lower of the punitive damages judgment plus twice the statutory rate of interest, ten percent of a defendant's net worth, or $100 million.[4]

As noted above, the jury in Engle eventually awarded the plaintiffs $145 billion in punitive damages. Under Florida's previous appeal bond rules, the defendants would have had to post an $181 billion bond to appeal this judgment, which would have bankrupted any company or group of companies. But because the legislature had passed the appeal bond cap, the tobacco companies were able to post a much lower bond and appeal the verdict. Their appeal was ultimately successful: on May 21, 2003, a Florida appeals court decertified the Engle class and set aside the jury's decision in the case. In an emphatic opinion, the court ruled that the class action approach for Engle was completely improper. But if the legislature had not acted to limit the appeal bond prior to the trial court's judgment in Engle, the previous bonding requirement would have bankrupted the entire industry, thrown thousands of people out of work, and deprived each state of its tobacco settlement revenues.

Florida did not act alone. Twenty-five other states have also enacted limits on the size of appeal bonds, two of them by court rule and the rest through legislation. Five other states (Connecticut, Maine, Massachusetts, New Hampshire and Vermont) automatically stay a judgment upon the filing of a notice of appeal. As a result, over half of the states currently limit the appeal bond requirement. The approaches taken by the states have differed somewhat, as summarized below.

In the year 2000, along with Florida, four other states enacted limits on the size of appeal bonds.[5] These states were Kentucky ($100 million limit) and Georgia, North Carolina and Virginia ($25 million limits). In each of these states, the limit applied only to the bond for the punitive damages portion of a judgment. Each of these states was concerned that if the Florida legislature did not act, the Florida plaintiffs might seek to seize tobacco company assets in these other states. Thus, these states limited the size of bonds for judgments entered by courts within their states, and further provided that if a plaintiff with an out-of-state judgment came to their state to collect on that judgment, the defendant could stop the plaintiff until the appeal was completed by posting the bond required in that state. These states were worried that the tobacco settlement proceeds might be threatened before an appeal could ever be completed, and they were also worried about the jobs that could be lost in their states if the tobacco companies were put out of business before they could appeal.

In 2001 Louisiana, Nevada, Oklahoma and West Virginia passed legislation that limited the size of the appeal bond that signatories of the Master Settlement Agreement would have to post to appeal a damages verdict of any kind, be it compensatory or punitive damages. [6] Again,

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[4] Fla. Stat. § 768.733 (2002).

[5] Florida (Fla. Stat. § 768.733), Georgia (Ga. Code Ann. § 5-6-46), Kentucky (Ky. Rev. Stat. Ann. § 205.1), North Carolina (N.C. Gen. Stat. § 1-289), and Virginia (Va. Code Ann. § 8.01-676.1 J.) each passed legislation in 2000.

[6] Louisiana (La. Rev. Stat. Ann. § 98.6), Nevada (Nev. Rev. Stat. § 20.035.1); Oklahoma (Okla. Stat. Ann. tit. 12 § 990.4 B.5); and West Virginia (W. Va. Code § 4-11A-4).

a primary motivating factor for these states was their financial interest in ensuring that settlement proceeds under the state tobacco settlement were not threatened because of an inability of the tobacco companies to appeal a judgment. The Oklahoma appeal bond cap was $25 million; the caps in Nevada and Louisiana were $50 million; and West Virginia's cap was $100 million for punitive damages and $100 million for compensatory damages.

As these states were doing their work, the Mississippi Supreme Court amended its court rules, which govern appeal bonds in that state, to limit the bond that a defendant of any kind would have to post to stay a punitive damages judgment while it appeals.[7] The amount of the limit in Mississippi was the lower of $100 million, 125 percent of the punitive damages award, or 10 percent of the defendant's net worth.

In 2002 three states enacted limits on the size of appeal bonds. Ohio adopted a $50 million limit,[8] while Indiana and Michigan[9] adopted a $25 million limit. These bond limitations were not tied in any way to tobacco companies or to the MSA. Rather, in each state, the limit that was adopted applies to damages of all kinds, including the costs a defendant might incur to pay for equitable relief, and it applies to any kind of defendant.

In 2003 Arkansas, California, Colorado, Idaho, Kansas, Missouri, New Jersey, Oregon, Pennsylvania, South Dakota, Tennessee, Texas and Wisconsin adopted appeal bond caps.[10] The Arkansas, Colorado, Tennessee, Texas and Wisconsin statutes apply to all litigants in civil litigation regardless of legal theory. The other states' laws are more limited in scope. Idaho's $1 million cap, for example, applies to all litigants in civil litigation but covers only the punitive damages portion of the appeal. The Kansas cap applies to appellants who are signatories or successors of signatories to the tobacco Master Settlement Agreement; California, Missouri, New Jersey, Oregon and Pennsylvania extend this application to also include affiliates of signatories to the tobacco Master Settlement Agreement. The amounts of the caps enacted in these states range from $25 million to $100 million.[11] In addition, the South Dakota Supreme Court amended its court rules to limit the bond required to stay the execution of a judgment during an appeal to $25 million.[12] Lastly, North Carolina and Florida broadened their existing

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7 Mississippi Rule of Appellate Procedure 8.

8 Ohio Rev. Code Ann. § 2505.09 (2002).

9 Ind. Code Ann. § 34-49-5-3 (2002); Mich. Comp. Laws. Ann. § 600.2607(1) (2002).

10 Ark. Code § 16-55-214 (2003); Cal. Health & Safety Code § 104558 (2003); Colo. Rev. Stat. 13-16-125 (2003); Idaho Comp. Stat. Ann. § 13-202 (2003); 2003 Kan. Sess. Laws 110 (not yet codified); Mo. Rev. Stat. § 512.085 (2003); 2003 N.J. Laws 195 (not yet codified); 2003 Or. Laws 804 (not yet codified); 2003 Penn. Laws 55 (not yet codified); Tenn. Code § 27-1-124 (2003); Tex. Civ. Proc. & Rem. Code § 52.006(b) (2003); 2003 Wis. Laws 105 (not yet codified).

11 Arkansas, Colorado, Kansas and Texas agreed to cap their appeal bonds at $25 million, while Missouri and New Jersey set their caps at $50 million. Tennessee set its cap at $75 million. The Pennsylvania and Wisconsin bills capped bonds at $100 million, and California and Oregon each set a cap of $150 million.

12 S.D.C.L. 15-26A-26.

statutes in 2003 to limit the appeal bond for money judgments under any legal theory, not just punitive damages.

Like these other states, the Alaska legislature should act to solve the problems caused by high appeal bonds immediately. While some states have passed broader measures that apply to any defendant in any kind of litigation, a bill limiting the appeal bond in cases involving signatories, successors of signatories, or affiliates of signatories to the MSA would be sufficient to solve the most problematic aspects of Alaska's current law. The legislature, in its role as the protector of the state's finances, has the authority to adopt such a measure,[13] which is important not only for Alaska, but also for all other states who are relying on the continued stream of tobacco revenues for vital public projects.

C. The Appeal Bond Limitation Laws Provide No Substantive Legal Protections To A Tobacco Company In Litigation, But They Do Protect Plaintiffs

A key point for each of the states discussed above is that, in limiting the bond, none of them changed their substantive law in any way. Bond limitation laws only ensure that defendants can fully exercise their right to an appeal without going into bankruptcy or being forced to settle with the plaintiffs. So, for example, had the tobacco companies lost their appeal in the Engle case in Florida, they would have had to pay the full amount of the judgment. Nothing in the bond limitation statute passed in Florida would have prevented that. In addition, virtually all of the laws passed in each state allow a judge to require a much larger bond if it is shown that a defendant is dissipating its assets to avoid a judgment. Thus, plaintiffs are protected under these bills in two ways: because the amount of the appeal bond even as limited is large in and of itself, and because in a case where the defendant is misbehaving, the court may require a larger bond.

Alaska should adopt legislation limiting the size of appeal bonds that MSA signatories, successors and affiliates must post to $25 million, regardless of the value of the judgment. Plaintiffs would be protected by the large but limited bond that is required and by the provision in the bill allowing a judge to require a higher bond if a defendant is improperly dissipating assets. A defendant's right to appeal would also be fully protected, by mandating a large but not impossibly high appeal bond. And Alaska and the other states would be protected, by ensuring

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[13] Although Article IV, section 15 of the Alaska constitution gives the Supreme Court primary authority over rules that affect court procedure, the Court upholds legislative enactments if the main subject of the statute is substantive with only an incidental effect on procedure. See, e.g., Ware v. City of Anchorage, 439 P.2d 793, 794 (Alaska 1968)(upholding statute requiring a non-resident plaintiff to provide security for the costs of litigation). An important part of the inquiry into whether the statute is substantive or procedural is "whether the rule or statute under scrutiny is more closely related to the concerns that led to the establishment of judicial rule making power, or to matters of public policy properly within the sphere of elected representatives." Nolan v. Sea Airmotive, 627 P.2d 1035, 1042-43 (Alaska 1987). Since the purpose of the appeal bond cap is to "secure and protect the monies to be received as a result of the Master Settlement Agreement," which is a substantive goal clearly within the purview of elected representatives, the legislature has the power to enact this statute.

that the MSA signatories can fully appeal an adverse judgment, thereby avoiding the necessity of seeking a stay in the bankruptcy court. This, in turn, will benefit Alaska and its citizens by preserving the uninterrupted flow of tobacco settlement revenues.

MSA Signed NOVEMBER 1998

Annual Payments to Each State

Year	1998	1999	2000	2001	2002	2003	2004 to 2007	2008 to 2017	2018 to 2025	Total
Amount	$2,400,000,000.00	$0.00	$6,411,750,000.00	$6,923,660,000.00	$8,313,294,800.00	$8,391,971,144.00	$7,004,000,000.00	$7,143,000,000.00	$8,003,999,997.00	$195,918,675,920.00
Alabama	$38,787,139.87	$0.00	$103,622,268.35	$111,895,403.67	$134,353,720.06	$135,625,232.71	$113,193,803.17	$115,440,225.02	$129,355,111.40	$3,166,302,118.81
Alaska	$8,194,049.54	$0.00	$21,890,915.46	$23,638,672.09	$28,383,145.58	$28,651,761.36	$23,912,967.90	$24,387,539.93	$27,327,155.19	$668,903,056.50
Arizona	$35,373,226.92	$0.00	$94,501,786.55	$102,046,748.46	$122,528,359.76	$123,687,958.17	$103,230,867.24	$105,279,566.63	$117,969,711.74	$2,887,614,909.02
Arkansas	$19,873,586.24	$0.00	$53,093,527.74	$57,332,480.87	$68,839,575.47	$69,491,067.60	$57,997,749.17	$59,148,761.04	$66,278,410.08	$1,622,336,125.69
California	$306,334,930.78	$0.00	$818,392,913.50	$883,732,877.84	$1,061,105,244.62	$1,071,147,458.11	$893,987,439.65	$911,729,337.72	$1,021,626,993.76	$25,006,972,510.74
Colorado	$32,900,674.16	$0.00	$87,896,207.30	$94,913,784.01	$113,963,751.40	$115,042,295.05	$96,015,134.08	$97,920,631.45	$109,723,748.27	$2,685,773,548.89
Connecticut	$44,556,896.25	$0.00	$119,036,533.13	$128,540,333.44	$154,339,422.45	$155,800,078.15	$130,031,875.55	$132,612,462.45	$148,597,248.93	$3,637,303,381.55
Delaware	$9,491,268.84	$0.00	$25,356,517.92	$27,380,966.02	$32,876,548.30	$33,187,689.27	$27,698,686.24	$28,248,388.89	$31,653,381.58	$774,798,676.89
D.C.	$14,570,838.84	$0.00	$38,926,906.65	$42,034,805.86	$50,471,532.83	$50,949,191.30	$42,522,564.69	$43,366,459.11	$48,593,747.53	$1,189,458,105.56
Florida	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Georgia	$58,906,980.41	$0.00	$157,373,679.86	$169,938,293.33	$204,046,289.14	$205,977,366.58	$171,910,204.50	$175,321,900.45	$196,454,779.60	$4,808,740,668.60
Hawaii	$14,444,759.81	$0.00	$38,590,078.62	$41,671,085.70	$50,034,811.08	$50,508,336.45	$42,154,624.04	$42,991,216.38	$48,173,273.94	$1,179,165,923.07
Idaho	$8,718,317.14	$0.00	$23,291,529.13	$25,151,109.85	$30,199,141.89	$30,484,944.11	$25,442,955.52	$25,947,891.39	$29,075,587.65	$711,700,479.23
Illinois	$111,701,933.67	$0.00	$298,418,697.16	$322,244,254.19	$386,921,293.46	$390,583,085.03	$325,983,476.42	$332,452,880.08	$372,525,948.64	$9,118,539,559.10
Indiana	$48,955,278.39	$0.00	$130,787,085.94	$141,229,042.84	$169,574,858.88	$171,179,701.52	$142,867,820.78	$145,703,147.32	$163,265,853.39	$3,996,355,551.01
Iowa	$20,872,006.95	$0.00	$55,760,871.07	$60,212,783.18	$72,297,977.85	$72,982,200.02	$60,911,473.61	$62,120,310.68	$69,608,143.15	$1,703,839,985.56
Kansas	$20,008,109.65	$0.00	$53,452,915.44	$57,720,561.87	$69,305,547.47	$69,961,449.52	$58,390,333.34	$59,549,136.35	$66,727,045.67	$1,633,317,646.19
Kentucky	$42,267,806.11	$0.00	$112,921,085.75	$121,936,632.68	$146,410,305.30	$147,795,920.49	$123,351,547.49	$125,799,557.93	$140,963,133.32	$3,450,438,586.10
Louisiana	$54,128,474.21	$0.00	$144,607,601.88	$156,152,979.89	$187,494,151.32	$189,268,580.68	$157,964,930.57	$161,099,871.36	$180,518,461.42	$4,418,657,915.22
Maine	$18,464,411.55	$0.00	$49,328,829.47	$53,267,211.52	$63,958,373.54	$64,563,670.37	$53,885,307.70	$54,954,704.87	$61,578,812.49	$1,507,301,275.81
Maryland	$54,250,967.50	$0.00	$144,934,850.37	$156,506,355.69	$187,918,452.52	$189,696,897.43	$158,322,406.83	$161,464,442.03	$180,926,976.56	$4,428,657,383.58
Mass.	$96,935,496.43	$0.00	$258,969,237.19	$279,645,174.68	$335,772,232.68	$338,949,953.70	$282,890,090.42	$288,504,271.26	$323,279,880.48	$7,913,114,212.77
Michigan	$104,446,741.41	$0.00	$279,035,997.59	$301,314,052.34	$361,790,230.09	$365,214,183.32	$304,810,407.01	$310,859,614.11	$348,329,882.46	$8,526,278,033.60
Minnesota	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mississipp i	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Missouri	$54,590,425.53	$0.00	$145,841,733.70	$157,485,644.00	$189,094,291.94	$190,883,864.90	$159,313,058.50	$162,474,753.97	$182,059,069.06	$4,456,368,286.30
Montana	$10,194,218.72	$0.00	$27,234,492.45	$29,408,876.82	$35,311,477.28	$35,645,662.22	$29,750,128.30	$30,340,543.46	$33,997,719.42	$832,182,430.63
Nebraska	$14,279,599.86	$0.00	$38,148,843.51	$41,194,622.66	$49,462,718.04	$49,930,829.17	$41,672,632.27	$42,499,659.09	$47,622,465.53	$1,165,683,457.48
Nevada	$14,638,443.42	$0.00	$39,107,516.49	$42,229,835.47	$50,705,706.47	$51,185,581.14	$42,719,857.37	$43,567,667.21	$48,819,208.77	$1,194,976,854.76
New Hampshire	$15,982,416.92	$0.00	$42,698,025.70	$46,107,008.63	$55,361,059.77	$55,884,992.33	$46,642,020.04	$47,567,668.35	$53,301,360.40	$1,304,689,150.27
New Jersey	$92,807,910.83	$0.00	$247,942,134.27	$267,737,674.95	$321,474,801.04	$324,517,212.33	$270,844,419.77	$276,219,544.60	$309,514,382.50	$7,576,167,918.47
New Mexico	$14,313,352.87	$0.00	$38,239,016.77	$41,291,995.30	$49,579,634.15	$50,048,851.76	$41,771,134.78	$42,600,116.47	$47,735,031.79	$1,168,438,809.05
New York	$306,288,745.07	$0.00	$818,269,525.50	$883,599,638.62	$1,060,945,263.21	$1,070,985,962.65	$893,852,654.37	$911,591,877.52	$1,021,472,964.43	$25,003,202,243.12
North Carolina	$15,974,840.09	$0.00	$149,540,283.73	$161,479,483.90	$193,889,727.95	$195,724,684.52	$163,353,241.67	$166,595,117.83	$186,676,091.64	$4,569,381,898.24
North Dakota	$8,784,330.94	$0.00	$23,467,889.12	$25,341,550.30	$30,427,805.29	$30,715,771.56	$25,635,605.78	$26,144,364.95	$29,295,743.66	$717,089,369.09
Ohio	$120,900,234.58	$0.00	$322,992,532.93	$348,780,049.22	$418,783,038.09	$422,746,366.61	$352,827,184.57	$359,829,323.15	$403,202,282.16	$9,869,422,448.51
Oklahoma	$24,867,287.65	$0.00	$66,434,513.15	$71,738,602.00	$86,137,122.12	$86,952,316.82	$72,571,034.45	$74,011,264.86	$82,932,404.27	$2,029,985,862.29
Oregon	$27,543,797.82	$0.00	$73,584,977.37	$79,459,954.68	$95,408,213.01	$96,311,148.56	$80,381,983.32	$81,977,228.27	$91,858,565.71	$2,248,476,833.11
Penn.	$137,924,610.41	$0.00	$368,474,217.00	$397,892,961.71	$477,753,311.05	$482,274,729.42	$402,509,988.05	$410,498,121.73	$459,978,575.54	$11,259,169,603.46
Rhode Island	$17,253,727.23	$0.00	$46,094,410.65	$49,774,558.78	$59,764,717.02	$60,330,325.43	$50,352,127.30	$51,351,405.67	$57,541,180.29	$1,408,469,747.28
South Carolina	$28,232,446.25	$0.00	$75,424,744.69	$81,446,607.84	$97,793,603.59	$98,719,114.28	$82,391,688.98	$84,026,818.16	$94,155,208.21	$2,304,693,119.82
South Dakota	$8,374,699.41	$0.00	$22,373,532.90	$24,159,821.39	$29,008,893.79	$29,283,431.59	$24,440,164.46	$24,925,199.13	$27,929,622.54	$683,650,008.54
Tennessee	$58,581,467.29	$0.00	$156,504,051.21	$168,999,234.09	$202,918,753.08	$204,839,159.61	$170,960,248.71	$174,353,092.02	$195,369,193.34	$4,782,168,127.09
Texas	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Utah	$10,677,285.47	$0.00	$28,525,035.47	$30,802,455.97	$36,984,759.08	$37,334,779.83	$31,159,878.10	$31,778,270.89	$35,608,747.04	$871,616,513.42
Vermont	$9,868,441.49	$0.00	$26,364,158.22	$28,469,055.67	$34,183,026.39	$34,506,531.76	$28,799,401.75	$29,370,948.99	$32,911,252.36	$805,588,329.25
Virginia	$49,073,882.70	$0.00	$131,103,944.75	$141,571,199.45	$169,985,689.11	$171,594,419.81	$143,213,947.68	$146,056,143.38	$163,661,398.74	$4,006,037,550.26
Washington	$49,278,196.65	$0.00	$131,649,782.25	$142,160,616.27	$170,693,406.67	$172,308,835.15	$143,810,203.90	$146,664,232.79	$164,342,785.78	$4,022,716,266.79
West Virginia	$21,275,048.98	$0.00	$56,837,623.03	$61,375,502.33	$73,694,064.18	$74,391,498.79	$62,087,684.60	$63,319,864.52	$70,952,288.31	$1,736,741,427.33
Wisconsin	$49,728,936.59	$0.00	$132,853,962.15	$143,460,937.12	$172,254,712.48	$173,884,917.03	$145,125,613.28	$148,005,747.52	$165,846,003.46	$4,059,511,421.32

Wyoming $5,960,276.82	$0.00	$15,923,252.04	$17,194,554.25	$20,645,640.96	$20,841,029.62	$17,394,074.52	$17,739,273.88	$19,877,523.19	$486,553,976.10
Amercian Samo a$365,208.62	$0.00	$975,677.65	$1,053,575.12	$1,265,036.21	$1,277,008.41	$1,065,800.48	$1,086,952.15	$1,217,970.74	$29,812,995.31
N. Marianas $202,503.22	$0.00	$541,000.00	$584,193.09	$701,445.39	$708,083.81	$590,971.89	$602,700.20	$675,348.22	$16,530,900.80
Guam $526,489.51	$0.00	$1,406,549.63	$1,518,847.65	$1,823,692.71	$1,840,951.99	$1,536,471.89	$1,566,964.41	$1,755,842.52	$42,978,803.27
US Virgin Island $416,623.09	$0.00	$1,113,034.64	$1,201,898.61	$1,443,129.42	$1,456,787.08	$1,215,845.06	$1,239,974.49	$1,389,438.02	$34,010,162.11
Puerto Rico $26,910,657.33	$0.00	$71,893,502.96	$77,633,434.04	$93,215,094.84	$94,097,274.89	$78,534,268.30	$80,092,843.87	$89,747,042.15	$2,196,791,813.07
$2,400,000,000.00	$0.00	$6,411,750,000.00	$6,923,660,000.00	$8,313,294,800.00	$8,391,971,144.00	$7,004,000,000.00	$7,143,000,000.00	$8,003,999,997.00	$195,918,675,920.00

ENACTED APPEAL BOND LEGISLATION

State	Bill Number	Date Approved	To Whom Limits Apply	Amount of Appeal Bond Limit	Scope of Appeal Bond Limit
California	A 1752	8/9/2003	Master Settlement Agreement signatories, successors, and affiliates	The lesser of 100% of the judgment or $150,000,000	Applies to all judgments in civil litigation regardless of legal theory
Colorado	HB 1366	5/20/2003	All litigants	$25,000,000	Applies to all judgments in civil litigation regardless of legal theory
Florida	HB 1721 SB 2826	5/9/2000 6/10/2003	All litigants in class actions Master Settlement Agreement signatories, successors, and affiliates	$100,000,000 $100,000,000	As passed in 2000, applied to judgments for non-compensatory damages. Broadened in 2003 to apply to all money judgments under any legal theory
Georgia	HB 1346	3/30/2000	All litigants	$25,000,000	Applies to punitive damages only
Idaho	HB 92	3/26/2003	All litigants	$1,000,000	Applies to punitive damages only
Indiana	HB 1204	3/14/2002	All litigants	$25,000,000	Applies to all judgments in civil litigation regardless of legal theory
Kansas	SB 64	4/21/2003	Master Settlement Agreement signatories and their successors	$25,000,000	Applies to all judgments in civil litigation regardless of legal theory
Kentucky	SB 316	3/29/2000	All litigants	$100,000,000	Applies to punitive damages portion of a judgment

Notes

* Created by court rule rather than legislation.

