Legislative Research Department August 20, 1975

M I N U T E S

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

July 22 - 23, 1975

Members Present

Senator Wesley H. Sowers, Chairman
Representative Earl D. Ward, Vice-Chairman
Senator Bert Chaney
Senator Frank D. Gaines
Senator Robert Talkington
Senator D. Wayne Zimmerman
Representative Ronald Hein
Representative Loren H. Hohman, II
Representative Rex B. Hoy
Representative Michael G. Johnson
Representative Marvin L. Littlejohn
Representative Ruth Luzzati
Representative Harry A. Sprague

Staff Present

Emalene Correll, Legislative Research Department
Bill Edds, Revisor of Statutes Office
Norman Furse, Revisor of Statutes Office
Bill Wolff, Legislative Research Department

Others Present

M. Don George, M.D., Wichita State Branch, Kansas University School of Medicine, Wichita, Kansas
James O. Foster, Wichita Area Chamber of Commerce, Wichita Kansas
Joan M. Baker, Kansas Insurance Department, Topeka, Kansas
Jack Roberts, Blue Cross, Topeka, Kansas
Frank L. Gentry, Kansas Hospital Association, Topeka, Kansas
John D. McGee, Kiowa District Hospital, Kiowa, Kansas
Cathy Talbert, Kansas Trial Lawyers Association, Topeka, Kansas
Jim Clark, Kansas Optometric Association, Topeka, Kansas
Cinda S. Vogel, Kansas Chiropractors Association, Topeka, Kansas
Mary Browne, Kansas Association of Osteopathic Medicine, Topeka Kansas

Others Present (Continued)

Alan Bodenhausen, Providence-St. Margaret Health Center, Kansas City, Kansas
Mark Bennett, American Insurance Association, Topeka, Kansas
William Gough, Jr., Kansas Association of Commerce and Industry, Topeka, Kansas
Ray Rathert, Kansas Insurance Department, Topeka, Kansas
Dick Brock, Kansas Insurance Department, Topeka, Kansas
Jim Talbert, Division of Purchases, Topeka, Kansas
R. A. Haines, M.D., Division of Mental Health and Mental Retardation, Social and Rehabilitation Services, Topeka, Kansas
Bruce Roby, Legal Division, State Department of Social and Rehabilitation Services, Topeka, Kansas
Linda Terrill, Office of the Minority Leader of the House, Topeka, Kansas
James L. Ketcherside, Alliance Insurance Group, McPherson, Kansas
Lee Dunn, Kansas University Medical Center, Kansas City, Kansas
David Robinson, M.D., University of Kansas Medical Center, Kansas City, Kansas
Michael J. Davis, General Counsel, University of Kansas, Lawrence, Kansas
Jeanne Eudaley, Governor's Office, Topeka, Kansas
Jeremy Slaughter, Kansas Medical Society, Topeka, Kansas
M. M. Halley, M.D., Kansas Medical Society, Topeka, Kansas
Steven C. Bruner, M.D., Frontenac, Kansas
Daniel J. Caliendo, Wichita, Kansas
Daniel H. Roberts, M.D., Kansas Medical Society, Wichita, Kansas
Tony McHaffy, M.D., Kansas Medical Society, Baxter Springs, Kansas
John L. Morgan, M.D., Kansas Medical Society, Emporia, Kansas
G. M. Snyder, M.D., Kansas Medical Society, Wichita, Kansas
Gary Caruthers, Kansas Medical Society, Topeka, Kansas
W. J. VonRuden, Kansas Medical Society, Hutchinson, Kansas
Shirley VonRuden, Kansas Medical Society, Hutchinson, Kansas
J. S. Hoeffler, M.D., Kansas Medical Society, Wichita, Kansas
Darb Ratner, Kansas Medical Society, Wichita, Kansas
Wendell Sullivan, Kansas Medical Society, Wichita, Kansas
Wayne Stratton, Kansas Hospital Association-Kansas Medical Society, Topeka, Kansas
Larry Zanto, AMIA, Chicago, Illinois
Ira Dennis Hawver, Kansas Department of Health and Environment, Topeka, Kansas
Walt Biddle, Kansas Trial Lawyers Association, Topeka, Kansas
Charles V. Hamm, Social and Rehabilitation Services, Topeka, Kansas
Ruth Groves, American Association of University Women, Topeka, Kansas
Paul E. Fleener, Kansas Farm Bureau, Manhattan, Kansas
James H. Hays, Division of the Budget, Topeka, Kansas
James E. Hill, M.D. Healing Arts Board, Arkansas City, Kansas
Francis McGuire, Healing Arts Board, Wichita, Kansas
Cesar Garza, Menninger Foundation, Topeka, Kansas
Dean T. Collins, M.D., Kansas Psychiatric Society, Topeka, Kansas
Robert T. Stephan, Judge of District Court, Wichita, Kansas

