvent.[19] This is a real concern. Although proposed AS 09.17.040(e) attempts to give plaintiffs some protection by compelling the court to require that some form of security be posted in order to ensure that the funds are available as periodic payments become due, this security is not foolproof and successful litigants may be forced to continuously litigate so that they may receive their due if the defendant, or his insurer, becomes uncooperative or insolvent.

Another change proposed by this section addresses attorney's fees in personal injury suits. Personal injury plaintiffs often enter into a contract to compensate their legal counsel on a contingency basis. By so doing, the plaintiff agrees to bear the costs of the litigation and pay the attorney a percentage of the total award received. The contract may provide for immediate payment at the end of a case or for payment over a period of time. The second proposed change to AS 09.17.040(d) adds language that seeks to reduce to present value the portion of the judgment awarded that a plaintiff has contractually agreed to pay his attorney, and have it paid in a lump sum (rather than by periodic payments).

The proposed statutory change will affect parties' unfettered ability to contract as they wish. Central to the evaluation of this provision is that damages are awarded to a plaintiff for his injuries. He may do with those funds what he wishes. If the damage award is reduced for the portion that is to be paid to the attorney, that may impact the contractual agreement between the litigant and his attorney. See, e.g., State v. Doyle, 735 P.2d 733, 742 (Alaska 1987).[20]

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[19] Insolvency that results in bankruptcy may in fact bar a successful litigant's ability to collect the balance of a damage award.

[20] The Alaska Supreme Court possesses exclusive authority to make rules governing practice and procedure in civil and criminal cases. The legislature may only change court made rules by two-thirds vote. Alaska Constitution, Article IV, § 15. The Alaska Supreme Court in Citizens Coalition v. McAlpine, 810 P.2d 162, 166-171 (Alaska 1991), held that an attempt to propose an initiative that would impose a contingent fee ceiling in personal injury cases intrudes upon the court's power to enact rules and was prohibited by § 7 of art. XI of the Alaska Constitution that limits the people's power to enact legislation directly.

SECTION 13: SECURITY FOR PERIODIC PAYMENTS

Subsection (e) of existing AS 09.17.040 grants the court authority to require, if it wishes, that some form of security be posted in order to ensure that the funds are available as periodic payments become due. The proposed change in section 13 changes the nature of this authority from discretionary to mandatory. As a result, a court would now be compelled to order that security be posted to ensure the availability of funds to make payments as they become due.

The proposed language does not affect the already existing prohibition that does not allow a court to require security "if an authorized insurer, as defined in AS 21.90.900, acknowledges to the court its obligation to discharge the judgment." AS 09.17.040(e). We note that the State of Alaska would not be subject to that exception as an "authorized insurer" under AS 21.90.900. Although the state or a municipality may be able to avoid posting security under AS 09.65.040,[21] proposed AS 09.17.040(e) should be clarified on this point.

Security is not defined in Title 9 and is often not foolproof.[22] Defendants and insurers sometimes become insolvent. As a result, there may be more litigation by successful plaintiffs to recover the full amount of their awards.

SECTION 14: INFLATION ON PERIODIC PAYMENTS

AS 09.17.040(f) presently provides that a judgment ordering the payment of future damages by periodic payment shall specify the recipient and the manner in which the payments shall be made over time. The amendments proposed by Section 14 of the bill first clarify that this provision is to apply to cases involving personal injury or death. The second change in the statute seeks to have the judgment clearly provide what, if any, increase shall be made to payments for inflation.

If the periodic payment scheme is to be fair to plaintiffs, future payments should be adjusted for inflation

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[21] AS 09.65.040(a) states that "[i]n an action or proceeding in a court in which the state or a municipality is a party or in which the state or a municipality is interested, no bond or undertaking is required of the state, a municipality, or an officer of the state or municipality."