State	Bill Number	Date Approved	To Whom Limits Apply	Amount of Appeal Bond Limit	Scope of Appeal Bond Limit
Louisiana	HB 1807 HB 1819	6/25/2001 7/2/2003	As passed in 2001, covered Master Settlement Agreement signatories only; broadened in 2003 to include "affiliates"	$50,000,000	Applies to all money judgments
Michigan	HB 5151	5/8/2002	All litigants	$25,000,000 plus COLA every 5th year	Applies to all judgments in civil litigation
Mississippi	Rule 8	4/26/2001	All litigants	$100,000,000	Applies to all litigation subject to court rule
Missouri	SB 242	7/10/03	Master Settlement Agreement signatories, successors, and affiliates	$50,000,000	Applies to all forms of judgments in civil litigation
Nevada	AB 576	5/29/2001	Master Settlement Agreement signatories	$50,000,000	Applies to all forms of judgments in civil litigation
New Jersey	SB 2738	11/21/2003	Master Settlement Agreement signatories, successors, and affiliates	$50,000,000	Applies to all forms of judgments in civil litigation
North Carolina	SB 2 SB 784	4/5/2000 4/23/2003	All litigants All litigants	$25,000,000	As passed in 2002, applied to judgments for non-compensatory damages. Broadened in 2003 to apply to all money judgments under any legal theory
Ohio	SB 161	3/28/2002	All litigants	$50,000,000	Applies to all forms of judgments in civil litigation
Oklahoma	SB 372	4/10/2001	Master Settlement Agreement signatories	$25,000,000	As passed in 2001, applied to all forms of judgments in civil litigation involving MSA signatories

State	Bill Number	Date Approved	To Whom Limits Apply	Amount of Appeal Bond Limit	Scope of Appeal Bond Limit
Oregon	HB 2368	9/24/2003	Master Settlement Agreement signatories, successors, and affiliates	$150,000,000	Applies to all judgments in civil litigation regardless of legal theory
Pennsylvania	*HB 1718*	*12/30/2004*	*Master Settlement Agreement signatories, successors, and affiliates*	*$100,000,000*	*Applies to all judgments in civil litigation regardless of legal theory*
South Dakota	Amend. to Sup. Ct. R. 15-26A-26	9/29/2003	All litigants	$25,000,000	Applies to money judgments
Tennessee	SB 1687	6/5/2003	All litigants	$75,000,000	Applies to all forms of judgments in civil litigation
Texas	HB 4	6/11/2003	All litigants	The lesser of 50% of the judgment debtor's net worth or $25,000,000	Applies to money judgments
Virginia	HB 1547	3/10/2000	All litigants	$25,000,000	Applies to punitive damages portion of a judgment
West Virginia	SB 661	5/2/2001	All Master Settlement Agreement signatories	$100,000,000 for all portions of a judgment other punitive damages; $100,000,000 for the punitive damages portion of a judgment	Applies to all civil litigation and provides that consolidated or aggregated cases shall be treated as a single judgment for purposes of the appeal bond limits
Wisconsin	AB 548	12/12/2003	All litigants	$100,000,000	Applies to all judgments in civil litigation regardless of legal theory

STATES THAT DO NOT REQUIRE BONDS

State	Governing Rule
Connecticut	Proceedings to stay noncriminal judgments shall be stayed automatically until the final determination of the cause. Conn. R. App. P. § 61-11.
Maine	The taking of an appeal operates as a stay of execution upon the judgment, and no supersedeas bond or other security shall be required. Me. R. Civ. P. 62.
Massachusetts	The taking of an appeal from a judgment shall stay execution upon the judgment during the pendency of the appeal. Mass. R. Civ. P. 62(d).
New Hampshire	No execution of a judgment shall issue until the expiration of the appeal period. N.H. Rev. Stat. Ann. § 527:1.
Vermont	The taking of an appeal operates to stay execution of the judgment during the pendency of the appeal; no supersedeas bond or other security is required. Vt. R. Civ. P. 62(d)(1).

American Heart Association®

Learn and Live℠

Appeal Bond Bill (SB 307/HB 468)

The American Heart Association is concerned about proposed SB 307/HB 468, legislation that would limit the amount of appeal bonds to $25 million in any civil lawsuit that involves a tobacco company, or any affiliate of a tobacco company, that participated in the 1998 Master Settlement Agreement, regardless of the amount of the legal judgment or the subject matter of the lawsuit. This legislation fails to protect the public health of all Alaskans, and it is not needed to protect the MSA payments that Alaska receives each year.

Appeal bond limits help only the big tobacco companies. Appeal bond limits are special interest, special protection bills to benefit the tobacco companies – and the tobacco companies certainly do not deserve special treatment or special protections.

The only reason the Alaska Legislature is being asked to consider this proposed legislation is because tobacco companies are trying to avoid being brought to justice for years of misinformation and deceit about so-called "light" cigarettes that killed and harmed millions of people. Because the judicial systems in other states have forced the tobacco companies to pay for the harm they have caused, the tobacco companies are now trying to legislate options away from judges, juries and the injured parties who file lawsuits in many states throughout the country, including Alaska.

Appeal bond limits hurt deserving plaintiffs who have won lawsuits. Appeal bond limits reduce the security and protections that are currently in place to protect worthy plaintiffs who win lawsuits. Appeal bond provisions require losing defendants to post bonds prior to appealing lawsuits that they have lost – and the winning plaintiffs have recourse to those posted bond amounts if the defendants lose on appeal and, for whatever reason, are no longer able to pay the damages they owe to the plaintiffs.

Through this mechanism, appeal bond requirements are meant to ensure that losing defendants do not use repeated frivolous appeals to avoid paying the damages owed to winning plaintiffs. They are also meant to ensure that losing defendants do not waste their assets or hide them during the appeal process, and appeal bonds protect plaintiffs against the possibility that the defendants lose their ability to pay during the appeal process. Low appeal bond limits fail to provide any of these protections in lawsuits where plaintiffs have been awarded damages that significantly exceed the amount of the appeal bond maximum.

No Alaska business has gone bankrupt under the existing appeals bond law. Only the tobacco companies are using this ploy to fight class-action suits.

The judicial system and existing laws already have sufficient protections in place to stop appeal bond requirements from bankrupting defendants. Tobacco companies who lose big lawsuits and have large damages judgments against them have numerous protections available:
1) They can file a motion with the court seeking to have the appeal bond amount reduced.
2) If the lower court refuses, they can file an appeal to a higher court to have the bond reduced.
3) They can work out a deal with the winning plaintiffs to post a smaller bond amount.

In April 2003, for example, Phillip Morris used existing avenues of appeal to get a court in Illinois to reduce an appeal bond in a large class action lawsuit from $12 billion to $ 6 billion. In fact, courts have already ruled that appeal bond requirements that force a losing defendant that wants to appeal into bankruptcy violate the constitutional right to due process. Other rulings on punitive damages indicate that forcing losing defendants into bankruptcy may also not be permissible.

Tobacco companies have access to enormous financial resources that can be used to satisfy even the largest appeal bond requirements. The tobacco companies (and their parent companies) have enormous assets, revenue streams, and profits – and have a vast capacity to borrow money or to raise needed revenue through price increases. In 2002, Altria (Philip Morris' parent company) had total assets of $87.5 billion, net revenues of $80.4 billion, and US tobacco revenues of $18.9 billion.

Tobacco companies can easily raise even very large appeal bond amounts by reducing their current non-essential spending. The tobacco companies (and their parent companies) currently spend enormous amounts of money on expenditures that are not necessary to protect their market share. Most notably, the companies could save a lot of money by reducing or eliminating their shareholder dividends and stock buybacks. Ironically, the $25 million cap that the tobacco companies seek is the very same amount that tobacco companies spend *every year* on marketing their deadly products in Alaska alone.

Tobacco companies' risk of being financially overwhelmed by multiple appeal bond requirements and lawsuit losses is very low. For example, tobacco companies are promoting this legislation in Alaska despite the fact that there is no indication that there will be a significant tobacco-related lawsuit in Alaska, and despite the fact that Alaska judges and juries have proven to be moderate in their damage awards.

There are other options that would protect payments while also protecting Alaska citizens. The above facts show that no appeal bond limits should be instituted at all. But if some appeal bond limit is destined to pass in Alaska, these arguments support a much higher appeal bond limit than those currently being pushed by Philip Morris and other tobacco companies. To date, they have proposed appeal bond limits of $25 million, but in order to protect legitimately harmed Alaskans who have prevailed in superior court, there is absolutely no justification for any appeal bond limit that is not in the billions of dollars.

Another alternative would be to set appeal bond limits to be no greater than the total value of a losing defendant's assets or no greater than a losing defendant's total revenues in the prior fiscal year. An even better alternative (if some appeal bond limit must be passed) would be to set guidelines for the courts. For example, a proposed bill could read: "Appeal bond limits shall not be set in an amount that would force a losing defendant into bankruptcy or otherwise cause severe financial strains that jeopardize the losing defendant's ability to stay in business or meet its preexisting financial obligations."

February 23, 2004

Northwest Division
Alaska Office

Fax Cover Sheet

To:	Vanessa Tondini – House Judiciary Committee
Fax #:	465-6592
Date:	March 5, 2004
Re:	HB468 – tobacco industry appeals bond cap

From: Emily Nenon
Alaska Advocacy Manager
American Cancer Society

Phone: (907) 263-2097

Fax: (907) 263-2073

Email: Emily.Nenon@cancer.org

Pages including cover sheet: 2

Vanessa:

This is a visual aid for my testimony this afternoon. Will you please have a copy of this ad available for committee members to see?

Thank you,

Emily

1057 West Fireweed Lane, Suite 204 • Anchorage, AK • 99503
(907) 277-8696 • (800) 478-9355 • Fax (907) 263-2073

FOR MORE INFORMATION, CALL 505-260-2105, EXTENSION 24.

AMERICAN LUNG ASSOCIATION.

American Heart Association.

COMMUNITIES TOBACCO

HB

472

(File 1 of 7)

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: February 16, 2004 **FURTHER REFERRALS:**

Date of Committee Action: March 22, 2004

The JUDICIARY Committee considered: **HB 472**

HOUSE BILL NO. 472 **CLAIMS AGAINST HEALTH CARE PROVIDERS**

"An Act relating to claims for personal injury or wrongful death against health care providers; and providing for an effective date."

Recommends it be replaced with [ ] HCS *or* [X] CS *for* HB 472 (JUD)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[ ] Same Title [ ] New Title**

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW **FISCAL NOTES** *Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero
LAW				✓
CED				✓

PREVIOUS **FISCAL NOTES**				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	**Printed Last Name**	**DP**	**DNP**	**NR**	**AM**
	SAMUELS			✓	
	Holm			✓	
	Coon		✓		
	Ogg			X	
Tom Anderson	ANDERSON	X			
Mark Gruenberg	Gruenberg		✓		
			✓		
Chair	McGuire	✓			
Chair:					

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 472
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: DCED
Title: Claims Against Health Care Providers
RDU: Insurance (116)
Component: Insurance Operations
Sponsor: Representative Anderson
Requester: House Judiciary
Component No.: 354

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This legislation limits the damages for non-economic losses that may be awarded against health care providers for personal injury or wrongful death.

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

Prepared by: Linda S. Hall, Director
Phone (907) 269-7900
Division: Insurance
Date/Time 2/19/04 4:54 PM
Approved by: Edgar Blatchford, Commissioner
Date 2/19/2004
Agency: Department of Community & Economic Development

(Revised 12/2003 OMB)

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: HB472-LAW-T&WC-2-20
Bill Version: HB 472
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: LAW
Title "An Act relating to claims for personal injury or wrongful death against health care providers..."
RDU CIVIL
Component Torts & Workers' Compensation
Sponsor Representative Anderson
Requester House Judiciary Committee
Component No.

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This bill adds a new section to the Code of Civil Procedure in order to place limits on the amount of recoverable damages for personal injury or wrongful death based on the provision of services by a health care provider. The bill makes a minor change to the requirement that health care providers obtain the informed consent of a patient prior to embarking on a course of action involving the patient, and that informed consent include information regarding risk of death, serious bodily harm, and common serious complications that may occur. The bill also makes clear that a health care provider is not responsible for certain types of advice given to advice that the patient elects not to follow.

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

Prepared by: Kathryn A. Daughhetee, Director
Phone 465-3673
Division Administrative Services
Date/Time 2/20/04 2:40 PM
Approved by: Kathryn Daughhetee for Gregg D. Renkes, Attorney General
Date 2/20/2004
Agency Department of Law

(Revised 12/2003 OMB)

1 of 1 DOCUMENT

VICKI MARSINGILL and PAUL MARSINGILL, wife and husband, Appellants, v. JAMES O'MALLEY, M.D., Appellee.

Supreme Court No. S-9859, No. 5643

SUPREME COURT OF ALASKA

58 P.3d 495; 2002 Alas. LEXIS 163

November 22, 2002, Decided

SUBSEQUENT HISTORY: Rehearing denied by, 12/11/2002

PRIOR HISTORY: **[**1]** Appeal from the Superior Court of the State of Alaska, Third Judicial District, Peter A. Michalski, Judge. Superior Court No. 3AN-95-9909 CI.

DISPOSITION: Vacated and remanded with directions.

CASE SUMMARY:

PROCEDURAL POSTURE: Several months after having stomach surgery, appellant patient called appellee surgeon complaining of abdominal pain and nausea. Several hours later, the patient lost consciousness from an intestinal blockage and suffered permanent injuries. The patient sued the surgeon for medical malpractice. A jury rejected the claims, and the Superior Court, Third Judicial District (Alaska), entered judgment for the surgeon. The patient appealed.

OVERVIEW: On appeal, the patient argued it was an error to exclude evidence of the surgeon's failure to pass tests for surgeon board certification and whether the jury instructions correctly described the standard for deciding whether the surgeon gave the patient adequate information. The appellate court found no abuse of discretion in the rulings excluding evidence. As licensed physicians could practice surgery in Alaska without board certification, the surgeon's inability to pass board certification tests did not necessarily tend to prove that the surgeon lacked minimally necessary surgical skills or knowledge. However, the appellate court held that the jury should have been instructed to use the reasonable patient standard to decide if the surgeon gave the patient sufficient information about treatment choices. In denying the request for the instruction, the trial court deprived the patient of her right to have the jury decide the issue directly from the standpoint of a reasonable patient. Because the given instructions hinged entirely on the testimony of competing experts rather than on the jury's common sense and experience, giving those instructions was reversible error.

OUTCOME: The judgment was vacated and remanded for a new trial.

LexisNexis (TM) HEADNOTES - Core Concepts:

Torts > Malpractice Liability > Healthcare Providers
[HN1] See *Alaska Stat. § 09.55.540(a).*

Civil Procedure > Appeals > Standards of Review > Abuse of DiscretionEvidence > Procedural Considerations > Rulings on Evidence

[HN2] Appellate courts review decisions excluding evidence for abuse of discretion. An abuse of discretion occurs only when the court is left with a definite and firm conviction, after reviewing the whole record, that the trial court erred in its ruling.

Evidence > Relevance > Character EvidenceEvidence > Relevance > Confusion, Prejudice & Waste of TimeEvidence > Relevance > Relevant Evidence
[HN3] Alaska R. Evid. 402 provides that, with certain exceptions, all relevant evidence is admissible. But among the recognized exceptions to this rule of general admissibility, the rules of evidence incorporate provisions allowing courts to exclude relevant evidence whose probative value is outweighed by its potential to prejudice or confuse the jury, Alaska R. Evid. 403, and evidence of character or conduct whose primary purpose is to show that a person acted in conformity therewith on a specific occasion. Alaska R. Evid. 404(b).

Torts > Malpractice Liability > Healthcare Providers
[HN4] Since licensed physicians are allowed to practice surgery in Alaska without board certification, a physician's inability to pass one or more board certification tests does not necessarily tend to prove that the physician lacks minimally necessary surgical skills or knowledge. By adopting as a matter of public policy a medical licensing standard that authorizes physicians to perform general surgery without obtaining board certification, Alaska law establishes a baseline standard that precludes expert witnesses from dictating a more rigorous certification requirement.

Evidence > Procedural Considerations > Rulings on EvidenceTorts > Malpractice Liability > Healthcare Providers
[HN5] Courts generally disfavor admission of evidence showing that a defendant failed board certification tests when that evidence is affirmatively offered to prove lack of professional knowledge or skill. But courts also recognize that considerably greater latitude exists to admit such evidence through cross-examination or in rebuttal when it counteracts affirmative defense evidence introduced to show a special degree of skill, knowledge or relevant expertise. Yet at the same time, appellate courts addressing issues of admissibility in this area have consistently emphasized the need for great deference to the trial court's superior ability to determine whether particular evidence would have been more probative than prejudicial in a given case.

Civil Procedure > Jury Trials > Jury InstructionsCivil Procedure > Appeals > Standards of Review > De Novo Review
[HN6] The sufficiency of proposed jury instructions is a legal question to which an appellate court applies its independent judgment. A legally erroneous instruction warrants reversal only when it prejudices a party, that is, when substantial rights of the parties were affected or the error had substantial influence.

Healthcare Law > Treatment > Failures to Warn & Disclose
[HN7] The physician-patient relationship is one of trust. Because the patient lacks the physician's expertise, the patient must rely on the physician for virtually all information about the patient's treatment and health. A physician therefore undertakes, not only to treat a patient physically, but also to respond fully to a patient's inquiry about his treatment, i.e., to tell the patient everything that a reasonable person would want to know about the treatment.

Healthcare Law > Treatment > Patient Consent
[HN8] Alaska's informed consent statute, *Alaska Stat. § 09.55.556(a)*, requires physicians to disclose the common risks and reasonable alternatives to a proposed treatment or procedure but fails to specify what standard governs the scope of the disclosure requirement.

Healthcare Law > Treatment > Patient Consent
[HN9] Expert testimony does not play a determinative role in the context of the reasonable patient rule. Under this modern view, expert testimony concerning the professional standard of disclosure is not a necessary element of the plaintiff's case because the scope of disclosure is measured from the standpoint of the patient. A physician must disclose those risks which are material to a reasonable patient's decision concerning treatment. Although expert testimony remains relevant in narrowing the field of risks that are potentially material, materiality itself must ultimately be judged by asking what a reasonable patient would want to know.