Others Present (Continued)

Roy C. House, Wesley Medical Center, Wichita, Kansas
Adib F. Farha, Wesley Medical Center, Wichita, Kansas
Judy Runnels, Kansas State Nurses Association, Topeka, Kansas
Robert F. Stadler, Judge of the District Court, Iola, Kansas
Randolph Carpenter, Judge of the District Court, Topeka, Kansas

The meeting was called to order by the Chairman, Senator Wesley H. Sowers.

The minutes of the June meeting were amended as follows: page 3 by adding S.B. 353 and a statement summarizing it; page 10 by changing "in Kansas" to "in the United States". A motion was made and seconded to approve the minutes as amended. Motion carried.

The Chairman noted there is some difference of opinion regarding the severity of the malpractice problem. Since the medical community feels it is more critical than indicated by the Insurance Commissioner's Office or by attorneys, he has asked that the doctors provide the Committee with information, by number if not by name, and be prepared to document it.

Dr. Don George, Interim Associate Dean, Wichita Branch, Kansas University School of Medicine, stated the problem is multifaceted but indicated that he would limit his remarks to the impact on medical education, specifically as related to the Wichita Branch. Since they have only seven full-time employees, their clinical education program is totally dependent on community facilities and private practitioners. (Approximately 40 part-time paid staff are private practitioners and approximately 200 clinical associates are not paid staff.)

When one participating group of six doctors tried to renew their policy, the insurance company attached a rider excluding teaching. Through their own efforts this group appears to have found a company willing to include teaching for a 50 percent additional premium. Since this type of exclusion is allowable on liability policies, the Insurance Commissioner's Office is not involved and, while aware of this case, is not aware of whether it is a general policy among companies. A major broker in Wichita has stated he is not aware of this type of exclusion as a widespread policy and one other company has stated it is not their policy. However, physicians in medical education are concerned that the practice of excluding teaching may become applicable to them when their policies come up for renewal. In some cases this could mean paying 50 percent more for insurance for the privilege of teaching for nothing.

If this policy becomes the trend, it could result in the closing of the Wichita branch or in the expenditure of money to provide full-time faculty and facilities which would be in competition with local practitioners and facilities.

Dr. George asked the Committee to address itself to the problem of assuring malpractice coverage for those teaching medical students.

In answer to questions, Dr. George stated the Insurance Commissioner has suggested that all doctors check their current policy to be sure it does not have a rider excluding teaching. He also noted that a physician is responsible for students practicing under his direction.

Medical malpractice premiums are distinguishable from other types of liability premiums and it was the former which was increased in the example given. Dr. George did not know of any actions which had been filed against the group of doctors to whom the exclusionary rider was applied as a result of their teaching activities. If there were actions pending as a result of their private practice, he felt this should not affect the premium covering teaching activities.

Mr. Mike Davis, general counsel, University of Kansas, introduced Lee J. Dunn, Jr., legal counsel for the University of Kansas Medical Center, who presented a written statement. (Attachment A).

In answer to questions, Mr. Dunn stated he saw some constitutional problems in laws such as that enacted by Indiana and hoped Kansas would not follow their example. Mr. Dunn suggested requiring a patient advocacy program but expressed the feeling that patient's rights legislation such as the model bill which has been developed would only add to the problem. He stated it was his understanding that some medical graduates going into private practice are having difficulty getting malpractice coverage but he did not know if this would influence them to go outside of Kansas to practice.

Clarifying a point in his presentation, Mr. Dunn stated he felt students practicing between graduation and the time they start their residency should be included in those considered as practicing without a license. It would then be the responsibility of the Insurance Commissioner to determine the status of coverage for this group and to see that whatever coverage is needed is extended. When a student starts his residency, he felt it was best to have a policy which covered both the supervising doctor and the resident. A question was raised relative to who employs and is responsible for the resident. Mr. Dunn stated that the check the resident receives is drawn on the State of Kansas.

