ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672
10859 HOUSE JUDICIARY

FIGURE 1

Malpractice Loss Payments in California as a Percentage of the U.S. Total, 1975–94

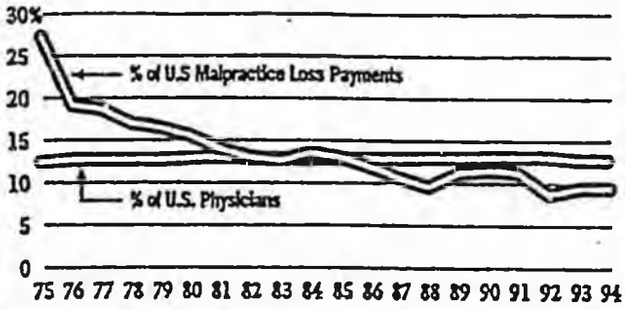
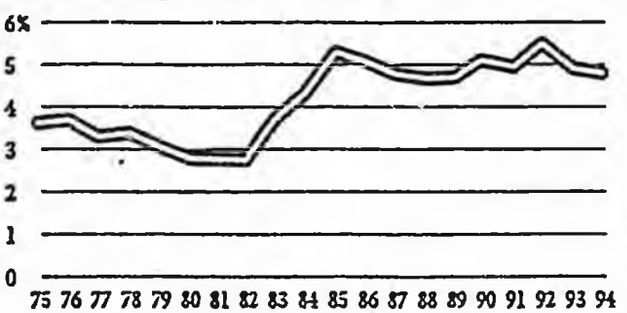


FIGURE 2

Malpractice Loss Payments in Ohio as a Percentage of the U.S. Total, 1975–94



ruling that overturned the cap. [See Figure 2.]

Such a cap should be established on a per-medical-injury basis at a level low enough to have an impact—at $250,000, for example. In addition, a mandatory collateral-source offset rule is needed to ensure that double and triple indemnification cannot be collected through multiple suits. Under this rule, a jury or judge would have to consider compensation paid from other sources.

Above all, the Academy report warns against piecemeal or faulty changes. Loss experience in New York shows that the individual tort reform measures adopted in that state over the past two decades did not improve costs relative to the U.S. total. "Poorly crafted malpractice reform—either individual measures that are too limited or broad transformations that are too far-reaching—can have unintended consequences that drive up costs," says Hurley.

Above all, the Academy report warns against piecemeal or faulty changes. "Poorly crafted malpractice reform—either individual measures that are too limited or broad transformations that are too far-reaching—can have unintended consequences that drive up costs."

The Academy's suggested approach involves what medical malpractice experts call "takeaway" reforms—preserving the current reliance on the tort system, but eliminating some of the costliest and most abused features.

Other voices in the debate, including representatives of the medical community, call for a back-to-the-drawing-board approach. Unfortunately, the design that comes back often relies on a no-fault model. While no-fault medical malpractice insurance would largely untangle the process from the legal system, no-fault often rewards individuals whose claims would otherwise be denied. Says Hurley, "No-fault would drive frequency of claims through the roof—some gue by a factor of at least two and perhaps by a factor of eight or more. It's scary how many things can be compensated under the typical no-fault system."

Frequency of claims, according to Hurley, is the key driver of costs. "Over the past two decades, the plateaus and surges of claims frequency have been difficult to anticipate and measure, but the long-term trend has been up," says Hurley. Size of claims also is an important cost factor, but dollar amounts in settlements have been increasing in a more predictable fashion over time.

No-fault also would take most cases out of court and make malpractice a transaction between insurer and claimant. Advocates claim that this would cut legal costs—which are enormous. For example, according to the Insurance Services Office, legal defense costs for insurers alone accounted for 14 percent of total tort costs in 1992.

However, experience in Florida and Virginia, where no-fault for obstetric cases is already in place, does not show substantially reduced costs or less need for legal counsel. Says Bovberg, "*Everyone* who uses the no-fault system in Florida and Virginia consults a lawyer."

Other options exist. A proposal by Jeffrey O'Connell, professor at the University of Virginia School of Law, seeks a middle way between no-fault and status quo. He would shorten the process and lower costs through an early offer of payment of noneconomic damages.

O'Connell is blunt about his disgust with the current state of affairs. "Medical malpractice is a nightmare of useless circularity," he says. However, according to O'Connell, the system is not co..sistently biased against defendants. Most proposed changes, on the other hand, invariably favor the defendant. Justice—as well as political reality—requires benefits for the plaintiff as well.

"Reform requires a quid pro quo," says O'Connell. "While the Academy has described quite lucidly the options for takeaway reform, such measures could not get through Congress without being so watered down as to be meaningless," says O'Connell. "True reform should involve a fair trade: making it easier for claimants to be paid, but paying them less, as under workers compensation laws."

An Offer You Can't Refuse

O'Connell's ideas have found sponsorship on Capitol Hill. A bill introduced in the 104th Congress by Sen. Mitch Mc-

Connell (R-Ky.) would create an early-offer plan for all tort claims, including medical malpractice. Under the proposal, a defendant in a personal injury claim is given the option of offering payment to the injured party within 180 days of the claim. The defendant purchases for the claimant a comprehensive major medical insurance policy that covers medical expenses, rehabilitation, and lost wages beyond monies received from collateral sources. In addition, reasonable hourly fees for the claimant's attorney would be paid.

Claimants who are offered such a settlement within 180 days of the claim would be obliged to accept. This won't get egregious medical offenders off the hook, however. A normal tort claim could be pursued for noneconomic damages, but with a higher-than-current standard of evidence.

> Medical malpractice is a nightmare of useless circularity.

The plaintiff must prove that the medical provider's misconduct was wanton or intentional.

Because the defendant would not be forced to offer a settlement, physicians and their insurers could take their chances in court in the case of bogus claims. However, the risk might be too great. O'Connell cites a prominent medical malpractice defense lawyer who estimates that he'd make an early offer in 200 of the his firm's 250 current cases. So the balance is tipped toward the defendant, but not without providing a substantial benefit to the plaintiff: Timely resolution and quick settlement.

The limit on legal fees would discourage what O'Connell calls "the unconscionable abuse of the system by some members of my profession." Among other criticisms, the Virginia professor points out that contingent fees are often not truly contingent on risk. Attorneys take the same settlement percentage from open-and-shut cases as from complex cases, a practice that subsidizes work on failed litigation and which O'Connell denounces as an illegal tax on deserving claimants.

Hurley gives O'Connell's proposal a mixed review. "To its credit, the early-offer plan is not mandatory for defendants, which leaves the tort system in place to challenge claims perceived as nonmeritorious," says Hurley. He also notes that periodic insurance payment to claimants allows compensation to be made as costs are incurred, eliminating the burden of large lump-sum payouts. Also, O'Connell's plan emphasizes two fundamentals that the Academy report identified: mandatory recognition of collateral benefits and controlling noneconomic damage costs. In fact, the O'Connell plan eliminates consideration of noneconomic damages altogether unless the case goes to court.

However, Hurley notes, the periodic payment plan theoretically would have to remain in force for decades. Will claimants be out in the cold after the disability policy limits are reached, or will the insurer face unlimited exposure? Another concern: Like no-fault, the early-offer plan could give incentives for unmerited claims. Insurers may pay a doubtful claim rather than incur expensive litigation costs and risk a large judgment award. In addition to increased costs, Hurley worries about a basic question: "Is it the right message to send to individuals who think doctors and insurers have deep pockets? The system may have practical advantages, but in terms of equity, it is hardly fair."

No matter which remedy is tried, no action will slash premium costs immediately, Hurley cautions. "Tying tort reform to premium reductions, as has been done in some states, is unrealistic," he says. "There is little evidence that the cost savings can be translated directly into lower costs for health care providers. More likely, reform will slow the rate of premium cost increases."

The course of reform will be determined by elected officials at the state and federal levels. The debate will be long, no matter which option—if any—is approved. In the meantime, the cost of inaction continues to be passed on to the public in the form of increased medical fees and reduced services.

By working together in recent years, insurers and healthcare providers have begun to bring medical spending under control. Effective medical malpractice reform is one way to keep the momentum going. □

Answer to Brain Drain, page 13: The house number is 76.

Fall
1996

ISSUE BRIEF
AMERICAN ACADEMY of ACTUARIES

Medical Malpractice Tort Reform: Lessons from the States

The cost of insuring physicians against medical malpractice claims has increased dramatically in recent years. Skyrocketing premium costs and a string of highly publicized lawsuits have led many physicians to curtail certain high-risk procedures. By reducing the availability of important medical services, this practice of defensive medicine could have serious public-health consequences. In addition, increased malpractice insurance expenses are passed on to patients and health plans, thus fueling medical inflation.

To combat these ill effects, several states have adopted reforms designed to reduce the cost of medical malpractice insurance. More recently, Congress has attempted to follow the initiative of the states but has been unable to enact comprehensive medical malpractice tort reforms into law.

To date, state efforts have enjoyed varying degrees of success in reducing medical malpractice insurance rates. What can be learned from the experience of the states? How can these conclusions be applied at the federal level? The American Academy of Actuaries Work Group on Medical Malpractice Reform has studied the impact of state reforms and offers its comments to state and federal officials who are considering national tort reform.

Findings

Any federal medical malpractice tort reform effort should be based on a *package* of measures that have exhibited some success in stabilizing medical malpractice costs. The most effective elements of such a package are a cap on noneconomic damages and an offset for collateral payments from other sources. These reforms would limit the financial exposure of health-care providers to lawsuits and would ensure that damages could not be collected through multiple suits. While there are significant limitations on data used to study specific tort reforms, persuasive results can be observed by looking at medical malpractice costs in certain states over time and relating that experience to the timing of particular tort reform measures.

In the following comparison of cost levels in three states that have enacted tort reform measures, paid losses of the individual states as a percentage of the U.S. total are used as the measure of costs. The percentage of physicians in each state as a total of U.S. physicians is used as a reasonable benchmark. The degree to which the percentage of paid losses differs from the percentage of physicians measures the effectiveness of the reforms. All else being equal, the relative cost percentages of paid medical malpractice claims should remain constant over time. Any observed changes in a state's relative cost levels provide an indication of the effectiveness of tort reform. The three states studied are California, New York, and Ohio.

The American Academy of Actuaries is the public policy organization for the actuarial profession, providing unbiased actuarial information to elected officials and regulators.

Members of the Work Group on Medical Malpractice Reform: James D. Hurley, ACAS, MAAA; William E. Burns, ACAS, MAAA; Linda A. Dembiec, FCAS, MAAA; Aileen C. Lyle, FCAS, MAAA; and Edward M. Wrobel Jr., FCAS, MAAA

AMERICAN ACADEMY of ACTUARIES

1100 Seventeenth Street NW 7th Floor Washington, DC 20036
Tel 202 223 8196 Fax 202 872 1948

Wilson W. Wyatt, Jr., Executive Director
Christine M. Cassidy, Director of Public Policy
Ken Krehbiel, Director of Communications
David F. Rivera, Legislative and Regulatory Specialist
Jeffrey Speicher, Manager of Member Communications

Reform Act (MICRA) package of reforms was enacted in 1975, medical malpractice costs have fallen substantially as a percentage of the U.S. total.

- New York. Individual reform measures were adopted in 1975, 1981, 1985, and 1986. No observable improvement in the state's relative costs has resulted. The New York reforms did not include a cap on damages.

Ohio. Reforms enacted in 1975 included a cap on damages. The cap was overturned in 1985, after which costs rose dramatically and have remained high.

California

The California loss data (Exhibit 1) illustrate that while the state's proportion of the U.S. physician population has remained relatively stable, its per-

Exhibit 1
Malpractice Loss Payments in California as a Percentage of the U.S. Total, 1975–94

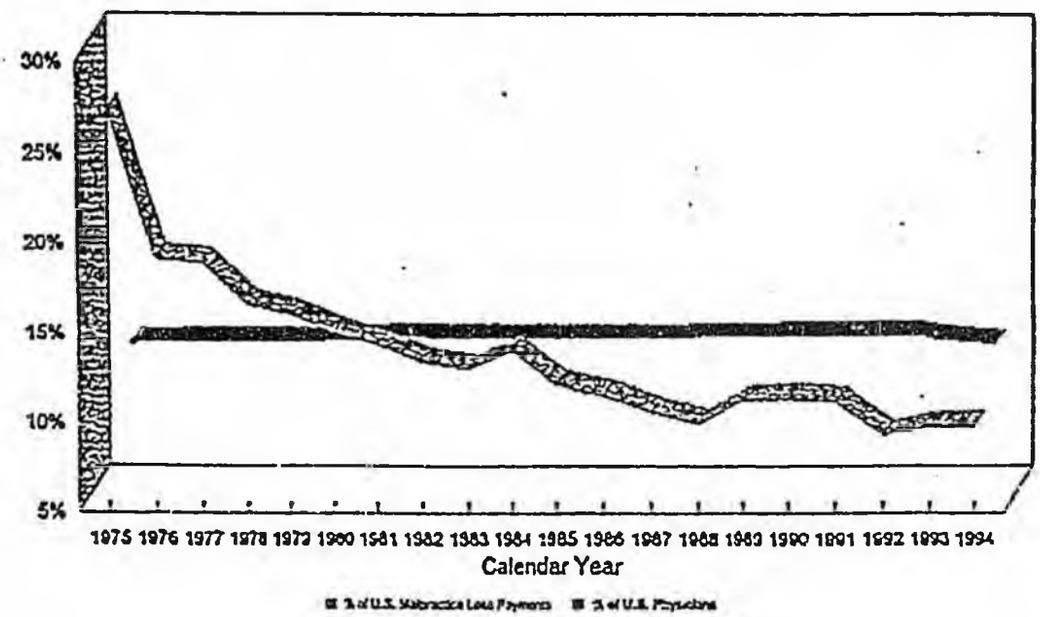
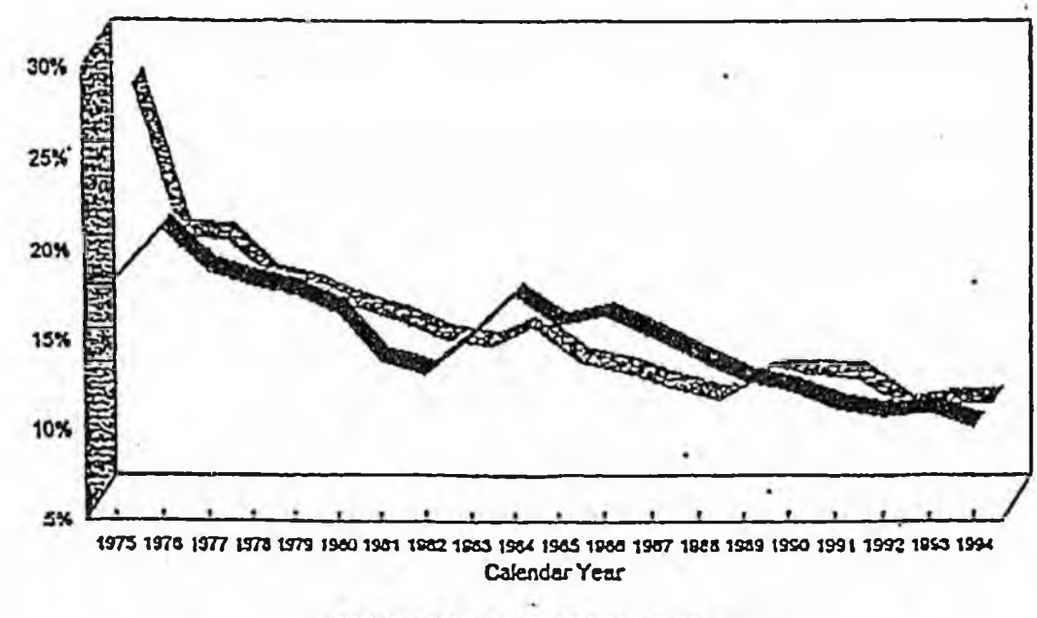


Exhibit 2
Malpractice Premiums and Malpractice Loss Payments in California as a Percentage of the U.S. Total,



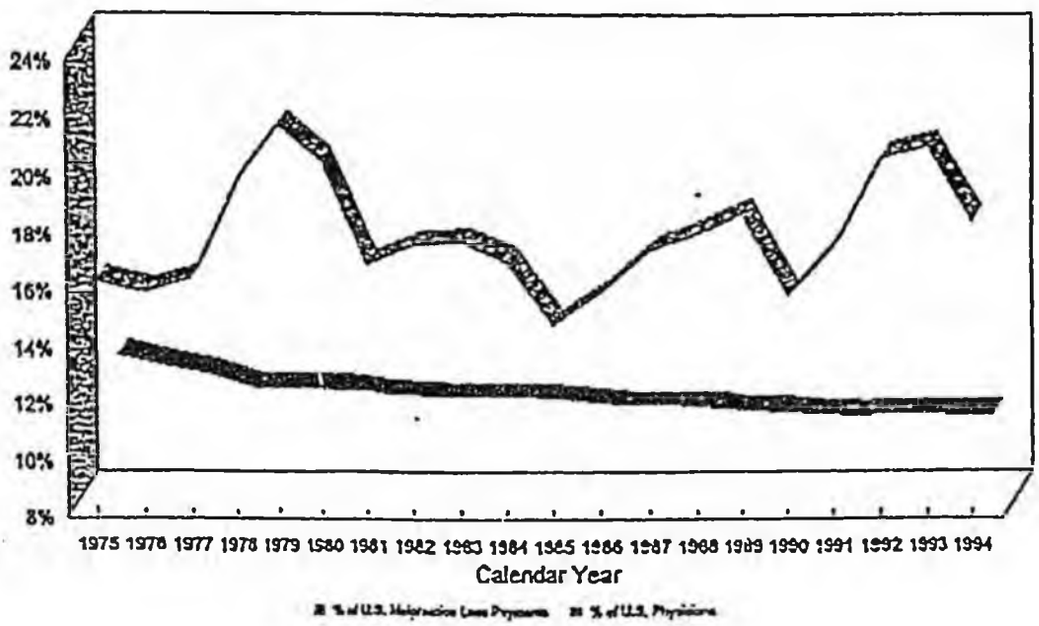
centage of loss payments has dropped dramatically since enactment of the MICRA package of tort reforms. Before MICRA's adoption in 1975, California's percentage of loss payments was significantly higher than its proportion of physicians. By 1981, California's loss payments had dropped and were about even with its percentage of physicians. Since that date, California has continued to benefit from MICRA: Costs continue to drop as a percentage of the U.S. total, even as the percentage of physicians remains stable. Although other factors affect these data, the relationship of decreased relative costs to the timing of reform provides strong evidence for the effectiveness of the MICRA package.