Healthcare Law > Treatment > Patient Consent

[HN10] The determination of materiality in disclosing risks to patients is a two-step process. The first step is to define the existence and nature of the risk and the likelihood of its occurrence. Some expert testimony is necessary to establish this aspect of materiality because only a physician or other qualified expert is capable of judging what risk exists and the likelihood of its occurrence. The second prong of the materiality test is for the trier of fact to decide whether the probability of that type of harm is a risk which a reasonable patient would consider in deciding on treatment. The focus is on whether a reasonable person in the patient's position would attach significance to the specific risk. This determination does not require expert testimony.

Healthcare Law > Treatment > Failures to Warn & Disclose
[HN11] In the context of a pre-existing patient/physician relationship involving post-operative care, a physician's recommendation to do nothing in the face of threatening symptoms is the equivalent of a treatment recommendation and should be accompanied by a duty of disclosure. A physician's acquiescence in a patient's decision not to seek treatment in the same circumstances should likewise be regarded as equivalent to a treatment recommendation subject to the same duty.

Evidence > Witnesses > Judges & Jurors
[HN12] Alaska R. Evid. 606(b) flatly prohibits parties from questioning jurors as to any matter influencing their deliberations except on the question whether extraneous prejudicial information was improperly brought to the jury's attention or whether any outside influence was improperly brought to bear upon any juror. The rule likewise categorically bars the receipt of evidence of any statement by the juror concerning a matter about which the juror would be precluded from testifying.

COUNSEL: Robert H. Wagstaff, Law Offices of Robert H. Wagstaff, Anchorage, for Appellant.

Donna M. Meyers and Howard A. Lazar, Delaney, Wiles, Hayes, Gerety, Ellis & Young, Inc., Anchorage, for Appellee.

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

OPINIONBY: BRYNER

OPINION: [*497] BRYNER, Justice.

I. INTRODUCTION

One night several months after having stomach surgery, Vicki Marsingill called her surgeon, Dr. James O'Malley, complaining of abdominal pain and nausea. Dr. O'Malley advised Marsingill to go to the emergency room and offered to meet her there, but Marsingill said she felt better and declined to go. Several hours later, Marsingill lost consciousness from an intestinal blockage and suffered permanent injuries. Marsingill sued Dr. O'Malley, claiming that he lacked the skill and knowledge to advise [**2] her properly and that the information he gave her over the telephone did not allow her to make an intelligent treatment decision. A jury rejected these claims. The main issues on appeal are whether the trial court erred in excluding evidence of Dr. O'Malley's failure to pass tests for board certification as a surgeon and whether the jury instructions correctly described the standard for deciding whether Dr. O'Malley gave Marsingill adequate information. We find no abuse of discretion in the court's rulings excluding evidence but hold that the jury should have been instructed to use the reasonable patient standard to decide if Dr. O'Malley gave Marsingill sufficient information about her condition and treatment choices.

II. FACTS AND PROCEEDINGS

In October 1994 Dr. O'Malley performed surgery to remove staples that another surgeon had previously placed in Vicki Marsingill's stomach to facilitate weight loss. By January 1995 Marsingill had recovered from the surgery and was cleared to return to work.

While dining out with a friend on the evening of February 14, 1995, Marsingill "suffered a sudden onset of illness, was in pain, felt nauseous, and was unable to eat, so [went] [**3] home." Her pain worsened over the next few hours, and she eventually asked her daughter to call Dr. O'Malley. Her daughter told Dr. O'Malley that Marsingill looked bad, that she was nauseous and in pain, that she was unable to burp or have a bowel movement, and that her stomach was "as hard as a rock." Dr. O'Malley then spoke directly with Marsingill, who sounded anxious and upset. She informed him that she was having abdominal pain, felt bloated, and could not burp. Dr. O'Malley advisedMarsingill that he could not

evaluate her over the phone but that "if she felt bad enough to call him at night" she should go the emergency room. He repeated this advice several times but did not venture any opinion about the cause of Marsingill's symptoms or tell her that her condition was potentially life-threatening or serious. He left it up to her whether to seek emergency room treatment.

When Marsingill asked what would happen at the emergency room, Dr. O'Malley informed her that the doctors there would probably take x-rays and insert a nasogastric tube to relieve the pressure in her stomach. n1 Dr. O'Malley knew that Marsingill had previously had nasogastric tubes inserted and, like [*498] most patients, [**4] strongly disliked them. Soon after hearing that she would likely need to have a nasogastric tube inserted if she went to the emergency room, Marsingill ended the call, telling Dr. O'Malley that she thought that she could burp and was feeling better.

n1 Inserting a nasogastric tube involves placing a tube through the patient's nose, down the back of the throat into the esophagus, and into the stomach.

After hanging up, Marsingill told her daughter that she was feeling better and would try to "tough it out for awhile." But later that night Marsingill's husband found her unconscious on the bathroom floor. Paramedics rushed her to the hospital, where an emergency operation later revealed that she had experienced an intestinal blockage. But by then the obstruction had caused Marsingill to go into shock; as a result, she suffered brain damage and partial paralysis.

Marsingill eventually filed suit against Dr. O'Malley, asserting four claims, only two of which currently remain relevant: (1) that the doctor lacked skill [**5] and knowledge in general surgery and, as a result, committed malpractice by giving Marsingill incompetent advice when she called about her symptoms and (2) that the doctor had breached his duty to give Marsingill enough information to enable her to make an informed choice about going to the emergency room for treatment.

To meet her burden of proving that Dr. O'Malley lacked knowledge and skills as a surgeon, Marsingill planned to introduce evidence that he had repeatedly failed tests for AMA board certification in general surgery. Marsingill maintained that this evidence was relevant to prove that Dr. O'Malley lacked the requisite degree of skill and knowledge and that it also would be admissible to impeach defense testimony and to establish the basis for her own experts' opinions.

But in a pretrial motion, Dr. O'Malley asked the trial court to exclude all evidence regarding his medical education and training except evidence that he had "graduated from medical school, completed a medical degree, and was not Board Certified." In support of his pretrial motion, Dr. O'Malley argued that evidence of his failed attempts at board certification was inadmissible character evidence and could [**6] not be properly used to show either a general lack of skill or an act of negligence on any particular occasion.

The trial judge granted Dr. O'Malley's motion to exclude the evidence and instructed both parties not to introduce evidence of "the details pertaining to Dr. O'Malley's medical education background." On several occasions during trial Marsingill moved to introduce evidence regarding Dr. O'Malley's lack of board certification, arguing that the doctor or his expert witnesses had opened the door to a broader inquiry into his background. The court denied each of these motions.

The expert testimony at trial focused on the symptoms of post-surgical bowel obstructions and the appropriate course of action for a physician to take in response to a patient's call complaining of these symptoms. Six medical experts testified -- three for Marsingill and three for Dr. O'Malley -- about the appropriateness of Dr.O'Malley's advice during the February 14 telephone call from Marsingill. Their opinions were sharply divided.

Marsingill's experts -- Drs. Battle, Modlin, and Ravden -- uniformly agreed that Dr. O'Malley's actions fell below the accepted standard of care. They particularly criticized [**7] Dr. O'Malley's failure to communicate to Marsingill the true seriousness of her situation, the extent of the risk she faced, and the importance of getting immediate help. Additionally, they questioned Dr. O'Malley's professional judgment in needlessly telling Marsingill that she would likely be treated with a nasogastric tube if she decided to go to the emergency room. Because installing such tubes involves a painful procedure, they emphasized, a competent physician who wanted to encourage a patient to seek emergency room treatment would not have offered up the prospect of being treated with a nasogastric tube.

In contrast, however, Dr. O'Malley's experts -- Drs. Gardiner, Macho, and Moossa -- uniformly disagreed with this assessment, insisting that on the whole Dr. O'Malley had provided "very good care." Dr. Gardiner, for example, described a physician's duty during a phone call as being very limited, concluding that Dr. O'Malley had done everything necessary to fulfil that duty. Dr. O'Malley's experts also were adamant in expressing their view that the doctor had acted properly in simply advising [*499] Marsingill to go to the emergency room, without engaging her in a speculative discussion [**8] of the possible causes of her symptoms. While acknowledging that Marsingill's prior abdominal surgeries placed her at heightened risk for an intestinal obstruction and that the symptoms she described on the telephone were consistent with such an obstruction, they emphasized that a physician cannot accurately diagnose a patient over the telephone and concluded that the doctor therefore had no "obligation to speculate." Dr. O'Malley's experts also took exception to the claim that it was improper for him to mention thelikelihood of Marsingill's being treated with a nasogastric tube at the emergency room. To the contrary, they claimed, Dr. O'Malley acted appropriately by giving Marsingill an honest and accurate answer to her question about what she could expect if she went to the emergency room.

In the course of their testimony, the expert witnesses also gave divergent opinions about the scope of a physician's ethical duty to give patients sufficient information to make intelligent treatment decisions. Section 8.08 of the AMA Code of Medical Ethics addresses this duty of disclosure, providing: "The patient's right of selfdecision can be effectively exercised only if the patient possesses [**9] enough information to enable an intelligent choice." Marsingill's experts maintained that Dr. O'Malley had violated Section 8.08 by failing to give her enough information to make an intelligent choice about whether to seek emergency room treatment. As already mentioned, Dr. O'Malley's experts took the opposite view, maintaining that the doctor had satisfied his duty simply by advising Marsingill that she should go to the emergency room for an examination.

Dr. O'Malley himself shifted positions: when initially questioned about his obligations under Section 8.08, he testified that the provision "applies to Mrs. Marsingill. It doesn't really apply to me." But he later reconsidered, acknowledging that Section 8.08 applied to his conduct -- that he did "have [an] obligation to give [Marsingill] enough information so that she could make an intelligent choice as to whether she should go to the emergency room."

At the conclusion of trial, Marsingill proposed jury instructions covering her alternative theories of liability -- that Dr. O'Malley committed malpractice by lacking adequate skill and knowledge to enable him to respond appropriately to her telephone calland that he breached [**10] his duty to give her enough information to enable her to make an informed decision about going to the emergency room for examination and treatment.

With respect to the second of these theories -- Dr. O'Malley's alleged breach of Section 8.08's duty to inform -- Marsingill's proposed instruction would have required the jury to decide the sufficiency of Dr. O'Malley's communications from the standpoint of a reasonable patient in Marsingill's position. But the trial court rejected the proposed "reasonable patient" instruction, instead directing the jury to measure Dr. O'Malley's compliance by relying exclusively on the expert testimony addressing his compliance with a general surgeon's professional standard of care.

After the jury returned a verdict in favor of Dr. O'Malley, Marsingill filed this appeal.

III. DISCUSSION

A. Evidentiary Claims Marsingill based her malpractice claim partly on the theory that Dr. O'Malley lacked the requisite skills and ability to recognize the likely cause of her symptoms and extent of the risk that she consequently faced; he thus negligently failed to communicate the urgency of her receiving immediate medical attention. n2 On appeal, Marsingill [**11] asserts [*500] that the trial court prevented her from proving this theory when it excluded relevant evidence revealing that Dr. O'Malley had repeatedly failed examinations for board certification in surgery. n3

n2 *AS 09.55.540(a)* defines the elements of a medical malpractice claim in Alaska:

[HN1] (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider, the plaintiff has the burden of proving by a preponderance of the evidence (1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing; (2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and (3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

n3 [HN2] We review decisions excluding evidence for abuse of discretion. *Anchorage Nissan, Inc. v. State, 941 P.2d 1229, 1238 n.17 (Alaska 1997); Agostinho v. Fairbanks Clinic P'ship, 821 P.2d 714, 716 n.2 (Alaska*

1991). An abuse of discretion occurs only "when we are left with a definite and firm conviction, after reviewing the whole record, that the trial court erred in its ruling." *Peter Pan Seafoods v. Stepanoff, 650 P.2d 375, 378-79 (Alaska 1982).*

[12]**

[HN3] Rule 402 of the Alaska Rules of Evidence provides that, "with certain exceptions, 'all relevant evidence is admissible.'" n4 But among the recognized exceptions to this rule of general admissibility, the rules of evidence incorporate provisions allowing courts to exclude relevant evidence whose probative value is outweighed by its potential to prejudice or confuse the jury n5 and evidence of character or conduct whose primary purpose is "to show that [a] person acted in conformity therewith" on a specific occasion. n6

n4 *Cummings v. Sea Lion Corp., 924 P.2d 1011, 1017 (Alaska 1996)* (quoting Alaska R. Evid. 402). Rule 401 defines relevant evidence as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence."

n5 Alaska R. Evid. 403.

n6 Alaska R. Evid. 404(b); *accord* Alaska R. Evid. 404(a). *Trombley v. Starr-Wood Cardiac Group PC, 3 P.3d 916, 918, 920 (Alaska 2000).*

n7

[13]** n7

Here, Marsingill correctly posits that Alaska's medical malpractice statute allows a finding of liability when a physician's lack of skill or knowledge proximately causes injury to a patient; n7 but she incorrectly reasons that Dr. O'Malley's failure to achieve board certification is relevant and admissible to prove that a specific defect in knowledge or skill caused him to injure Marsingill on the occasion at issue.

[HN4] Since licensed physicians are allowed to practice surgery in Alaska without board certification, a physician's inability to pass one or more board certification tests does not necessarily tend to prove that the physician lacks minimally necessary surgical skills or knowledge. Thus, even if Marsingill's expert witnesses might have been willing to testify as to their personal opinion that a competent general surgeon should possess knowledge and skill necessary to receive board certification, the trial court correctly recognized that this testimony would be irrelevant under Alaska law. For by adopting as a matter of public policy a medical licensing standard that authorizes physicians to perform general surgery without obtaining board certification, Alaska law establishes **[**14]** a baseline standard that precludes expert witnesses from dictating a more rigorous certification requirement. n8

n8 *See Jackson v. Buchman, 338 Ark. 467, 996 S.W.2d 30, 34 (Ark. 1999)* ("Board certification is not required by law to practice surgery in Arkansas. Accordingly, the legal standard of care set out in [the Arkansas malpractice statute] is in no way affected by board certification.").

To prevail on her malpractice claim, then, Marsingill needed to make a more particularized showing that Dr. O'Malley lacked specific knowledge or skills that a competent surgeon would need regardless of board certification. Notably, the trial court gave Marsingill broad latitude to ask questions and introduce evidence for the purpose of showing that Dr. O'Malley did not know the common signs and symptoms of a bowel obstruction and that this particular lack of knowledge fell below the accepted standard of professional competence. Her ability to introduce this evidence gave Marsingill ample opportunity **[**15]** to present her malpractice claim to the jury. Considering the totality of the circumstances, we hold that it was not an abuse of discretion to grant Dr. O'Malley's pretrial motion to exclude evidence of his failed attempts **[*501]** to pass the test for board certification in general surgery.

After the trial court granted Dr. O'Malley's pretrial motion to exclude this evidence, Marsingill repeatedly sought its admission during the course of trial, maintaining that Dr. O'Malley and his experts opened the door to its use to impeach

and contradict their testimony. The trial court consistently declined to admit the evidence. Marsingill now challenges the trial court's rulings, renewing the arguments she raised below.

We begin by acknowledging that Marsingill's arguments on these points present close issues. As already noted above, [HN5] courts generally disfavor admission of evidence showing that a defendant failed board certification tests when that evidence is affirmatively offered to prove lack of professional knowledge or skill. But courts also recognize that considerably greater latitude exists to admit such evidence through cross-examination or in rebuttal when it counteracts affirmative defense **[**16]** evidence introduced to show a special degree of skill, knowledge or relevant expertise. n9 Yet at the same time, appellate courts addressing issues of admissibility in this area have consistently emphasized the need for great deference to the trial court's superior ability to determine whether particular evidence would have been more probative than prejudicial in a given case. n10

n9 *See, e.g., Campbell v. Vinjamuri, 19 F.3d 1274, 1277 & n.2 (8th Cir. 1994); Gipson v. Younes, 724 So. 2d 530, 532 (Ala. Civ. App. 1998)* ("When a physician sued for malpractice testifies as an expert, the fact that he had failed a board certification examination is relevant to his credibility as an expert."); *McCray v. Shams, M.D., 224 Ill. App. 3d 999, 587 N.E.2d 66, 70, 167 Ill. Dec. 184 (Ill. App. 1992)* (stating that failure to pass boards was material issue in examination of expert witness "because it bore on whether she was qualified to meet the standards of the specialty").

n10 *See Gipson, 724 So. 2d at 533* ("We have reviewed a number of decisions from other jurisdictions in which the courts have been required to determine whether a physician who testifies as an expert witness may be cross-examined about his failure to pass a board certification exam. The decisions are virtually unanimous in upholding the trial court's determination -- regardless of whether the determination resulted in admission or in exclusion of the evidence.").

[17]**

Here, Marsingill first claimed that Dr. O'Malley opened the door during a portion of his own testimony that occurred shortly after one of Marsingill's expert witnesses who was from England -- Dr. Modlin -- had finished testifying. When asked if he was board certified by the American College of Surgeons, Dr. O'Malley answered: "No, I'm not." He then added, "Neither is Dr. Modlin." Marsingill argued that, in giving this unsolicited response, Dr. O'Malley unfairly attempted to portray himself as being equally qualified with Dr. Modlin, when in fact Dr. Modlin is board certified in the United Kingdom and thus is accepted by the American College of Surgeons as having the equivalent of board certification in the United States.

Although the trial court denied Marsingill's request to refute Dr. O'Malley's unsolicited response with examination concerning his failures to pass the board certification test, the court did expressly allow Marsingill to correct any misleading impression through further questioning about the nature of Dr. Modlin's United Kingdom board certification and by confirming that Dr. O'Malley had no comparable qualifications.

Marsingill argues that Dr. O'Malley's statement **[**18]** was a gratuitous and improper attempt to mislead the jury. Since this is one reasonably possible view of the statement, the trial court might have had discretion to allow inquiry into Dr. O'Malley's board failures. But the trial court's alternative approach to the issue effectively prevented Dr. O'Malley from creating any misleading impression; and at the same time it avoided taking recourse in a remedy that would have answered one impropriety with yet another. On balance, we cannot say that the trial court abused its discretion in finding that Dr. O'Malley did not open the door in this instance.

Marsingill also attempted to introduce the board certification evidence to impeach what she claimed were Dr. O'Malley's attempts to portray himself as extensively qualified. Specifically, Dr. O'Malley testified on direct examination that he had operating privileges at all area hospitals and covered **[*502]** for virtually every surgeon in Anchorage; that he directed both the trauma center at Alaska Regional Hospital and the burn unit at Providence Hospital; that he received out-of-state referrals based on his expertise with burn patients; and that he had been contacted by the television program NOVA **[**19]** about filming a segment on treating frostbite patients. Marsingill argued that this testimony went "far beyond [Dr. O'Malley's] basic licensure qualifications," that it affirmatively raised the issue of Dr. O'Malley's general expertise as a surgeon, and that it thereby entitled Marsingill to impeach these claims by questioning Dr. O'Malley about his repeated failures to become board certified.

Dr. O'Malley rejoined that his testimony simply gave "general background information" and would not be perceived as asserting any extraordinary level of skill; moreover, he emphasized, the special expertise that he described was in the area of treating frostbite, not in gastro-intestinal surgery. The trial court found this argument persuasive and declined to allow impeachment through evidence of Dr. O'Malley's board failures.

It is a close question whether Dr. O'Malley's testimony exceeded the scope of the superior court's pretrial order, which limited the scope of testimony that both parties could present covering Dr. O'Malley's education and training. Thus, while inquiring into Dr. O'Malley's board failures would have been permissible as impeachment, we again must conclude that the trial [**20] court did not abuse its broad discretion in excluding that evidence. Under Evidence Rule 403, the trial court bears primary responsibility for determining admissibility of evidence by balancing its probative value evidence against its potential to create undue prejudice and confusion. Since the areas of expertise that Dr. O'Malley mentioned on direct examination were not germane to the areas at issue in Marsingill's claim, we cannot say as a matter of law that the probative value of Marsingill's proposed impeaching evidence outweighed its potential for causing prejudice and confusion.