It was clarified that money appropriated by the 1975 Legislature was for the purchase of coverage for students only.

Mr. Dunn stated the situation relative to the formation of PSRO's is so confused it is difficult to know what the stage of development is.

Mr. Dunn is to forward information on the Cleveland Clinic and Massachusetts General Hospital programs to the Research Department. Representative Hein will summarize the material for the Committee.

Dr. David Robinson, Acting Executive Vice-Chancellor, University of Kansas Medical Center, stated that doctors, because of the malpractice crisis, are not trying new and innovative things and are practicing more defensive medicine which, it is estimated, is adding 12 to 15 billion dollars per year to medical bills. Many lawsuits do involve people in training and therefore the chief-of-service who is more visible and has more coverage is more liable to be named in a suit.

Dr. Robinson stated he presently has a "claims made" policy so he will have to carry coverage three to five years after retiring. He indicated he will consider early retirement because of the malpractice situation.

In answer to questions, Dr. Robinson stated there is a formal teaching situation as long as the persons is considered a student. He then pointed out that the student on a preceptorship is probably covered if the doctor he is serving under is covered. However, it would be preferable to have each of them specifically covered. This would also cover cases where the preceptor is sent to another state which requires that he be covered by malpractice insurance.

Dr. Robinson referred to the advertising of bids for insurance coverage for the state and noted that no bids had been received for a policy to cover medical students in Kansas although students in other states are covered. He asked that there be a wider offering of bids, mentioning specifically that St. Paul Fire and Marine be asked to bid.

Dr. Robinson indicated that in some instances doctors are performing procedures for which they are not formally trained. He suggested the Committee may want to consider the practice in Europe of requiring a doctor to qualify for each specialty.

In answer to a question, he stated his belief that the Board of Healing Arts has the authority to censure and discipline but that they are reluctant to use it. Mr. Dunn pointed out that in some states, board members are immune from civil liability when acting in their official capacity.

Frank Gentry, Executive Director, Kansas Hospital Association, summarized the points made in the Association's previous testimony in June adding that the Association Board has now approved the concepts presented in the report of the Kansas Medical Society.

Mr. Gentry then introduced Mr. John McGee, administrator of a small hospital in Kiowa, Kansas, who presented a written statement. (Attachment B)

In answer to questions, Mr. McGee stated that coverage is available in the case of hospitals of which he has knowledge but it is more difficult to get and the premiums are higher.

In response to questions Mr. McGee stated that hospital records have been maintained since the Kiowa Hospital opened twenty-five years ago. It does not take a court order to get a record but the patient must give his consent. The hospital has never had a patient ask for a copy of his record. The service at the Kiowa hospital is limited which reduces the risk. Their liability coverage is $300,000 for total liability. Mr. McGee stated many hospitals are going to one million.

Dick Brock, Kansas Insurance Department, stated that the ad for bids referred to by Dr. Robinson was for coverage for state employees and did not have any relationship to coverage for medical students. Specifications for insurance coverage for medical students are being put together now for approval by the Committee on Surety Bonds and Insurance.

Jim Talbert, Division of Purchases, stated the specifications should be prepared for the industry by next week. There is at least one person who has indicated an interest in the KU coverage.

A question was raised as to whether or not the state can be liable since they are purchasing the insurance and whether the state could be brought in for amounts larger than the limits of the policy. Mr. Talbert stated the Attorney General will have to review these aspects.

The Committee recessed for lunch.

The Chairman reconvened the meeting at 1:30 p.m.

Dr. Robert A. Haines, Division of Mental Health and Mental Retardation Services, Department of Social and Rehabilitation Services, stated that presently doctors who are foreign graduates can receive a fellowship license which permits them to practice in state institutions. Since all institutions do not have a licensed physician on the staff some are now practicing under Dr. Haine's license. Because of this, he is unable to get malpractice insurance. In one instance they tried to get a local private practitioner to assume this responsibility. However, he refused to do it after being advised by his attorney not to do so and after being told by his insurance company that they would not cover him if he did.

Mr. Charles Hamm, general counsel, Department of Social and Rehabilitation Services, presented a written statement. (Attachment C) and reviewed a case currently pending.