Many opponents of tort reform argue that insurance premiums do not drop after medical malpractice reform. Indeed, costs and premiums normally rise with inflation, and tort reform may only slow the increases. However, the California data show that premiums declined as losses declined. Exhibit 2 compares the paid loss data from Exhibit 1 with California premiums as a percentage of the total U.S. medical malpractice premiums. Although year-to-year fluctuations do occur, premiums have fallen in proportion to the decline in losses. Competition tends to keep companies at an appropriate profit margin, and any extra profits are normally short-lived.

New York

The New York loss experience is shown in Exhibit 3. It shows that the individual tort reform measures implemented in New York did not improve New York's experience relative to that of other states. New York's loss payment percentage does not show any observable pattern of decline or improvement over the 19-year period, despite the various tort reform measures adopted. The New York reforms did not include a cap on damages and were enacted in piecemeal fashion. Therefore, this result supports the merits of a cap on damages and the concept of a package of reforms.

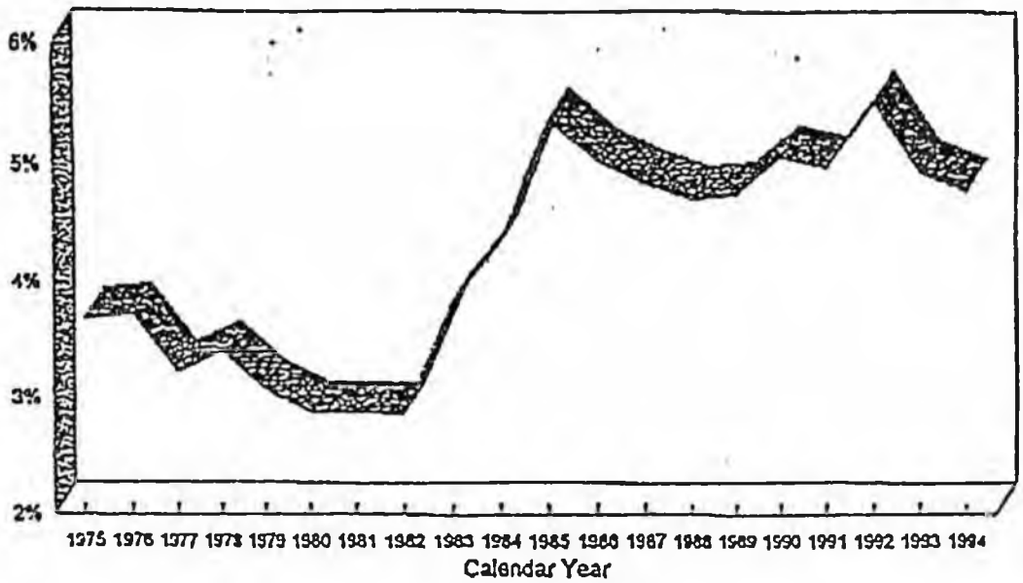
Exhibit 3
Malpractice Loss Payments in New York as a Percentage of the U.S. Total, 1975–94



Ohio

The final example is Ohio, with data presented in Exhibit 4. The data show a gradual decline in costs following tort reform in 1975. The Ohio cap on damages came under court challenge in 1982, resulting in sharp increases that reached a peak in 1985 when the cap was finally overturned. Since 1985, costs in Ohio have remained high, with no signs of decreasing. Again, the data appear to support a tort reform package and the specific benefit of a cap on noneconomic damages.

Exhibit 4
Malpractice Loss Payments in Ohio as a Percentage of the U.S. Total, 1975–94



Conclusions

California's experience indicates that properly implemented medical-malpractice tort reform can reduce the cost of medical malpractice insurance. After reviewing several states' experience with medical malpractice tort reform and examining studies on the issue, the Academy work group has concluded the following:

- a package of reforms is more likely than individual reforms to achieve savings in malpractice losses and insurance premiums, and
- key among the reforms in the package are a cap on noneconomic awards and a mandatory collateral-source offset rule.

For reform to be effective in reducing costs, the cap on noneconomic awards should be established on a per-medical-injury basis at a level low enough to have an impact (e.g., $250,000). In addition, a mandatory collateral-source offset rule is needed to ensure that double and triple damages cannot be collected through multiple suits. Under this rule, each suit would have to consider damages already paid from other sources.

Although these reforms have been successful in reducing the cost of medical malpractice insurance, elected officials and regulators must still consider the effects of medical malpractice reform on physicians, consumers, health plans, and other interested parties. When considering medical malpractice reform, state and federal officials should weigh the impact on society as a whole and strive for a balanced, comprehensive solution.

HEARTBEAT

The "Pulse" of ALASKA STATE MEDICAL ASSOCIATION MEMBERS Volume 105 Nov/Dec 2002

Informed Consent
Recent Supreme Court Decision

A recent Alaska Supreme Court decision may impact how you provide informed consent.

Marsingill v. O'Malley (Supreme Court No. 5-9859, Opinion No. 5643, dated 11/22/02), according to several Anchorage defense attorneys, may provide for new standards for providing informed consent with a potential impact on the delivery of care in Alaska.

Attorney Howard Lazar wrote a letter to ASMA physician officers that expressed his analysis of this case, advice he would provide to physicians, and a suggestion that the issues raised be addressed by the Legislature.

The case, which was the subject of the decision, involved a call at night to a physician. The physician recommended that the patient go to the ER, but the patient chose not to go and subsequently lost consciousness and suffered permanent injuries. The basic issue was that a recommendation to go to the emergency room constituted a "treatment" and therefore needed appropriate informed consent. The most far-reaching corollary is that the Supreme Court stated that the informed consent must be in terms of what a "reasonable patient" would want to know about the treatment.

Mr. Lazar states in part, in his letter of 12/19/02, to ASMA's officials:

"...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 the 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...."

ASMA recommends that you contact both your professional liability insurance company and your attorney to seek guidance regarding "informed consent" in your practice in light of this decision.

The issues involved are important and ASMA is exploring ways, including legislation, to resolve them.

* * *

American Medical Association

Physicians dedicated to the health of America

FOR IMMEDIATE RELEASE **December 8, 2003**

MEDICAL STUDENTS NOT IMMUNE TO NATION'S MEDICAL LIABILITY CRISIS

New AMA survey shows medical students reconsidering choice of specialty and state for residency

CHICAGO—America's medical liability crisis is causing the nation's medical students to seriously consider whether they want to practice a high-risk specialty or apply for a residency in one of the 19 states currently in crisis, according to a new American Medical Association survey (highlights available online at http://www.ama-assn.org/ama1/pub/upload/mm/31/ms-mlrhighlights.pdf). This is the first survey conducted of medical students to determine what impact the nation's medical liability environment is having on medical students' decision-making. Nearly 4,000 surveys were completed from 45 states and the District of Columbia. The survey was conducted by the AMA Division for Market Research and Analysis.

"It's very sad that our nation's medical students are being forced to make career decisions based on factors other than their passion for medicine and where they would receive the best training," said AMA Medical Student Trustee David A. Rosman. "We watched, horrified, as the crisis was forcing our most experienced mentors to stop performing high-risk procedures or providing care in crisis states. It is frightening to realize that because this crisis is affecting specialty choice, there may not be anyone to take their place."

The survey found that 96 percent of students indicated the issue of medical liability is a crisis or a major problem. Half of the respondents indicated the current medical liability environment was a factor in their specialty choice, and 39 percent said the medical liability environment was a factor in their decision about a state in which they would like to complete residency training.

Additional top-line survey findings include:

- 69 percent of students whose professors discussed the liability situation said the professors also discussed defensive medicine, including increasing unnecessary or excessive care.
- 61 percent of students are extremely concerned the current medical liability environment is decreasing physicians' ability to provide quality medical care.
- 48 percent of students in their third or fourth year of medical school indicated the liability situation was a factor in their specialty choice.

"These survey results will be an important benchmark to gauge how the crisis continues to affect patients' access to medical care," said AMA President Donald J. Palmisano, MD, JD. "The students' responses underscore the need for America's lawmakers to listen. Fix the crisis now. Enact meaningful medical liability reform legislation."

The AMA strongly urges the U.S. Senate to support a vote on legislation—The Patients First Act of 2003 (S. 11)—which was introduced earlier this year. Similar legislation (HR 5) already has passed the U.S. House of Representatives.

Visit http://www.ama-assn.org/ama/pub/article/3216-8223.html to read more, including comments from medical students on how they have been personally affected by the crisis.

For more information, please contact:

Daniel Blaney-Koen
Field Communications Manager
(312) 464-4415

AMA survey: Medical students' opinions of the current medical liability environment

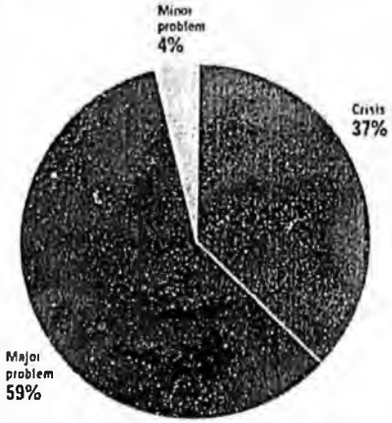
Highlights

Background

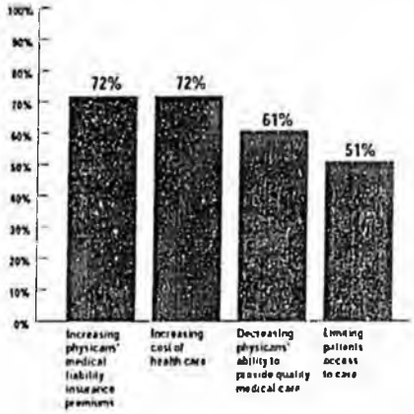
There have been numerous surveys of physicians on the current medical liability environment, including AMA's recent National Professional Liability Survey. However, this is the first major survey of medical students on the subject. This survey examined medical students' awareness of the medical liability situation, concerns related to the current medical liability environment, and the impact of the current medical liability environment on medical students' specialty decision and their choice of state in which they would like to complete their residency training.

Students are concerned

Nearly all respondents indicated that the issue of medical liability is a crisis or a major problem; 37 percent indicated that it is a crisis, and 59 percent indicated that it is a major problem.



Of the seven possible effects on the practice of medicine asked about in the survey, the majority of students are extremely concerned that the current medical liability environment is increasing physicians' medical liability insurance premiums, increasing the cost of health care, decreasing physicians' ability to provide quality medical care, and limiting patients' access to care.



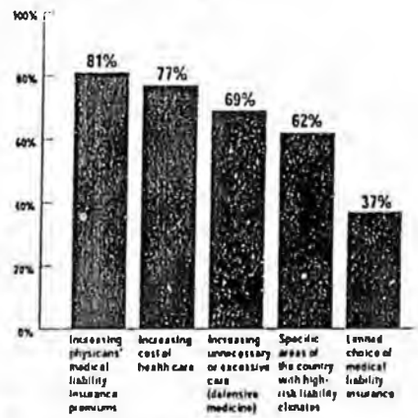
Crisis affects future physicians

Thirty-nine percent of the respondents indicated that the medical liability situation was a factor in their decision about the state in which they would like to complete residency training. Fifty percent of the respondents indicated that the medical liability situation was a factor in their specialty choice. Forty-eight percent of students in their third or fourth year of medical school indicated the liability situation was a factor in their specialty choice.

Professors talking with students

Thirty-eight percent of the respondents indicated that their professors discussed the current medical liability situation with them. Those whose professors had discussed the situation were asked to indicate from a list of topics what had been discussed. The table below shows what proportion of students whose professors discussed the issue covered certain topics.

Did your professor discuss...*



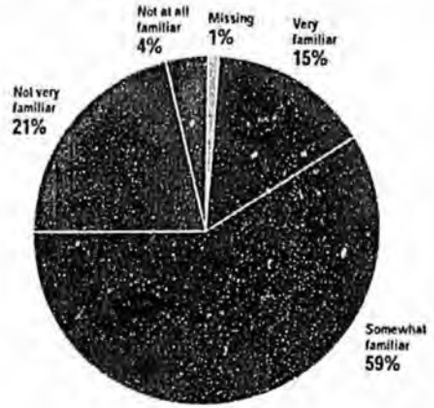
*Of those respondents whose professors discussed the current medical liability situation

American Medical Association Division of Market Research and Analysis. November 2003

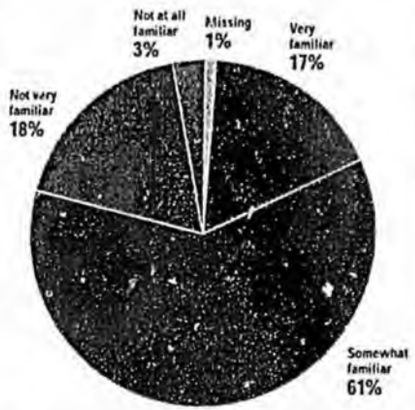
Awareness of the situation

To assess awareness of the medical liability situation, respondents were asked how familiar they are with the current medical liability, or medical malpractice, situation.

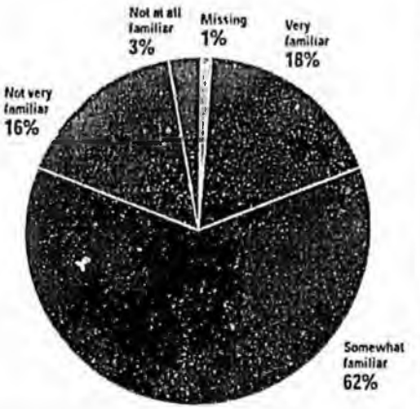
Their responses were:



Those medical students attending school in crisis states were more familiar with the liability situation. Those students who plan to practice in high risk specialties also were more familiar with the issue.



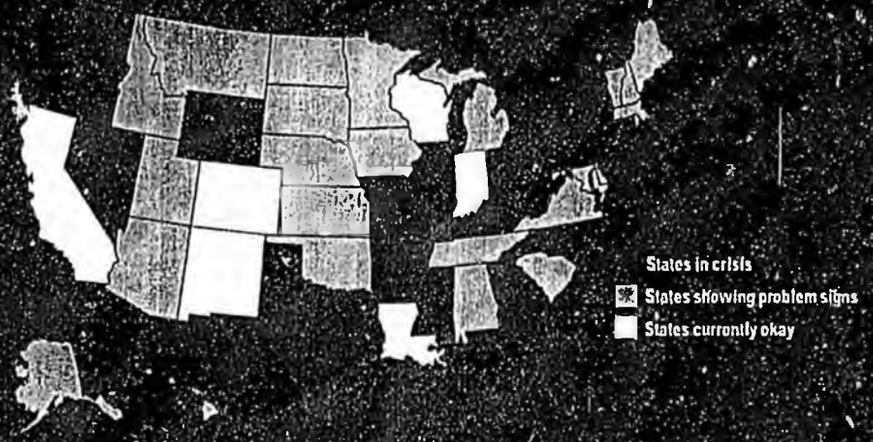
Students attending medical school in crisis state



Students who plan to practice in high risk specialty

American Medical Association Division of Market Research and Analysis. November 2003

A state of crisis



In August 2003 an e-mail with a hyperlink to the online survey was sent to 20,976 medical students for whom the AMA has e-mail addresses. A total of 3,952 surveys were completed and returned, for a response rate of 19 percent.

Analysis of the data was conducted to examine differences in results by year in medical school, specialty in which student plans to practice, (high risk specialty versus non-high risk specialty), and state of medical school (crisis state versus non-crisis state).

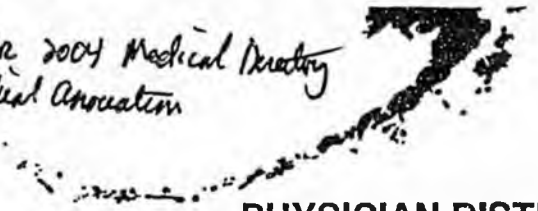
The specialties identified as high risk were: emergency medicine, general surgery, neurosurgery, obstetrics/gynecology, orthopedic surgery, and thoracic surgery.

The 19 crisis states that have been identified by the AMA are: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia and Wyoming.