[22] "Security" is broadly defined in AS 13.06.050, AS 45.08.102, and AS 45.55.130.

because the trier of fact is required to reduce a future damage award to present value. See AS 09.17.040(b). As a practical matter, however, this can present a difficult and time-consuming task for courts because they will be called upon to determine the inflation rate in effect over the lifetime of the payment scheme.

SECTION 15: COLLATERAL BENEFITS

Section 15 repeals and reenacts AS 09.17.070, changing the way in which collateral benefits may be used as evidence and may reduce a claimant's recovery from a third party. Proposed AS 09.17.070(a) states the initial premise that a claimant may not recover damages for amounts received from collateral sources, except where the collateral source is a federally funded program that by law must seek subrogation or has a right of subrogation by law or contract and except for life insurance death benefits. This change alters the common law rule that bars collateral benefits from being considered in a court action. The common law rule provides that a damages award against a tort defendant will not be reduced by reason of such collateral benefits (i.e., medical bills paid by a health insurer). Where the collateral source has no right to reimbursement from a plaintiff's recovery against a third party (subrogation), the plaintiff at common law may actually recover damages for an expense he has not personally paid. Under proposed AS 09.17.070(a), that plaintiff could not recover damages for benefits he received from a collateral source that has no legal right of subrogation.

Subsections (b) and (c) address how and when evidence of collateral benefits may be used in a lawsuit. These paragraphs are somewhat confusing. First, proposed AS 09.17.070(b) states that various types of disability, workers' compensation, and health benefits paid to a claimant may be introduced into evidence by a defendant. That proposition is qualified by the next sentence: "However, evidence of a collateral source that has a right of subrogation under law or contract may not be introduced under this subsection." Proposed AS 09.17.070(b). We assume that this sentence partially negates the first one, so that the fact finder is not told of collateral benefits from sources that have a legal right of subrogation, even if they are of the type indicated initially as admissible. If that is the intent, it is unclear why the second sentence of subsection (b) does not also include "a federal program that by law must seek subrogation," as that phrase is repeated throughout this section.

Evidence of collateral benefits not introduced under subsection (b), excluding those from a federally funded program or other source with a legal right of subrogation and excluding life insurance death benefits, are only admissible to the court after

the fact finder has rendered an award. Proposed AS 09.17.070(c). Whether introduced as evidence to the fact finder or the court before or after an award is rendered, those collateral benefits that are admissible (i.e., where the source has no legal right of subrogation) will reduce the claimant's recovery, with a few adjustments. Proposed AS 09.17.070(b) and (c).

The last subsection of the new collateral benefits provision states that a "person who provides a collateral benefit admissible under (a) or (b) of this section" may not recover any amount from the claimant as reimbursement for those benefits. This is apparently a misplaced reference to proposed AS 09.17.070(b) and (c), as (a) does not address admissibility of evidence at all. This provision prevents a claimant whose recovery has been reduced by the amount of some collateral benefit (in which the source has no right of subrogation by law or contact) from having to repay that benefit out of the reduced award.

As written, we do not believe this section presents constitutional problems.

SECTIONS 16 and 17: <u>APPORTIONMENT OF FAULT</u>

Sections 16 and 17 amend AS 09.17.080(a), which pertain to the apportionment of fault among those responsible for personal injuries. The present law was passed by the voters as part of the 1987 tort reform initiative, with the express purpose of establishing purely several liability and eliminating joint and several liability. Rather than holding all tortfeasors jointly accountable for the injuries a victim suffered, the intention was to make each tortfeasor liable only for its own percentage of fault. The present law is an imperfect vehicle to that end.

AS 09.17.080(a) currently requires the fact finder in a court action to apportion fault among all "parties" to each claim, including third-party defendants and persons who have been released from the litigation. A dilemma arises when a plaintiff chooses not to sue all potentially liable persons or entities. Can or must the named defendants bring a third-party action against other tortfeasors in order to have their fault considered by the fact finder? Should the court allow the named defendants to argue that others who have never been named as parties to the litigation are fully or partially responsible for the plaintiff's injuries, for purposes of allocation of fault? Or should the plaintiff's choice of defendants limit those among whom the fact finder apportions fault, even though there may be other potentially liable persons who are not parties to the action and the named defendants may thereby be held liable for the fault of others?