Dr. Bruce Roby, Legal Division, Department of Social and Rehabilitation Services, pointed out malpractice problems are intensified in the institutions because the relationship with the patient is not ideal because of the circumstances i.e., involuntary commitment, etc. He stated that money is needed to provide liability coverage for personnel and for personnel to continue litigation if legal services cannot be provided by the Department or the Attorney General's Office. He also pointed out there is no funding or authorization for the Attorney General's Office or SRS to make a settlement.

In answer to questions, Mr. Hamm stated they do not know if the decision from the Brown case is going to be retroactive. Dr. Haines stated that since the Brown case, institutional doctors need malpractice coverage and SRS does not purchase blanket coverage. He feels the lack of insurance is a factor in hiring doctors especially since mental health center boards provide this coverage. It was also pointed out that other than doctors need to be covered. Mr. Hamm stated Missouri has created a tort defense fund and has authorized the attorney general to use it to settle cases in which there may be some merit.

Mr. Hamm clarified that when he was speaking of governmental immunity, he was referring to government organizations and not immunity for individual employees.

Dr. James Hill, Board of Healing Arts, listed changes he felt were needed in the Healing Arts Act. These are included in H.B. 2008.

Dr. Hill stated the Board's belief that it is important that they have their own attorney. Mr. Hill also referred to a phrase relative to competency in the statute pertaining to removal of a license which had evidently been omitted in the last revision of the statute. Putting this phrase back in and including professional, mental and physical competency would, he felt, favorably affect the malpractice situation.

Mr. Loughbom, attorney for the Board, stated that H.B. 2008 contains some things that favorably affect the workability of filing actions relating to incompetency and makes the investigative function more clear. He also feels that limited licensure has much merit and would also affect the malpractice situation.

In answer to a question, Dr. Hill stated he thought it was appropriate and would be a good idea for the Board of Healing Arts to establish criteria for periodic relicensure.

Francis McGuire, investigator for the Board of Healing Arts, presented a written statement. (Attachment D). Mr. McGuire then presented some suggested statutory amendments to the Committee.

In K.S.A. 65-2836 (a) Mr. McGuire recommended adding "or deceit" after "fraud" since if the person were licensed in another state the license could not be revoked here because it would not constitute fraud. He also recommended that "or professional incompetency" be inserted after "conduct" in K.S.A. 65-2836 (b). He expressed the belief that the subject matter of K.S.A. 65-2836 (d) could be handled by rules and regulations. Mr. McGuire recommended two-additions to the statute based on supreme court rules (609 C.J.Q. and 615 C.J.Q.) i.e., "or has any physical or mental disability that interferes with his practice of a healing art" and "failure to submit to medical or psychiatric examination as required by the Board of Healing Arts." He also noted that the Committee might want to consider the appointment of a guardian ad litem.

Mr. McGuire also said that K.S.A. 65-2837 be amended by adding a subsection, "(p) requiring payment in advance for any proposed course of therapy, treatment or diagnosis, or offering a discount from the price of such course if the patient will pay in advance. (Not to be construed as a prohibition against putting a pateint on a pay-as-you-go basis)."

In K.S.A. 65-2842 Mr. McGuire's recommendation was that "provision should be made for the Secretary of the Board to appoint a subcommittee of three members, one from each of the principal healing arts, to hear evidence, then make recommendations to the board as a whole as to what action should be taken to notify respondent of board action taken: Respondent be given a reasonable time (perhaps 20 days) to file his acceptance or exception to board findings: If he files exception, it should be in proper District Court as in 65-2848."

Mr. McGuire also recommended changes in other statutes as noted below:

K.S.A. 65-2844. After phrase, "if all annual renewal fees have been paid, provision should be made that licensee must have fulfilled all requirements and conditions imposed by the board at time of suspension."

K.S.A. 65-2864. "As in CJQ Rule #608, all communications to this board should be privileged in any defamation action; all hospitals, professional associations or societies or clinics to furnish information to the board under same terms as licensee; application for licensure should be deemed waiver of applicant's right to privilege when any licensee or other entity is required to make disclosure concerning the respondent licensee; board or board committees should be provided all possible protection against civil action arising from performance of their duties."