Finally, Marsingill sought to use the board certification evidence to impeach various statements by Dr. O'Malley's experts regarding Dr. O'Malley's general qualifications -- particularly an opinion expressed by Dr. Gardiner that Dr. O'Malley is not deficient in knowledge or skills and an opinion by Dr. Moossa that Dr. O'Malley has the requisite level of surgical skill, as well as the judgment and knowledge to handle difficult problems. But as with the previous evidentiary decisions, the trial court's broaddiscretion to assess the admissibility and likely prejudicial impact of evidence precludes us from [**21] saying that the court abused its discretion. n11

n11 *See, e.g., Campbell, 19 F.3d at 1277; Hinson v. Clairemont Cmty. Hosp., 218 Cal. App. 3d 1110, 267 Cal.Rptr. 503, 510-12 (Cal. App. 1990).*

B. Jury Instructions Concerning the Standard for Deciding Breach of Duty To Disclose Marsingill next claims that the trial court erred in rejecting her proposed jury instructions regarding Dr. O'Malley's duty to give her adequate information during the February 14 phone call. As previously mentioned, Marsingill pursued two alternative theories of liability at trial that remain relevant on appeal. Under the first theory, she claimed that Dr. O'Malley lacked sufficient knowledge and skill to advise her properly as to her treatment choices and that these deficiencies caused him to commit malpractice by giving her deficient advice. Under the second theory, Marsingill claimed that a physician owes a duty to give patients enough information to make intelligent treatment choices. Marsingill [**22] claimed that Dr. O'Malley breached this duty of disclosure by failing to adequately inform her about the potential seriousness of her symptoms and the risks of failing to seek immediate examination and emergency room treatment.

Marsingill proposed separate jury instructions covering these theories. Her proposed instruction on her claim for failure to inform would have directed the jury that the question whether Dr. O'Malley breached his duty to give her sufficient information [*503] must be measured from the standpoint of the "reasonable patient." The trial court rejected this instruction and instead used a single instruction for both the medical malpractice theory and duty-to-inform theory. Although this instruction advised the jury of the separate factual basis underlying each of Marsingill's theories, it effectively treated both as medical malpractice claims, requiring the jury to determine whether Dr. O'Malley had given Marsingill sufficient evidence to meet his duty to inform by relying exclusively on expert testimony concerning whether the doctor's advice breached the professional standard of care. Marsingill challenges the trial court's ruling, asserting that the "reasonable patient" [**23] standard should have governed the jury's determination of whether Dr. O'Malley breached his duty to give her enough information to make an intelligent treatment choice. n12 We agree.

n12 [HN6] The sufficiency of proposed jury instructions is a legal question to which we apply our independent judgment. *Fairbanks N. Star Borough v. Kandik Constr. Inc., 795 P.2d 793, 797 (Alaska 1990), vacated in part on other grounds, 823 P.2d 632 (Alaska 1991); Chenega Corp. v. Exxon Corp., 991 P.2d 769, 775 (Alaska 1999)* ("A legally erroneous instruction warrants reversal only when it prejudices a party -- that is, when 'substantial rights of the parties were affected or the error had substantial influence.' ") (internal citations omitted).

Marsingill's alternate theory of liability did not question the competency of any medical care or treatment administered by Dr. O'Malley and so did not depend on whether he breached the professional standard of care that governs a general surgeon; [**24] rather it questioned the adequacy of the information that he disclosed concerning Marsingill's treatment options, asserting that the doctor owed her a duty of disclosure and that he breached this duty. Our decisions have previously distinguished between the standard that governs a physician's duty to render adequate care and the standard that governs a physician's duty to disclose or inform. We first noted the distinction in *Pedersen v. Zielski*:

[HN7] The physician-patient relationship is one of trust. Because the patient lacks the physician's expertise, the patient must rely on the physician for virtually all information about the patient's treatment and health. A physician therefore undertakes, not only to treat a patient physically, but also to respond *fully* to a patient's inquiry about his treatment, i.e., to tell the patient everything that a reasonable person would want to know about the treatment. n13

n13 *822 P.2d 903, 909 (Alaska 1991).*

Elaborating further on this distinction in *Korman* [**25] *v. Mallin*,n14 we noted that [HN8] Alaska's informed consent statute n15 requires physicians to disclose the common risks and reasonable alternatives to a proposed treatment or procedure but fails to specify what standard governs the scope of the disclosure requirement. n16 After observing that the law traditionally measured a physician's duty to disclose "by the professional standard in the field," *Korman* rejected that approach in favor of "the modern trend" of case law, which "measures the physician's duty of disclosure by what a reasonable patient would need to know in order to make an informed and intelligent decision." n17

n14 *858 P.2d 1145 (Alaska 1993).*

n15 *See AS 09.55.556(a).*

n16 *Korman, 858 P.2d at 1148.*

n17 *Id. at 1148-49.*

Korman went on to hold that [HN9] expert testimony does not play a determinative role in the context of the reasonable patient rule: "Under this modern view, expert testimony concerning the [**26] professional standard of disclosure is not a necessary element of the plaintiff's case because the scope of disclosure is measured from the standpoint of the patient." n18 Emphasizing that "a physician must disclose those risks which are 'material' to a reasonable patient's decision concerning treatment," n19 *Korman* borrowed from the Louisiana Supreme Court's decision in *Hondroulis v. Schuhmacher* n20 to explain that, although expert testimony remains relevant [*504] in narrowing the field of risks that are potentially material, materiality itself must ultimately be judged by asking what a reasonable patient would want to know:

[HN10] The determination of materiality is a two-step process. The first step is to define the existence and nature of the risk and the likelihood of its occurrence. "Some" expert testimony is necessary to establish this aspect of materiality because only a physician or other qualified expert is capable of judging what risk exists and the likelihood of its occurrence. The second prong of the materiality test is for the trier of fact to decide whether the probability of that type of harm is a risk which a reasonable patient would consider in deciding on treatment. [**27] The focus is on whether a reasonable person in the patient's position would attach significance to the specific risk. This determination does not require expert testimony. n21

n18 *Id. at 1149.*

n19 *Id.*

n20 *553 So. 2d 398 (La. 1989).*

n21 *Korman, 858 P.2d at 1149* (quoting *Hondroulis, 553 So. 2d at 412).*

In the present case, Marsingill insists that *Korman*'s reasonable patient rule -- not the professional standard of care in the field -- governed the scope of Dr. O'Malley's duty to give her enough information to enable her to make an intelligent treatment decision. n22 Dr. O'Malley responds that neither *Korman* nor Alaska's informed consent law should extend to this case because the duty of disclosure they describe "simply does not apply unless the physician recommends or proposes a specific treatment or procedure." n23 According to Dr. O'Malley, in the present case, "the factual predicate for the . . . duty to disclose, i. **[**28]** e., a recommended treatment or procedure is totally absent." Hence, Dr. O'Malley contends, "Marsingill's theory that Dr. O'Malley failed to adequately appreciate and communicate the seriousness of her condition was properly included in the ordinary medical negligence instruction."

n22 Marsingill also cites California cases in support of her position, primarily *Truman v. Thomas, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (Cal. 1980),* and *Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (Cal. 1972).*

n23 Dr. O'Malley discusses cases from California and New Jersey in support of this proposition. *See, e.g., Arato v. Avedon, 5 Cal. 4th 1172. 858 P.2d 598, 605, 23 Cal. Rptr. 2d 131 (Cal. 1993); Scalere v. Stenson, 211 Cal. App. 3d 1446, 260 Cal.Rptr. 152 (Cal. App. 1989); Farina v. Kraus, 333 N.J. Super. 165, 754 A.2d 1215, 1223-24 (N.J. Super. 1999); Eagel v. Newman, 325 N.J. Super. 467, 739 A.2d 986, 989-90 (N.J. Super. 1999).*

[29]**

But on the particular facts of this case, Dr. O'Malley's position is unpersuasive. We assume for present purposes that Dr. O'Malley is correct in asserting that *Korman* and Alaska's implied consent statute both extend only to situations involving recommendations for specific medical procedures and treatment. Yet when Marsingill called Dr. O'Malley on the night of February 14, she was seeking a recommendation for treatment of her abdominal pain and distress. Uncontradicted evidence establishes that Dr. O'Malley advised her to go to the emergency room for treatment that would likely entail having a nasogastric tube inserted into her stomach. And despite Dr. O'Malley's argument to the contrary, the record supports the conclusion that this advice amounted to a recommendation for treatment. n24

n24 Dr. O'Malley asserts that one of Marsingill's experts, Dr. Ravden, "admitted" that "simply going to the hospital is neither a treatment or procedure." Yet this argument neglects to mention that Dr. Ravden expressly identified nasogastric intubation as a procedure "used in the treatment of a bowel obstruction."

[30]**

Furthermore, there was evidence that Dr. O'Malley acquiesced in Marsingill's decision not to go to the emergency room. [HN11] In the context of a pre-existing patient/physician relationship involving post-operative care, a physician's recommendation to do nothing in the face of threatening symptoms is the equivalent of a treatment recommendation and should be accompanied by a duty of disclosure. A physician's acquiescence in a patient's decision not to seek treatment in the same circumstances should likewise be regarded as equivalent to a treatment recommendation subject to the same duty.

As we have previously mentioned, Section 8.08 of the AMA Code of Medical Ethics gives rise to a duty of disclosure in such situations, requiring that patients be given "enough information to enable an intelligent **[*505]** choice." All six expert witnesses at trial agreed that this duty to inform applied in Marsingill's case. Indeed, even Dr. O'Malley conceded that the duty attached, expressly acknowledging that he had an "obligation to give [Marsingill] enough information so that she could make an intelligent choice as to whether she should go to the emergency room." Hence, no one disagreed that a duty of reasonable **[**31]** disclosure existed -- that Dr. O'Malley did in fact have a duty to give Marsingill enough information to make an intelligent choice about immediately going to the emergency room for treatment; the only significant disagreement centered on issues concerning the scope and breach of the duty to inform. n25

n25 The consensus of testimony agreeing that this duty of disclosure arose in the present setting makes it unnecessary for us to determine whether Alaska's informed consent statute would have independently encompassed the duty had Section 8.08 not applied.

Yet these are precisely the issues that *Korman* describes as lying outside the realm of professional expertise and as falling within the fact-finding powers that the reasonable patient rule assigns to lay jurors. In denying the request for an instruction on the reasonable patient standard, then, the superior court deprived Marsingill of her right to have the jury decide the issue directly, from the standpoint of a reasonable patient. The court instead required **[**32]** the jury to filter its decision through the experts' views of what patients should be told. Because the instructions hinged the determination of breach entirely on the testimony of competing experts rather than on the common sense and experience of the jury, we must conclude that giving those instructions amounted to reversible error. n26

n26 Dr. O'Malley cursorily argues that if any error occurred on this point it was harmless because the factual similarity between Marsingill's medical malpractice and failure-to-inform theories of liability rendered any difference between the two theories immaterial. But this argument is unpersuasive, for, as *Korman* expressly recognizes, the differences in the standards that govern the jury's determination of breach make these theories significantly different. Although Dr. O'Malley further contends that Marsingill "conceded that she could argue her theory within the confines of the general medical malpractice instruction," this argument misstates the concession: While acknowledging that the malpractice instruction actually given allowed her to argue her factual theory, Marsingill specifically objected that the instruction would deprive her of the right to have her theory decided under the correct legal standard.

[33]**

IV. CONCLUSION

The judgment is VACATED, and this case is REMANDED for a new trial on Marsingill's claim for breach of the duty to provide enough information to allow her to make an intelligent treatment choice. On remand, the jury must be instructed to decide the claim from the standpoint of a reasonable patient. n27

n27 Because our decision on the standard for determining a breach of the duty to disclose requires a remand for retrial, we need not resolve Marsingill's remaining claims of error. To provide appropriate guidance on remand, however, we think it necessary to comment on two aspects of the remaining claims.

First, Marsingill argues that reversible error occurred when Dr. O'Malley's trial counsel argued in his closing argument to the jury that "plaintiff is asking you to basically take everything he's worked for his whole life, to ruin his reputation as a physician. That's unbelievable." Although we need not decide if this comment amounted to reversible error, we believe that it could readily have been understood as an improper suggestion that a judgment awarding damages against Dr. O'Malley would not be covered by his insurance.

Second, Marsingill argues that the superior court erred in denying her motion for a new trial, which was based on the jury's alleged confusion regarding an aspect of the jury instructions. Because this issue emerged from a post-trial interview with jurors conducted by a paralegal who worked for Marsingill's trial counsel and was supported by the paralegal's affidavit, we take this opportunity to remind counsel that [HN12] Evidence Rule 606(b) flatly prohibits parties from questioning jurors as to any matter influencing their deliberations except "on the question whether *extraneous* prejudicial information was improperly brought to the jury's attention or whether any *outside* influence was improperly **[*506]** brought to bear upon any juror." Alaska R. Evid. 606(b) (emphasis added). The rule likewise categorically bars the receipt of "evidence of any statement by the juror concerning a matter about which the juror would be precluded from testifying."

[34]**

ALASKA STATE LEGISLATURE

Rep. Lesil McGuire, Chair
Rep. Tom Anderson, Vice-Chair
Rep. Jim Holm
Rep. Dan Ogg
Rep. Ralph Samuels
Rep. Les Gara
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House Judiciary Committee

Memorandum

To: Leg. Legal

From: Vanessa Tondini, Committee Aide
House Judiciary Committee

Date: March 22, 2004

Re: CS Request

Please create a final draft House Judiciary Committee Substitute for work order # 23-LS1743\D, HB 472, incorporating the attached amendment (Conceptual Amendment #1). The bill was passed out of committee today.

If you have any questions, please call me at 4990. Thank you!

conceptual
AMENDMENT #1 - PASSED

OFFERED IN THE HOUSE
BY REP. HOLM

TO: CSHB 472 (JUD)

Page 2, Line 22, following "death.":

Insert "The limits on damages in this subsection do not apply if it is shown by clear + convincing evid. that the personal injury or wrongful death was the result of reckless or intentional misconduct."

Page 2, Line 25, following "judgment":

Insert "unless it is shown by clear + convincing evidence that the personal injury or wrongful death was the result of reckless or intentional misconduct"

clear + convincing evidence

conceptual to conform to 9.17.020(b) (pun. dam.)

A. to A #1 to include gross negligence FAILED

* (incorporate) use the same exact language, criteria & standard of proof that is used for punitive damages in AS 9.17.020(b)
(create a separate subsection or incorporate into existing subsections ... however you feel is most appropriate.

23-LS1743\A.6
Bullock
3/22/04

AMENDMENT #2 - FAILED
by Rep. Gara

OFFERED IN THE HOUSE
TO: CS HB 472(JUD)

Page 2, line 19, following $250,000:

Insert ", except that the limit on damages is $1,000,000 if it is shown, by clear and convincing evidence, that the injury is a serious debilitating physical injury or disfigurement. Each limit applies"

(DELETED) RESCINDED

A. to A#2 - PASSED

Insert:
"or if the defendant acts with criminal negligence as defined in AS 04.21.080(1), except that the term "reasonable person" shall be/mean "reasonable medical practitioner in the field."

Page 2, line 25:

Delete "$250,000"

Insert "the limit in (d) of this section"

L

From Jerry Lockhart

Courts that have addressed this burden of proof issue under similar statutory provisions have required proof by "clear and convincing" evidence. *See, e.g., Castellano v. Bitkower,* 216 Neb. 806, 346 N.W.2d 249, 252 (Neb. 1984) (stating that the appropriate standard of evidence regarding lost notes is "clear and convincing" evidence); *Lutz v. Gatlin,* 22 Wash. App. 424, 590 P.2d 359, 361 (Wash. App. 1979) ("To establish a lost instrument, the evidence must be clear, cogent and convincing.")

Clear and convincing evidence has been characterized as evidence that is greater than a preponderance, but less than proof beyond a reasonable doubt. *Castellano* provides a useful statement of the standard, holding that "clear and convincing evidence means and is that amount of evidence which produces in the trier of fact a firm belief or conviction about the existence of a fact to be proved." 346 N.W.2d at 253; *see also Welton v. Gallagher,* 2 Haw. App. 242, 630 P.2d. 1[illegible]t of 81 (Haw. App. 1981), *aff'd,* 65 Haw. 528, 654 P.2d 1349 (Haw. 1982)

Rep Gara
Attn: Ryan

23-LS1743\A.5
Bullock
3/16/04

AMENDMENT #6 - FAILED
Reoffered by Rep. Gruenberg A#3 CSHB472(JUD) FAILED

OFFERED IN THE HOUSE BY REPRESENTATIVE GARA

TO: HB 472

Page 2, following line 27:

Insert a new subsection to read:

"(g) The limitation on damages under (d) of this section shall be adjusted by the administrative director of the Alaska Court System on October 1 of each year, calculated to the nearest whole percentage point between the index for January of that year and January of the prior year according to the Consumer Price Index for all urban consumers for the Anchorage metropolitan area compiled by the Bureau of Labor Statistics, United States Department of Labor. The administrative director of the Alaska Court System shall provide notification of a change in the limitation of damages to the clerks of court in each judicial district of the state. The court shall adjust the award for noneconomic damages under this subsection and (e) of this section, if necessary, before the entry of judgment."

23-LS1743\D
Bullock
3/22/04

CS FOR HOUSE BILL NO. 472(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - SECOND SESSION

BY THE HOUSE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES ANDERSON, Fate

A BILL

FOR AN ACT ENTITLED

"An Act relating to claims for personal injury or wrongful death against health care providers; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that the national medical malpractice crisis continues to affect the state, and patient access to physicians will be dramatically affected if physicians cannot afford, or obtain at any price, malpractice insurance.

(b) It is the intent of this Act to

(1) alleviate a medical malpractice insurance crisis that the legislature believes will, if not corrected, threaten the quality of the state's health care; the legislature believes that the continuing availability of adequate medical care depends directly on the availability of adequate insurance coverage, which in turn operates as a function of costs associated with

medical malpractice litigation; the legislature believes that decreasing the limits on noneconomic damages will help to contain the costs of malpractice insurance by controlling damages and will significantly help to provide for a stable malpractice insurance market for health care providers, thereby maximizing the availability of medical services to meet the state's health care needs;

(2) modify the decisions of the Alaska Supreme Court in Marsingill v. O'Malley, 58 P.3d 495 (Alaska 2002) and Korman v. Mallin, 858 P.2d 1145 (Alaska 1993); and

(3) clarify the law of informed consent in medical malpractice cases.

*** Sec. 2.** AS 09.55.548 is amended by adding new subsections to read:

(c) In an action to recover damages for personal injury or wrongful death based upon the provision of services by a health care provider, damage claims for noneconomic losses shall be limited to compensation for pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, injury to reputation, and other nonpecuniary damage.

(d) Notwithstanding AS 09.17.010, the damages awarded by a court or a jury for claims allowed under (c) of this section, including a loss of consortium or other derivative claim, arising out of a single injury or death may not exceed $250,000 regardless of the number of health care providers against whom the claim is asserted or the number of separate claims or causes of action brought with respect to the injury or death.

(e) The jury may not be informed about the limitation on damage claims for noneconomic losses in (c) of this section, but an award for noneconomic losses in excess of $250,000 shall be reduced before the entry of judgment.

(f) Multiple injuries sustained by one person as a result of a single incident shall be treated as a single injury.

*** Sec. 3.** AS 09.55.556 is amended to read:

Sec. 09.55.556. Informed consent. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the

common risks and reasonable alternatives to the proposed treatment, [OR] procedure, **or course of action,** and that, but for that failure, the claimant would not have consented to the proposed treatment, [OR] procedure, **or course of action**.

(b) It is a defense to any action for medical malpractice based upon an alleged failure to obtain informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that the patient would **or would not** undergo the treatment, [OR] procedure, **or course of action** regardless of the risk involved or that the patient did not want to be informed of the matters to which the patient would be entitled to be informed;

(3) under the circumstances, consent by or on behalf of the patient was not possible; or

(4) the health care provider, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent that the alternatives or risks were disclosed to the patient because the health care provider reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition.

*** Sec. 4.** AS 09.55.556 is amended by adding new subsections to read:

(c) A health care provider, when informing a patient of the common risks and reasonable alternatives to a proposed treatment, procedure, or course of action, shall disclose a known risk of death or serious bodily harm and explain the common complications that may occur. A health care provider is required only to disclose that information that a skilled health care provider of the same or reasonably similar specialty would disclose under similar circumstances.

(d) A health care provider is not liable for advice given to a patient by telephone, radio, electronic mail, telemedicine, or other electronic communication if the advice is that the patient seek further care or evaluation at the health care provider's office, a clinic, an emergency room, or a hospital, and the patient elects not to follow that advice.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

APPLICABILITY. This Act applies to suits against health care providers initially filed on or after the effective date of this Act.

* **Sec. 6.** This Act takes effect July 1, 2004.