American Medical Association
Physicians dedicated to the health of America

515 North State Street,
Chicago, Illinois 60610

Source: Mock-up For 2004 Medical Directory
Alaska State Medical Association



Dorl

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 4, ~~2002~~ 2003

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Girdwood	~~630~~ 675	~~36~~ 37	~~68~~ 61	~~27~~ 24	~~761~~ 797
Barrow	35				35
Bethel	~~19~~ 18	2			~~21~~ 20
Cordova	2				2
Delta Junction	1				1
Dillingham	89				89
Eagle River	~~11~~ 12				~~11~~ 12
Fairbanks/North Pole	~~130~~ 131		36 34	1	166 -
Fort Yukon	1				1
Glennallen	23				23
Golovin	1				1
Haines	82				82
Homer	~~15~~ 18				~~15~~ 18
Juneau/Auke Bay	~~69~~ 68	2			~~71~~ 70
Kenai	76			1	87
Ketchikan/Klawock	30	3			33
Kodiak	~~20~~ 15	4			~~24~~ 19
Kotzebue	8 10				10
~~Metlaktla~~	~~1~~				~~1~~
Naknek	1				1
Nome	~~11~~ 10				~~11~~ 10
Palmer	~~26~~ 25				~~8~~ 25
Petersburg	56				56
Seldovia	1				1
Seward	56				56
Sitka	19	11			30
Soldotna	~~38~~ 39				~~38~~ 39
Talkeetna	1				1
Tok	1				1
Valdez	43				43
Wasilla	~~38~~ 41				~~38~~ 41
Wrangell	84				84
TOTAL	~~1115~~ 1164	59 ✓	~~104~~ 95	~~28~~ 26	~~1306~~ 1344

Source : 2003 Medical Directory
Alaska State Medical Association

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 4, 2002

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Girdwood	630	36	68	27	761
Barrow	3				3
Bethel	19	2			21
Cordova	2				2
Delta Junction	1				1
Dillingham	8				8
Eagle River	11				11
Fairbanks/North Pole	130		36		166
Fort Yukon	1				1
Glennallen	2				2
Golovin	1				1
Haines	3				3
Homer	15				15
Juneau/Auke Bay	69	2			71
Kenai	7			1	8
Ketchikan/Klawock	30	3			33
Kodiak	20	4			24
Kotzebue	9				10
Metlaktla	1				1
Naknek	1				1
Nome	11				11
Palmer	26				6
Petersburg	5				5
Seldovia	1				1
Seward	5				5
Sitka	19	11			30
Soldotna	38				38
Talkeetna	1				1
Tok	1				1
Valdez	4				4
Wasilla	38				38
Wrangell	3				3
TOTAL	**1115**	**59**	**104**	**28**	**1306**

Jim Jordan

From: "Gavitt, Brian (Murkowski)" <Brian_Gavitt@murkowski.senate.gov>
To: "Jim Jordan" <asma@alaska.net>
Sent: Tuesday, January 20, 2004 11:57 AM
Attach: ATT23321.gif
Subject: FW: fyi - - great story on AK victory

Did you see this article? Also, what are you hearing from the physician community? CMS just sent their press release highlighting the adjustment for Alaska. Let me know what you're hearing...thanks! Brian

-----Original Message-----
From: Maggie Elehwany [mailto:Maggie.Elehwany@ama-assn.org]
Sent: Tuesday, January 20, 2004 3:47 PM
To: Gavitt, Brian (Murkowski)
Subject: fyi - - great story on AK victory

GOVERNMENT & MEDICINE

Medicare law aims to bring Alaska physicians in from the cold

The reform package adds millions of dollars to help stabilize Medicare access for seniors in the state.

By Markian Hawryluk, *AMNews staff.* Jan. 19, 2004.

Washington -- Dwight Smith, MD, a family physician in Anchorage, Alaska, has a patient who can come to see him only in the winter. That's when the rivers are frozen over.

The elderly patient spends a full day traveling by snowmobile to get to his car, then drives four hours to see Dr. Smith. Other doctors are closer, but they don't take Medicare.

With this article
- Heavy patient load
- See related content
- Topic: Medicare

"We're in a health care crisis," Dr. Smith said. "And Alaska is the canary in the coal mine."

Now help for Alaska's physicians and their patients is on the way. The Medicare reform bill signed into law last month includes a payment

payment
▫ Regional news: West

boost for Alaska doctors and reforms to help rural physicians nationwide. But Dr. Smith and other Alaska physicians wonder if it's too little, too late.

Like everything in Alaska, the state's Medicare access woes are a lot bigger. Only two facilities still take new Medicare patients in Anchorage, which is home to about half of the state's population. One is the community health center, and the other is the state's only family practice residency program.

"All the other providers either left town because they went bankrupt or couldn't make it financially with Medicare, or they got out of Medicare and take only private insurance and private-pay patients," Dr. Smith said.

2003 Medicare payments in Alaska covered 37% of physicians' costs.

Even the residency program limits the number of new Medicare patients it takes every month. "We're still booked into December [2004]," Dr. Smith said.

Outside of Anchorage, the situation is even worse.

"If you're in a small town such as Toke or Glenallen where you've only got one doc, they've got nobody else to go to, so you cannot turn anybody away whether they have Medicare, Medicaid or no insurance," he said. "Docs are struggling to survive because they cannot make it with their patient care mix."

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, including 47,000 Medicare beneficiaries. Only six states had a lower doctor-to-patient ratio.

"We start from a situation where we have one of the lowest numbers of physicians per capita, and that has caused some pretty extensive and severe access problems for Medicare beneficiaries," said Jim Jordan, executive director of the Alaska State Medical Assn. "And there are specific shortages in some of the specialty areas that would tend to be types of docs seeing Medicare patients."

General internists are particularly in short supply. Part of the problem, Jordan said, is that Alaska has few options for training new doctors. The state has no medical school and only one residency program. Alaska sends 10 students a year to the University of Washington School of Medicine under a loan program and graduates another eight from the residency program.

In 2002,

"That's nowhere near dealing with the work-force situation," Jordan said. Because more

Medicare beneficiaries out of a population of 644,000.

rates up to at least the national average for all physicians. But Alaska's doctors were already paid above the average and would not benefit from that provision.

At the Alaska congressional delegation's insistence, the Medicare reform bill included $53 million for Alaskan physicians over the next two years. on top of $8 million in additional spending resulting from the elimination of a nationwide 4.5% cut scheduled for 2004. And Alaska's physicians will be able to make use of a 5% bonus payment available to areas in the bottom 20% in terms of physician supply.

Dr. Smith said the payments would help offset some of the added costs doctors incur by practicing in Alaska. But he doesn't think it's enough.

"All increasing the reimbursement for Alaska is going to do is slow the diuresis of physicians opting out of Medicare," he said. "All we're trying to do is put a plug in the dike, and it's not going to last very long."

Back to top.

ADDITIONAL INFORMATION:

Heavy patient load

Alaska's Medicare access problems are caused partly by a general physician shortage. Only six states had more people per non-federally employed physician than Alaska in 2002.

	Population per physician
Idaho	544
Oklahoma	540
Mississippi	529
Nevada	507
Wyoming	495
Iowa	490
Alaska	478

Source: American Medical Association

Back to top.

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1 of 1 DOCUMENT

JULIE KORMAN, Appellant, v. ROBERT E. MALLIN, Appellee.

No. 4002, Supreme Court File No. S-4976

SUPREME COURT OF ALASKA

858 P.2d 1145; 1993 Alas. LEXIS 90; 28 A.L.R.5th 845

September 3, 1993, Decided

PRIOR HISTORY: [**1]

Superior Court File No. 3AN-90-3486 Civil. Appeal from the Superior Court of the State of Alaska, Third Judicial District, Anchorage, Karen L. Hunt, Judge.

DISPOSITION:

REVERSED and REMANDED.

CASE SUMMARY:

PROCEDURAL POSTURE: Appellant patient challenged the grant of summary judgment by the Superior Court of the State of Alaska, Third Judicial District, in favor of appellee doctor in a medical malpractice action. The patient alleged that the doctor failed to establish, as a matter of law, that he adequately disclosed the risk of painful and unsightly scarring before the patient consented to elective breast reduction surgery.

OVERVIEW: When the patient consulted the doctor about a breast reduction operation, she was shown two videotapes that discussed the scarring that might be expected to occur, and the doctor informed her about some of the risks of the procedure and gave her pamphlets to read. The patient brought this action alleging medical negligence and lack of informed consent after her surgery resulted in broad, wide, and painful scars. The court reversed the grant of summary judgment by the superior court, holding that the scope of disclosure required under *Alaska Stat. § 09.55.556(a)* had to be measured by what a reasonable patient would need to know in order to make an informed and intelligent decision about the proposed treatment. The record did not show that the doctor explained to the patient in lay terms the nature and severity of the risk and the likelihood of its occurrence. Because the patient requested further information about scarring at the second consultation and the doctor did not explain the increased risk of such scarring attributable to the patient's smoking, the court was unable to conclude that the doctor's explanation of the risks satisfied his duty of disclosure as a matter of law.

OUTCOME: The court reversed, concluding that the superior court erred in granting summary judgment for the doctor on the record presented in this medical malpractice action, and remanded for further proceedings.

LexisNexis (TM) HEADNOTES - Core Concepts:

Civil Procedure > Summary Judgment > Summary Judgment Standard

[HN1] In reviewing a grant of summary judgment, the court will independently determine whether there were any genuine issues of material fact and whether the moving party is entitled to judgment as a matter of law. The court must draw all reasonable inferences in favor of the nonmoving party and against the movant.

Torts > Malpractice Liability > Healthcare Providers
[HN2] *Alaska Stat. § 09.55.556(a)* provides that a physician 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, and that but for that failure the claimant would not have consented to the proposed treatment or procedure.

Torts > Malpractice Liability > Healthcare Providers
[HN3] The scope of disclosure required under *Alaska Stat. § 09.55.556(a)* must be measured by what a reasonable patient would need to know in order to make an informed and intelligent decision about the proposed treatment. Under the reasonable patient rule, a physician must disclose those risks which are "material" to a reasonable patient's decision concerning treatment. 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. 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.

Torts > Malpractice Liability > Healthcare Providers
[HN4] Merely identifying a risk does not necessarily provide a patient with the information necessary for an informed decision. A physician must not only disclose the identity of all known material risks, but also the likelihood of their occurrence in meaningful terms.

Civil Procedure > Summary Judgment > Summary Judgment StandardTorts > Malpractice Liability > Healthcare Providers
[HN5] For a trial court to decide on summary judgment that a doctor has disclosed sufficient information to allow a reasonable patient to make an informed decision about treatment, the record must establish that the physician explained to the patient in lay terms the nature and severity of the risk and the likelihood of its occurrence.

Civil Procedure > Jury Trials > Province of Court & Jury
[HN6] Whenever nondisclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of facts.

COUNSEL:

Charles W. Ray, Jr., Anchorage, for Appellant.

Sanford M. Gibbs, Hagans, Brown, Gibbs & Moran, Anchorage, for Appellee.

JUDGES: Before: Moore, Chief Justice, Rabinowitz, Matthews, and Compton, Justices. [Burke, Justice, not participating].

OPINIONBY: MOORE, Chief Justice.

OPINION:

[*1146] I. Introduction

In this "informed consent" case, Julie Korman appeals the trial court's grant of summary judgment in favor of Dr. Mallin. Korman maintains that Dr. Mallin failed to establish, as a matter of law, that he adequately disclosed the risk of painful and unsightly scarring before Korman consented to elective breast reduction surgery.

In deciding this case, we address for the first time the scope of disclosure required by the "informed consent" doctrine [**2] under Alaska law. We conclude that a physician must disclose those risks and benefits of a proposed procedure which a reasonable patient would need to know in order to make an informed and intelligent decision. Applying this reasonable patient standard to the case at bar, we conclude that the trial court erred in granting summary judgment [*1147] on the record presented and remand this case for further proceedings.

II. Facts and Proceedings

In April 1988 Julie Korman consulted Dr. Mallin, an Anchorage plastic surgeon, to inquire about a possible breast reduction operation. At this initial visit, Korman viewed two videotapes concerning breast reduction surgery. n1 Dr. Mallin then talked alone with Korman for approximately ten minutes about her needs and conducted a brief physical examination. After the examination, Dr. Mallin discussed the specific procedures with Korman in the presence of his medical assistant, Bari Lasky.

n1 The first videotape, entitled "Realistic Expectations," provides a general overview of the risks and benefits of plastic surgery. The second videotape, entitled "Reduction Mammaplasty," focuses on the breast reduction procedure itself. Both videotapes emphasize that plastic surgery results in permanent scars and that the degree of scarring is unique to each patient.

[**3]

Dr. Mallin's office notes indicate that he told Korman about some of the risks of the procedure at this time.

> Talked about infection, hemorrhage, nipple numbness, scars, possible need for implant to give upper fullness as well as nipple turning black and falling off. . . . Talked about how they heal in a different way, there can be allergies, infections, hemorrhage, numbness, scar capsules they would feel hard but get softer.

Lasky confirms that Dr. Mallin informed Korman of the risks of the procedure, including the risk of permanent scarring. In her deposition, Korman stated that in this discussion Dr. Mallin told her

> about the scarring, about what I could expect; the results . . . and . . . a little bit about insurance.

Dr. Mallin then gave Korman pamphlets on reduction mammaplasty and breast implants to read at home. n2

n2 The pamphlet on breast reduction provides the following information on scarring.

> Although the surgeon makes every effort to keep scars as inconspicuous as possible, reduction mammaplasty scars are extensive and permanent. The patient must be willing to accept the change from large uncomfortable breasts without scars to small comfortable breasts with scars. Scars remain highly visible for a year following surgery, then fade to some degree.

Line drawings indicate the location of the incisions and resulting scars.

[**4]

Korman visited Dr. Mallin's office on May 4 to complete the necessary consent forms. At this time, Dr. Mallin described the proposed surgery and drew a diagram of the operative procedure. While she was reading through the consent form, Korman states that she expressed concern over the risk of scarring and asked Dr. Mallin what she could expect. According to Korman, Dr. Mallin told her that there was no cause for concern.

> His exact words to me were I've done--don't worry about it, I've done hundreds of these. The worst that has ever happened is I had a lady lose one of her nipples; but her breasts were very large. I think that you'll be happy with the results.

In her affidavit, Korman states that Dr. Mallin did not explain to her "that thickened or widened scars[] and extremely painful scars" could occur. She also states that he did not explain to her in this context that her risk of scarring was 50% greater because she was a smoker. However, Korman admits to reading the following paragraph in "Dr. Mallin's Surgery and Procedure Consent Form."

> I am aware that all complications that have been told to me either verbal or written are increased by 50% because I smoke.

Lasky [**5] was also present during this discussion and stated in her affidavit that Dr. Mallin answered Korman's questions regarding her concerns of the risk of surgery and that Korman indicated that she understood the risks and that all of her questions were answered before she consented to the surgery. Wendy Brown, one of Dr. Mallin's office employees, witnessed Korman's execution of the consent forms and stated in her affidavit that Korman indicated that all of her questions regarding surgery were answered to her satisfaction and that [*1148] she understood that no guarantees were given to her concerning the outcome of the surgery.

Korman underwent surgery a few days later. She was very unhappy with the results -- particularly the broad, wide and painful scars.

In April 1990 Korman filed this malpractice action against Dr. Mallin, alleging both medical negligence and lack of informed consent. Pursuant to *AS 09.55.536*, an Expert Advisory Board was appointed to review Korman's medical malpractice claim. In January 1991 the Board rendered its decision, finding that Korman had not been injured by Dr. Mallin's care. The Board did not address Korman's informed consent claim.

Following the Board's decision, [**6] Dr. Mallin moved for summary judgment in May 1991. Korman opposed this motion. After oral argument, Judge Hunt granted Dr. Mallin's motion, commenting that reasonable minds "could not differ [in concluding] . . . that under the facts of this case [Korman] did give an informed consent, because she was advised of the scarring risk." This appeal followed.

III. Discussion

A. Standard of Review

[HN1] In reviewing a grant of summary judgment, we will independently determine whether there were any genuine issues of material fact and whether the moving party is entitled to judgment as a matter of law. *Drake v. Hosley, 713 P.2d 1203, 1205 (Alaska 1986).* We must draw all reasonable inferences in favor of the nonmoving party and against the movant. *Swenson Trucking & Excavating, Inc. v. Truckweld Equip. Co., 604 P.2d 1113, 1116 (Alaska 1980).*

B. The Doctrine of Informed Consent

[HN2] *Alaska Statute 09.55.556(a)* provides that a physician 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 [**7] risks and reasonable alternatives to the proposed treatment or procedure, and that but for that failure the claimant would not have consented to the proposed treatment or procedure.

AS 09.55.556(a).

Although *AS 09.55.556(a)* states that a physician must disclose the common risks and reasonable alternatives to a proposed procedure, it does not set forth the standard by which this disclosure should be measured. n3 The legislative history is similarly silent on this issue. This is a question of first impression in Alaska. n4

> n3 Compare *AS 09.55.540(a)(1)* which requires a patient to establish the professional standard of care in the field or speciality as one element of a medical negligence claim.
>
> n4 Prior to the enactment of *AS 09.55.556*, this court specifically declined to reach "the difficult and complex questions . . . regarding the duty and scope of disclosure required by the informed consent doctrine."

> *Poulin v. Zartman, 542 P.2d 251, 275 (Alaska 1975)* (holding that father of infant blinded after oxygen treatment failed to make out a prima facie informed consent claim because he failed to show that he would have declined the procedure if he had known of alternative treatment).

[8]**

Traditionally, a physician's duty to disclose information concerning treatment has been measured by the professional standard in the field. See, e.g., *Potter v. Wisner, 170 Ariz. 331, 823 P.2d 1339, 1341 (Ariz. App. 1991); Jacobs v. Painter, 530 A.2d 231 (Me. 1987).* See generally Laurent B. Fantz, Annotation, Modern Status of Views as to General Measure of Physician's Duty to Inform Patient of Risks of Proposed Treatment, *88 A.L.R.3d 1008, 1020-27 (1978).* This rule reflects the belief that holding a physician to a lay standard of disclosure would interfere with the flexibility a physician must have in determining what therapy would best suit the patient's needs. See *Ross v. Hodges, 234 So. 2d 905, 908-09 (Miss. 1970).* In order to establish a prima facie case, a plaintiff must usually present expert testimony of the professional standard of disclosure in the community and of the physician's failure to meet that standard. See *Culbertson* **[*1149]** *v. Mernitz, 602 N.E.2d 98, 102-04 (Ind. 1992)* (expert testimony of professional standard of disclosure **[**9]** required except where deviation from the standard of care is a matter commonly known to lay persons); see also Daniel E. Feld, Annotation, Necessity and Sufficiency of Expert Evidence to Establish Existence and Extent of Physician's Duty to Inform Patient of Risks of Proposed Treatment, *52 A.L.R.3d 1084, 1091-92 (1973).*

However, the modern trend is to measure the physician's duty of disclosure by what a reasonable patient would need to know in order to make an informed and intelligent decision. The Louisiana Supreme Court has articulated this standard as follows:

> The informed consent doctrine is based on the principle that every human being of adult years and sound mind has a right to determine what shall be done to his or her own body. Surgeons and other doctors are thus required to provide their patients with sufficient information to permit the patient to make an informed and intelligent decision on whether to submit to a proposed course of treatment. Where circumstances permit, the patient should be told the nature of the pertinent ailment or condition, the general nature of the proposed treatment or procedure, the risks involved in the proposed **[**10]** treatment or procedure, the prospects of success, the risks of failing to undergo any treatment or procedure at all, and the risks of any alternate methods of treatment.