These questions have been addressed by both the federal and state courts, but not by the Alaska Supreme Court. The courts are split on how to interpret AS 09.17.080(a)'s directive to apportion fault among "parties," while at the same time adhering to the law's objective of several liability. See Judge H. Russel Holland's opinion in Carriere v. Cominco Alaska, Inc., case no. A91-373 Civil, United States District Court for the District Court of Alaska, March 22, 1993, and Judge Larry Zervos' opinion in Owens v. Robbins, case no. 1SI-90-354 Civil, Superior Court for the First Judicial District at Sitka, September 27, 1991; cf. Judge Dana Fabe's opinion in Dunaway v. The Alaska Village, case no. 3AN-90-3526 Civil, Superior Court for the Third Judicial District at Anchorage, July 25, 1991, and Judge James Singleton's decision in Robinson v. U-Haul Co., 785 F. Supp. 1378, 1383 (D. Alaska 1992).

This bill would resolve the current problem by requiring the fact finder to allocate fault among all persons responsible for the damages to each claimant, regardless of whether they are or could have been named as parties to the action. Proposed AS 09.17.080(a)(2). In addition, section 17 provides that an assessment of a percentage of fault against a person who is not a party does not subject the person to liability in that action or another action and may not be used as evidence of liability in another action. Proposed AS 09.17.080(c).

These changes will better implement the goal of pure several liability, so that those who are named as parties are only held accountable for their own percentage of fault. However, it must be noted that the plaintiff will not be able to collect damages from persons who are not parties to the action merely by virtue of an allocation of fault to those persons. If the plaintiff decides to sue those persons in another action, the fact finder's allocation of fault in the first action is neither binding nor evidence in that separate action.

One other effect should be noted. The bill would allow the finder of fact to allocate fault to entities that the plaintiff cannot sue (e.g., employers in a work-related injury context)[23] or who are immune from liability (e.g., governmental units, Good Samaritans). The plaintiff would not be able to recover for the percentage of such non-parties' fault.

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[23] This would expressly overrule the holding of the Alaska Supreme Court in Lake v. Construction Mach., Inc. 787 P.2d 1027 (Alaska 1990).

SECTION 18: EFFECT OF RELEASE

Section 18 fills in another gap in the current tort reform law, by creating a new section regarding the effect of a settlement with one of two or more potentially liable persons. The bill provides that when a claimant settles with one tortfeasor, it does not discharge the liability of anyone else for an injury or wrongful death unless a release or covenant not to sue or not to enforce judgment explicitly provides otherwise. Proposed AS 09.17.091(1). The release or covenant does discharge the settling tortfeasor from all liability for contribution to any other person, which means that no one else can later claim that the settling person paid the claimant too little. Proposed AS 09.17.091(2).

The bill also provides that a release or covenant not to sue or enforce judgment to one person "reduces the claim" against others who are civilly liable for the same injury or wrongful death to the extent of any stipulated amount or the settlement amount, whichever is greater. Proposed AS 09.17.091(1). This provision is ambiguous and problematic, when read in conjunction with the amendments to AS 09.17.080(a) and (c) proposed in sections 16 and 17. Essentially, AS 09.17.091 provides that the settlement of one tortfeasor reduces the total damages that may be recovered from others, but proposed AS 09.17.080 directs the finder of fact to determine that tortfeasor's percentage of fault. It is unclear how these two concepts are to be reconciled. Assume that one negligent party settles for $100,000 and is later found by a jury to be 50 percent at fault; the non-settling defendant is 50 percent at fault and the plaintiff's total damages were $300,000. Should the $300,000 be reduced by $100,000 before multiplying the percentages of fault? If so, the non-settling defendant gets the benefit of the settlement twice, by having the total damages reduced and having its fault decreased by the percentage allocated to the settling party; it pays only 50 percent of $200,000, instead of 50 percent of the total damages, by virtue of the settlement "reducing the claim" of the plaintiff. If that is not the intent, then clearer language should be used to explain how allocation of fault of settling parties is to mesh with giving credit to non-settling defendants for the settlements of others.