23-LS1743\A.1
Bullock
3/10/04

AMENDMENT #1 - PASSED
by Rep. Gara

OFFERED IN THE HOUSE

TO: HB 472

Page 2, line 19, following "$250,000":

Insert ", except that, in the case of severe permanent physical impairment or severe disfigurement, the damages may not exceed $1,000,000. The limit on damages applies"

Page 2, line 25:

Delete "$250,000"

Insert "the maximum amount allowed under (d) of this section"

m/ rescind
action on adopting
A #1
~~MASS~~ PASSED

L

ALASKA STATE LEGISLATURE

Rep. Lesil McGuire, Chair
Rep. Tom Anderson, Vice-Chair
Rep. Jim Holm
Rep. Dan Ogg
Rep. Ralph Samuels
Rep. Les Gara
Rep. Max Gruenberg

State Capitol, Room 120
Juneau, AK 99801-1182
(907) 465-4990
Fax (907) 465-6592

House Judiciary Committee

Memorandum

To: Leg. Legal

From: Vanessa Tondini, Committee Aide
House Judiciary Committee

Date: March 20, 2004

Re: CS Request

Please create a work draft House Judiciary Committee Substitute for work order # 23-LS1743\A, HB 472, with the attached two amendments (4A and 4B). I have also written the changes into the text of the accompanying bill draft for clarification. The bill will be reheard on Monday, March 22 at 1:00p.m.

If you have any questions, please call me at 4990. Thank you!

Gara

Amendment 4A - PASSED

~~Default~~

Delete at p3 line 22

~~"serious bodily" and~~ ("most")

P. 3

A.4B Delete at line 23, "serious" - PASSED

~~and insert at line 22 the words~~

~~"risks" after "common"~~

and

HOUSE BILL NO. 472

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE ANDERSON

Introduced: 2/16/04
Referred: Judiciary

A BILL

FOR AN ACT ENTITLED

"An Act relating to claims for personal injury or wrongful death against health care providers; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that the national medical malpractice crisis continues to affect the state, and patient access to physicians will be dramatically affected if physicians cannot afford, or obtain at any price, malpractice insurance.

(b) It is the intent of this Act to

(1) alleviate a medical malpractice insurance crisis that the legislature believes will, if not corrected, threaten the quality of the state's health care; the legislature believes that the continuing availability of adequate medical care depends directly on the availability of adequate insurance coverage, which in turn operates as a function of costs associated with

medical malpractice litigation; the legislature believes that decreasing the limits on noneconomic damages will help to contain the costs of malpractice insurance by controlling damages and will significantly help to provide for a stable malpractice insurance market for health care providers, thereby maximizing the availability of medical services to meet the state's health care needs;

(2) modify the decisions of the Alaska Supreme Court in Marsingill v. O'Malley, 58 P.3d 495 (Alaska 2002) and Korman v. Mallin, 858 P.2d 1145 (Alaska 1993); and

(3) clarify the law of informed consent in medical malpractice cases.

* **Sec. 2.** AS 09.55.548 is amended by adding new subsections to read:

(c) In an action to recover damages for personal injury or wrongful death based upon the provision of services by a health care provider, damage claims for noneconomic losses shall be limited to compensation for pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, injury to reputation, and other nonpecuniary damage.

(d) Notwithstanding AS 09.17.010, the damages awarded by a court or a jury for claims allowed under (c) of this section, including a loss of consortium or other derivative claim, arising out of a single injury or death may not exceed $250,000 regardless of the number of health care providers against whom the claim is asserted or the number of separate claims or causes of action brought with respect to the injury or death.

(e) The jury may not be informed about the limitation on damage claims for noneconomic losses in (c) of this section, but an award for noneconomic losses in excess of $250,000 shall be reduced before the entry of judgment.

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* **Sec. 3.** AS 09.55.556 is amended to read:

Sec. 09.55.556. Informed consent. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the

common risks and reasonable alternatives to the proposed treatment, [OR] procedure, **or course of action,** and that, but for that failure, the claimant would not have consented to the proposed treatment, [OR] procedure**, or course of action**.

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(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that the patient would **or would not** undergo the treatment, [OR] procedure**, or course of action** regardless of the risk involved or that the patient did not want to be informed of the matters to which the patient would be entitled to be informed;

(3) under the circumstances, consent by or on behalf of the patient was not possible; or

(4) the health care provider, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent that the alternatives or risks were disclosed to the patient because the health care provider reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition.

*** Sec. 4.** AS 09.55.556 is amended by adding new subsections to read:

(c) A health care provider, when informing a patient of the common risks and reasonable alternatives to a proposed treatment, procedure, or course of action, shall disclose a known risk of death or serious bodily harm and explain the ~~most~~ common ~~serious~~ complications that may occur. A health care provider is required only to disclose that information that a skilled health care provider of the same or reasonably similar specialty would disclose under similar circumstances.

(d) A health care provider is not liable for advice given to a patient by telephone, radio, electronic mail, telemedicine, or other electronic communication if the advice is that the patient seek further care or evaluation at the health care provider's office, a clinic, an emergency room, or a hospital, and the patient elects not to follow that advice.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

APPLICABILITY. This Act applies to suits against health care providers initially filed on or after the effective date of this Act.

*** Sec. 6.** This Act takes effect July 1, 2004.

23-LS1743\A.3
Bullock
3/10/04

AMENDMENT #2 - FAILED
by Rep. Ogg

OFFERED IN THE HOUSE

TO: HB 472

Page 2, line 22, following "death.":

Insert "The limits on damages in this subsection do not apply if the personal injury or wrongful death was the result of gross negligence or reckless or intentional misconduct."

Page 2, line 25, following "judgment":

Insert "unless the personal injury or wrongful death was the result of gross negligence or reckless or intentional misconduct"

23-LS1743\A.4
Bullock
3/10/04

AMENDMENT #3 - FAILED
by Rep. Gruenberg

OFFERED IN THE HOUSE

TO: HB 472

Page 3, lines ~~19~~ 20 - ~~30~~ 25:

Delete all material.

Renumber the following bill sections accordingly.

2 Amdts to H0472 "A" Version

By: Gruenberg WITHDRAWN

A.5A.

(A) page 3 ~~between~~ line 22 after "and" insert "clearly"

(B) page 3 line 26 after "advice" insert "clearly"

AMENDMENT #1 - withdrawn (never offered)

To HB 472

IN THE HOUSE JUDICIARY COMMITTEE

March 3, 2004

Page 2, Line 11-16 Delete all language

Insert:

(c) In an action to recover damages for personal injury or wrongful death based upon the provision of services by a health care provider, damages shall include both economic and non economic damages. Damage claims for non economic losses shall be limited to compensation for pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, injury to reputation, and other non pecuniary damage.

Page 4, Line 4, after "*Sec.6." insert:

AS 09.55.560 is amended by adding a new subsection to read:
(6) "Economic damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of or payment for (or failure to provide, use or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities. All other damages are "non economic" damages.

Renumber language in old Section 6 accordingly.

AMENDMENT #2 - withdrawn (never offered)

To HB 472

IN THE HOUSE JUDICIARY COMMITTEE

March 3, 2004

Page 3, Line 20 -23, Delete all language through "...that may occur."

Medical Malpractice in Alaska

Amounts Paid Per Claim, by Year

Year	# of Claims Paid	Average Amount Paid per Claim (Total Damages)
1993	17	$278,785
1994	19	$212,577
1995	9	$108,917
1996	15	$58,081
1997	24*	$137,942
1998	13*	$198,315
1999	20	$380,102
2000	26*	$305,952
2001	26	$218,564
2002	22	$322,998
2003	18	$341,983

*one award amount is listed as "confidential" in this year

Information provided by the Alaska State Medical Board

ALASKA STATE MEDICAL BOARD

REVISED 03/05/2004

SORTED BY DATE PAID

Board	Practitioner Name	Occurred	Award	Case/Court #	Date Paid	Res	Brief Description of Claim
MED	Veuthey, Pierre	11/7/1983	$5,000		5/16/1990	SET	Willard case - no details available
MED	Kemp, Aaron	08/89	$22,000	3131	7/1/1990	SET-B	Alleged UGI bleed following anti-inflammatory med for hem disc
MED	Hoag, Robert	1983-87	$15,000	87-2-19441-8	8/3/1990	SET-A	Pap smear misdiagnosed
MED	Tangpricha, Vilhavas	5/18/1988	$45,000	88-18043	8/30/1990	SET-B	Alleged failure to dx & tx respiratory arrest; pt death
MED	Foote, James Timothy	7/6/1987	$75,600	4FA-88-908CIV	11/1/1990	SET-A	Delayed dx of appendicitis resulting in rupture
MED	Nathanson, Steven E.	11/3/1988	$7,500		11/8/1990	SET-B	After rhinoplasty pt complained of obstruction on nose
MED	Brown, Carolyn	9/12/1985	$20,000		12/3/1990	SET-B	Alleged negligent tx of ectopic pregnancy
MED	Kennedy, Ronald E.	12/2/1985	$269,112	3AN-87-377	3/17/1991	SET-A	Alleged negl vein/vein rather than vein/artery graft during bypass
MED	Manuel, Michael	12/13/1988	$10,750		5/7/1991	SET-B	Sponge left in breast during augmentation surg
MED	Halter, Loren	1/22/1987	$55,000	3KO-88-504	6/14/1991	SET-A	Alleged misdx & tx of burns resulting in additional wounds;tx
MED	Heilman, Doris	8/12/1987	$150,387	4FA-89-1375	6/17/1991	CA	Alleged unnec surg w/o full consent
MED	Brudenell, Ross	11/13/1987	$125,000	3AN-89-09303	6/18/1991	SET-A	Alleged negl bone graft to r wrist; wound infect & sepsis
MED	Ake, Burton Kenneth	7/28/1987	$71,500	3AN-91-1314	6/25/1991	SET-A	Alleged sexual misconduct during office pelvic exam
MED	Johnson, R. Holmes	8/12/1978	$200,000	3AN-91-2051	6/26/1991	SET-A	Alleged failure to dx & transfer for tx epidural hemorrhage
MED	Doramus, Alfred	3/14/1988	$28,000	4FA-90-350	8/26/1991	SET-A	Alleged failure to remove post introcular lens that dislocated
MED	Mays, Denton	3/1/1988	$140,000	3AN-88-11350	9/23/1991	SET-A	Alleged improp use of hypnosis for SLE & sex assault
MED	Deal, Clyde	7/28/1981	$15,000	3KO-87-72CI	10/8/1991	SET-A	Alleged negl hernia repair/surg resulting in rmvl of testicle
MED	Stewart, Mary Lu	11/1/1985	$500,000	57-254504 K3	10/30/1991	SET-B	Alleged that chemotherapy was factor in death
MED	O'Malley, James E.	1/9/1988	$30,000	3AN-90-5688	11/22/1991	SET-A	Alleged failure to remove sponge following appendectomy
MED	Nicholson, Thomas A.		$20,000		11/22/1991	CA	Pt alleged injured 2 fingers during barium enema
MED	Reinbold, William B	8/17/1983	$4,000	3AN-90-8759CIV	12/17/1991	OOC	Scalpel blade left in knee after surgery
MED	Belknap, Alan R.	1/14/1987	$10,000	90-C-321	12/18/1991	SET-A	Alleged failure to note breast masses in mammograms
MED	Beal, David	3/18/1987	$145,000	3AN-89-1690	12/27/1991	SET-A	CSF leak following sinus surgery
MED	Borgeson, Marvin E.	2/6/1987	$128,859	4FA-88-221CIV	1/16/1992	SET-A	Alleged delay in dx septic hip resulting in osteomyelitis
MED	Dingeman, Robert	2/6/1987	$128,859	4FA-88-221CIV	1/16/1992	SET-A	Alleged delay in dx septic hip resulting in osteomyelitis
MED	Kruger, Sandford M.	10/23/1989	$60,000		2/1/1992	SET-A	Pediatric death of 20-month old due to croup
MED	Johnson, Jay	8/3/1987	$325,000	23-349650	2/4/1992	SET-A	Failure to dx infection in hand of diabetic pt
MED	Boyeler, Natalie	4/11/1989	$225,000		2/14/1992	SET-B	Alleged failure to FU radiologist recomm re lung lesion; delay dx
MED	Rostykus, Paul S.	4/7/1989	$52,500	90CF0093	4/14/1992	SET-A	Alleged failure to dx & refer for tx; cardiac arrest, death
MED	Joosse, John W.	8/3/1989	$160,000	4FA-90-51CIV	4/17/1992	SET-A	Alleged negl fusion at L4-5 rather than L5-S1
MED	Heilman, Doris	5/16/1989	$50,000		4/20/1992	SET-B	Alleged tubal ligation while pg load to fetal death
MED	Barry, Peter A.	12/4/1989	$30,000	147341	4/27/1992	SET-A	Arthroscopy done on wrong knee
MED	Strohmeyer, Richard R.	3/22/1986	$60,000	3AN-88-3082	4/28/1992	SET-A	Alleged negl surg; casting of fx elbow; compt synd, fasciotomy
MED	Matrisciano, John D.	07/88	$29,950	NW CO49 980	6/1/1992	SET-B	Alleged pain during sex following inguinal hernia repair
MED	Borden, James B.	7/29/1991	$58,490		6/5/1992	SET-B	Alleged damage to bile duct during laporos cholecystectory
MED	Asher, Richard W.	6/18/1988	$90,000	A-90-381	6/10/1992	SET-A	Alleged failure to dx botulism & initiate tx
MED	Asher, Richard W.	6/18/1988	$17,500	A-90-381	6/10/1992	SET-A	Alleged failure to dx botulism & initiate tx
MED	Ellis, Richard	8/5/1986	$95,000	A275397	7/17/1992	SET-A	Alleged failure to dx & tx aseptic necrosis R femoral head
MED	Harrison, Harry	2/20/1987	$159,500	3AN-89-1262	7/21/1992	SET-A	Alleged delayed dx of necrotizing enterocolitis in newborn
MED	Jacob, Jack	2/20/1987	$53,000	3AN-89-1262	7/21/1992	SET-A	Alleged delayed dx of necrotizing enterocolitis in newborn
MED	Vasileff, Thomas	2/28/1989	$45,000	3AN-91-6689	8/3/1992	SET-A	Arthoscoped wrong knee
MED	Farleigh, Denise C.	2/20/1987	$148,750		8/5/1992	SET-B	Alleged delayed dx of necrotizing enterocolitis in newborn
MED	Moeller, Mark	11/11/1988	$150,000	3AN-90-8975	8/5/1992	SET-A	Alleged failure to dx abdominal aortic aneurysm rupture
MED	Johnstone, Bruce B.	1/72-7/74	$175,000		8/31/1992	SET-A	Alleged "physical contact" w/ pt result in emotional injury
MED	Emenhiser, Donald L.	5/1/1989	$17,500	L89-656	9/1/1992	SET-A	Failure to dx heart disease; failure to refer
MED	Alvarez, Rene	3/22/1988	$122,500	3KO-90-394	9/10/1992	SET-A	Alleged unnec TAB/BSO for tx of PID; alleged unnec surg
MED	Sangster, Joseph A.	10/6/1986	$300,000	3KN-88-825	9/22/1992	OOC	Alleged negligent performance in dx ureteral obstruction

ALASKA STATE MEDICAL BOARD

REVISED 03/05/2004

SORTED BY DATE PAID

Board	Practitioner Name	Occurred	Award	Case/Count #	Date Paid	Res	Brief Description of Claim
MED	Grimm, Arthur R.	1/12/1988	$200,000		11/3/1995	SET-B	Alleged failure to dx lung Ca resulting in death of pt
MED	Orlando, Michael R.	11/14/1991	$600,000	F300179/TM	12/19/1995	CA	During endoscopic sinus surg, optic nerve, rectu muscle cut
MED	Hoag, Robert (w/ Ritzen)	90-92	$150,000		1/1/1996	SET-B	Alleged negligence in interpret of pap smear
MED	Ritzen, Alex (w/ Hoag)	90-92	$150,000		1/1/1996	SET-B	Alleged negligence in interpret of pap smear
MED	Walker, Enlow R.	11/17/1994	$8,333	98-100062-SR	3/15/1996	SET-B	Alleged failure to notify pt of abnormal pap
MED	Dumas, Marc	2/16/1993	$70,000	4 FA 95 415	5/23/1996	SET-A	Failed to admit/observe inebriated pt; later dx cervical fx
MED	Tyler, Earl D.	2/17/1993	$70,000	4FA-95-415	5/28/1996	SET-A	Alleged negligent interpretation of MRI of spine
MED	Klepp, A. Leonard	4/15/1993	$5,040		7/19/1996	CA	Removal of lesion by laser & developed keloid.
MED	Liberatore, Marcia A.	9/23/1995	$2,245		7/26/1996	SET-B	Failure to Dx fractures/inadequate discharge instructions
MED	Davidhizar, Lavern R.	6/27/1994	$1,063	3KN-96-223	8/21/1996	SET-A	PA employee failed to advise pt of meds' side effects to sun
MED	Mackie, Scott P.	2/18/1989	$77,598	3AN-89-7746	8/29/1996	SET	HIV test w/o consent-results given to spouse before pt told
MED	Merchant, Clifford R.	5/20/1995	$23,500		9/11/1996	SET-B	Alleged failure to hosp w/ chest pain; pt had MI next day
MED	Palmer, William M.	5/5/1989	$150,000	1JU-96-1040	9/25/1996	SET-A	Alleged delay in Dx, treatment of breast cancer
MED	Williams, John D.	7/9/1992	$32,856	3AN-94-5234	9/30/1996	CA	Jury found insufficient data to support surgery repair to ear
MED	Roode, Peter G.	10/7/1994	$37,500		11/8/1996	SET-A	Alleged failure to diagnose heart attack
MED	Kim, Eui G.	10/19/1994	$35,000	3AN-96-6375	12/11/1996	SET-A	Urinary incontinence surgery complications
MED	Worley, Floyd	5/29/1995	$18,500		12/12/1996	SET-B	Alleged failure to dx ectopic prognancy w/ tubal rupture
PAD	Jones, Gary P.	9/14/1994	$25,000		2/25/1997	SET-B	Negligent care while responding to accident
MED	McConkey, Samuel A.	1/19/1991	$69,592	4FA-93-857	3/10/1997	CA	Following laser trtmt pt lost central vision in left eye
MED	Fortier, George M.A.	3/3/1982	$150,000	WRM129OUP0356	3/13/1997	CA	Alleged incompl vagotomy result in recurrent ulcer & 2nd surgery
MED	Fortson, Jayne S.	8/7/1996	$8,000		3/13/1997	SET-B	Pt received 1st degree burns during ultraviolet light therapy
MED	Crouch, Edward E.	2/2/1993	$70,000	7011398-M	4/10/1997	SET-B	Tunic of eye punctured due to negligent injection of Kenalog
MED	Tinsley, Ronald E.	4/8/1994	$54,000	1JU-95-747	4/10/1997	SET-A	Alleged failure to remove nasal packing resulted in reoperation
MED	Palmer, William M.	5/5/1994	$180,000	1JU-95-2173	4/14/1997	SET-A	Alleged unnec laporoscopic surg; negligent follow-up
MED	Murphy, Neil J.	10/4/1994	$750,000		5/6/1997	SET-B	Wrongful death, gas embolism of heart during routine hys/lap
MED	Lacort, Linda L.	12/14/1990	Confidential	93-1648 RI SupCt	5/12/1997	SET-A	Breach of care; labor & delivery management
MED	Jackson, M. Marcell	1/28/1993	$10,000	3AN-95-1961	5/13/1997	SET-A	Alleged overdose of drug --withdrawal symptoms; fail to refer
MED	Gower, Roland E.	9/23/1992	$15,000	3AN-93-7693CI	5/15/1997	SET-A	Alleged negligent laparoscopic cholecystectomy
MED	Palmer, William M.	4/16/1996	$65,000		5/20/1997	SET-B	Alleged negl performance abd laparoscopy w/ injuries
MED	Senta, Michael	12/5/1994	$65,000	3PA-96-971	7/1/1997	SET-A	Failure to dx /tx colonoscopy--death due to hemorrhage
MED	Beyeler, Natalie	12/6/1994	$65,000	3PA-96-971	7/1/1997	CA	Failure to dx/treat compl/colonscopy/death/2nd splenic hemor
MED	Klester, W. Scott	6/1/1992	$15,000	3AN-96-10106	7/11/1997	SET-A	Failure to dx/tx cholesteatoma
MED	Newton, Douglas E.	4/18/1995	$50,000		8/6/1997	SET-B	Pt dx w/ anxiety; presented next day w/ MI
MED	Hileman, Stephen L.	2/6/1992	$65,000	93-01-07969-CV	8/28/1997	SET-A	Pt w/pancreatitis died of alleged fluid overdose
MED	Hibeg, Alisa M. Little	10/31/1995	$12,500		8/28/1997	SET	Perineal laceration after infant's delivery
MED	Linehan, Charles K.	7/9/1993	$565,000	96-2090	10/3/1997	CA	Delay in dx of melanoma; pt died of metastic Ca
MED	Swayman, Kenneth C.	2/24/1993	$50,000	95-2-33462-2SEA	10/31/1997	SET-A	Alleged improper & unnecessary foot surgery
MED	Smith, John James	7/20/1992	$394,704	3AN-94-10736	11/5/1997	SET-A	Pt died from rare Ca not dx by Pap tests
MED	Johnson, R. Holmes	2/4/1994	$222,500	A96-030	11/14/1997	SET-A	Alleged delay dx/tx cervical spine inj resulting in C-5 quardp
MED	Nathanson, Steven E.	12/31/1996	$250,000	3AN-97-3209	12/3/1997	SET-A	Allegation of poor surgery outcome
MED	Fellman, Lawrence J.	8/27/1994	$21,373	4FA-96-1874	12/18/1997	SET-A	Alleged negligent eval of thumb laceration;tendon lac req surg
MED	Wood, Lawrence P.	09/94	$85,000	128815	1/29/1998	SET-B	Failure to dx subtle C-spine fx
MED	Hawkins, Ileana	1/31/1991	$75,000		4/10/1998	SET-B	Misdiagnosed malignant lymphoma, result was death
MED	Heraper, Peter David	11/14/1997	$11,672		4/10/1998	SET-B	Dura perfd during ethmoidectomy w/ corebrospinu fluid leak
MED	Stephens, Burl S.	1/22/1994	$750,000	A [illegible]-259	6/9/1998	SET-A	Alleged failure to dx mass effect /cerebellum on CT scan
MED	Anderson, Richard S.	5/12/1997	$40,000		7/16/1998	SET-B	Inadvertant fetal death following amniocentesis
MED	Andersen, Roger Carl	7/13/1995	$150,000	97-[illegible]-Civ-HRH	7/24/1998	SET-A	Following surg for incont; lost kidney due to obstruct of ureter
MED	Conley, Thomas L.	11/5/1993	$658,104	98-10115 [illegible]-SW	7/30/1998	SET-A	Renal failure necessitating kidney transplant from mother
MED	Shannon, Charles R.	10/30/1995	$40,000	3AN-96-[illegible]3439	9/11/1998	SET-A	Misdx colonscopy of suspect tumor; tumor not found in surg