Hondroulis v. Schuhmacher, 553 So. 2d 398, 411 (La. 1989) (citations omitted). See generally Fantz, supra, at 1034-43. 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.

Our recent comments on the nature of the physician-patient relationship echo the concerns outlined by the Hondroulis court.

> 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.

Pedersen v. Zielski, 822 P.2d 903, 909 (Alaska 1991) **[**11]** (citations omitted). We are persuaded that the modern view is the better rule and hold that [HN3] the scope of disclosure required under *AS 09.55.556(a)* must be measured by what a reasonable patient would need to know in order to make an informed and intelligent decision about the proposed treatment.

Under the reasonable patient rule, a physician must disclose those risks which are "material" to a reasonable patient's decision concerning treatment. See *Hondroulis, 553 So. 2d at 411; Canterbury v. Spence, 150 U.S. App. D.C. 263, 464 F.2d 772 (D.C. Cir. 1972),* cert. denied, *409 U.S. 1064, 34 L. Ed. 2d 518, 93 S. Ct. 560 (1972).*

> 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 **[**12]** 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.

Hondroulis, 553 So. 2d at 412.

We also note that, in certain circumstances, a physician's failure to disclose a risk may be privileged.

> **[*1150]** The physician retains a qualified privilege to withhold information on therapeutic grounds, as in those cases where a complete and candid disclosure of possible alternatives and consequences might have a detrimental effect on the physical or psychological well-being of the patient, or where the patient is incapable of giving his consent by reason of mental disability or infancy, or has specifically requested that he not be told. Likewise the physician's duty to disclose is suspended where an emergency of such gravity and urgency exists that it is impractical to obtain the patient's consent. Finally disclosure is not required where the risk is either known to the patient or is so obvious as to justify presumption of such knowledge, nor is the physician under a duty to discuss the relatively remote risks inherent in **[**13]** common procedures, when it is common knowledge that such risks inherent in the procedure are of very low incidence. Conversely, where the physician does not know of a risk and should not have been aware of it in the exercise of ordinary care, he is under no obligation to make disclosure.

Sard v. Hardy, 281 Md. 432, 379 A.2d 1014, 1022-23 (Md. 1977); Canterbury, 464 F.2d at 788-79; see generally Alan Meisel, The "Exceptions" to the Informed Consent Doctrine: Striking a Balance between Competing Values in Medical Decisionmaking, *1979 Wis. L. Rev. 413.* As noted by the courts which have examined this issue, the burden of going forward with evidence pertaining to a privilege rests on the physician in whose hands the necessary evidence ordinarily rests. See *Hondroulis, 553 So. 2d at 413; Canterbury, 464 F.2d at 791.*

C. The Adequacy of Dr. Mallin's Disclosure

After deciding which legal standard to apply, the issue becomes whether the information Dr. Mallin provid[illegible] Korman satisfies this standard as a matter of law. Although Korman maintains **[**14]** that a patient would have "no inkling" that painful and unsightly scarring is a normal consequence of uncomplicated breast reduction surgery after reviewing the pamphlets, videos and consent forms provided by Dr. Mallin, we cannot agree. Dr. Mallin's office notes indicate he discussed scarring at both visits. Both the videos and pamphlets provided by Dr. Mallin emphasize that breast reduction surgery resulted in permanent scars. Finally the consent forms signed by Korman specifically refer to the risk of "unsightly and painful scarring." The trial court concluded that the information Dr. Mallin provided Korman clearly advised her of the scarring risk and therefore granted Dr. Mallin's motion for summary judgment.

Nonetheless, [HN4] merely identifying a risk does not necessarily provide a patient with the information necessary for an informed decision. n5 [HN5] For a trial court to decide on summary judgment that a doctor has disclosed sufficent information to allow a reasonable patient to make an informed decision about treatment, the record must establish that the physician explained to the patient in lay terms the nature and severity of the risk and the likelihood of its occurrence. See *Hondroulis, 553 So. 2d at 420.* **[**15]**

> n5 It is meaningless to tell a patient that a given risk is increased by 50% unless the patient is also told the original or baseline risk factor. For example, assuming the risk of unsightly scarring for nonsmokers is 2%, the risk for a smo[illegible]r rises to 3%. However, if the risk factor for nonsmokers is 20%, the risk for a smoker rises to 30%, a very significant increase. A physician must not only disclose the identity of all known material risks, but also the likelihood of their occurrence in meaningful terms. See *Hondroulis, 553 So. 2d at 420.*

After reviewing the record on appeal, we are unable to conclude that Dr. Mallin's explanation of the risks inherent in this procedure satisfied his duty of disclosure as a matter of law. In her affidavit, Korman states that she requested additional information about the scarring at the second consultation and that, in response, Dr. Mallin told her "not to worry" and that she would be happy with the results. A number of courts have held that a **[**16]** patient's request for more detailed information regarding a risk is a factor in determining whether there has been adequate disclosure. **[*1151]** See *Distefano v. Bell, 544 So. 2d 567, 571 (La. App. 1989)* (holding that physician's duty of disclosure was

"expanded" when patient requested physician to explain the "least likely" complications of proposed surgery), writ denied, *550 So. 2d 650 (La. 1989);* see also *Kinikin v. Heupel, 305 N.W.2d 589, 595 (Minn. 1981)* (holding that where a doctor is aware or should be aware that a patient attaches particular significance to a risk, further disclosure may be required even under the professional community standard). Our own comments in Pedersen emphasize a physician's duty to respond fully to a patient's questions concerning treatment. *822 P.2d at 909.*

Furthermore, although it is undisputed that Korman read that portion of the consent form which states that all risks of the procedure were increased by 50% because she smoked, this information has little meaning in the absence of a base probability figure establishing the average **[**17]** risk to an average patient. The record does not indicate that Dr. Mallin disclosed to Korman the probability that painful and unsightly scarring would occur in her case or explained the increased risk of such scarring attributable to smoking. Cf. *Barner v. Gorman, 605 So. 2d 805, 806 (Miss. 1992)* (where plaintiff, who underwent plastic surgery to minimize prominent neck scar, alleged that the surgeon had failed to disclose to her the risk of more severe scarring inherent in that procedure despite the fact that the risk of such recurrence was greater in a patient with her skin coloring); see also *Nisenholtz v. Mount Sinai Hosp., 126 Misc. 2d 658, 483 N.Y.S.2d 568, 570 (N.Y. Sup. 1984)* (holding that physician has a duty to provide a "reasonable explanation" of potential risks and available alternatives under New York informed consent statute).

There is no question that an individual contemplating elective cosmetic surgery will attach particular significance to the risk of "unsightly and painful" scarring. Although Dr. Mallin certainly provided Korman with a significant amount of information concerning the proposed procedure and its attendant **[**18]** risks, we cannot say that he satisfied his duty of disclosure as a matter of law in light of the above circumstances. [HN6] "Whenever nondisclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of facts." *Canterbury, 464 F.2d at 788* (footnote omitted). We conclude that it is a factual question whether Dr. Mallin's explanation of the scarring risk was adequate to allow a reasonable patient to make an informed and intelligent decision whether to undergo the procedure.

IV. Conclusion

We conclude that a physician must provide a patient with a reasonable explanation of the material risks of a proposed procedure so that the patient can make an informed decision concerning treatment. Taking the record in the light most favorable to Korman, we cannot conclude that Dr. Mallin discharged this duty as a matter of law. We therefore reverse the trial court's entry of summary judgment in favor of Dr. Mallin and remand for jury consideration of this issue.

REVERSED and REMANDED.

Alaska State Medical Association

Statement
to the

State of Alaska
House of Representatives
Judiciary Committee

By:

James Jordan, Executive Director
Alaska State Medical Association

February 25, 2004

Madam Chair McGuire, House Judiciary Committee Members, I am Jim Jordan, Executive Director for the Alaska State Medical Association, and will be testifying in that capacity today.

However, by way of disclosure, I also serve on the Board of Directors for the Medical Underwriters of California, which is the "attorney in fact", which is the operating company for the Medical Insurance Exchange of California (MIEC), one of the two remaining providers of medical liability insurance coverage for physicians in Alaska. You will receive testimony from an executive representing MIEC.

With the Chair's indulgence, I would like to tell you a short story about medical care in Alaska. This story is about a patient who had a routine physical last summer done by a general internist in Anchorage. That doctor, during the course of the examination discovered a suspicious tumor in the patient's lower GI tract. A hastily arranged colonoscopy, along with a biopsy, confirmed a very rare cancerous tumor – and one that is normally without symptoms. As a matter of fact, this type of cancer is typically not discovered until it has spread to the brain, heart and/or lungs. The good news is that it was caught at a very early stage by a skilled doctor and was successfully treated by surgical removal. So, you may wonder why I am relating this story to you that has a happy ending.

For one reason, this story is very personal. The patient referred to is my wife. For another, it highlights the need in Alaska for well trained physicians in sufficient numbers to provide the care that our citizens need and deserve.

The general internist who saw my wife is Dr. Richard Neubauer, who happens to be about my age as well as my own personal physician. Dr. Neubauer graduated from Yale Medical School and did graduate medical education at the University of Michigan. As I previously mentioned, he is a general internist. General internists are in very short supply in Alaska. A Fall 2002 Providence study shows a shortage of 43.25 full time experienced general internists in Anchorage alone. I believe you will hear testimony that the number of general internists continues to drop. Those remaining are overtaxed in their practices, in their emergency room call and coverage schedules, and, in some cases, have simply left the state to pursue a practice that allows them to have a family life.

What would have happened had Dr. Neubauer not been around for my wife? Or for that fact, the surgeon, Dr. June George, who is one of only two board certified colo/rectal surgeons in the entire state? Perhaps a general surgeon could have treated her, but that same Providence study also shows a deficiency in Anchorage alone of 19.8 full time equivalent general surgeons. The shortages are real. Dr. Neubauer and I, being contemporaries, often muse, "Who will be around to care for us?"

HB 472 is an important element necessary to create the practice environment that will help us recruit the doctors we need in Alaska.

Now I will turn the testimony over to Dr. Alex Malter, and I will be happy to respond to any questions that you might have.

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

TO: Honorable Lesil McGuire # Pages 11

FROM: James Jordan, Executive Director

DATE: 2/27/04 To Fax # 907-465-6592

SUBJECT: Information Requested at HB 472 Hearing

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 27, 2004

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

Transmitted by Fax:
907-465-6592

Re: Information Requested at the 2/25/04 Hearing - HB 472

Dear Representative McGuire:

There were several requests for more information by two House Judiciary Committee members – Representative Ogg and Representative Gruenberg.

Representative Ogg requested that the number of physicians in Alaska from 1995 to the present be provided. Attached is that data, which came from ASMA's database, and is published in its Medical Directory. This data shows the number by location and by type of practice as well.

Representative Gruenberg asked ASMA to share with the Committee what ASMA had suggested to the Administration regarding an idea to help in recruiting new doctors to Alaska. This idea was presented to Joel Gilbertson, Commissioner of the Department of Health and Social Services. The suggestion was to have multi-departmental involvement – DHSS from the public health interest and Department of Community and Economic Development. The concept would be to use the already developed tourism promotional programs to highlight Alaska and what it has to offer. The connection is the "lifestyle" recruitment. Those of us living in Alaska also are tourists. The concept is to have a booth at select specialty societys' annual, national meetings. The national specialties targeted would obviously be ones that represent specialists in critical, short supply in Alaska. The physician community would partner by having a practicing, Alaska doctor at the booth to answer practice environment questions. (The critical shortage specialties could be identified by a joint effort of ASMA, the State Medical Board, DHSS, and perhaps also the Alaska State Hospital and Nursing Home Association).

I have spoken with the executive director of one of the national specialty societies (neurology) about such an effort at one of its national meetings. The concept met with a favorable response.

Please let me know if I may be of further assistance.

Sincerely,

James J. Jordan
Executive Director

PHYSICIAN DISTRIBUTION IN ALASKA

As of January 31, 1996

Town	Private Practice	Public Health	Military	Municipal State & Fed.	TOTAL
Adak			2		2
Anchor Point	1				1
Anchorage	446	56	59	29	590
Barrow		6			6
Bethel	17	2			19
Chugiak	1				1
Cordova	2				2
Delta Junction	2				2
Dillingham	10				10
Eagle River	9				9
Fairbanks/North Pole	125		40	1	166
Girdwood	2				2
Glennallen	2				2
Golovin	1				1
Haines	2				2
Homer	7				7
Juneau/Auke Bay	44	3		1	48
Kenai	4				4
Ketchikan	20	4			24
Kodiak	13	3			16
Kotzebue	5				5
Mellaktla	2				2
Naknek	1				1
Nome	8	1			9
Palmer	24				24
Petersburg	3				3
Seldovia	1				1
Seward	3				3
Sitka	11	14	1		26
Soldotna	28				28
Talkeetna	2				2
Valdez	4				4
Wasilla	25				25
Wrangell	1				1
TOTAL	826	89	102	31	1048

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 31, 1996

Town	Private Practice	Public Health	Military	Municipal State & Fed.	TOTAL
Adak			2		2
Anchor Point	1				1
Anchorage	493	52	68	33	646
Barrow	4	5			9
Bethel	22	2			24
Chugiak	1				1
Cordova	3				3
Delta Junction	2				2
Dillingham	9				9
Eagle River	10				10
Fairbanks/North Pole	122	2	38	1	163
Girdwood	2				2
Glennallen	2				2
Golovin	1				1
Haines	2				2
Homer	9				9
Juneau/Auke Bay	46	2		1	49
Kenai	4				4
Ketchikan	29	8			37
Kodiak	17	2			19
Kotzebue	9				9
Metlaktla	2				2
Naknek	1				1
Nome	8				8
Palmer	21				21
Petersburg	3				3
Seldovia	1				1
Seward	2				2
Sitka	18	12			30
Soldotna	32				32
Talkeetna	1				1
Valdez	4				4
Wasilla	24				24
Wrangell	3				3
TOTAL	908	85	108	35	1136

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 31, 1997

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Adak			1		1
Anchorage	520	43	62	32	657
Barrow	2	1			3
Bethel	21	2			23
Chugiak	1				1
Craig	1				1
Cordova	2				2
Delta Junction	2				2
Dillingham	10				10
Eagle River	10				10
Fairbanks/North Pole	129		31	1	161
Girdwood	1				1
Glennallen	2				2
Golovin	1				1
Haines	2				2
Homer	10				10
Juneau/Auke Bay	50	3		1	54
Kenai	4				4
Ketchikan	25	5			30
Kodiak	17	1		1	19
Kotzebue	8				8
Metlaktla	1				1
Naknek	1				1
Nome	9				9
Palmer	26				26
Petersburg	3				3
Seldovia	1				1
Seward	1				1
Sitka	17	12			29
Soldotna	33				33
Talkeetna	1				1
Valdez	4				4
Wasilla	26				26
Wrangell	4				4
TOTAL	**945**	**67**	**94**	**35**	**1141**

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 31, 1998

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage	531	36	54	34	655
Barrow	4	1			5
Bethel	25	3			28
Chugiak	1				1
Cordova	3				3
Delta Junction	2				2
Dillingham	11				11
Eagle River	10				10
Fairbanks/North Pole	133		40	1	174
Girdwood	1				1
Glennallen	1				1
Golovin	1				1
Haines	2				2
Homer	10				10
Juneau/Auke Bay	56	3		1	60
Kenai	4				4
Ketchikan	25	3			28
Kodiak	17	1			18
Kotzebue	7				7
Metlaktla	1				1
Naknek	1				1
Nome	9				9
Palmer	29				29
Petersburg	4				4
Seldovia	1				1
Seward	4				4
Sitka	19	10			29
Soldotna	33				33
Talkeetna	1				1
Valdez	4				4
Wasilla	23				23
Wrangell	4				4
TOTAL	977	57	94	36	1164

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 31, 1999

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage	564	38	78	38	718
Barrow	5				5
Bethel	19	2			21
Cordova	2				2
Delta Jct/Dot Lake	2				2
Dillingham	11				11
Eagle River	9				9
Fairbanks/North Pole	132		41	1	174
Fort Yukon	1				1
Glennallen	1				1
Golovin	1				1
Haines	3				3
Homer	12				12
Juneau/Douglas	56	2		1	59
Kenai	5				5
Ketchikan	27	5			32
Kodiak	17	4			21
Kotzebue	7				7
Metlaktla	2				2
Naknek	1				1
Nome	13				13
Palmer	28				28
Petersburg	5				5
Seldovia	1				1
Seward	4				4
Sitka	19	11			30
Soldotna	38				38
Talkeetna	1				1
Tok	1				1
Valdez	4				4
Wasilla	30				30
Wrangell	3				3
TOTAL	**1024**	**62**	**119**	**40**	**1245**

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 20, 2000

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Chuglak	566	38	73	38	715
Barrow	6				6
Bethel	20	3			23
Cordova	2				2
Delta Jct/Dot Lake	2				2
Dillingham	9				9
Eagle River	12				12
Fairbanks/North Pole	131		37		168
Fort Yukon	1				1
Glennallen	2				2
Golovin	1				1
Haines	3				3
Homer	14				14
Juneau/Douglas	59	2			61
Kenai	4				4
Ketchikan/Klawock	28	3			31
Kodiak	19	4			23
Kotzebue	5				5
Metlaktla	2				2
Naknek	1				1
Nome	13				13
Palmer	31				31
Petersburg	5				5
Saldovia	1				1
Seward	4				4
Sitka	18	11			29
Soldotna	38				38
Talkeetna	1				1
Tok	1				1
Valdez	4				4
Wasilla	30				30
Wrangell	3				3
TOTAL	1036	61	110	38	1246