K.S.A. 65-2878. "Board apparently has statutory authority to engage services of professional or clerical people as the board deems necessary to perform its duties, but this needs some clarification as to who controls what the board must restrict itself to in employing qualified help, and whether the provisions of the statute obtain when departmental regulations are brought to bear on the board's decisions in these matters."

Dr. Dean Collins, Kansas Psychiatric Association, presented a written statment. (Attachment E). In answer to a question, Dr. Collins stated that one member had been suspended by his professional association in recent years. Professional organizations only have the right to withhold membership and cannot limit the practice of their members. He was not aware of action taken by a professional society being reported to the Board of Healing Arts or being made available to hospitals. Committees are reluctant to take action and report this action to other bodies because the person involved may contest it. Legislation providing immunity in these circumstances would be helpful.

Meeting adjourned at 3:00 p.m.

July 23, 1975

The meeting was called to order at 9:05 a.m. by the Chairman, Senator Wesley Sowers.

Mr. Frank Gentry, Kansas Hospital Association referred to material which was sent to the Committee subsequent to the meeting (Attachment F). He then introduced Roy House, Administrator, Wesley Medical Center, Wichita.

Mr. House stated Wesley Medical Center is a 717 bed plus 60 bassinet, acute care, non-profit hospital deeply involved in undergraduate and graduate medical education. He stated that for them as well as for the total medical field there is a malpractice crisis which is a societal or total health problem.

He summarized Wesley's experience as follows:

From mid 1958-mid 1969 Wesley paid a total premium of $118,000 ($13,000 per year) with a total cost, including payouts, administrative costs and reserve of $123,000, or a 104.2 percent loss ratio for the company.

From mid-1969-mid 1973 the total premium was $516,000 ($103,000 per year) for a total cost of $239,000 and a loss ratio of 46.4 percent.

From mid 1973-mid 1974 the total premium was $158,000 per year for a total cost of $17,300 and loss ratio of 11 percent.

In November 1974, Wesley received notice their coverage was being cancelled as of January 1, 1975. Their carrier was dropping malpractice insurance. After an unsuccessful search for insurance, Mr. Bell and others were able to get the carrier to extend coverage to April 1. After looking at the state, national and international markets, and getting only three bids, one of which was unsatisfactory, the hospital secured basic and umbrella policies effective April 1 with a premium of $642,000 or a 300 percent increase. This increased the cost per patient day from 66¢ to $2.68 necessitating a $2.00 increase in the daily service charge. Of more concern is the fact the company may cancel the policies at anytime with 30-day notice and without giving a defined reason.

Mr. House discussed the following additional concerns:

1. The medical malpractice situation is jeopardizing arranging for hospital capital financing on a long-term basis.

2. It poses a threat to rendering emergency service. The group providing 24-hour emergency service in Wesley Medical Center, which have been in operation eight years with no claims against them, cannot renew their policy. The hospital was told if they included the group in their policy, the policy would be cancelled. The group was finally able to get coverage with a premium increase of about 14 times which will mean a 60¢ to $1.00 additional charge to each patient. Each member of this group is a specialist in a given area and at least partially qualified as an emergency specialist.

3. Some high risk but important services are jeopardized. For example, the perinatal van program for high risk mothers and high risk infants which covers about 80% of the state is in jeopardy because some doctors volunteering in the program are finding carriers reluctant to cover them. One doctor has withdrawn from the program.

4. Medical education in Kansas is threatened, especially in Wichita where they depend heavily on private practitioners.

5. The availability of malpractice insurance poses problems in hospitals developing and expanding outpatient programs where all pateints are supervised by private practitioners because of additional premium costs.

6. Because of technical advances in medicine, the problem can spread to other employees in special units of the hospital.

7. There is evidence that doctors are going to be increasingly reluctant to expose themselves to risk not only in urban areas but also in rural areas where they are expected to know all things and are isolated from other doctors and specialists.

Mr. House noted that he has been told that Wesley is in a situation which is basically uninsurable and that they are subject to lawsuits for actions which occurred to an infant 18 or 19 years ago even though they are not aware that anything happened.

He recommended the Committee give serious consideration to the proposals of the Kansas Medical Society which are generally supported by the Kansas Hospital Association.