ALASKA STATE MEDICAL BOARD

REVISED 03/05/2004

SORTED BY DATE PAID

Board	Practitioner Name	Occurred	Award	Case/Court #	Date Paid	Res	Brief Description of Claim
MED	Tieva, Martin H.	8/4/1997	$700,000	SA-99-CA-1390	12/12/2000	SET-A	Failure to dx/tx papillary craniopharyngioma
MED	Deramus, Alfred D.	4/2/1997	$195,000	4FA-99-781	12/19/2000	SET-A	Alleged negl cataract surg & suspension of med; PO pt death
MED	Khabir, Jeffrey A.	Unknown	$287,500	95-8389NH	01/01/01	SET-A	Wrongful death
MED	Walters, Laura Marie	7/15/1997	$325,000	PR-000812TK	1/4/2001	PC	Failure to dx & tx angina, pt death
MED	Unsicker, Carl	8/1/1998	$62,500	PR99-02-007	1/22/2001	SET-B	Alleged failure of dx of fx carpal navicular
MED	Van Houten, Jay	4/9/1996	$450,000	3AN-99-114	2/7/2001	SET-A	Alleged improper management of medication, pt death
MED	Marble, Stephen P.	9/1/1992	$64,780	95-0902248	4/1/2001	SET-A	Alleged failure to supervise treatment/procedure
MED	Faucett, Ellen D.	7/17/1997	$500,000	3PA99625C1	4/2/2001	SET-A	Alleged failure to dx & trt Strep B in mother; injuries to newborn
MED	Godersky, John C.	5/27/1998	$325,000	3AN006554	5/21/2001	SET	Did spinal fusion surg on wrong site
MED	Van Houten, Jay	2/25/2000	$550,000	3AN-00-6907	5/29/2001	SET-A	Alleged excessive presc of meds, result in addiction, death
MED	Gower, Roland E.	3/24/1999	$250,000	3AN 00-03943CI	6/5/2001	CA	Alleged negligent transection of common bile duct
MED	Szekely, Daniel R.	7/19/1999	7/18/2228	C00-5432	7/6/2001	SET-A	Pt alleged should have been hospitalized nite before induct/fetal dth
MED	Crouch, Edward E.	10/11/1995	$701,500	3AN-97-8539CI	7/11/2001	SET-A	Alleged failure inform pt risks due to hx ROP; vision loss Rt eye
MED	Dix, Richard Michael	9/3/1997	$150,000	DM0662869622M001	7/25/2001	SET-B	Failure to prov antibiotics; closed fx radius/ulna w/ wound infect
MED	Kelley, William J.	3/9/1999	$55,000	3KN-00-1056	8/15/2001	SET-A	Wrongful death; cardiac arrest following bowel obstru surg
MED	Ford, Robert O.	10/26/1998	$175,000	71871	9/7/2001	SET-A	Alleged injury w/ Lasik surg; shouldn't have surg due to abn corneas
MED	Burton, Mark N.	1/13/1997	$131,250	SC20010059	9/17/2001	SET-A	Xray failed to reveal pulm nodule, delay in dx of lung Ca
PAD	Siddall, James J.	10/13/1998	$275,000	4FA-01-690 CIV	9/19/2001	SET-A	Removal of stuck contact lens resulted in corneal damage; transplt
MED	Lynch, Michael J.	8/23/1994	$120,000	97000305MI	10/2/2001	SET-A	Improper mgmt of diabetes during chemo for Ca
MED	Nordlund, John R.	1/25/1996	$312,300	3AN-98-3345	10/3/2001	SET-A	Alleged failure to dx post comm artery aneurysm
MED	Carlson, R. Lynn	7/13/1999	$175,000	43331	10/15/2001	SET-B	Pt w/ resp distr, PA gave inj in wrong loc; damaged radial nerve
MED	R. Lynn Carlson	7/13/1999	$175,000	Norcal 43331	10/15/2001	SET-B	PA injected Benadryl distally damaging radial nerve
MED	Barton, Theodore D.	2/4/2000	$217,000	3AN-01-07752CI	10/15/2001	SET-A	Alleged lack of informed consent, negl performed br biopsies
MED	Boesch, David E.	10/12/1999	$32,500	CV2000-018264	10/25/01	SET-A	Failure to dx dislocation of R 4th finger
MED	Anderson, John Nels	1998	$15,000	3KN-99-707	11/16/01	SET-A	Failure to obtain consent to use eggs for other pt
MED	Beal, David D.	10/14/1997	$125,000	3AN-99-10484	12/4/2001	SET-A	Unnec tonsillectomy due to mitigating circumstances
MED	Sitter, Stephen C.	10/14/1997	$23,333	3AN-99-10484	12/4/2001	SET-A	Alleged failure to supv CRNA, premature dischrg of pt from recovry
MED	Matsutani, Osamu	8/4/1997	$65,000	3AN-99-8672CI	12/11/2001	SET-A	Alleged failed to prevent suicide
MED	Fortson, Jayne	9/8/1997	$10,000	3AN-99-09717	1/18/2002	SET-A	Alleged sunburn-like reaction to tx of PUVA lite therapy for psoriasis
MED	Krauss, Seth L.	5/31/1999	$300,000	3AN-00-11749CI	1/22/2002	SET-A	Alleged negligence in failure to dx MI
MED	Cable, Harold F.	June, 1997	$1,000,000	3AN-98-6532CI	2/5/2002	SET-A	Alleged back problem worsed following surgery
MED	Magen, Ned A.	2/11/1998	$275,000	3KN00-97CI	2/19/2002	SET-A	Alleged misdx of meningococcus-meningococcemia
MED	Hansen, Peter O.	3/1/2001	$572,798	48611	3/10/2002	SET-B	Alleged negl prescribing of atenolol
MED	Boling, M. Todd	4/14/2000	$590,000	M000057852	3/21/2002	SET-B	Complications fr laparoscopic exam & adheiolysis
MED	Paton, William A.	3/16/1999	$60,000	3AN-01-05517	3/22/2002	SET-A	Alleged negl severed right median nerve during carpal tun surg
MED	Adams, Peter B.	5/14/1999	$80,000	3AN-01-7212	3/26/2002	SET-A	
MED	Goldberg, Marshall	5/24/1999	$50,000	30/519-92-8525	3/27/2002	PC	Alleged misdx/mistx of severe pre-eclampsia; fetal death
MED	Lawrence, Jeffrey D.	5/2/2000	$250,000	none	4/23/2002	SET-B	Suture in bladder from bladder suspension surg
MED	Stewart, Glenn	6/8/2000	$1,603,362	3AN-00-08446	4/26/2002	SET-A	Alleged that use of radiation to trt plantar's warts below std of care
MED	Jacoby, Kamy	3/31/1997	$25,000	98-2140640	4/30/2002	SET-A	Alleged negligence in removing drain, part of drain left in wound
MED	Belcher, Mark D.	9/4/1997	$83,333	3AN-99-9629	5/8/2002	SET-A	surg for perf apndx; died; autopsy found blood in lung pleural space
MED	Wennen, William W.	7/22/1999	$65,000	4FA-01-1400	8/5/2002	SET-A	Pt unhappy with outcome of eyebrow tattooing - darker than desired
MED	Snyder, John M.	9/2/1998	$400,000	3AN 00 9698	8/23/2002	SET-A	Alleged lack of post-op monitoring caused brain infarction
MED	Nyboer, Jan H.	4/22/1999	$5	3AN-01-5736	9/8/2002	SET-A	Alleged neg of two employees supp causing a detached retina
MED	Fawley, Howard H.	8/3/2001	$17,500	DMO663321502A002	10/23/2002	SET	Alleged failure to dx finger fracture
MED	Fawley, Howard Huff	8/3/2001	$17,500	DM0663321502A002	10/23/02	SET-B	alleged failure to dx finger fx on xray
MED	Nolan, Declan R.	1/19/1999	$650,000	2ANO13883C	11/5/2002	SET-A	Alleged negligent surgy and post-op follow up (?)
MED	Whipple, Bruce	4/1/1998	$561,455	4FA-00877CI	11/06/02	SET-A	Alleged negl in failure/delay to dx cerfical osteomyelitis
MED	Fell, William Russell	10/30/1999	$45,000	3PA011169C	11/14/02	SET-A	Residual facial nerve weakness following surgery, known risk

LEGISLATIVE RESEARCH REPORT

APRIL 16, 2003

REPORT NUMBER 03.177

PHYSICIANS IN ALASKA

PREPARED BY KATHLEEN L. WAKEFIELD, LEGISLATIVE ANALYST,

You asked several questions about physicians in Alaska, including the number of doctors per capita, the rate of growth in the number of physicians, the average age of physicians in Alaska, and factors that affect the number of doctors in the state. You wished to know if Alaska has difficulty attracting physicians, and if certain areas of the state experience a lack of doctors, as well as the number of Alaska students attending medical school. Finally, you wished to know about retired doctors in Alaska, limited liability laws in other states for retired doctors wishing to volunteer their services, and any cost benefits for retaining retired physicians.

NUMBER OF DOCTORS PER CAPITA

According to *State Rankings 2002*, Alaska ranked 46th out of the fifty states in the number of physicians per capita in 2000.[1] This report showed 193 physicians per 100,000 residents for

[1] "Rate of Nonfederal Physicians in 2000," *State Rankings 2002: A Statistical View of the 50 States*, Kathleen O'Leary Morgan and Scott Morgan, editors, 2002, p. 351.

Alaska; the national rate was 277 physicians per 100,000 residents.[2] Table 1 shows the rate of growth of the number of physicians in Alaska compared to population growth. As you can see, there is no correlation between population growth and growth in the number of doctors.

Table 1: Growth Rate for Physicians Compared to Alaska Population, 1985-2002

Fiscal Year	Number of Active Doctors*	Rate of Growth (Percentage Change by Year)	Population	Rate of Growth (Percentage Change by Year)
1985	815		543,900	
1986	934	15%	550,700	1%
1987	1,027	10%	541,300	-2%
1988	1,089	6%	535,000	-1%
1989	925	-15%	538,900	1%
1990	1,038	12%	553,171	3%
1991	1,004	-3%	569,054	3%
1992	1,152	15%	586,722	3%
1993	1,183	3%	596,906	2%
1994	1,417	20%	600,622	1%
1995	1,419	0%	601,581	0%
1996	1,593	12%	605,212	1%
1997	1,603	1%	609,655	1%
1998	1,826	14%	617,082	1%
1999	1,810	-1%	622,000	1%
2000*	2,034	12%	629,831	1%
2001*	1,850	-9%	633,900	1%
2002*	2,080	12%	637,943	1%

Notes: * These figures include only active medical doctors and doctors of osteopathy (with the exception of podiatrists, because those numbers include both active and inactive practitioners.) * Population figures for FY00-02 are estimates.

Sources: Alaska State Medical Board, Department of Community and Economic Development; State Demographer, Department of Labor and Workforce Development.

According to the Alaska State Medical Board, as of August 2002, approximately 52 percent of physicians licensed to practice medicine in Alaska are under age 50.[3] Acccrding to the American Medical Association, in 2000, of the 813,770 physicians licensed to practice in the United States, 17 percent were under age 35, 65 percent were age 35-64, and 18 percent were age 65 and over.[4]

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[2] These numbers include only "nonfederal" physicians. Federal physicians are those working at federally funded public health clinics, such as Indian Health Services doctors.

[3] Personal communication from Leslie Gallant, Executive Administrator, Alaska State Medical Board, Department of Community and Economic Development. Ms. Gallant can be reached at 907-269-8163.

[4] "Physicians in the United States and Possessions by Selected Characteristics," *Physician Statistics Now*, American Medical Association, *http://www.ama-assn.org/ama/pub/category/2688.html*, accessed April 8, 2003.

HEALTHCARE

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OTHER TOPICS

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FACTSHEET

Five Dangerous Myths About California's Medical Malpractice Restrictions

Myth#1: Legal Restrictions on Victims Lowered California Doctors' Malpractice Premiums.

Facts: Californians enacted the strongest insurance rate regulation in the nation in 1998 through insurance reform Proposition 103 (Prop 103), a ballot initiative passed by the voters and authored by FTCR president Harvey Rosenfield. This law resulted in a rate freeze, a rate rollback, and stringent regulation that reduced premiums in all lines of insurance -- including medical malpractice.

In 1975, California enacted a series of legal restrictions on injured patients -- the Medical Injury Compensation Reform Act (MICRA). Data from the National Association of Insurance Commissioners, summarized in graphs linked to below show that:

- Overall, California medical malpractice premiums increased dramatically during the first thirteen years with MICRA and substantially decreased after voters' approved Proposition 103. (See graph)
- Medical malpractice premiums remained extremely volatile after MICRA and did not stabilize until Prop 103 imposed rate regulation in 1988.
- In 1986, after a decade of MICRA, California was once again mired in an insurance crisis, with medical malpractice premiums rising at a rate of 26% annually, faster than premiums rose nationally during the same period. In fact, the year MICRA's cap of damages was upheld in cour (1985), California malpractice premiums increased by 20% and the following year rates jumped an additional 40%.
- Conversely, after three years of insurance regulation under Prop 103, medical malpractice rates had fallen by more than 20%. During the first decade of regulation, premiums were down by 7% and, if we adjust for inflation, medical malpractice premiums are down by 35% since the enactment of regulation.

adn.com
Anchorage Daily News

Patient Power

National groups and Alaska watchdogs encourage consumers to question health care providers

By ANN POTEMPA
Anchorage Daily News

(Published: March 2, 2004)

NEXT TIME YOU PAY A VISIT TO YOUR DOCTOR, ask questions.

Here's one to start with: "Did you wash your hands?"

Patients may take it for granted that doctors and nurses head to the sink before each exam, but local hospitals admit some of their employees don't. At one, a study showed that about a third of the staff wasn't washing up.

This new approach is a healthy self-defense for patients. It's a shift away from automatically trusting that the folks in scrubs and stethoscopes always do the right thing. This year, a national hospital accreditation agency gave consumers some muscle by creating seven National Patient Safety Goals that hospitals must meet (see list at left).

Too often, patients think: "Gosh, they're a *hospital*. They know what they're doing," said Dr. Norman Wilder, one of the founding members of Alaska's Patient Safety Collaborative, a group of patient safety advocates from medical facilities around the state.

But medical professionals make mistakes. Intentional or not, they can be deadly. An Institute of Medicine report in 1999 concluded that mistakes made in hospitals cause more deaths nationwide than do car accidents, breast cancer or AIDS. The report, "To Err Is Human: Building a Safer Health System," drew from studies of Utah, Colorado and New York hospitals. Alaska was not a focus of the study, but the error rates from participating states were extrapolated over total U.S. hospital admissions in 1997. The institute estimated that errors killed 44,000 to 98,000 people every year.

National agencies and Alaska's own advocates are coming up with new ways to help lower those numbers. Alaska's group is giving patients stickers that tell them to question their doctors. They're asking doctors to wear stickers that say they welcome inquiries.

Members of the collaborative talked about a recent serious error on the East Coast. Last year, a teen girl died after a medical team at Duke University Hospital performed a heart-lung transplant on her using an organ donor with the wrong blood type.

Alaska's collaborative didn't just point fingers Outside. Medical staff here admitted to giving the wrong drugs to patients. From now on, staff have to find two ways to correctly identify each patient before giving medications or taking blood. It's no longer acceptable to allow patients to simply nod "yes" when a doctor asks if they go by a certain name; patients might be stressed or tired and nod

METHODS

Study Design

A team of researchers from the Harvard School of Public Health and the Kaiser Family Foundation designed and analyzed both surveys. They were conducted in the United States.

Physicians

The fieldwork for the survey of physicians was conducted by Harris Interactive. The sample was randomly selected from the national list of physicians provided by Medical Marketing Service. This list, which includes both physicians who are members of the American Medical Association and nonmembers, is updated weekly. A questionnaire was mailed to 1332 physicians along with a check for $100 as an incentive for completing it. The survey was conducted between April 24 and July 22, 2002. A total of 831 physicians either completed the questionnaire on paper and returned it by mail (777) or completed and submitted it online (54). The response rate was 62 percent.[19] The margin of error was ±3.5 percentage points.

The General Public

A total of 1803 members of the public were contacted and deemed eligible for the national telephone survey, performed with random-digit dialing; 1207 adults (18 years of age or older) completed the survey. It was conducted in Spanish and English by International Communications Research between April 11 and June 11, 2002. Respondents were not given a financial incentive to participate. The response rate was 67 percent.[19] The margin of error was ±2.6 percentage points.

The Survey Questionnaire

To conduct parallel surveys, a single questionnaire was developed and modified to be appropriate for each group of respondents. The questionnaire was reviewed by physicians and experts in medical errors and was then pretested for length and comprehensibility. Both surveys were revised on the basis of the results of these tests. Twenty-nine questions were included in the survey of physicians and 38 in the survey of the public; 8 questions in each instrument had multiple parts. The questions focused on inpatient errors, since the majority of proposals address such errors.

The questionnaire asked whether an error had ever been made in the respondent's own care or that of a family member and, if so, what the health consequences of that error had been. Respondents were asked to state in their own words what they considered to be the two most important problems with health care and medicine. The responses were grouped in categories, one of which was medical errors. No respondents in the survey of the public and few in the survey of physicians used the term "medical error" when answering the question. Most respondents used terms such as "incompetent doctors" and "mistakes."

After answering the open-ended question, respondents in both surveys were given the following statement defining "medical error" to ensure that they had a common understanding of the term: "Sometimes when people are ill and receive medical care, mistakes are made that result in serious harm, such as death, disability, or additional or prolonged treatment. These are called medical errors. Some of these errors are preventable, whereas others may not be."

Respondents were asked how many in-hospital deaths they thought resulted from preventable medical errors each year. They were given a choice of five numbers from 500 to 500,000 or more. Among the choices were the IOM's higher estimate of 98,000 (rounded to 100,000), the IOM's lower estimate of 44,000 (rounded to 50,000), and the estimate of 4500 (rounded to 5000) made by another team of researchers using a different set of assumptions.[12] We also asked respondents to rate the importance of 11 factors that might contribute to medical errors and the effectiveness of 16 possible solutions.

We asked the following question about high-volume centers: "Suppose a patient needs a specialized medical procedure. This person can choose either a hospital that does a large number of these procedures or a hospital that does not do as many. At which hospital do you think this patient would be more likely to have a preventable medical error made in his or her care, or wouldn't it make a difference?"