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 20, 2001

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Chugiak	595	34	70	35	734
Barrow	5				5
Bethel	21	3			24
Cordova	3				3
Delta Junction	1				1
Dillingham	9				9
Eagle River	12				12
Fairbanks/North Pole	134		37		171
Fort Yukon	1				1
Glennallen	2				2
Golovin	1				1
Haines	3				3
Homer	14				14
Juneau/Auke Bay	66	2			68
Kenai	7				7
Ketchikan/Klawock	33	3			36
Kodiak	19	4			23
Kotzebue	10				10
Metlaktla	1				1
Naknek	1				1
Nome	11				11
Palmer	28				28
Petersburg	5				5
Seldovia	1				1
Seward	3				3
Sitka	17	11			28
Soldotna	36				36
Talkeetna	1				1
Tok	1				1
Valdez	3				3
Wasilla	34				34
Wrangell	2				2
TOTAL	**1080**	**57**	**107**	**35**	**1279**

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 4, 2002

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Girdwood	630	36	68	27	761
Barrow	3				3
Bethel	19	2			21
Cordova	2				2
Delta Junction	1				1
Dillingham	8				8
Eagle River	11				11
Fairbanks/North Pole	130		36		166
Fort Yukon	1				1
Glennallen	2				2
Golovin	1				1
Haines	3				3
Homer	15				15
Juneau/Auke Bay	69	2			71
Kenai	7			1	8
Ketchikan/Klawock	30	3			33
Kodiak	20	4			24
Kotzebue	9				10
Metlaktla	1				1
Naknek	1				1
Nome	11				11
Palmor	26				6
Petersburg	5				5
Seldovia	1				1
Seward	5				5
Sitka	19	11			30
Soldotna	38				38
Talkeetna	1				1
Tok	1				1
Valdez	4				4
Wasilla	38				38
Wrangell	3				3
TOTAL	**1115**	**59**	**104**	**28**	**1306**

Source: Mock-up For 2004 Medical Directory
Alaska State Medical Association

Done

PHYSICIAN DISTRIBUTION IN ALASKA

As of December 4, ~~2002~~ 2003

Town	Private Practice	Public Health	Military	Municipal State & Fed	TOTAL
Anchorage/Girdwood	~~630~~ 675	~~36~~ 37	~~68~~ 61	~~27~~ 24	~~761~~ 797
Barrow	~~8~~ 5				~~8~~ 5
Bethel	~~19~~ 18	2			~~21~~ 20
Cordova	2				2
Delta Junction	1				1
Dillingham	~~8~~ 9				~~8~~ 9
Eagle River	~~11~~ 12				~~11~~ 12
Fairbanks/North Pole	~~130~~ 131		38 34	1	166
Fort Yukon	1				1
Glennallen	~~2~~ 3				~~2~~ 3
Golovin	1				1
Haines	~~3~~ 2				~~3~~ 2
Homer	~~15~~ 18				~~15~~ 18
Juneau/Auke Bay	~~69~~ 63	2			~~71~~ 70
Kenai	~~7~~ 6			1	~~8~~ 7
Ketchikan/Klawock	30	3			33
Kodiak	~~20~~ 15	4			~~24~~ 19
Kotzebue	~~8~~ 10				10
~~Metlaktla~~	~~1~~				~~1~~
Naknek	1				1
Nome	~~11~~ 10				~~11~~ 10
Palmer	~~26~~ 25				~~28~~ 25
Petersburg	~~5~~ 6				~~5~~ 6
Seldovia	1				1
Seward	~~5~~ 6				~~5~~ 6
Sitka	19	11			30
Soldotna	~~38~~ 39				~~38~~ 39
Talkeetna	1				1
Tok	1				1
Valdez	~~4~~ 3				~~4~~ 3
Wasilla	~~38~~ 41				~~38~~ 41
Wrangell	~~3~~ 4				~~3~~ 4
TOTAL	~~1115~~ 1164	59 ✓	~~104~~ 95 254	~~28~~ 26	~~1306~~ 1344

NORCAL Mutual Insurance Company

Legal Department

560 Davis Street, 2nd Floor • San Francisco, California 94111
(415) 397-9700 • (800) 652-1051 • Facsimile (415) 835-9819 • www.norcalmutual.com

February 20, 2004

Representative Tom Anderson
Alaska State House of Representatives
Alaska State Capitol, Room 432
Juneau, AK 99801

Re: AB472 Letter of Support

Dear Representative Anderson:

NORCAL Mutual Insurance Company, a physician owned and managed insurer providing medical liability insurance to approximately one-half of the practicing physicians in Alaska, supports AB472 because this legislation will make health care more readily available to the citizens of Alaska.

NORCAL, as the successor to MICA, has provided medical liability insurance to hundreds of Alaska physicians since 1991. During that time, there have been several efforts to reform the tort law in Alaska to bring Alaska law into parity with other states. Unfortunately, these efforts have not had the desired effect. HB472 is necessary to accomplish where other efforts have failed.

Today, Alaska finds itself as one of the costliest states for physicians. A major cost for Alaska physicians is medical liability insurance. Alaska physicians pay on average $30,627 per year, which is the eighth highest average cost in the county. By comparison, California physicians pay $14,564 per year on average. This means Alaska physicians pay 110% more on average each year than California physicians.

Alaska's expensive medical liability premiums are the result of high jury awards and settlements. The average medical liability payment in Alaska during 2001 was $308,476. This means Alaska payments are the fourteenth highest in the country. California payments by comparison averaged $178,499. This means Alaska payments were 72% higher than California.

Over the years, Alaska has experienced some of the most dramatic increases in the cost of medical liability in the country. According to the National Association of Insurance Commissioners (NAIC), Alaska premiums have increased by 1593.47% between 1976 and 2001.

Only seven states have seen a higher rate of increase. By comparison, California medical liability premiums have only increased by 182.16% during the comparable period.

Numerous studies have been done to determine why some states have experienced higher premiums, larger awards, and more dramatic year-to-year increases in cost than other states. These studies have uniformly found that medical liability reform is the single most important factor controlling medical liability premiums and losses. California's Medical Injury Compensation Reform Act (MICRA) has been identified as the most successful effort to control medical liability costs. MICRA's $250,000 cap on non-economic damages is the keystone of this legislation. We believe the $250,000 cap on non-economic damages contained in HR472 will go a long way toward bringing the cost of Alaska's medical liability insurance into line with national averages.

For these reasons, Alaska physicians and their patients will benefit through enactment of this legislation.

Very truly yours,

Philip R. Hinderberger
Senior Vice President and General Counsel
NORCAL Mutual Insurance Company

PRH/cm

cc: Steven S. Fountain, M.D.
Ronald Keller, M.D.
Jim Jordan, ASMA
Mike Hogan, APNS

February 23, 2004

Representative Lesil McGuire
Chair, House Judiciary

Re: **Support for HB 472**

Dear Representative McGuire,

I am writing as a healthcare provider in **support of HB 472**, relating to medical malpractice claims for personal injury and wrongful death.

While the focus of Section 1(a) is physicians, Advanced Nurse Practitioners in Alaska are experiencing skyrocketing liability insurance rates as well. Advanced Nurse Practitioners have been advised by our underwriters to expect a 75% increase in our rates this year alone. Certified Nurse Midwives now typically pay about $20,000 per year for malpractice insurance. These increased costs are ultimately passed on to patients, which decrease access to care for those with limited resources.

HB 472, which will limit non-economic damages in malpractice lawsuits to $250.000, will be very helpful in curbing the escalating cost of healthcare.

Respectfully,

Cathy Giessel

Cathy Giessel, MS, FNP-CS
12701 Ridgewood Rd
Anchorage, AK 99516
907 345 5470
cgiessel@mac.com

Alaska Board of Nursing
Alaska Nurse Practitioner Association Legislative Affairs Representative
American Academy of Nurse Practitioners, State Representative
Anchorage Health and Human Services Commission

Providence | Health System

3200 Providence Drive
P.O. Box 196604
Anchorage, Alaska
99519-6604

Tel 907.562.2211

February 20, 2004

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

Dear Representative McGuire:

I understand that the House Judiciary Committee is holding a hearing on House Bill No. 472, relating to claims for personal injury or wrongful death against health care providers. Unfortunately, I will be traveling out of state on the day of the hearing, but I wish to add my voice in support of this important piece of legislation.

Providence Health System is in a unique position to experience first-hand the affects of the many critical issues facing Alaska's health care delivery system. Dramatic increases in awards for pain and suffering and other non-economic damages have led to significant increases in physicians' medical malpractice insurance rates and the loss of carriers willing to write medical malpractice insurance in Alaska. As I'm sure you are hearing from physicians and patients alike, some physicians are curtailing the kinds of care they provide and some are getting out of the business entirely as a result.

A physician needs assessment for the Anchorage community conducted by Providence Health System in the fall of 2002, revealed that based upon national physician benchmarks, Anchorage had 153 physicians less than the national average. This same assessment showed that by 2008, Anchorage falls close to 180 physicians below the national average. Providence has employed an aggressive physician recruitment strategy in an effort to bring Anchorage in line with the national physician benchmarks. One of the things we've learned in our recruitment efforts is that a reasonable limit on non-economic damages in medical malpractice cases, such as is called for in HB 472, is a key element in achieving positive results in recruitment efforts.

The passage of this legislation will go a long way toward helping create a better economic environment for physician practices, thus decreasing the physician shortage. I encourage members of the Alaska Legislature to vote for this bill's passage.

Sincerely,

E. Al Parrish
CE/VP, Alaska Region
Providence Health System

Gary L. Livengood
PO Box 10377
Fairbanks, Alaska 99710

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill number 472- Medical TORT Bill

Dear Representative Anderson:

I am writing to encourage your support of House Bill 472. I feel it is important to put a cap on awards issued in frivolous lawsuits. The costs for physicians and health care facilities keep going up. This increases the cost of health care. Also, Physicians have limited, or quit, their practices because of insurance costs.

Thank you for your time.

Sincerely,

Gary L Livengood

Gary L. Livengood

cc: Interior Delegation
House HESS Committee

Jane Walsh
1097 Vicki Lane
North Pole, AK 99705

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson:

Healthcare costs are at an all-time high. Alaska must join the other 25 states in passing this type of non-economic liability reform. Failure to act on this bill will threaten the quality of healthcare in every community in Alaska.

I urge you to vote in favor of the TORT Bill and enact legislation that will limit non-economic damages.

Thank you for your time and consideration,

Jane Walsh

Cc: Interior Delegation
House Judiciary

Shelby Nelson
340 Snowy Owl Lane
Fairbanks, AK 99701

Phone: 907-455-7112
Email: sdnelson@acsalaska.net

March 1, 2004

Representative Tom Anderson
Room 432
State Capital
Juneau, AK 99801-1182

RE: House Bill No. 472—Medical TORT Bill

Dear Representative Anderson:

Alaska must pass effective liability reform. Patient access to care is suffering and will worsen if the State fails to act. Physicians are being forced to limit services, retire early, or move to other states where liability premiums are more stable—all of which seriously threaten access to quality health care services.

This is a statewide problem that deserves and Alaskan solution. Currently, 25 states have enforceable damage caps. Damage caps are and effective way of stabilizing the liability insurance market by prohibiting excessive damage awards. Excessive awards can result in increased liability insurance premiums for all physicians. A full 72% of Americans favor capping non economic damages in medical liability cases, according t a 2003 Gallup poll.

I urge the senate to pass SB319 and the House to pass HB 472. Your actions now will save a potential crisis in the future.

Sincerely,

Shelby Nelson

Cc: Interior Delegation
House Judiciary

Jon Lundquist
752 Donohue Drive
Fairbanks, AK 99712
March 1, 2003

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT

Dear Representative Anderson:

I support the medical Tort Bill (H.B. No. 472). Due to the escalating costs and exorbitant jury awards, the costs of being a physician are increasing to the point where people are no longer willing to take the risk of becoming a doctor. In order to control these costs and avoid shortages, especially in rural areas, I urge you and your fellow Representatives to pass House Bill No. 472.

Sincerely,

Jon Lundquist

cc: Interior Delegation
House HESS Committee

Charles E. Holyfield
P. O. Box 10789
Fairbanks, Alaska 99710

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson:

I would like to voice support of HB-472, Medical TORT Reform as a way to continue premium healthcare in Alaska. By capping the potentially huge judgments in professional liability cases, the cost of healthcare can be maintained at a less expensive level for the public, physicians would be more readily available, and more high-risk procedures could be available to those requiring them.

HB 472 does not limit any economic damages, such as, past and future medical expenses. loss of earnings, or cost of domestic services, but rather, limits the non-economic damages to one quarter of a million dollars.

Please support this bill and help Alaska's healthcare future.

Sincerely,

Charles E. Holyfield

Cc: Interior Delegation
House Judiciary

Sheryl Barnett
1027 Noel Drive
Fairbanks, AK 99712

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson,

I am writing you in support of House Bill 472. I have lived in Interior Alaska for 25 years and have always appreciated having access to skilled health care in my "home town." But recently; I, like others in this community have become aware of physicians being forced to limit their practice or retire early or even worse move to other states where their liability premiums are more affordable and stable. I recognize this as a serious threat to my access to healthcare. Because of this threat I am writing in support of your introduction of House Bill 472 and I urge the House and Senate to support the Medical Tort Bill.

Sincerely,

Sheryl Barnett

Cc: Interior Delegation, House HESS Committee

Rodney Perdue
1422 Kent Court
Fairbanks, Alaska

February 27, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative And rson:

I am writing in response to the current situation with healthcare in Alaska, specifically with respect to Alaska's medical liability system.

I think that this situation is approaching the state of being a crisis because if left as is, it will cause a shortage of quality healthcare providers. This is a statewide problem and needs to have a statewide solution. He rising costs of medical insurance will make it unfeasible for many to continue in the field of practice that they are currently in.

I urge the Senate to pass SB319 and I also urge the House to enact similar legislation.

Sincerely,

Rodney Perdue

cc: Interior Delegation
House Judiciary

Sandra Larson
2537 Talkeetna
Fairbanks, Alaska 99709

February 27, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 - Medical TORT Bill

Dear Representative Anderson:

I am writing to you about the current situation with healthcare in Alaska, and Alaska's medical liability system.

The frivolous lawsuits that are commonplace today are endangering the availability of healthcare in the future. Liability insurers are leaving the market or raising the rates to astronomical levels.

Patients are paying escalating costs that are generated by our nation's dysfunctional medical liability system. The cost of liability insurance for physicians continues to escalate which causes physicians to limit services, retire early or move to other states where liability premiums are more stable. The continued availability of adequate medical care depends directly on the availability of adequate insurance coverage.

I urge the Senate to pass SB319 and I also urge the House to enact similar legislation.

Sincerely,

Sandy Larson

Sandy Larson

cc: Interior Delegation
House Judiciary

Elizabeth Woodyard
1070 Ellesmere
Fairbanks, Alaska 99709

February 27, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson:

I am writing in order to voice my opinion about the current situation with healthcare in Alaska, specifically with respect to Alaska's medical liability system.

Patients are paying escalating costs that are generated by our nation's dysfunctional medical liability system. The cost of liability insurance for physicians continues to escalate which causes physicians to limit services, retire early or move to other states where liability premiums are more stable.

The frivolous lawsuits that are commonplace today are endangering the availability of healthcare in the future.

I urge the Senate to pass SB319 and I also urge the House to enact similar legislation.

Sincerely,

Liz Woodyard

cc: Interior Delegation
House Judiciary

Debra Hall
959 Windflower Lane
Fairbanks, AK 99712

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson,

I am writing you in support of House Bill 472. I have lived in Interior Alaska for 25 years and have always appreciated having access to skilled health care in my "home town." But recently; I, like others in this community have become aware of physicians being forced to limit their practice or retire early or even worse move to other states where their liability premiums are more affordable and stable. I recognize this as a serious threat to my access to healthcare. Because of this threat I am writing in support of your introduction of House Bill 472 and I urge the House and Senate to support the Medical Tort Bill.

Sincerely,

Debra Hall

Cc: Interior Delegation, House HESS Committee

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
Administrative Offices 4141 Ambassador Drive
Anchorage, Alaska 99508
Telephone: 907-729-1900
Facsimile: 907-729-1901

Sent via facsimile: (907) 465-6592

March 2, 2004

The Honorable Lesil McGuire
Alaska House of Representatives
State Capitol, Room 118
Juneau, AK 99801-1182

Dear Representative McGuire:

Re: Opposing the $100 million "Plan B" Medicaid Program Reductions Proposed by the House Finance Committee's Health and Social Services Subcommittee

I write to urge you to oppose the "Plan B" reductions to the Alaska Medicaid Program recently proposed by the Health and Social Services Subcommittee of the House Finance Committee.

These proposed reductions would significantly impact Alaskans most in need—seniors, those with mental illness, developmental disabilities, and low-income adults. The reductions would:

- Eliminate dental services for 5,400 people;
- Eliminate speech and hearing therapy for 1,200 individuals;
- Eliminate eye glasses and other vision services for 12,000 people;
- Reduce access for 31,000 Medicaid patients by cutting rates to physicians by 10%;
- Reduce rates to hospitals by 10%, significantly hurting the sustainability of all of Alaska's hospitals, particularly the small rural hospitals; and
- Reduce pharmacy rates to 85% of the Average Wholesale Price, down from the current 95% level, hurting the ability of Alaska health providers to provide reasonably-priced pharmaceutical drugs to those Alaskans with the greatest need and least ability to pay.

Moreover, because the federal government in all cases pays at least a 50% match for State Medicaid expenditures, and pays up to 100% of Medicaid expenditures in many cases, **the overall economic impact to the State can reasonably be calculated to be in excess of $250 million, including a loss of at least $150 million in federal funds coming into Alaska.**

In conclusion, the proposed $100 million "Plan B" Medicaid cut will hurt not only those Alaskans who are most in need, it will also have a potentially disastrous effect on Alaska's economy.