In answer to questions about claims, factors contributing to them and programs to eliminate them, Mr. House stated he thought they had had three judgments against them or in connection with a doctor or another entity. There is not much question but that the majority of claims are related to professional acts or judgment but the hospital will always be named too because it has the most assets. He said the hospital is definitely encouraged by their carrier to make settlements.

There is a set procedure by which a doctor is admitted to practice in Wesley Medical Center and his practice may be limited. There is a continuing medical audit of each department which tends to "surface" problems. The doctor who fails to meet hospital standards is talked to and can be denied hospital privileges. The hospital governing body can initiate and take action against a doctor but usually his practice is reviewed by a peer committee first. The governing body can then confirm or override the recommendation of the Committee. Doctors in hospitals are subject to the most severe peer review but on the whole doctors do not "relish" peer review programs.

At Wesley Medical Center there is a patient representative program. While it is helpful, Mr. House would not make it mandatory as it would not be practical for some hospitals to have a paid employee in this area. Wesley also has one administrator and one secretary who spend most of their time looking into complaints and reported accidents. These records are not available to patients without a subpoena and Mr. House expressed the belief they should not be.

According to Mr. House factors contributing to law suits are the unrealistic expectations of the public and the impersonal nature of practice and institutions. Some suits are brought as a nuisance factor but attorneys seem to be doing more to weed these out.

In answer to other questions, Mr. House stated that part of Wesley's increased premium is due to increased coverage. The reasons given to them for the increased rates were that this risk was not a good type of business to be in; there was no way reliable actuarial figures could be developed on which to base rates; and the sharp upward trend in jury awards.

Mr. House felt, if the private sector does not make malpractice insurance available, the state should go into the

insurance business since this is a public problem. The state must at least establish limits, boundaries, etc., governing malpractice cases. The new emergency services law and the increased use of paraprofessionals will involve elements of liability unless some type of immunity is provided for the persons involved.

Mr. House stated he had some reservations about the testimony relative to programs at the Cleveland Clinic and Massachusetts General since he had not seen either program written up in the literature. Because the Cleveland Clinic is a very tightly controlled corporation of doctors and is highly specialized it cannot be compared with a general hospital utilizing private physicians.

Judge Robert Stephan, District Court, Wichita, gave the following statistics provided by a Wichita law firm handling about 80% of the cases and based on cases filed in district court for the period January 1, 1971 to July 16, 1975: 36 percent of the cases were settled before trial (30 cases); 10.8 percent were dismissed (9 cases); 13.2 percent went to trial (11 cases); and 39.6 percent were pending (33 cases).

In his ten and one half years on the bench, Judge Stephan has tried about six cases. He stated these cases usually run for longer periods of time, four to eight weeks, than other civil cases and the scheduling is very difficult.

In answer to questions, Judge Stephan stated that in accordance with the decision of the Kansas Supreme Court, the doctor must completely inform the patient. If he does not, he can be held liable and the judge must so inform the jury. Although informed consent is a major element in almost all trials, he did not know whether eliminating informed consent would mean less suits would be filed. One cause of the increased number of suits is the fact that people are more aware they can sue.

The jury sets the amount of the settlement but they cannot be informed of other sources of restitution such as insurance payments. He felt it would make it more difficult for the jury if the amount given in the pleadings was required to be stated only as above or below a specified amount. He also felt that permitting evidence concerning awards made in other cases or using such awards as guidelines would make jury decisions more difficult. It would be difficult to determine a sum to be awarded, the income from which could pay for the care of the patient. The judge cannot alter the amount awarded by the jury unless it "shocks the conscience of the court." Judge Stephan did not know of any way judgements could be paid periodically rather than in a lump sum.

Judge Stephans suggested that what constitutes malpractice could be set out more specifically and that informed consent could be more clearly defined. This might mean it would be less necessary to set upper limits on awards. Any upper limit set might not cover the actual cost of caring for the person in some cases.

He knew of no practical way, other than the contingency fee, that people could get adequate representation and he did not

know what system could be used to replace contingency fees. Also, the contingency fee can negatively affect the number of cases because the attorney knows the settlement would be too small for the amount of involvement required. He did not feel qualified to comment on limiting contingent fees or establishing a contingent fee scale.

According to Judge Stephan, most civil cases come to trial in one year or at most in two years. If a case were appealed and there was a reversal it might take longer but probably not as long as five years.