The questionnaires included the following vignette, developed by physicians[20]: "A 67-year-old man goes to the hospital for surgery. He has an allergy to antibiotic drugs, which is noted on his medical record. The surgeon does not notice the information about the allergy and orders an antibiotic to be given at the end of the surgery. A hospital nurse gives the patient the antibiotic." To examine the hypothesis that respondents' views on the appropriate consequences for the health professionals would vary according to the severity of the error's outcome, we randomly varied the health consequences for the patient. Half of each group of respondents were told that the patient was harmed: "The patient wakes up with a rash all over his body and is gasping for air. The mistake is noticed, and the antibiotic is stopped, but the patient stops breathing. Despite every effort, the patient dies." The other half were told that the patient was not harmed: "The patient wakes up with a rash all over his body. The mistake is noticed, the antibiotic is stopped, and the patient fully recovers." The physicians were told that the language of the vignette had been simplified so that laypeople would understand it.

Statistical Analysis

We compared responses by testing differences between proportions, using Fisher's exact test. The statistical program that we used took into account the design effects for each of the surveys by calculating the effective sample size. Because previous research has shown that the salience of an issue is an important factor in the level of support for change, we limited analyses of graded responses to the proportion of respondents who said that a cause of errors was "very important" or that a solution would be "very effective."[21] All reported P values are based on two-sided tests.

To adjust for sampling biases due to sociodemographic differences in nonresponse rates and to ensure that the sample was representative, survey responses were weighted by computer with the use of a predetermined weighting scheme. The data in the survey of the public were weighted on the basis of the latest U.S. Census numbers for sex, age, race or ethnic group, level of education, number of people in the household, and number of land telephone lines. The data in the survey of physicians were weighted for region, specialty, training (foreign vs. U.S.), and number of years since graduation from medical school. There were no qualitative differences between unweighted and weighted results.

RESULTS

Experiences with Medical Errors

Thirty-five percent of physicians and 42 percent of the public reported that they had experienced an error in their own care or that of a family member (Table 1). Eighteen percent of physicians and 24 percent of the public reported an error that had had serious health consequences, including death (reported by 7 percent of physicians and 10 percent of the public), long-term disability (6 percent and 11 percent, respectively), and severe pain (11 percent and 16 percent, respectively). About a third of the respondents in both groups who reported experience with an error said that the health professionals involved in the error had told them about it or apologized to them.

Seventy percent or more of both groups of re-

LEGISLATIVE RESEARCH REPORT

MARCH 3, 2004

REPORT NUMBER 04.184

PHYSICIANS PRACTICING IN ALASKA

PREPARED FOR REPRESENTATIVE LES GARA

BY PATRICIA YOUNG, MANAGER

You wished to know the number of physicians practicing in Alaska as compared to the population over the last several years. You particularly wished to know if the per capita number of physicians is in a declining trend.

The attached table shows the number of active, state-licensed physicians by year since 1985, as well as the population and the number of practicing physicians per 1,000 residents for each year since that time.[1] As you will see, by this measure, the number of physicians per 1,000 residents has, overall, increased steadily.

We also include a chart prepared by the State Medical Board showing the numbers of physicians as well as other primary health providers since 1985.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

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[1] These numbers reflect active, state-licensed medical doctors and doctors of osteopathy only. Doctors of podiatric medicine are not included because the numbers of active and inactive practitioners are not separated. We do not include federal physicians; because they are not licensed by the State Medical Board, their annul numbers are far less readily available.

907-465-3991
907-465-3908 (fax)

Alaska Legislature
Legislative Research Services
w3.legis.state.ak.us/Research/research_home.htm

State Capitol
Juneau, AK 99801

Fiscal Year	Population	State Licensed Physicians	State-Licensed Physicians per 1,000 Residents
1985	543,900	815	1.50
1986	550,700	934	1.70
1987	541,300	1,027	1.90
1988	535,000	1,089	2.04
1989	538,900	925	1.72
1990	553,171	1,038	1.88
1991	569,054	1,004	1.76
1992	586,722	1,152	1.96
1993	596,906	1,183	1.98
1994	600,622	1,417	2.36
1995	601,581	1,419	2.36
1996	605,212	1,593	2.63
1997	609,655	1,603	2.63
1998	617,082	1,826	2.96
1999	622,000	1,810	2.91
2000	627,576	2,034	3.24
2001	632,674	1,850	2.92
2002	641,482	2,080	3.24
2003	648,818	2,099	3.24

Notes: Numbers of physicians reflect active state-licensed medical doctors and doctors of osteopathy only; doctors of podiatric medicine are not included because their numbers include both active and inactive practitioners; federal physicians are not included because they are not licensed by the State Medical Board.

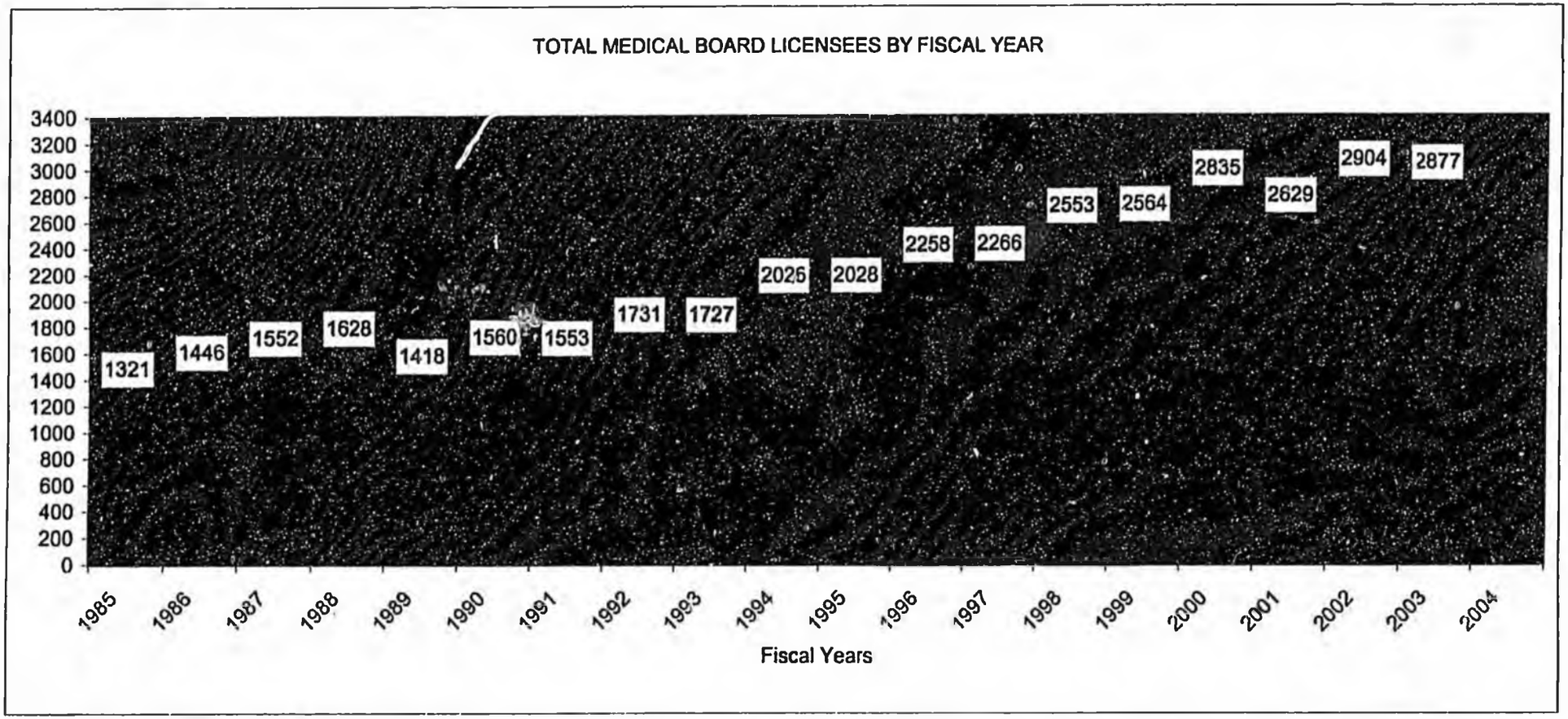
According to the American Medical Association, as reported in "Federal Physicians in 2001," Health Care State Rankings, 2003 (Morgan Quitno Press, 2003, p. 430), in 2001, Alaska had 147 federal physicians.

Population figures for 2003 are provisional.

Sources: Alaska State Medical Board, and Alaska Department of Labor and Workforce Development.

TOTAL PHYSICIANS, PHYSICIAN ASSISTANTS, AND PARAMEDICS BY FISCAL YEAR

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY04
MD/DO Active	815	934	1027	1089	925	1038	1004	1152	1183	1417	1419	1593	1603	1826	1810	2034	1850	2080	2099	
MD/DO Inactive	317	305	279	322	255	254	273	263	243	243	262	262	277	266	300	289	285	268	249	
DPM-Act/Inact	0	11	11	0	0	0	9	11	12	15	13	14	14	15	15	16	16	17	18	
PA-C-Act/Inact	111	111	134	126	138	157	159	186	177	216	200	231	221	255	244	266	245	284	266	
MICP-Active	78	85	101	91	100	111	108	119	112	135	134	158	151	191	195	230	233	255	245	
TOTAL	**1321**	**1446**	**1552**	**1628**	**1418**	**1560**	**1553**	**1731**	**1727**	**2026**	**2028**	**2258**	**2266**	**2553**	**2564**	**2835**	**2629**	**2904**	**2877**	
% Variance from Previous Year	–	+9.4	+7.3	+4.8	-12.9	+10	- .05	+11.4	- .02	+17.3	–	+11.3	.03	+12.6	+.04	+11	-7.8	+10.4	-.09	



MD - Medical Doctor (allopathic)

DO - Doctor of Osteopathy

DPM - Doctor of Podiatric Medicine

PA-C - Physician Assistant-Certified

MICP - Mobile Intensive Care Paramedic

Source: Leslie Gallant, Alaska State Medical Board

Part 1. The Real Relationship between Caps and Med Mal Premiums

On the surface, the theory behind caps on non-economic damage awards seems logical: caps would limit the payouts by insurers, and the lower payouts, in turn, would naturally enable the insurers to reduce med mal premiums. As we shall demonstrate below, however, in the real world of the med mal insurance business, only the first half of this theory is working.

Caps do reduce the burden on insurers...

Using data provided by the National Practitioner Data Bank, we compared the median payouts in the 19 states with caps to those in the 32 states without caps[4] for the period between 1991 and 2002, with the following results:

- **Payouts reduced.** In states without caps, the median payout for the entire 12-year period was $116,297, ranging from $75,000 on the low end to $220,000 on the high end. In states with caps, the median was 15.7% lower, or $98,079, ranging from $50,000 to $190,000.[5] Since caps in many states were not imposed until late in the 12-year period, this represents a significant reduction.

- **Growth in payouts slowed substantially.** The median payout in the 32 states without caps increased by 127.9%, from $65,831 in 1991 to $150,000 in 2002. In contrast, payouts in the 19 states with caps increased at a far slower pace—by 83.3%, from $60,000 in 1991 to $110,000 in 2002.

In short, it's clear that caps do accomplish their intended purpose of lowering the average amount insurance companies must pay out to satisfy med mal claims.

But insurers continue to increase premiums at a rapid pace, regardless of caps.

Using 1991 to 2002 data published by the Medical Liability Monitor, we examined the median med mal premiums paid by doctors in three high-risk specialties—internal medicine, general surgery, and obstetrics/gynecology. The results:

1. **States with caps had sharper increases in median annual premiums.** Since the insurers in the states with caps reaped the benefit of lower med mal payouts, one would expect that they'd reduce the premiums they charged doctors. At the very minimum, they should have been able to slow down the rate of premium increases. Surprisingly, the data show they did precisely the opposite:

    - In the 19 states with caps, the median annual premium increased by 48.2%, from $20,414 in 1991 to $30,246 in 2002.

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[4] For the purposes of this analysis, the District of Columbia is being referred to as a "state" since it effectively operates as such with regard to insurance regulation.

[5] Adjusted for inflation in order to evaluate figures spanning multiple years.

Americans for Insurance Reform - Fact Sheet

California Restrictions On Malpractice Victims Have Not Affected Malpractice Premiums

Premium Data Shows California Law Is No Model For The Nation

Data released today by two consumer groups show that California's 22-year experience with the nation's most draconian limits on the rights of medical malpractice victims has failed to slow premium increases for doctors and hospitals. In fact, over the last decade, the average malpractice premium in California has grown more quickly than it has in the nation overall.

The California-based Foundation for Taxpayer and Consumer Rights and New York-based Center for Justice & Democracy (CJ&D) hired nationally recognized actuary J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator under Ford and Carter, to compare national malpractice premium trends to those in California. Hunter found that from 1991 to 2000, malpractice premiums in California have stayed close to national premium trends. The 2000 average premium per doctor in California was only 8.2 percent below that of the nation ($7,200.61 vs. $7,843.75) while the average malpractice premium in California between 1991 and 2000 actually grew more quickly (3.5 percent), than it did in the nation overall (1.9 percent.) According to Hunter, "there is not much difference in the rates or the rate of change between California and the nation based on the latest decade of experience."

In the mid-1970s, California enacted severe laws restricting the rights of patients who have been injured by malpractice, allowing them to recover no more than $250,000 in noneconomic compensation no matter how egregious the malpractice or serious the injury. The medical establishment is campaigning to spread this severe cap on damages not only to other states, but to the entire nation in recently introduced federal legislation (H.R. 4600), arguing falsely that this cap has kept premiums dramatically downward.

"If there are savings to limiting the rights and recovery of innocent victims of dangerous and culpable doctors, then insurers have not passed them on to physicians," said Jamie Court, executive director of the Foundation for Taxpayer and Consumer Rights. "California is a failed model for the national restrictions being proposed on patients. California patients have been denied adequate compensation and representation for their injuries, and California doctors have seen almost no premium savings. Only the insurers have gotten rich in the good times."

"This study disputes one of the most sensationalized fictions driving the movement to limit lawsuits against malpracticing doctors and hospitals – the notion that California's brutal restrictions on patients' rights, enacted in the mid-1970s, have slowed the growth of malpractice premiums," said CJ&D Executive Director Jo[illegible]ne Doroshow. "In fact, the opposite has happened. Over the last 10 years, California's premiums have grown faster than the nation's.

"This analysis has, for the first time, exposed as an insidious public relations scam the notion that California's cruel law has controlled the growth of malpractice insurance premiums. This law has had terrible consequences for many innocent people, while doing nothing to improve the affordability of liability insurance for doctors."

in Ga. over malpractice; Sharply rising insurance expenses cause some doctors to drop services," *Macon Telegraph*, December 30, 2002.

Illinois

In Illinois, ***the number of malpractice claims stayed about even over the course of the 1990s.*** ... Payouts to people who sued both doctors and hospitals jumped sharply in the early 1990s, but they've held relatively even since then. ... ***76 percent of malpractice claims were dismissed without payment in 1999.***" (emphasis added). Editorial, "Ups And Downs," *St. Louis Post-Dispatch*, February 3, 2003, part 1 of a 2 part series entitled, "Malpractice Insurance: Q & A."

Kentucky

"[T]he number of ***doctors per person in Kentucky has increased faster than in the rest of the nation since the early 1980s.***" Gideon Gil, "2003 Kentucky General Assembly; Study: Jury award limits wouldn't cut doctors' premiums," *Courier-Journal* (Louisville, KY), February 25, 2003. "In 2001, 69 malpractice suits went to trial in Kentucky, according to the Kentucky Trial Court Review. Plaintiffs won only 19. And just six plaintiffs won $1 million or more." John Cheves and Karla Ward, "Ob/Gyn, Bye Patient Illustrate Problem," *Lexington Herald-Leader*, February 4, 2003.

Mississippi.

"Medical groups have claimed doctors are fleeing Mississippi, relocating to states with more stable legal climates. So far, the numbers don't bear that out. In fact, ***the state has gained 564 doctors over the past five years.*** The state Medical Association has said the growth in doctors lags behind the state's population growth. But while Mississippi still ranks last in the nation in the number of doctors per capita, it has made dramatic gains since 1995. ***Only four states have grown faster in physician population***: Alabama, Alaska, Arkansas and South Dakota. (emphasis added). Joey Bunch, "Crisis or PR campaign?; Pro and con forces seek to win hearts and minds of Mississippians," Biloxi Sun-Herald, August 11, 2002.

In October 2002, lawmakers limited jury awards for non-economic "pain and suffering" damages to $500,000. Despite enactment of the cap, premiums continued to skyrocket and, for some doctors, coverage is still unavailable at any price. See., e.g., Ben Bryant, "Tort reform has done little to ease malpractice crisis," *Biloxi Sun-Herald*, February 2, 2003.

Missouri

"[Gov. Bob] Holden's insurance report, a four-month study of the medical malpractice market, said ***that litigation that resulted in a cash payment had dropped 42 percent from 1988 to 2001,*** and that ***the number of claims overall had fallen from 2,244 to 1,599, or 29 percent, since 1987.*** (emphasis added). Deslane Aaron, "Malpractice rates gain Holden's attention," *Springfield News-Leader*, February 7, 2003. "In Missouri, the number of malpractice claims actually dropped over the course of the 1990s. ...In Missouri, average payments to patients who sued doctors rose 23 percent from 1992 to 2001. But that was less than the 26 percent rise in the consumer price

Legislative Research Services

Alaska State Legislature
Legislative Affairs Agency
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March 16, 2004

Memorandum

TO: Representative Les Gara

FROM: Cherie Nienhuis
Legislative Analyst

RE: Per Day Recovery for Noneconomic Losses Totaling $250,000

You requested information about the daily recovery for noneconomic losses over a period of 50 years. You specifically referenced House Bill 472, which provides a maximum of $250,000 for these types of losses.

As you requested, with no compounding, the per day recovery would simply be the amount of $250,000 divided by 18,262 (365.25 times 50 years).[1] Using this formula, we calculate a rate of $13.69 per day for the maximum noneconomic losses attainable under HB 472.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

[1] There will be approximately 12 leap years over a 50-year time span, adding 12 days to the calculation.

AARP Alaska

March 11, 2004

The Honorable Lesil McGuire, Chair
House Judiciary Committee
Alaska State Capitol, Room 118
Juneau, Alaska 99801-1182

RE: HB 472 (Anderson)—Oppose Unless Amended

Dear Chair McGuire:

On behalf of the AARP members in Alaska, we ask that you and your colleagues on the House Judiciary Committee oppose HB 472, authored by your Committee Vice-Chair Representative Tom Anderson and co-sponsored by Representative Bud Fate, unless it is amended.

The issue of medical malpractice is often perceived as a battle between trial lawyers and insurance companies and physicians. We think it is also important to consider the victim of malpractice as well as **the ultimate goal of medical error reduction.**

AARP believes that state legislatures should not place limits on the amount of punitive damages or on joint and several liability, or unreasonable limits on damage awards for pain and suffering. We believe that a cap of $250,000 is, on its face, unreasonable.

For a cap to be reasonable, it would:

- Start at a level based on current conditions, not the arbitrary $250,000 figure chosen in California some 20 years ago,
- Provide flexibility for different types of cases,
- Include exceptions for egregious cases,
- Be indexed for inflation, and
- Be tied to other reforms, including mandatory error reporting and prompt payment requirements.

We oppose caps on punitive damages because these awards are relatively rare and generally imposed only in the most egregious cases, and thus are not a significant factor in malpractice premium problems

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James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org

Should you have any questions about our position, please feel free to contact Marie Darlin (907-586-3637), Coordinator of the AARP Capital City Task Force, Patrick Luby (907-762-3314), Legislative Representative, or me (907-245-5259.

Thank you for your consideration.

Sincerely,

Marguerite Stetson

Marguerite Stetson
AARP State Coordinator for Advocacy
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907-245-5259 (voice)
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CC: Vice-Chair Tom Anderson
Representative Jim Holm
Representative Dan Ogg
Representative Ralph Samuels
Representative Les Gara
Representative Max Gruenberg
Representative Bud Fate
Marie Darlin
Patrick Luby

Subject: Quotes from Insurance Company executives
Date: Mon, 1 Mar 2004 12:22:56 -0900
From: "Jeff Friedman" <jfriedman@frwusa.com>
To: <Representative_mike_hawker@legis.state.ak.us>
CC: <Representative_tom_Anderson@legis.state.ak.us>,
<Representative_les_gara@legis.state.ak.us>,
<Representative_lesil_mcguire@legis.state.ak.us>, <Senator_con_bunde@legis.state.ak.us>

Mike,

Regarding HB 472, there is little if any credible evidence to support the claims that malpractice litigation is a significant driver of health care costs. It is my understanding that when insurance industry executives were put under oath by the Florida legislature last year, they admitted that the rate increases they were passing on to doctors, were the result, by and large, not of judgments or settlements, but of their own investment failures. Other insurance executives and pushers of "tort reform" including caps on non-economic damages have repeatedly admitted that such caps will not result in lower insurance rates for doctors:

"I don't like to hear insurance-company executives say it's the tort system - it's self inflicted."