Sincerely,

Don Kashevaroff
Chairman/President

March 2, 2004

To: Members of the House Judiciary Committee

Certain members of the legislature seemed poised to give the insurance industry, and our high and mighty brothers and sisters in the medical profession, yet another huge gift at the expense of ordinary Alaskans. Why? Ninety-eight thousand Americans die every year from medical errors in hospitals.[1]

If this was the aviation industry, killing what amounts to a couple of jumbo jets full of people a week, America would do something about it. Those planes would be grounded, investigations would be launched, ingenuity would be brought to bear and the problem would be solved or mitigated. Instead, the answer of some in the legislature, as reflected in SB 319 and HB 472, is to further immunize those at the helm of this unmitigated disaster and to further ensure that the few checks and balances that now exist will be further weakened and displaced.

Accurate records are not kept on these matters, but I pay pretty close attention. By my count, in the history of the state and territory of Alaska, there have been something on the order of fifteen jury verdicts in favor of plaintiffs in medical negligence cases.[2] That's all. Many of these verdicts, like one I acquired a few years ago, were Pyrrhic victories. The recoveries were relatively insignificant. This is apparently the "crisis" that motivates certain members of the legislature to strip Alaskans of their right to place their claims before a jury for its evaluation of their damages.

This legislation is not just bad public policy, in light of existing medical and legal reality, it is an embarrassment.

Very truly yours,

LAW OFFICES OF
MICHAEL J. SCHNEIDER, P.C.

Michael J. Schneider

---

[1]40% of Americans, in general, and a third of doctors say that they or their family members have been the victims of a preventable medical error. 10% of doctors say that a family member has died as a consequence of medical negligence. *New England Journal of Medicine,* December 12, 2002.

[2]Medical negligence cases broadly defined, e.g. nursing malpractice, dental malpractice, etc.

AARP Alaska

March 11, 2004

Vanessa OK

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.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | 907-341-2277 | 907-341-2270 fax | 1-877-434-7598 TTY
James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org

It's not just physicians who need malpractice reform. Consumers injured by medical errors are also served badly by the tort system, and real reform requires going beyond the doctor vs. lawyer debate.

The tort system does a poor job of compensating people injured by medical errors. It is slow, expensive, and most injured people get nothing at all. The tort system also encourages providers to cover up mistakes in order to avoid lawsuits, rather than report errors in order to learn how to prevent them in the future.

We need to move beyond the debate over caps. Proposals to set unreasonable limits on pain and suffering awards do not help injured people get compensation or reduce errors. In fact, such caps can make it even harder for people who are injured to get fair compensation. AARP believes they are also unfair to older people with limited income potential who thus get little in economic damages.

Real reform should lead to fair compensation and error reduction. The Institute of Medicine (IOM) has proposed demonstration projects to test reform designed to fix what is broken for consumers. IOM has proposed testing non-judicial, no-fault alternatives to the tort system for medical errors (but not for other types of harm to patients, such as nursing home negligence). These alternatives could foster fair compensation and error reduction—what we believe should be the goals of consumer-oriented reform.

Under the IOM proposal, people with legitimate cases of medical injury could be identified and compensated appropriately. Payments would be based on "avoidability" of errors rather than "negligence." Amounts would be preset in schedules for specific categories of errors, which would provide reasonable limits that may help stabilize malpractice premiums. Health providers would have to report errors and make payments promptly, which would help injured people get fair compensation.

Errors could be reduced so fewer people would be injured. By requiring providers to report errors, the IOM claims that experts would be able to analyze system-wide errors and find ways to prevent them. The result would be a system in which patient safety is continually improved. With fewer errors, the cost of compensating injured people could decline.

We assume that reducing medical errors is in the best interest of all Alaskans and is the real intent of Representative Anderson and HB 472. We encourage you and your colleagues on the House Judiciary Committee to amend HB 472 to reflect the recommendations of the Institute of Medicine. Fair compensation and error reduction—AARP thinks we can all live with that.

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
3009 Northwood Street
Anchorage, AK 99517-1871
907-245-5259 (voice)
907-245-5279 (fax)
ffmas@aurora.uaf.edu

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: [Fwd: House Bill 472]
Date: Mon, 01 Mar 2004 17:40:35 -0900
From: Mike Hawker <Representative_Mike_Hawker@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Representative Lesil McGuire <Representative_Lesil_McGuire@legis.state.ak.us>, Representative Tom Anderson <Representative_Tom_Anderson@legis.state.ak.us>, Representative Dan Ogg <Representative_Dan_Ogg@legis.state.ak.us>, Representative Jim Holm <Representative_Jim_Holm@legis.state.ak.us>, Representative Ralph Samuels <Representative_Ralph_Samuels@legis.state.ak.us>, Representative Les Gara <Representative_Les_Gara@legis.state.ak.us>, Representative Max Gruenberg <Representative_Max_Gruenberg@legis.state.ak.us>

Vanessa-
P3 part in
my HB 472
packet so Q
can reference
THX
J

-------- Original Message --------
Subject: House Bill 472
Date: Sun, 29 Feb 2004 19:53:49 EST
From: Junelawyer@cs.com
To: Representative_Mike_Hawker@legis.state.ak.us

Representative Hawker:

As a resident of your district, I am writing you today about House Bill 472 and its corresponding Senate Legislation seeking to limit non-economic loss compensation to victims of medical malpractice to $250,000. The supposed justification is excessive verdicts/settlements causing insurers to cease doing business in Alaska and indirectly making it harder to attract good physicians to our State. While I am unable to comment on what facts of a specific case that would persuade a jury to award more than $250,000 and do not even practice in the area of medical malpractice, I can say that the purported justification does not make sense. There is nothing to indicate that the current recovery limits are inadequate or abused.

Awards of non-economic loss of greater than $250,000 are newsworthy events. Both defense and plaintiff lawyers are anxious to learn of these trials for purposes of evaluating cases. Similarly, so is the media. The same principles hold true for settlements without trial. I have not heard and question that there are examples of "runaway juries" in Alaska. With only a handful of insurers, the Legislature should be provided with verifiable facts. The truth of the matter is that lawyers for accident victims are constantly reminded that Alaska juries have become "conservative" in their damage awards. At the same time, insurer income has been more adversely impacted by the depressed state of investment markets than by jury verdicts.

In 1997, the Legislature promulgated comprehensive Tort Reform legislation. If there is truth to the conservative nature of Alaska juries, then it appears that the Tort Reform effort is working and there is no showing to further limit the rights of malpractice victims. On a Federal level, Congress has considered and rejected a similar cap. Again, the insurers were unable to demonstrate an income crisis related to jury verdicts.

If there is no crisis, what is prompting the push for legislation. I suspect the insurance and medical professions are like any business seeking to reduce costs in order to maximize profits. With policies having already been sold, reducing the risk potentially reduces costs and increases profits and nothing to increase the availability of coverage or to prevent medical malpractice.
While there is nothing wrong with a business being a profit maximizer, it is wrong for a highly paid profession to proclaim a crisis when one does not exist. Doing so is simply an exercise in fearmongering.

From a public policy standpoint the proposed legislation serves only to limit the recovery of the most egregious of accident victims and undermine the jury system. I would encourage you to do all you can to prevent passage of this legislation.

Marc W. June.
Law Office of Marc June
807 G. St., Suite 150
Anchorage, Ak. 99501

PS. Good luck on the Fiscal Crisis. I appreciate that is where you are spending the bulk of your time this session but know that this legislation will not pass if you do not support it.

Subject: [Fwd: HB 472]
Date: Mon, 01 Mar 2004 17:41:55 -0900
From: Mike Hawker <Representative_Mike_Hawker@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Representative Lesil McGuire <Representative_Lesil_McGuire@legis.state.ak.us>, Representative Tom Anderson <Representative_Tom_Anderson@legis.state.ak.us>, Representative Dan Ogg <Representative_Dan_Ogg@legis.state.ak.us>, Representative Jim Holm <Representative_Jim_Holm@legis.state.ak.us>, Representative Ralph Samuels <Representative_Ralph_Samuels@legis.state.ak.us>, Representative Les Gara <Representative_Les_Gara@legis.state.ak.us>, Representative Max Gruenberg <Representative_Max_Gruenberg@legis.state.ak.us>

For my HB 472 file

-------- Original Message --------
Subject: HB 472
Date: Mon, 1 Mar 2004 11:30:30 -0900
From: "Jeff Friedman" <jfriedman@frwusa.com>
To: <Representative_mike_hawker@legis.state.ak.us>

1) Before reversing the Marsingill and Korman cases, I think you should read them. (disclosure: Our office is involved in the Marsingill retrial coming up this year) These cases take a common sense approach and allow the jury to use a reasonable person standard. The question is not what battling experts say should have happened, but what a reasonable person would have understood and done in those circumstances. 2) why are health care professionals given a break that other defendants don't have? Subsection d says they only have to pay a maximum of $250,000 in non-economic damages. Other defendants may be required to pay more than that amount in non-economic damages. 3) AS 09.55.556 (d) is a new section that is troubling. In Marsingill, the patient called the doctor on the phone. The doctor recomended going to the ER, but then told her things that would reasonably lead her to believe that going to the ER was not necessary. This mixed message is the basis for her claim. A physician should not be able to avoid liability by starting all phone conversations with "you should come to my office" and then proceding to give additional advice that undercuts the first statement. I think a jury should be trusted to decide whether the doctor's advice was negligent. 4) Then there is the final question as to whether there is even a malpractice crisis that needs to be addressed. In states where the legislature has put people under oath, no one has been willing to testify that there is a shortage of doctors or that high premiums are forcing doctors out of the state or the practice of medicine. In addition, insurance executives have testified under oath that capping damages does not have an effect on premiums. I'm working on getting you a copy of that testimony, but Sen. French should have it already from my partner, Jeff Rubin. Thanks for listening. Jeff

Subject: [Fwd: Quotes from Insurance Company executives]
Date: Mon, 01 Mar 2004 17:43:05 -0900
From: Mike Hawker <Representative_Mike_Hawker@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Representative Lesil McGuire <Representative_Lesil_McGuire@legis.state.ak.us>,
Representative Tom Anderson <Representative_Tom_Anderson@legis.state.ak.us>,
Representative Dan Ogg <Representative_Dan_Ogg@legis.state.ak.us>,
Representative Jim Holm <Representative_Jim_Holm@legis.state.ak.us>,
Representative Ralph Samuels <Representative_Ralph_Samuels@legis.state.ak.us>,
Representative Les Gara <Representative_Les_Gara@legis.state.ak.us>,
Representative Max Gruenberg <Representative_Max_Gruenberg@legis.state.ak.us>

V Same 472 file

-------- Original Message --------
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>

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

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>

V. 472 file PB JHS

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:

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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

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE
PATIENT SAFETY
◂ Previous Volume 347:1933-1940 December 12, 2002 Number 24 Next ▸

Views of Practicing Physicians and the Public on Medical Errors

Robert J. Blendon, Sc.D., Catherine M. DesRoches, Dr.P.H., Mollyann Brodie, Ph.D., John M. Benson, M.A., Allison B. Rosen, M.D., M.P.H., Eric Schneider, M.D., M.Sc., Drew E. Altman, Ph.D., Kinga Zapert, Ph.D., Melissa J. Herrmann, M.A., and Annie E. Steffenson, M.P.H.

ABSTRACT

Background In response to the report by the Institute of Medicine on medical errors, national groups have recommended actions to reduce the occurrence of preventable medical errors. What is not known is the level of support for these proposed changes among practicing physicians and the public.

Methods We conducted parallel national surveys of 831 practicing physicians, who responded to mailed questionnaires, and 1207 members of the public, who were interviewed by telephone after selection with the use of random-digit dialing. Respondents were asked about the causes of and solutions to the problem of preventable medical errors and, on the basis of a clinical vignette, were asked what the consequences of an error should be.

Results Many physicians (35 percent) and members of the public

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Special Article

PATIENT SAFETY

VIEWS OF PRACTICING PHYSICIANS AND THE PUBLIC ON MEDICAL ERRORS

ROBERT J. BLENDON, SC.D., CATHERINE M. DESROCHES, DR.P.H., MOLLYANN BRODIE, PH.D., JOHN M. BENSON, M.A., ALLISON B. ROSEN, M.D., M.P.H., ERIC SCHNEIDER, M.D., M.SC., DREW E. ALTMAN, PH.D., KINGA ZAPERT, PH.D., MELISSA J. HERRMANN, M.A., AND ANNIE E. STEFFENSON, M.P.H.

ABSTRACT

Background In response to the report by the Institute of Medicine on medical errors, national groups have recommended actions to reduce the occurrence of preventable medical errors. What is not known is the level of support for these proposed changes among practicing physicians and the public.

Methods We conducted parallel national surveys of 831 practicing physicians, who responded to mailed questionnaires, and 1207 members of the public, who were interviewed by telephone after selection with the use of random-digit dialing. Respondents were asked about the causes of and solutions to the problem of preventable medical errors and, on the basis of a clinical vignette, were asked what the consequences of an error should be.

Results Many physicians (35 percent) and members of the public (42 percent) reported errors in their own or a family member's care, but neither group viewed medical errors as one of the most important problems in health care today. A majority of both groups believed that the number of in-hospital deaths due to preventable errors is lower than that reported by the Institute of Medicine. Physicians and the public disagreed on many of the underlying causes of errors and on effective strategies for reducing errors. Neither group believed that moving patients to high-volume centers would be a very effective strategy. The public and many physicians supported the use of sanctions against individual health professionals perceived as responsible for serious errors.

Conclusions Though substantial proportions of the public and practicing physicians report that they have had personal experience with medical errors, neither group has the sense of urgency expressed by many national organizations. To advance their agenda, national groups need to convince physicians, in particular, that the current proposals for reducing errors will be very effective. (N Engl J Med 2002;347:1933-40.)

THE prevention of serious errors in medical care has long been of concern to health professionals, as well as courts and legislatures.[1] However, the recent report by the Institute of Medicine (IOM), *To Err Is Human*, focused attention on the problem, particularly its conclusion that, each year, more Americans die as a result of medical errors made in hospitals than as a result of injuries from automobile accidents.[2,3] At the time the report was released, a survey showed that half the American public followed the media coverage of it.[4] Since then, there have been many new efforts to reduce the incidence of medical errors.[5-10] However, there are those who disagree with the report's conclusions, arguing that the report overstated the magnitude of the problem.[11-14]

Still not known are the views of practicing physicians and the public with regard to both the number of deaths due to errors and the recommendations of national groups for reducing these errors. Many of the recommendations would change the daily practice of individual physicians and hospitals, so the support of practicing physicians may be crucial. New legislation and changes in public policy may require the backing of both physicians and the public.[15-18]

We conducted parallel surveys of physicians and the public to learn their views on medical errors. We posed the following questions: Have you had a personal experience with medical errors made in your care or that of a family member? How frequent and how serious is the problem of medical errors as compared with other problems in health care? What are the most important causes of medical errors? What actions should be taken to prevent medical errors? What should be the consequences for a health professional or institution involved in a medical error?

From the Department of Health Policy and Management, Harvard School of Public Health, Boston (R.J.B., C.M.D., J.M.B., A.B.R., E.S.); the Kaiser Family Foundation, Menlo Park, Calif. (M.B., D.E.A., A.E.S.); Harris Interactive, Rochester, N.Y. (K.Z.); and ICR/International Communications Research, Media, Pa. (M.J.H.). Address reprint requests to Dr. Blendon at the Harvard School of Public Health, Health Policy and Management, 677 Huntington Ave., Boston, MA 02115.

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 1603 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-

TABLE 1. RESPONDENTS' PERSONAL EXPERIENCE WITH PREVENTABLE MEDICAL ERRORS.

RESPONSE	PHYSICIANS (N=831)	PUBLIC (N=1207)	P VALUE
	percent		
All respondents			
Error made in own or family member's care	35	42	<0.001
Health consequences			
Serious	18	24	<0.001
Minor	10	13	0.03
None	7	5	0.06
Serious consequences			
Severe pain	11	16	<0.001
Substantial loss of time at work or school, or in other important activities	12	17	<0.001
Temporary disability	8	12	0.009
Long-term disability	6	11	0.003
Death	7	10	0.01
Respondents reporting an error*			
Parties who had "a lot" of responsibility for the error			
Doctors	70	81	<0.001
Nurses	25	25	0.15
Other health professionals	15	26	<0.001
The institution (e.g., a hospital, clinic, or nursing home facility)	22	43	<0.001
Health professional involved			
Told respondent that an error had been made	31	30	0.19
Apologized to respondent or family member	34	33	0.14
Respondent or family member sued health professional	2	6	<0.001

*A total of 290 physicians and 507 members of the public reported an error in their own care or that of a family member.

spondents who reported experience with an error assigned "a lot" of responsibility to the physicians involved (Table 1). The public was significantly more likely than physicians to attribute the error to the institution involved. Malpractice lawsuits after an error were reported infrequently (by 2 percent of physicians and 6 percent of the public). However, 48 percent of physicians reported that they had been named in a malpractice lawsuit at some time in their career.

Twenty-nine percent of physicians reported having seen an error in the previous year in their capacity as physicians. Among these physicians, 60 percent believed that a similar error was very or somewhat likely to occur at the same institution during the next year.

Views of Medical Errors

Neither physicians nor the public named medical errors as one of the largest problems in health care today. The problems cited most frequently by physicians were the costs of malpractice insurance and lawsuits (cited by 29 percent of the respondents), the cost of health care (27 percent), and problems with insurance companies and health plans (22 percent). In the survey of the public, the issues cited most frequently were the cost of health care (cited by 38 percent of the respondents) and the cost of prescription drugs (31 percent). Only 5 percent of physicians and 6 percent of the public identified medical errors as one of the most serious problems.

Before being given the definition of the term "medical error," 68 percent of the respondents in the survey of the public reported that they did not know what the term meant. After being given the definition, approximately half the respondents thought these errors are made very often or somewhat often when people seek help from health professionals, as compared with only one fifth of physicians (Table 2).