SECTION 21: LIMITATION ON AWARDS OF PREJUDGMENT INTEREST

Section 21 adds a new subsection (c) to AS 09.30.070, which addresses the rate of prejudgment interest and the date it begins to accrue. The new language provides that prejudgment interest "may not be awarded for future economic damages, future noneconomic damages, or for punitive damages." The rationale behind this change is that interest in future damages does not

"vest" in the injured party on the date of the injury but is compensation for the continuing nature of the injury.[24] Prejudgment interest is not generally allowed on punitive damage awards. See Andersen v. Edwards, 625 P.2d 282, 289 (Alaska 1981); Beech Aircraft Corp. v. Harvey, 558 P.2d 879,888 (Alaska 1976). This section does not present legal or constitutional problems.

SECTION 25: CAP ON WRONGFUL DEATH AWARDS

Section 25 creates two new subsections to AS 09.55.580, the statute that governs wrongful death actions. Proposed AS 09.55.580(g) would cap economic damage recoveries at $10,000 in wrongful death cases where the deceased did not have a surviving spouse, minor child, or dependents. In this subsection, the term "dependent" is limited to the following relationships: "father, mother, child, grandchild, or sibling who is dependent on the deceased at the time of death." Proposed AS 09.55.580(g). This definition distinguishes between relatives who are dependent on the deceased at the time of death, and those who may, or probably would have, become dependent on the deceased at some future time. It excludes consideration of others, family or not, who are dependent on the deceased, such as aunts, uncles, grandparents, unmarried companions and their children. Furthermore, this section would limit economic damages even where the deceased leaves heirs and beneficiaries, if they do not fit within the category of spouse, minor child, or dependent.

These classifications would limit economic damage recovery in a number of arguably meritorious situations. An example might be an adult child who is self supporting, but in the early stages of a debilitating disease at the time the parent died. While that parent would have been able to provide support for the child in the later stages of the disease after the disability became real, the tortfeasor who caused the parent's death could invoke the $10,000 cap on the ground that the child was not "dependent on the deceased at the time of death." In light of the possibility the court would find the distinctions made by this section irrational, the statute may not survive due process or equal protection scrutiny.

Additionally, this section would write into law the proposition that it is cheaper to kill someone than it is to merely injure them. In Hanebuth v. Bell Helicopter International, 694

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[24] The court has indicated in dicta that prejudgment interest may be appropriate on an award of compensation for lost earning capacity (which includes future income). Hertz v. Berzanske, 704 P.2d 767, 773 n.9 (Alaska 1985).

P.2d 143, 147 (Alaska 1984), our court adopted the view of former U.S. Supreme Court Justice Harlan who said: "where existing law imposes a primary duty, violations of which are compensable if they cause injury, nothing in ordinary notions of justice suggests that a violation should be non-actionable simply because it was serious enough to cause death. On the contrary, that rule has been criticized ever since its inception and described in terms such as 'barbarous.'"

Consider this example: a negligent driver on a remote highway crosses the centerline and collides with another vehicle. The negligent driver is essentially uninjured but the other driver is badly injured. There are no witnesses. The negligent driver recognizes the injured party and realizes that the person is a twenty-one year old unmarried woman without any dependents. The negligent driver believes that if he rushes this person to a hospital, or acts quickly to obtain medical aid, the victim will survive, but with permanent injuries. The negligent driver also believes that if he delays in obtaining treatment, the victim will probably die. Proposed AS 09.55.580(g) would tempt the negligent driver to let the victim die because it would save a potentially great sum of money.[25]

While this no doubt sounds like an extreme example, it is the kind of thing that does happen in real life. There are many situations where a tortfeasor will have it in his or her control to decide whether an injured person lives or dies, and there will be no evidence of the process by which that decision was reached. Even if there were clear and convincing evidence that the negligent party delayed getting help so that the victim died of her injuries, this section still caps economic damages at $10,000, which in many cases would be less money than the tortfeasor would have to pay if the victim survived with permanent injuries.