> ~Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California, Wall Street Journal, June 24, 2002.

"No responsible insurer can cut its rates after a [medical malpractice tort 'reform'] bill passes."

> ~Bob White, President of First Professional Insurance Company, the largest medical malpractice insurer in Florida, talking about a proposed $250,000 cap in the January 29, 2003 Palm Beach Post.

"I don't think we would argue that the premiums are likely to go down. We believe it will have the effect of reducing the increases in the future. And one of the reasons the premiums won't go down is that even if noneconomic damages are capped, the losses for economic loss, medical expenses, for example, are still in this current environment escalating at, medical inflation is running in the double digits. I forget exactly what it was last year. So even if you were to cap noneconomic damages, the economic damages will still cause acceleration in the premiums. So it would not go down, I want to clarify if I misspoke and said I thought the premiums would go down."

> ~Cliff Webster, representing the Washington State Medical Association & Chairman of the Washington Liability Reform Coalition, testifying before the Washington State Legislature, House Judiciary Committee, Feb. 21, 2003.

"Insurers never promised that tort reform would achieve specific premium savings..."

> ~From a press release published March 13, 2002, by the American Insurance Association (AIA).

"[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'"

> ~Victor Schwartz, General Counsel of the American Tort Reform Association, as paraphrased and quoted in "Tort Reforms Don't Cut Liability Rates, Study Says," published in Business Insurance July 19, 1999.

"We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."

> ~Sherman Joyce, President of the American Tort Reform Association, as quoted in "Study Finds No Link Between Tort Reforms and Insurance Rates," Liability Week, July 19, 1999.

"Insurance was cheaper in the 1990s because insurance companies knew that they could take a doctor's premium and invest it, and $50,000 would be worth $200,000 five years later when the claim came in. An insurance company today can't do that."

~Victor Schwartz, general counsel to the American Tort Reform Association, "Dose of Legality," Honolulu Star-Bulletin, April 20, 2003.

"While MICRA was the legislature's attempt at remedying the medical malpractice crisis in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California."

~James Robertson, Assistant Vice President and Associate Actuary, SCIPIE Indemnity Company (California's second largest medical malpractice insurer), in written testimony responding to a question from an administrative law jugdge who is overseeing a case in which SCIPIE has requested a 15.6 % rate hike. April 30, 2003

Alaska State Medical Association

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Testimony Provided by

Alex Malter, MD, MPH
President

Alaska State Medical Association

Before the State of Alaska
House of Representatives
Judiciary Committee

February 25, 2004

Testimony of the Alaska State Medical Association
Presented February 25, 2004

Madam Chair McGuire and House Judiciary Committee Members, my name is Alex Malter. I am an internist in private practice in Juneau, and also have the privilege of representing the Alaska State Medical Association (ASMA) as its current president. ASMA represents physicians statewide and is primarily interested in ensuring that Alaskans receive high quality health care

I am here today to express ASMA's support of HB 472, and to urge you to support the bill as well. The medical liability reforms it establishes are important to Alaskans for a variety of reasons. I expect others to testify, for example, how HB 472 will help stabilize the professional liability market, and, by so doing, effectively temper future increases in federal and state expenditures on health care. I would like to concentrate my remarks, however, on explaining how strong medical liability reforms will be critically helpful in recruiting and retaining enough well-trained physicians to provide for the future health care needs of Alaska's citizens.

Access to health care services is precariously limited in the state. Alaska has one of the smallest-- if not the smallest-- number of physicians per capita in the country. A January 19, 2004 American Medical News story pertaining to the special Medicare payment reforms for Alaska noted the crisis in work force: "Alaska has long ranked among the worst states in terms of physician supply. In 2002, the state had fewer than 1,350 doctors in private practice and another few hundred in the military or other government posts. The state has a population of 644,000 ... Only six states had a lower doctor to patient ratio".

The article went on to identify Idaho as the state with the worst physician shortage, estimating that state had one non-government physician for every 544 patients. However numbers from ASMA's own 2002 database-- which we believe to be more accurate than data used in the article-- showed only 1,115 physicians in active practice, or approximately one physician per 578 patients. Thus, it is quite probable that for 2002 Alaska actually had the lowest physician to patient ratio in country. Updated calculations based on our 2003 numbers indicate this is almost certainly still true, with one physician per 553 patients. By comparison, the state would need about 50% more actively practicing physicians to approach the national average of one doctor per 360 patients.

Further exacerbating the problem, Alaska's physician work force is relatively old compared to the rest of the country. The ASMA database shows that over half of the state's practicing physicians are older than 51, setting up a looming recruitment crisis. This scenario was was corroborated by the State Medical Board in a September 2002 Anchorage Daily News article titled "Shingle Shortage?" Finally, a 2002 local study of physicians by Providence Health System confirms the work force is aging, and highlights immediate shortages of certain specialists in Anchorage, including general internal medicine, psychiatry, and general surgery.

It is because of this imminent recruiting challenge that medical liability reform is so critically important in Alaska right now. This state does not have the capacity to "grow" physcians on its own. Alaska has no medical school, and of the small number of students who graduate annually from the WWAMI program, some do not return to practice here. Likewise, our lone family practice residency training program is relatively small. Alaska is-- and will continue to be-- a net importer of doctors. As such, we compete with other states that have physician shortages, a competition that is largely influenced by the state's medical practice environment.

A recent American Medical Association study of medical students found that the legal environment and the availability of affordable medical liability insurance plays a major part in a graduate's decision as to where to consider setting up practice. Alaska needs to optimize its medical-legal environment to help us recruit the doctors we need. That is why the Alaska State Medical Association supports HB 472. With its $250,000 cap on non-economic damages, the bill provides the "gold standard" liability reforms that will help create the healthy practice environment so important to physician recruitment.

ASMA understands that medical liability reform is only one element in developing this healthy environment. Still, because the State has already had the foresight to enact other important medical practice reforms, we believe liability reform is the most critical element remaining. Indeed, we are pleased to have been able to help state reach this point through our recent work on other important legislation, including the Alaska Patient Bill of Rights, Prompt Pay legislation, Physician Joint Negotiation legislation, and federal Medicare payment reforms targeted to Alaska. ASMA has even offered ideas to the current Administration regarding strategies by which the state could actively "market" Alaska to out-of-state physicians. As a result of these previous and ongoing efforts, ASMA believes that, except for strong medical liability reform, Alaska's practice environment is actually quite favorable.

Finally, I'd like to point out that in the gallery today are Dr. Jeanne Bonar, ASMA's immediate Past President, and Dr. Paul Worrell, the Association's President Elect. Their attendance today, along with mine, demonstrates that ASMA's past, present, and future are all committed to work to help attract the well-trained doctors the state needs. Thank you for your attention, and I again urge you to support HB 472.

I'd be happy to answer any questions that you may have at this time.

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EUGENE F. WILES
1922-1990

December 19, 2002

John Troxel, M.D.
Jeanne Bonar, M.D.
Peter Lawrason, M.D.
Alaska State Medical Association
4107 Laurel Street
Anchorage, Alaska 99508

RE: Marsingill v. O'Malley, M.D.

Dear Dr. Troxel, Dr. Bonar, and Dr. Lawrason:

I am writing this letter to you in your capacity as officers of the Alaska State Medical Association. The Supreme Court of the State of Alaska recently issued an opinion in Marsingill v. O'Malley, Supreme Court No. S-9859. The case arose out of post-surgical care provided by James O'Malley, M.D., to Vicky Marsingill in February, 1995. Plaintiff's allegations specifically arose out of a telephone conversation between Dr. O'Malley and Mrs. Marsingill late one evening, where Mrs. Marsingill made complaints that were of disputed significance. Dr. O'Malley advised her to go to the Emergency Department, but she elected not to follow that advice. A jury trial resulted in a verdict in favor of Dr. O'Malley, and plaintiff appealed. The Supreme Court, in overturning the verdict, ruled that the trial court should have given an instruction proferred by Marsingill indicating that the question of Dr. O'Malley's breach of his duty to "give sufficient information" must be measured "from the standpoint of the reasonable patient". For reasons explained below, I believe the decision may have significant impact on the potential liability of all health care providers in the state and should be addressed with the incoming State Legislature. I suggest you consult with your own counsel concerning my analysis and the potential impact the Marsingill decision may have on the delivery of health care in Alaska.

The first 13 pages of the court's opinion are more or less irrelevant insofar as the reversal is concerned. They are also irrelevant as far as your daily practice is concerned.

The court begins the critical aspect of its analysis on p. 14. It notes that Marsingill had two theories of liability, only the first of which it seems to have classified as a medical malpractice claim. The second theory is Marsingill's claim "that a physician owes a duty to give patients enough information to make intelligent treatment choices." They characterized Dr. O'Malley's breach of the duty of disclosure as a failure to "adequately inform Marsingill about the potential seriousness of her symptoms and the risk of failing to seek immediate examination and emergency room treatment." The supreme court noted that Judge Michalski, in instructing the jury, treated both claims as "medical malpractice claims", "requiring the jury to determine whether Dr. O'Malley had given Marsingill sufficient evidence to meet his duty to inform by relying exclusively on expert testimony concerning whether the doctor's advice breached the professional standard of care."

The court reasoned that the alternate theory of liability did not question Dr. O'Malley's competency or the medical care or treatment Dr. O'Malley actually provided. To that degree, once we get to the retrial of this matter we will argue that that issue had already been decided and need not be retried. We will also argue, based upon the court's statements, the decision has already been made that there was no breach of the professional standard of care that governs a general surgeon. Specifically, the court has stated that the second, or alternative theory "did not depend on whether he breached the professional standard of care that governs the general surgeon. It was based solely on the "adequacy of the information" disclosed about treatment options. What is extremely difficult to fathom about the decision is that all of the cases relied upon by the court as well as all of the language used comes from informed consent, which is governed by statute in Alaska, or so we thought.

The court distinguishes between the standard that governs the duty to render adequate care and the standard that governs a physician's duty to disclose information. It cited Pedersen v. Zielski and noted: "A physician therefore undertakes, not only to treat a patient physically, but also to respond *fully* to a patient's inquiry about his treatment, i.e., to tell the patient everything that a reasonable person would want to know about the treatment." Of course, as I am sure you note, that case refers specifically to "treatment". The Pedersen case, which I was involved with, concerned a transected aorta and allegations of actual fraud on the part of the physician. None of the allegations were upheld.

The court further goes on and notes that under the Korman v. Mallin decision it has adopted the so-called "modern trend" which "measure[s] the physician's duty of disclosure by what a reasonable patient would need to know in order to make an informed and intelligent decision." What is left out in that quotation is that Korman again specifically involved informed consent and specifically involved actual treatment of the patient.

The court discounts the need for expert testimony in establishing this scope of disclosure, but does not totally eliminate it. On p. 16 of the decision it indicates expert testimony is not a necessary element because the scope of disclosure is measured from the standpoint of the patient. However, it goes on to say on p. 17 that expert testimony remains relevant in narrowing the field of risks that are "potentially material". By that, I take it that expert testimony is appropriate in describing what the risks are. It indicates that "some" expert testimony is necessary to establish materiality because only a physician or other qualified expert is capable of judging risks and the likelihood of its occurrence. It defines the focus as "whether a reasonable person in the patient's position would attach significance to the specific risk" and further notes that this "determination does not require expert testimony".

The court internally recognizes that its prior decisions were all made in the context of what could only be characterized as informed consent allegations when it states: "We assume for present purposes that Dr. O'Malley is correct in asserting that Korman and Alaska's informed consent statute both extend only to situations involving recommendations for specific medical procedures and treatment". I believe they assume that because that's what the statute says. Recognizing what the statute says, the court then does what most of us are not allowed to do in real life, it takes the square peg and puts it in the round hole. It makes the jump of saying a recommendation to go to the emergency room "amounted to a recommendation for treatment". It glosses over the idea that none of our experts considered going to the hospital or the emergency department as "treatment" nor did Dr. Ravden, their expert, believe that "simply going to the hospital is a treatment or a procedure". The court then blindly and with apparent deafness, accepts Wagstaff's assertion that "nasogastric intubation is a procedure". If nasogastric intubation is their procedure or treatment, then it seems like the only thing O'Malley should have had to advise Marsingill on would have been the risk associated with nasogastric intubation and the alternative to nasogastric intubation.

The court really goes out on a limb with its assertions on pp. 18 and 19 where it suggests Dr. O'Malley "acquiesced" in Marsingill's decision not to go to the emergency room and then goes on to say "a physician's recommendation to do nothing in the face of threatening symptoms is the equivalent of a treatment recommendation and should be accompanied by a duty of disclosure." How any human being with an IQ that exceeded zero could have concluded from this record that Dr. O'Malley "recommended doing nothing" and that was somehow the equivalent of a treatment recommendation is beyond comprehension. Somehow Dr. O'Malley's telling Mrs. Marsingill to go to the emergency department several times, informing her O'Malley would meet her there, informing her that O'Malley would assure that she would not have to wait in the waiting area with other patients, and informing her of various steps that might be taken to diagnose

her complaints, metamorphed into a "recommendation to do nothing".

In that the "recommendation to do nothing" was "equivalent to a "treatment recommendation'", we now have informed consent kicking in. Once that leap has been made by the court it can then invoke Section 8.08 of the AMA Code of Medical Ethics, which specifically involves informed consent. Under Section 8.08 the duty of disclosure is to give "enough information to enable an intelligent choice." The dramatic weakness in the court's decision comes in Marsingill's own rejection of the idea that she had an informed consent claim. She repeatedly, through her attorney, maintained she did not have an informed consent claim. The court's ultimate decision was that failure to give the instruction "deprived Marsingill of her right to have a jury decide the issue directly, from the standpoint of a reasonable patient."

How does this affect physician's practice and what a physician needs to do from this point forward? First, we must start with the idea that the overwhelming support of your peers concerning the appropriateness of any advice you give to a patient will not be enough to prevent you from having to go through a trial concerning that advice. In every instance and for virtually everything you do, you must first look to what the mythical "reasonable patient" would want to know. That can apply to telephone conversations, conversations in the hospital, or conversations in your office with your patients. I believe the most immediate concern involves the same situation Dr. O'Malley was involved with here -- the telephone call in the middle of the night. Unfortunately, what is lost in all of this is that it doesn't really look to what a reasonable physician would say to a patient when confronted with a complaint over the telephone. Virtually anything you tell the patient can be misconstrued, and if the patient decides not to follow advice you provide, you can conceivably be held responsible for that patient's failure to follow that advice. Regardless of the nature of the complaint, if you decide to take a telephone call, I recommend a graduated approach with the ultimate goal being

for the patient to report to the emergency department virtually every time you receive such a call. I would provide the patient with all conceivable scenarios with the reported symptoms until the patient agreed to go to the emergency department. I would specifically include statements to the effect that there is a reasonable chance the patient could die or suffer serious bodily harm by failing to go to the emergency department. I would have a dictaphone available at all times to enable you to document for your records what actually transpired in any of those telephone conversations. The safest method might simply be to inform the patient at the commencement of the telephone conversation that you are recording the conversation for purposes of your records, and then simply placing the tape of that conversation in your medical record, with transcription only occurring in the event there was a dispute that developed over the contents of the conversation. This method would not work if you were away from home or office.

Alternatively, I would instruct answering services to simply play a pre-recorded message to all patients who call to the effect that any complaint they have may be serious, cannot be diagnosed on the telephone, and that they should proceed immediately to the emergency department for evaluation by an emergency physician. Using that approach, no questions can possibly exist concerning what transpired within the confines of the telephone conversation and there can be no "acquiescence".

Both approaches lessen a physician's ability to have a meaningful interaction with his patient in the context of reported complications or symptoms. Both approaches may dramatically affect patient census in the emergency department and will undoubtedly cause unnecessary visits to the emergency department by patients who truly do not need to go. Eventually, this approach may cause patients to cease calling physicians giving the limited meaningful information they can be provided. Unfortunately, I cannot see any alternative given the court's decision.

I hope this has been helpful. If you have any questions, please give me a call. Thank you for your attention to this matter.

Sincerely,

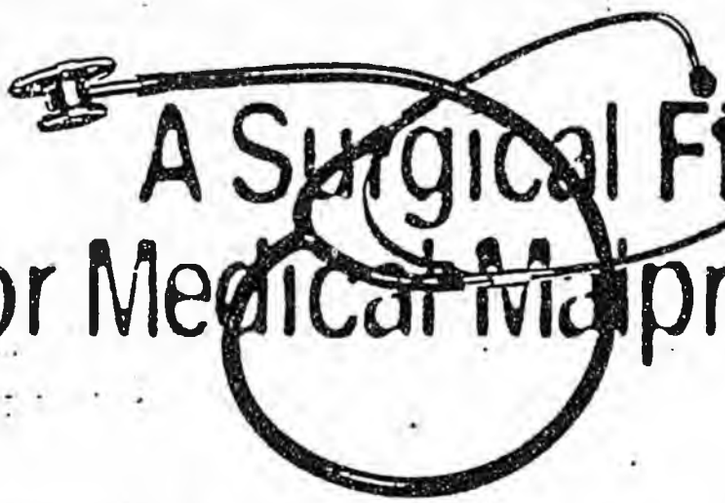
DELANEY, WILES, HAYES,
GERETY & ELLIS, INC.

Howard A. Lazar

HAL:msb

Enc.

65830w



A Surgical Fix for Medical Malpractice

Reforms Work Best as a Package, Study Shows

By Jeffrey Speicher

Almost everyone agrees: The medical malpractice system in the United States serves no one well. Although a few multimillion dollar settlements draw public attention, most individuals who suffer real injury at the hands of their physician or hospital accept less than the full value of their claim—and endure long delays before receiving compensation. Those most harmed—people left with lifelong medical needs or permanent loss of income—are most likely to be underpaid.

Physicians, who in the 1950s faced a 1-in-7 chance of being sued over the course of a career, now see the odds reduced to 1-in-7 *per year.* As a result malpractice insurance premiums have skyrocketed, causing many practitioners to abandon their specialties or adopt costly defensive-medicine procedures. Many insurers, buffeted since the early '70s by recurrent cycles of higher claims frequency and larger jury awards, have withdrawn from the market, which has reduced availability of coverage and further driven up costs. And as for attorneys . . . . well, even some thoughtful legal scholars believe the system is out of whack.

According to Randall Bovbjerg of Washington's Urban Institute, author of numerous studies on medical malpractice, many of the system's problems arise from a basic difference between doctors and lawyers: Physicians think about healing injuries, attorneys about resolving disputes. Says Bovbjerg, "Doctors see medical malpractice as a way to make injured patients whole—financially as well as physically. Lawyers come into the process after a conflict arises, and their focus is on justice for their client."

Jeffrey Speicher is manager of member communications for the Academy and an editor for Contingencies.

This difference in worldview intertwines medical malpractice with the legal system. Malpractice must balance the need to compensate deserving claimants, deter future violations by making doctors more careful, and obtain justice for both patients and medical providers. All this from what Bovbjerg defines as "mainly an insurance system run by experts."

A group of those insurance experts, members of the American Academy of Actuaries, recently suggested an approach to make the system less costly. According to the Academy report, "Medical Malpractice Tort Reform: Lessons from the States," the mixed results of reform attempts by the states point the way to effective federal action.

"Congress should adopt a comprehensive approach to tort reform by adopting a package of measures," says Jim Hurley, an actuary with Tillinghast/Towers Perrin and leader of the Academy group. "Our report provides a synthesis of measures that have been effective at the state level."

A Package Deal

The California Medical Injury Compensation Reform Act (MICRA) of 1975 shows the success of the package approach. Before MICRA's adoption, the state's percentage of total U.S. loss payments was significantly higher that its proportion of the nation's physicians. By 1981, California's loss payments had dropped and were about even with its percentage of physicians. Costs continue to fall, even as California's share of physicians remains stable. Writes the Academy group: "The relationship of decreased relative costs to the timing of reform provides strong evidence for the effectiveness of the MICRA package." [See Figure 1.]

At the head of the Academy's list for lawmakers is a nationwide cap on jury awards for noneconomic damages such as pain and suffering. As evidence, Hurley points to Ohio where malpractice costs fell after a 1975 cap on damages, only to rise dramatically after court challenges led to a 1985

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