The majority of both physicians and the public believed that 5000 or fewer deaths in hospitals each year are due to preventable medical errors — a much lower number than either the high or low IOM estimate. A majority of respondents in both surveys thought that one half or fewer of these deaths could have been prevented.

Causes of Medical Errors

Of the 11 items listed as possible causes of medical errors, only 2 were thought by at least half the physicians to be very important causes: understaffing of nurses in hospitals (53 percent) and overwork, stress, or fatigue on the part of health professionals (50 percent) (Table 3). In the survey of the public, at least half

TABLE 2. BELIEFS ABOUT THE FREQUENCY OF MEDICAL ERRORS AND PREVENTABLE DEATHS.*

QUESTION AND RESPONSE	PHYSICIANS (N=837)	PUBLIC (N=1207)	P VALUE
	percent		
How often are preventable medical errors made?			
Very often	1	10	<0.001
Somewhat often	19	39	<0.001
Not very often	59	37	<0.001
Not often at all	21	8	<0.001
No response	0	6	
How many Americans die in hospitals each year because of preventable medical errors?			
500	17	24	<0.001
5000	46	36	<0.001
50,000	25	20	0.002
100,000	9	7	0.12
≥500,000	1	4	<0.001
No response	1	9	
What proportion of these deaths could realistically have been prevented?			
All of them	8	11	0.04
Three quarters of them	27	29	0.48
Half of them	41	42	0.71
One quarter of them	21	13	<0.001
None of them	2	1	0.05
No response	1	3	

*Percentages may not always sum to 100 because of rounding.

the respondents considered seven of the causes very important. The top four causes considered to be very important were physicians' not having enough time with patients (72 percent); overwork, stress, or fatigue on the part of health professionals (70 percent); failure of health professionals to work together or communicate as a team (67 percent); and understaffing of nurses in hospitals (65 percent).

When asked whether mistakes made by health professionals or those made by health care institutions were a more important cause of medical errors, a majority of respondents in both groups chose mistakes made by health professionals as the more important cause (55 percent of physicians and 55 percent of the public). In addition, a majority of both groups thought that patients were very often or somewhat often at least partially responsible for errors made in their care.

Proposed Solutions

Of the 16 proposed solutions, a majority of physicians thought that 2 would be very effective at reducing the number of medical errors: requiring hospitals to develop systems for preventing medical errors (55 percent) and increasing the number of nurses in hospitals (51 percent) (Table 4). A majority of the respondents in the survey of the public rated eight items as very effective. The top four items were giving physicians more time to spend with their patients (78 percent), requiring hospitals to develop systems for preventing errors (74 percent), providing better training of health professionals (73 percent), and using only physicians trained in intensive care medicine on intensive care units (73 percent).

There were important areas of divergence in the views of the two groups. For instance, only 3 percent of physicians but 50 percent of the public viewed suspension of the licenses of health professionals as a very effective way to reduce medical errors ($P<0.001$) — a difference of 47 percentage points — and only 23 percent of physicians but 71 percent of the public viewed a requirement that hospitals report errors to a state agency as very effective ($P<0.001$) — a difference of 48 percentage points. Only 21 percent of physicians, but 62 percent of the public, thought that encouraging voluntary reporting of serious medical errors to a state agency would be very effective. Eighty-six percent of physicians believed that hospital reports of errors should be kept confidential, whereas 62 percent of the public believed that reports should be made public ($P<0.001$).

High-Volume Centers

Seventy-one percent of physicians thought that an error would be more likely at a hospital that performs a low volume of procedures than at a high-volume center. The public was divided on this issue; about half the respondents thought that an error would be more likely at a low-volume center (49 percent), and the other half thought either that an error would be more likely at a high-volume center (23 percent) or that volume would make no difference (26 percent) (Table 4). In neither group did a majority of respondents think that limiting certain high-risk procedures to high-volume centers would be a very effective way to reduce medical errors (Table 3).

Consequences for Health Professionals Who Make Errors

The attribution of responsibility for an error in the vignette did not appear to be influenced by whether or not the error was associated with harm to the patient. Most respondents in both groups said that the surgeon had "a lot" of responsibility; a smaller proportion held the hospital responsible (Table 5). Physicians were more likely than the public to hold the nurse responsible for the error, regardless of the outcome.

In general, the public was more likely than physicians to believe that the surgeon should be sued for malpractice and fined and that the surgeon's license should be suspended, as well as to support sanctions against the hospital. Support for various consequences for those involved in the medical error differed sub-

TABLE 3. CAUSES OF PREVENTABLE MEDICAL ERRORS.

RESPONSE	PHYSICIANS (N=831)	PUBLIC (N=1207)	P VALUE
	percent		
Very important causes			
Understaffing of nurses in hospitals	53	65	<0.001
Overwork, stress, or fatigue on the part of health professionals	50	70	<0.001
Failure of health professionals to work together or communicate as a team	39	67	<0.001
Influence of HMOs and other managed-care plans on treatment decisions*	39	48	<0.001
Complexity of medical care	38	62	<0.001
Insufficient time spent by doctors with patients	37	72	<0.001
Poor training of health professionals	28	54	<0.001
Poor handwriting by health professionals	21	48	<0.001
Poor supervision of health professionals	16	50	<0.001
Uncaring health professionals	15	47	<0.001
Lack of computerized medical records	13	35	<0.001
The more important reason for errors			
Mistakes made by individual health professionals	55	55	0.72
Mistakes made by institutions	43	38	0.009
No response	2	7	
Volume of procedures†			
An error is more likely at a high-volume hospital	4	23	<0.001
An error is more likely at a low-volume hospital	71	49	<0.001
Volume does not make a difference	24	26	0.23
No response	1	3	
Patients are at least partially responsible for errors made in their own care			
Very often	10	11	0.51
Somewhat often	48	48	0.89
Not very often	41	35	0.002
Never	1	5	<0.001
No response	0	1	

*HMOs denotes health maintenance organizations.

†Percentages for the public do not always sum to 100 because of rounding.

stantially according to the outcome of the vignette. If the patient was harmed, physicians were significantly more likely to support malpractice lawsuits against the surgeon, the nurse, and the hospital, and the public was substantially more likely to support lawsuits and suspension of the surgeon's license.

DISCUSSION

Our results have a number of implications for national efforts to reduce medical errors. First, major efforts to change hospital and medical practice are likely to face some important challenges. Even though significant percentages of practicing physicians and the public reported personal experience with medical errors that had serious consequences and despite the media's interest in the problem, medical errors are not viewed by either group as one of the most important problems in health care. The costs of malpractice insurance, lawsuits, and health care costs were considered more important. The public and physicians are concerned about individual cases of medical errors, and when the patient is seriously harmed, both groups want some action to be taken. However, both groups believe that the number of in-hospital deaths resulting from errors is much lower than that suggested by the IOM and also believe that a substantial proportion of these deaths are not preventable.

Second, physicians and the public differ in their beliefs about measures that would be very effective in reducing the incidence of errors. The public appears to believe that a range of proposals aimed at reducing medical errors would be very effective. However, the majority of practicing physicians view only two proposals as very effective: requiring hospitals to develop systems for preventing medical errors and increasing the number of nurses in hospitals.

In particular, although the physicians surveyed believe that high-volume medical centers have fewer medical errors — a view espoused by several authors[22-25] — only a minority believed that moving patients to high-volume centers would be a very effective way to reduce medical errors. This may be due to the belief that errors occur infrequently and that changing medical practice would therefore have a limited effect. Half

TABLE 4. POSSIBLE SOLUTIONS TO THE PROBLEM OF MEDICAL ERRORS.*

SOLUTION	PHYSICIANS (N=931)	PUBLIC (N=1207)	P VALUE
	percent		
Very effective			
Requiring hospitals to develop systems for preventing medical errors	55	74	<0.001
Increasing the number of nurses in hospitals	51	69	<0.001
Giving physicians more time to spend with patients	46	78	<0.001
Limiting certain high-risk procedures to hospitals that perform many of these procedures	40	45	0.03
Improving the training of health professionals	36	73	<0.001
Using only physicians trained in intensive care medicine on intensive care units	34	73	<0.001
Reducing the work hours of physicians in training to prevent fatigue	33	66	<0.001
Increasing the use of computers to order drugs and medical tests	23	45	<0.001
Requiring hospitals to report all serious medical errors to a state agency	23	71	<0.001
Encouraging hospitals to report serious medical errors voluntarily to a state agency	21	62	<0.001
Including a pharmacist on hospital rounds when physicians review the care of patients	20	40	<0.001
Increasing the use of computerized medical records	19	46	<0.001
Having hospitalized patients taken care of by hospital physicians rather than by their regular physicians	6	16	<0.001
Suspending the licenses of health professionals who make medical errors	3	50	<0.001
Increasing lawsuits for malpractice	1	23	<0.001
Having a government agency fine health professionals who make medical errors	2	40	<0.001
Physicians should be required to tell patients when errors are made in their care			
Yes	77	89	<0.001
No	22	9	
No response	1	3	
Hospital reports of serious medical errors			
Should be confidential (used only to learn how to prevent future mistakes)	86	34	<0.001
Should be released to the public	14	62	<0.001
No response	0	4	

*Percentages for the public do not always sum to 100 because of rounding.

the respondents in the survey of the public did not see an advantage of high-volume centers, suggesting a need for education of physicians and the public if a strategy based on the volume of procedures is pursued.

Our results point to a substantial difference between the views of physicians and those of the public on the reporting of medical errors to state agencies, a recommendation embraced by a number of national groups. The public sees reporting as a very effective way of reducing errors and wants these reports to be publicly available. Physicians are more skeptical about this proposal and would prefer that reports be kept confidential.

Finally, the results point to a gap between the views of the public and proposed approaches to preventing medical errors. One of the central statements in the IOM report is that errors should be viewed as due primarily to failures of institutional systems rather than failures of individuals. This is not a premise that the public embraces. The public believes that persons responsible for errors with serious consequences should be sued, fined, and subject to suspension of their professional licenses. Nor do physicians seem to believe that individual health professionals are blameless. A majority of physicians believe that individual health professionals are more likely to be responsible for preventable medical errors than are institutions. Moreover, although few physicians believe that an increase in malpractice suits would be effective in preventing individual errors, many believe that health professionals who make errors with serious consequences should be subject to lawsuits. The results of our surveys show

TABLE 5. RESPONSES TO THE VIGNETTE.*

RESPONSE	OUTCOME WITHOUT HARM			OUTCOME WITH HARM			P VALUE FOR DIFFERENCE IN OUTCOME	
	PHYSICIANS (N=404)	PUBLIC (N=603)	P VALUE	PHYSICIANS (N=427)	PUBLIC (N=604)	P VALUE	PHYSICIANS	PUBLIC
	percent			percent				
Party with "a lot" of responsibility for the error								
Surgeon	90	89	0.67	95	92	0.04	0.006	0.04
Nurse	81	52	<0.001	82	48	<0.001	0.86	0.19
Hospital	42	55	<0.001	48	57	0.01	0.09	0.64
Should be sued for malpractice								
Surgeon	4	30	<0.001	55	69	<0.001	<0.001	<0.001
Nurse	3	12	<0.001	44	21	<0.001	<0.001	<0.001
Hospital	2	22	<0.001	33	44	<0.001	<0.001	<0.001
Should be fined by a government agency								
Surgeon	5	51	0.001	21	65	<0.001	<0.001	<0.001
Nurse	6	26	0.001	18	29	<0.001	<0.001	0.27
Hospital	9	39	0.001	21	50	<0.001	<0.001	<0.001
Should have license suspended								
Surgeon	0	23	<0.001	8	50	<0.001	<0.001	<0.001
Nurse	1	11	<0.001	8	25	<0.001	<0.001	<0.001
Hospital should lose its accreditation	1	11	<0.001	1	15	<0.001	0.73	0.03
Should be required to report the error to the patient or family								
Surgeon	85	95	<0.001	90	95	0.003	0.05	0.60
Nurse	74	67	0.02	70	57	<0.001	0.12	<0.001
Hospital	60	78	<0.001	71	84	<0.001	<0.001	0.005
Should be required to undergo training in the prevention of the type of error that was made								
Surgeon	66	80	<0.001	78	80	0.53	<0.001	0.89
Nurse	71	67	0.17	81	72	<0.001	<0.001	0.05
The hospital should be required to develop systems for preventing similar errors	74	79	0.09	84	84	0.86	<0.001	0.01

*The following vignette was used: "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." The respondents who received the version that did not involve harm were told, "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 respondents who received the version that did involve harm were told, "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."

that the public and, to a lesser extent, physicians hold individual health professionals personally responsible for errors. Although they do support a requirement that hospitals develop systems to prevent future errors, the public is unlikely to support the substitution of a system in which individuals are not subject to sanctions.

The momentum for instituting changes to reduce medical errors is sustained primarily by a range of groups and by the media's interest in the problem — not by practicing physicians or the public. Our findings highlight the issues and potential barriers that national groups such as the IOM, the Leapfrog Group (a consortium of purchasers of health insurance), and the American Medical Association must address if they are to succeed in their efforts to reduce medical errors. Perhaps the most critical issue will be to provide skeptical physicians with scientific proof that the proposed strategies will, in fact, reduce preventable medical errors and the harm they cause.

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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.

[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

State Licensed Physicians and Alaska Population, 1985-2003

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.

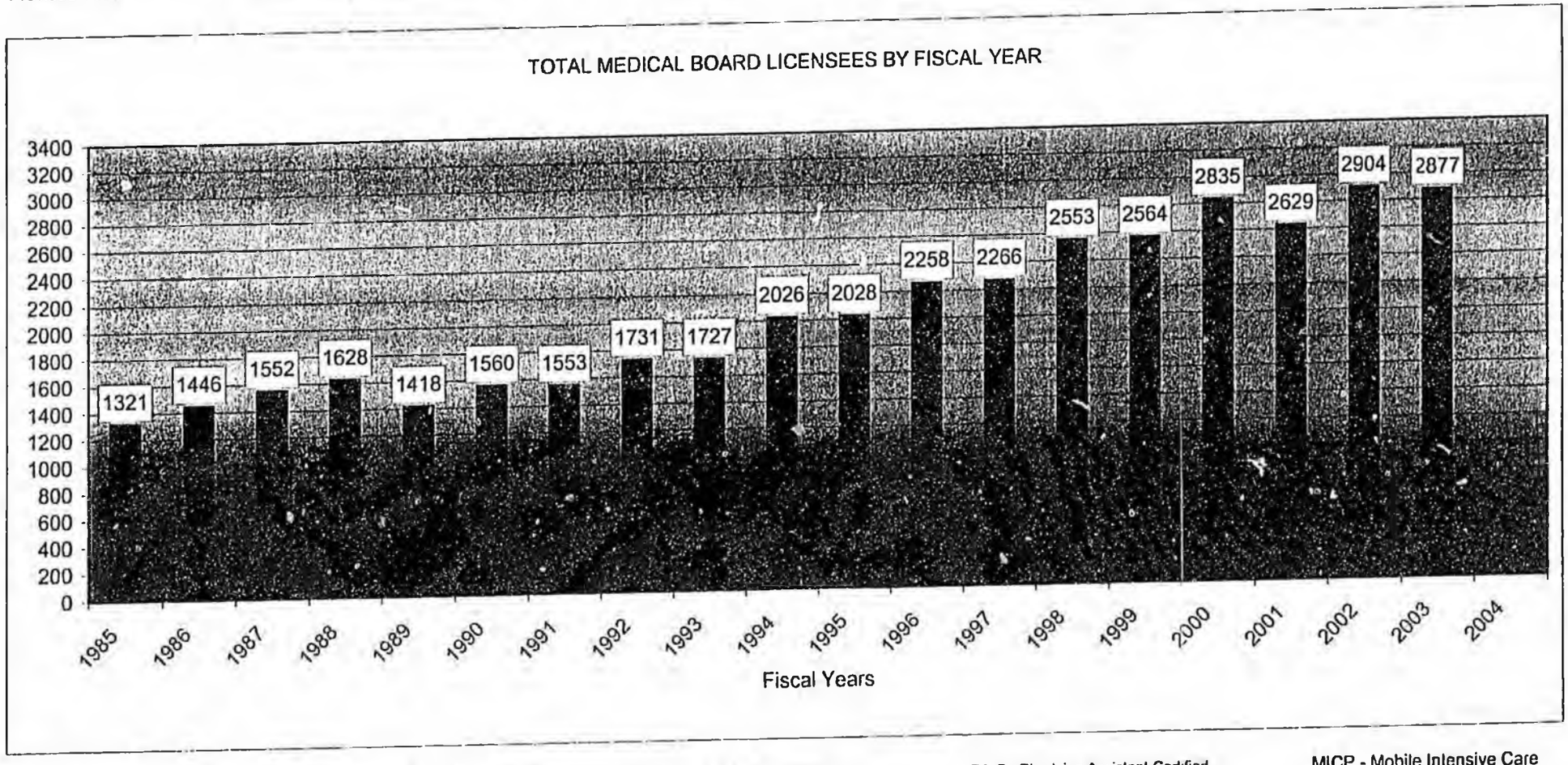
According to the American Medical Association, as reported in "Federal Physicians in 2001," Health Care State Rankings, 2003 (Morgan Quitno Press, 2003, p. 430), in 2001, Alaska had 147 federal physicians.

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

THE ALASKA ACTION TRUST
PO BOX 102323
ANCHORAGE, ALASKA 99501
907-258-4040
AKACTIONTRUST@AOL.COM

POSITION PAPER ON HOUSE BILL 472/SENATE BILL 319
Alaska Action Trust

INTRODUCTION

In Alaska, to suggest that there is a medical malpractice crisis is at best disingenuous and at worse fraudulent. In short, there is no empirical evidence to support the proposition of a relationship between medical malpractice premiums, medical malpractice litigation and availability of health care providers.