The addition of subsection (h) to AS 09.55.580, which permits higher awards in the case of a "class A" or "unclassified" felony would not change this analysis in many cases. In the

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[25] The criminal penalties do not vary greatly between criminally negligent homicide (the probable charge if the victim dies) and third degree assault (the probable charge if the victim survives with serious injuries). Either charge is a class "C" felony, with the same maximum term of imprisonment. Because it would be difficult, if not impossible, to prove a more serious degree of homicide under these facts (barring a confession to the deliberate delay in obtaining medical help), the criminal penalties would not offer much deterrence to the preference for death that this section writes into the law.

example given above, this exception to the cap would not apply if the death merely amounted to manslaughter or criminally negligent homicide. Many wrongful death situations arise from ordinary negligence -- not conduct that amounts to a felony, such as criminal negligence, recklessness, or intentional misconduct -- so the $10,000 cap will limit economic damages without exception. Moreover, where the exception does apply, it may be more a matter of form than substance, as a lawsuit against a "class A" felon may not result in any actual recovery for the victim because the tortfeasor is likely to be judgment proof, and serving a lengthy term in prison.[26]

Section 25 of the bill will provide a financial motive to let some injured people (particularly children) die when they might have been saved. The question for the Alaska Supreme Court under equal protection analysis will be whether the findings and purpose in Section 1 can possibly justify such a social policy. We question whether the court would uphold a law that creates a financial incentive to allow someone to die -- especially when the benefits of the legislation are apparently so slight. See Hanebuth, 694 P.2d at 147.

SECTION 26: ABOLISHING RULE 82 FEE AWARDS TO PREVAILING PARTIES IN TORT CASES

Rule 82 of the Alaska Rules of Civil Procedure presently provides a scheme that sets the amount a prevailing party may obtain for attorney's fees in a civil action, unless the parties agree otherwise. The amount of attorney's fees that may be awarded is affected by whether the case was uncontested or contested, and if contested, whether it was concluded with or without trial. The rule was recently changed by the Alaska Supreme Court, effective July 15, 1993, after much work and debate that included

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[26] Subsection (h), as written, will also lead to confusion in its application since it does not specify whether a criminal conviction for a felony is a necessary prerequisite to an award above the $10,000 limit. This is in contrast to the existing provision of AS 09.17.030 which limits the recovery of a person who is injured in the commission of a felony -- but only if the person is first convicted of that crime. Subsection (h) should be amended to provide for a burden of proof on the criminal conduct, and guidance should be given about how this exception is to be litigated in the context of a civil wrongful death action.

its evaluation by a committee of practitioners from around the state.[27]

Section 26 of the bill will act to repeal Rule 82 in the context of civil actions for personal injury, death, or property damage related to or arising out of fault. Proposed AS 09.60.010. The courts will be barred from awarding attorney's fees in such cases, unless authorized by statute or agreement between the parties. The Alaska Supreme Court generally does not take a formal position with respect to legislation. Nevertheless, we understand that the court has formally opposed the bill's abolition of Rule 82 in the tort context. It is noteworthy that many tort reform efforts in other states seek to create attorney fee provisions like Rule 82, rather than repeal them.

CONCLUSION

From our perspective, the sections of the bill not explicitly addressed in this letter do not present legal or constitutional difficulties. Thank you for the opportunity to present our comments. Please feel free to contact us if you have further questions.