If this proposed legislation passes, you will be responsible for eliminating the ability of stay at home moms and dads, retired or elderly citizens, children, and those with subsistence lifestyles or limited incomes to bring claims against negligent or even reckless doctors or other health care providers. This will be true even when they are blinded, maimed, suffer serious neurological injuries, rendered sexually dysfunctional or even killed by medical malpractice. What makes this proposed legislation even more egregious is that the entire premise for its utility is based upon anecdotal information, unsupported by credible empirical evidence and indeed is contrary to conclusions reached in existing and reliable studies.[1] Even more appalling, there is no corresponding assurance from those most benefited (the insurance industry) that the legislation will have *any* effect whatsoever on medical malpractice rates.

THE HISTORY OF TORT REFORM IN ALASKA

While the following discussion will illustrate the points referenced above, a brief chronological history of similar tort reform efforts in the State of Alaska demonstrates that capping or limiting damages will have absolutely no effect on medical malpractice insurance rates or the availability of medical malpractice insurance to doctors in Alaska or the availability of health care in Alaska.

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[1] Studies repeatedly relied upon by the insurance industry and health care providers pushing similar legislation have been widely discredited. The Milliman report, for instance, relies on data from the National Practitioner Data Bank (NPDP) that has been slammed by the Government Accounting Office (GAO). (*See, e.g.*, GAO: "National Practitioner Data Bank: Major Improvements are Needed to Enhance Data Bank's Reliability," Nov. 2000; Mary Jane Fisher, "GAO Report Slams National Practitioner Data Bank," *National Underwriter*, Jan. 1, 2001). It also fails to adjust any of its figures for medical inflation to offset its conclusion that medical malpractice losses have risen 32% over the last decade in states without caps. When adjusted for 51% in medical inflation for the same time period, paid losses are actually *falling*.

Dating back to 1976 with the passage of A.S. 09.55.548, medical malpractice insurers and health care providers have enjoyed a unique benefit unavailable to other insurers or private citizens. A.S. 09.55.548(b) in effect immunizes these entities and individuals from payment for all past medical expenses incurred as a result of physician and/or health care malpractice paid by private health care plans.

This has resulted in a significant windfall to medical malpractice carriers (and uninsured health care providers) since a private health care plan has no subrogation rights under the statute. The only exception to this windfall is when the collateral source of payment is governmental or quasi governmental such as under Medicare, Medicaid or federal employees who are insured under the federal health care plan. In many cases, this results in savings totaling hundreds of thousands of dollars which are absorbed, unfairly, by other health care plans and ultimately by the citizens of this state through higher health care premiums.

In 1978, again at the urging of medical malpractice insurance carriers and health care providers, the Legislature passed A.S. 09.55.536 requiring the appointment of expert advisory panels in all medical malpractice actions. These panels were appointed by the court and reviewed claims brought by injured Alaskans to determine whether or not malpractice had occurred and, if so, whether the malpractice had caused the patient's injuries. The purported basis for this legislation (as argued by its proponents) was to eliminate or at least minimize frivolous malpractice claims. While the efficacy of the expert advisory panel was always questionable, it has been all but abandoned by health care providers themselves and is no longer requested (it is waived in virtually all cases).

In 1986, the Legislature enacted tort reform legislation placing damage caps on non-economic damage. That legislation capped non-economic damages for injuries that did not result in severe permanent physical impairment or severe disfigurement to $500,000. There was no cap, however, on those injuries that did result in severe permanent impairment or severe disfigurement.

In 1997, sweeping tort law revision was enacted by the Legislature. The previous cap on non-economic damages in cases involving physical injury was reduced to $400,000 (or the injured person's life expectancy multiplied by $8,000) A definitive cap was placed on cases involving severe permanent physical impairment and severe disfigurement of $1,000,000 or the injured persons life expectancy in years multiplied by $25,000. In other words, to exceed the $1,000,000 limitation, a person's life expectancy would have to exceed 40 years.[2]

While the 1997 changes benefited all insurance carriers in the state of Alaska, health

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[2] We mistakenly advised the Committee last week that the cap on non-economic damages was the lesser of $1,000,000 or a multiplier of a person's life expectancy. After reviewing the statute, we realized our mistake. Our oversight underscores the rarity of any claim for non-economic damages exceeding that threshold.

care providers were given additional protection in the form of limiting expert witnesses who could testify on behalf of an injured Alaskan in medical malpractice actions.

A.S. 09.20.185 was enacted requiring that only board certified physicians having expertise and training directly related to the particular field or matter at issue would be allowed to testify regarding standard of care. This requirement is now necessary even though the offending doctor is not board certified in any practice group or specialty. Needless to say, this has made it even more difficult to obtain expert witnesses to testify against offending doctors, particularly since the same doctors belong to national organizations and often know each other personally.

In the face of these sweeping reforms, the insurance industry has repeatedly argued that tort reform benefits policyholders and the public at large. To date, there have been *no* reductions to my knowledge in any insurance rates charged to individual Alaskans. The current legislation that will benefit only health care providers will result in the same outcome. There will be no reduction in health care costs and no reduction in medical malpractice premiums charged in the state of Alaska. As discussed below, this has been repeatedly demonstrated throughout the United States.

THE HISTORY OF MALPRACTICE PREMIUMS IN ALASKA

To best illustrate this point, it is helpful to review the medical malpractice premiums charged in this state dating back to 1993 and compare those to California, the state much touted by the insurance industry because of its previously imposed caps on non-economic damages through the Medical Injury Compensation Reform Act (MICRA). Although the only published premium information readily available deals with the specialties of Internal medicine, General Surgery and OB/GYN, these seem to be the specialties of most concern at least by those physicians and health care providers who testified before the House Judiciary last week.[3]

A cursory review of the premiums charged illustrates the utter lack of credibility of the positions taken by this legislation's proponents. An important thing to remember when reviewing the premiums discussed below is that these are the amounts *charged* by the malpractice carriers. Both NORCAL and MIEC (the current and historical dominant carriers in the Alaska market) give credits back to their insureds. These credits are *not* reported in the data available but it is highly likely that these credits would further substantially reduce the published premiums paid by individual health care providers.[4]

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[3] Medical Liability Monitor [MLM] of Chicago publishes annual rate surveys from premium submissions provided by medical malpractice carriers or obtained directly from state insurance departments throughout the United States.

[4] MLM notes in all of its annual surveys that such credits, discounts and other factors can greatly diminish and sometimes completely offset rate increases. None of the surveys reflect this data, however.

In 1993, NORCAL's premium rates were $12,102 for Internal Medicine doctors, $37,750 for General Surgeons, and $64,518 for OB/GYN's. MIEC's premium rates for the same specialties were $5,487, $19,752, and $32,916 respectively. From 1994 through 1996, NORCAL's rates remained relatively stable. In 1994, MIEC raised its premiums for General Surgeons and OB/GYN's to $38,228 and $63,712 respectively. In 1995, MIEC reduced those rates by about 10 percent.[5]

Between 1997 and 1999, premium rates actually decreased significantly. NORCAL's rates dropped to $8,770 for Internal Medicine doctors, $28,587 for General Surgeons, and $48,706 for OB/GYN's. MIEC reduced its rates to $8,172, $29,420, and $49,032 respectively.[6]

There is no dispute that during this time frame and extending into 2001, most carriers in most states were reducing malpractice premiums because of intense competition in the industry. This competition was reflected in the state of Alaska by the joining of at least two other malpractice carriers to the competitive market.[7] The introduction of new carriers into the competitive market was a national phenomenon. Fierce competition continued to drive down rates for medical professional liability insurance in 1997.[8] In 1999, medical malpractice carriers had been battered from several years of brutal competition, with price cutting the name of the game, even when it meant selling *below* the break-even point.[9]

Back then, leaders in the industry were optimistic that the market would "harden" over the next three years.[10] Then vice president of Florida Physicians Insurance Company, Melodee Dixon, stated, "It will take that amount of time [three years] for claims on policies written at today's grossly inadequate rates to shake out."

Everyone in the industry during this time frame recognized that the amount of

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5 MLM annual surveys for 1993-1995.

6 MLM annual surveys for 1997-1999.

7 Although other carriers may have been in the Alaska market during this time frame, the only entities reporting premiums to MLM appear to be NORCAL, MIEC and joined in 1996 by Physicians Ins. Ex. of Washington and Doctors Co. in 1997. Northwest Physicians Mutual began reporting in 1999. It is unknown when CNA began writing coverage in Alaska.

8 MLM annual survey comments, 1997.

9 "Medical professional liability writers express a very pragmatic, but somewhat optimistic outlook about their market niche. Battered from several years of brutal competition, with price-cutting the name of the game, even when it means selling below the break-even point, these insurers nevertheless think that a market shake-out will come." MLM annual survey, 1999.

10 Market "hardening" is discussed, *infra*.

competition in the industry was causing drastic price cutting and exposing numerous carriers to significant financial risks in the future. These risks were self-inflicted and the resulting losses from malpractice claims were anticipated and predicted by competent actuaries.

The trend of lower malpractice premiums continued through 2000 in the state of Alaska. In 2001, as competition in Alaska and the national market waned, the predicted market "hardening" began to take form. Those carriers that had engaged in risky if not reckless underwriting began to pull out of markets in this state and across the United States. Notwithstanding, the malpractice premium rates in Alaska remained unchanged at MIEC through 2002 and were increased only slightly by NORCAL. In 2001, NORCAL raised its rates to $9,580 for Internal Medicine doctors, $30,872 for General Surgeons, and $52,600 for OB/GYN's.[11]

In 2003, with the market firmly "hardened," the rates from both carriers increased. NORCAL raised its rates for Internal Medicine doctors to $11,209, for General Surgeons to $36,122 and for OB/GYN's to $61,545. MIEC's premium rates were $7,432, $26,748, and $44,580 respectively. Notwithstanding, the premiums charged for 2003 were *less* than those charged by NORCAL for the same practice specialties in 1993, 1994, 1995, 1996 and only slightly higher than those charged in 1997 and 1998. The premium rates charged by MIEC in 2003 were less than those charged by the carrier in 1994, 1995, 1996, 1997, 1998, 1999, and only slightly higher than the premiums charged in 2001 and 2002.[12]

The significance of this rate comparison is even greater when comparing the discounted value of 2003 dollars with the previous years of lower premium rates. In short, these figures reflect an actual *reduction* in malpractice premiums over this time period when viewed in that light without considering the premium credits refunded to health care providers over this same time period. Moreover, when comparing these premiums to the inflation rate of health care costs (and resulting income to physicians), it is clear that these rates have not resulted in *any* increase to the cost of malpractice insurance premiums to health care providers in Alaska through 2003.

THE CALIFORNIA EXPERIENCE

Since California's non-economic damage cap legislation seems to be the model being touted by the proponents of this legislation, it is helpful to review the medical malpractice premiums charged in that state.

Between 1991 and 1997 In California, the medical malpractice premiums for internal medicine doctors, general surgeons and OB/GYNs remained relatively constant between 1991 and 1997. The premium rates charged by NORCAL over that time

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11 MLM annual survey 2000-2001.

12 MLM annual survey 2003.

period for Internal Medicine doctors ranged from $5,692 to $9,472, for General Surgeons, $18,916 to $29,440, and for OB/GYN's, from $31,624 to $49,208. MIEC's premium rates were $5,776, $20,792, and between $34,648 and $39,268 respectively.[13]

Of particular note, and as recognized by numerous commentators, the reason for the relative consistency over this time period had little or nothing to do with medical malpractice non-economic damage caps.

In 1975, California enacted the Medical Injury Compensation Reform Act (MICRA) that placed a cap of $250,000 on non-economic damages in medical malpractice actions. MICRA was touted by the insurance industry and health care practitioners as the solution to the "malpractice crisis" and the solution to increasing malpractice insurance rates. By 1988, however, medical malpractice premiums were 190% higher than 1976 levels (40% when adjusted for inflation to 2001 levels).[14]

In 1988 California voters passed Proposition 103, an insurance reform proposal. This proposition roiled back insurance rates 20% and froze rates for one year. It mandated billions of dollars worth of refunds to policyholders and created a system that required approval of insurance rates, allowing the insurance Commissioner to deny rate proposals that were too high or too low to be actuarially justified. It is following this proposition through 1996 that malpractice insurance rates actually stabilized.[15]

Beginning in 1997, insurance rates in California *again* began to increase substantially. In 1997, NORCAL's premium rates for Internal Medicine doctors ranged up to $9,472, for General Surgeons, up to $29,440 and for OB/GYN's, up to $49,208. The rates continued to increase slightly between 1999 and 2001. Since that time, through 2003, the rates have increased to ranges up to $25,178, $58,830, and $77,814 respectively. During this same time period, MIEC's premium rates have increased from their 1996 -- 1998 rates to a range up to $9,305, $27,682, and $50,340 respectively. Accordingly, even with MICRA reform, malpractice rates have steadily *risen* in California and are comparable to or substantially greater than malpractice premium rates charged in this state by the same companies notwithstanding the lack of additional caps on non-economic damages.[16]

THE INSURANCE INDUSTRY ADMITS THAT CAPS WILL NEITHER REDUCE PREMIUMS NOR ARE CAPS RELATED IN ANY WAY TO THE AVAILABILITY OF HEALTH CARE

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13 MLM annual surveys, 1991-1997.

14 *How Insurance Reform Lowered Doctors Medical Malpractice Rates in California*, The Foundation for Taxpayer and Consumer Rights, February 10, 2003, excerpted from N.C. trial lawyers expose on malpractice rates in N.C.

15 *Id.*

16 MLM annual surveys, 1996-2003.

Misinformation regarding the efficacy of caps on non-economic damages and purported decreases in medical malpractice premiums has been disseminated by health care providers and malpractice insurers in other states as well.

In Florida, after pushing through a sweeping medical malpractice bill in August with a promise to reduce ever-increasing insurance premiums for Florida's physicians, malpractice insurance carriers followed up the bill's passage with a request to increase premiums by as much as 45 percent.[17]

In 2003, Oklahoma passed a tort reform bill that included a severe cap on compensation available to certain medical malpractice victims. Following passage of that bill, the insurance company owned by the state medical association requested an astounding 83 percent rate hike which was subsequently approved on the condition that it be phased-in over three years.[18]

In January 2003, Ohio lawmakers enacted a cap on compensation for patients injured by medical malpractice. Almost immediately, all five major malpractice insurance companies in Ohio announced that they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.[19]

This should come as no surprise to those familiar with the insurance industry and particularly with malpractice carriers.

Bob White, president of First Professional Insurance Co., the largest medical malpractice insurer in Florida stated that "no responsible insurer can cut its rates after a [medical malpractice tort reform] bill passes."[20] Cliff Webster representing the Washington State Medical Association and Chairman of the Washington Liability Reform Coalition told the Washington State Legislature, House Judiciary Committee in 2003 that "I don't think we would argue that the premiums are likely to go down."[21]

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17 *See, e.g.*, Julie Kay, "Medical Malpractice; Despite Legislation that Promised to Rein in Physicians Insurance Premiums, Three Firms File For Big Rate Increases," *Palm Beach Daily Business Review*, Nov.20, 2003.

18 *BestWire*, Dec. 2, 2003.

19 Laura Bischoff, "Taft Signs Malpractice Reform Bill; Cap on Awards for Pain and Suffering," *Dayton Daily News*, Jan. 11, 2003; Andrew Welsh-Huggins, "Doctors Pushing for Short-Term Relief From Malpractice Rates," *Associated Press*, Jan. 10, 2003; "Despite New Law, Insurance Companies Won't Lower Rates Right Away," *Associated Press*, Jan. 9, 2003.

20 *Palm Beach Post*, Jan. 29, 2003.

21 Testimonial excerpt from testimony before the Washington State Legislature, House Judiciary, Feb. 21, 2003.

Sherman Joyce, President of the American Tort Reform Association candidly acknowledged, "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."[22] James Robertson, Assistant Vice President and Associate Actuary for SCPIE Indemnity Company (California's second largest medical malpractice insurer) stated "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." He made that statement in a written response to a question from an administrative law judge overseeing the case in which his company had requested another 15.6% rate hike.

In short, virtually every reliable empirical source underscores the certainty that limiting an injured persons access to the court system for damages has little or nothing to do with insurance premiums for the cost of health care delivery.

In January 2004, the Congressional Budget Office (CBO) concluded that legislation to cap damages in medical malpractice lawsuits would do little to hold down health care spending or eliminate the practice of defensive medicine. Moreover, the report found that medical malpractice insurance premiums have increased in part because of reduced income from insurer investments and short-term factors in the insurance market. The report found that although malpractice insurance premiums are somewhat lower in states with caps on damages, even a large savings in premiums would have a small impact on total health care spending because malpractice insurance costs account for less than two percent of health care spending. The CBO concluded that caps on damages in malpractice suits would not likely end the practice of defensive medicine. That is because physicians who practice defensive medicine may do so less because they fear liability than to generate more income. Equally compelling, the GAO concluded that many reported shortages of health care services [based on these factors] could not be substantiated or did not widely affect access to health care.[23]

In a sweeping and thorough investigation for AIR under the direction of Mr. Robert Hunter (former Federal Insurance Administrator and Texas Insurance Commissioner) it was determined that insurers make most of their profits from investment income. During years of high interest rates or excellent returns in the market, insurance

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22 "Study Finds No Link Between Tort Reforms and Insurance Rates," *Liability Week*, July 19, 1999.

23 *Congress Daily,* Jan. 13, 2004. The same argument of "fleeing" doctors and fear of inability to attract new ones has been completely debunked in Washington. Doctors for Medical Liability Reform claimed that 500 doctors had left the state between 1998 and 2004. They failed to mention, and did not research, however, how many doctors had moved to Washington over the same time frame. According to the 2003 GAO report, there were more doctors per capita in 2001 than in 1998. Moreover, despite arguments to the contrary, there was no indication that health care delivery was being curtailed or eliminated. Carol Ostrom, "Contrary to Ads, Doctors Replaced, Clinics Still Open," *Seattle Times*, Feb. 23, 2004.