Very truly yours,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: Jim Forbes
Jim Forbes
Assistant Attorney General

By: Susan D. Cox
Susan D. Cox
Assistant Attorney General

BMB:SDC:JF:pch

cc: Raga Elim, Legislative Liaison
Deborah Behr, AAG

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[27] A poll of all Alaska practitioners was conducted by the committee prior to the amendment to Rule 82. The majority of the practitioners who responded voted to either leave the prior rule alone or repeal the whole concept. The proposed amendment adopts the latter view.

get Physicians Statutes?

Maine Shields Physicians from Malpractice Charges

Physicians and state legislators worked side by side in Maine last session to pass the first measure in the nation that helps shield doctors from malpractice lawsuits if they follow a set of state-approved guidelines.

Far from grumbling about state control, 93 percent of the state's emergency physicians, 96 percent of the obstetricians, 90 percent of the anesthesiologists and more than 97 percent of eligible radiologists are now enrolled in the program.

The success of the "medical liability demonstration project" will be determined when malpractice lawsuits are filed. To date, no participating doctors have been sued.

Administered by the state board of registration and medicine and the board of osteopathic examination and registration, the Maine project sets explicit treatment guidelines for specific conditions, such as Caesarean delivery of babies or procedures for anesthesia.

Physicians agree to follow risk management procedures developed by state-appointed committees of doctors and insurance, hospital and consumer representatives. By enrolling in the project and practicing the state-approved protocols, doctors are protected in any malpractice or pretrial proceedings.

The medical project sets aside a portion of the savings from malpractice insurers to help rural doctors pay their malpractice premiums.

Although malpractice premiums run as high as $100,000 a year for some specialists, the larger culprit in rising costs is the exorbitant price of "defensive medicine" practiced by doctors in order to avoid lawsuits—estimated to be $27 billion annually nationwide.

Because Maine's protocols provide a shield for participating physicians, doctors can cut down on the extra tests and other superfluous procedures taken to avoid lawsuits.

As Maine makes strides in its efforts to cap health care costs, other states have devised programs to attain the same goal. Many states have passed laws to cap damage awards, limit attorneys' fees and shorten the time during which a plaintiff can file a medical lawsuit.

Arizona, Hawaii, Louisiana, Nevada, North Carolina, Texas and Washington offer state subsidies for obstetric liability premiums.

Virginia and Florida have medical malpractice "no-fault" programs that create compensation funds for participating obstetricians sued for severe brain and spinal cord injuries.

Florida has developed a law that directs the state health agency to develop and adopt practice parameters in cooperation with medical, chiropractic and other health organizations. The project, similar to Maine's, would allow participating doctors to use the parameters as a defense in liability actions.

In Minnesota, the state health commissioner has been charged with developing and approving outcome-based practice parameters for all medical procedures. Legislators in Vermont will vote in 1994 on practice guidelines that are part of two proposals to provide for universal access.

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subrogation within the time limit set forth in subsection 6, the court shall reduce that portion of the judgment that represents damages paid or payable by a collateral source.

3. **Federal benefits.** The court shall also reduce the judgment by the amount of Medicare, Medicaid or Social Security disability benefits paid or payable to the plaintiff for the plaintiff's expenses or losses, provided that the court enters an order requiring the defendant to indemnify and make whole the plaintiff for any subrogation claim made for those benefits and for the costs, including attorney's fees, for that indemnification claim, as the court finds are reasonably required to enforce this provision.

4. **Offsetting reduction.** The court may reduce the reduction in subsection 2 by an amount equal to:

A. The claimant's payments over the 2-year period immediately predating the personal injury to the collateral source in the form of payroll deductions, insurance premiums or other direct payments by the claimant, as determined by the court to be appropriate in each case; and

B. The portion of the total costs incurred by the plaintiff in the action, including discovery, witness fees, exhibit expenses and attorney's fees. This reduction is calculated as the amount that is the same percentage of the total costs incurred by the plaintiff in the action as the amount paid or payable by the collateral source is of the total verdict.

5. **Limit.** The reduction made under this section may not exceed the amount of the judgment for economic loss or that portion of the verdict that represents damages paid or payable by a collateral source.

6. **Notice of claim or verdict required.** No later than 10 days after a verdict for the plaintiff, the plaintiff's attorney shall send notice of the claim or verdict by registered mail to all persons known to the attorney who are entitled by contract or law to a lien against the proceeds of the plaintiff's recovery. If a lienholder does not notify the court of the lienholder's right to subrogation within 30 days after receipt of the notice, the lienholder loses the right of subrogation.

7. **Preexisting obligation required.** For purposes of this section, benefits from a collateral source are not considered payable unless the court makes a determination that there is a previously existing contractual or statutory obligation on the part of the collateral source to pay the benefits.

1989, c. 931, § 3.

SUBCHAPTER IX

MEDICAL LIABILITY DEMONSTRATION PROJECT

Historical and Statutory Notes

Codification

Laws 1989, c. 931, § 4, enacted Subchapter IX, Medical Liability Demonstration Project.

§ 2971. Medical liability demonstration project

The Bureau of Insurance and the Board of Registration in Medicine shall, by January 1, 1992, establish a medical liability demonstration project as provided in this subchapter.

1989, c. 931, § 4.

§ 2972. Medical specialty advisory committees established

1. **Medical specialty areas.** The Medical Specialty Advisory Committee on Anesthesiology, in accordance with Title 5, section 12004-I, subsection 58-A; the Medical Specialty Advisory Committee on Emergency Medicine, in accordance with Title 5, section 12004-I, subsection 58-B; the Medical Specialty Advisory Committee on Obstetrics and Gynecology, in accordance with Title 5, section 12004-I, subsection 58-C; and the Medical Specialty Advisory Committee on Radiology, in accordance with Title 5, section 12004-I, subsection 58-D are established and shall develop practice parameters and risk management protocols for their respective medical specialty areas.

2. **Membership.** The medical specialty advisory committees are made up as follows.

A. The Medical Specialty Advisory Committee on Anesthesiology consists of members with an interest in and knowledge of the specialty area. It consists of 6 members:

(1) One physician who practices in a tertiary hospital, appointed by the Board of Registration in Medicine;

(2) One physician who practices in a medium-sized hospital, appointed by the Board of Registration in Medicine;

(3) One physician who practices primarily in a rural area, appointed by the Board of Registration in Medicine;

(4) One board-certified anesthesiologist, appointed by the Governor in consultation with the Maine Chapter of the American Society of Anesthesiologists; and

(5) Two public members:

(a) One representing the interests of payors of medical costs, appointed by the President of the Senate; and

(b) One representing the interests of consumers, appointed by the Speaker of the House of Representatives.

B. The Medical Specialty Advisory Committee on Emergency Medicine consists of members with an interest in and knowledge of the specialty area. It consists of 9 members:

(1) One physician who practices in a tertiary hospital, appointed by the Board of Registration in Medicine from nominations submitted by the Maine Medical Association;

(2) One physician, appointed by the Board of Osteopathic Examination and Registration from nominations submitted by the Maine Osteopathic Association;

(3) One physician who practices primarily in a rural area, appointed by the Board of Registration in Medicine from nominations submitted by the Maine Medical Association;

(4) One family practice physician, appointed by the Board of Registration in Medicine from nominations submitted by the Maine College of Family Physicians;

(5) Two physicians, appointed by the Governor, at least one of whom is board certified in emergency medicine, appointed in consultation with the Maine Chapter of the American College of Emergency Medicine Physicians; and

(6) Three public members:

(a) One representing the interests of payors of medical costs, appointed by the President of the Senate;

(b) One representing the interests of consumers, appointed by the Speaker of the House of Representatives; and

(c) One representing allied health professionals, appointed by the Governor.

C. The Medical Specialty Advisory Committee on Obstetrics and Gynecology consists of members with an interest in and knowledge of the specialty area. It consists of 9 members:

(1) One physician who practices in a tertiary hospital, appointed by the Board of Registration in Medicine from nominations submitted by the Maine Medical Association;