He pointed out that in all trials there is a pretrial conference but he was not sure these led to settlements in a significant number of cases. After a brief discussion of screening panels, he stated he felt these might be feasible. In answer to questions, the Chairman stated it was his understanding that material from screening or medical review panels could be admitted in court as evidence either by admitting the findings of the panel or by questioning witnesses who had appeared before the panel.

Judge Stephan stated there is malpractice, but there has to be some kind of sane approach to the problem.

Judge Robert Stadler, 4th Judicial District, Iola, stated that in the rural areas they have very little malpractice litigation partly because of the close and personal relationship between patient and doctor. When he came on the bench in 1969 there was one case pending. Since then there have been three cases, none of which have come to trial and one case is now pending. Judge Stadler felt this was typical of other rural judicial districts. He has not tried a malpractice case.

Judge Stadler referred the Committee to the July 1975 issue of the Judges Journal.

In answer to questions, Judge Stadler stated the statute of limitations and discovery period cover a long period and sometimes means witnesses have died or cannot be located which makes it difficult to reconstruct what happened. He did not think shortening the period for minors would have any substantial affect since his experience has been that someone acts in loco parentis in the case of minors. He did not have any recommendations as to what the time limits should be.

Judge Stadler felt a screening panel could be useful in cases that are not obvious such as leaving a sponge in the patient. Making the panel's decision binding on either party might raise a constitutional question.

Factors Judge Stadler felt contribute to the increased number of cases are that litigation is available and can be taken advantage of and the higher awards being made. He felt that notifying

the defendant prior to the filing of an action might be of some benefit. Doctors would welcome knowing at the time that their services were less than satisfactory thus giving them an opportunity to perhaps prevent more serious damages.

Judge William R. Carpenter, District Court, Shawnee County, stated that to his knowledge no malpractice case had gone to a jury in the last five years in Shawnee County; some large friendly suits were settled and approved by the court; at the present time about 20 of the pending 1,500 civil cases are malpractice cases. However, he felt there are indications that the number of cases may increase. Also litigation costs are becoming higher even to defend unmeritorious claims. He noted that attorneys now feel they have to take extra depositions, etc., to protect themselves from a lawuit by their client.

In answer to a question, Judge Carpenter stated there is a need to look at the system of paying the cost of civil litigation because of the massive defense costs and the affect that increased litigation is having on dockets when people feel they have very little to lose. Having the judge or jury awarding attorney fees might reduce the number of suits and would allow the litigants to recoup some of their litigation costs. However, this approach could mean some people with legitimate claims but limited financial resources could not go to court. He pointed out that under the contingency fee system there is the speculative factor in that if an attorney keeps filing cases he may win a big one. He suggested that statutorily setting guidelines stipulating the portion of attorney costs to be paid in nonmeritorious civil cases might be a more practical solution than setting limits on contingency fees.

Judge Carpenter feels there are pressures to settle out of court, i.e., the expense of defense, especially in nonmeritorious cases; insurance is less than the amount being sued for; law firms have specialized in this type case; the defendant is fearful of not being vindicated if the case goes to trial.

Judge Carpenter stated the judge does not have any authority to order awards be paid over a period of time rather than in one sum. He did not think the jury could stipulate awards be made this way either.

He discussed legal fictions with which the courts deal: the jury knows the plaintiff attorney will be paid but must be instructed to take into account only actual damages suffered; collateral sources are not admissable for jury consideration although the jury knows they may exist; a jury must award for economic loss in cases of a spouse when the spouse has remarried.

If the statute of limitations is lowered there is the problem of legitimate claims where the injuries are not know for years. However, a statute could require notice and have a provision for handling these exceptions.

Jim Clark, Kansas Optometric Association, stated availability and requirements for availability rather than cost is their concern. He distributed an article (Attachment G) noting Aetna Life and Casualty which handles the majority of optometric insurance will not insure an optometrist now unless he is a member of the optometric association. A letter to several members indicates Aetna will not carry their malpractice insurance unless other coverage is also with them. Mr. Clark then discussed requirements for level of care referring to the Helling decision and an article regarding it. (Attachments H and I). He also distributed copies of the Kansas Optometric standards. (Attachment J).

The meeting recessed for lunch.

The meeting was reconvened at 1:30 p.m., by the Chairman.

Jerry Slaughter, Executive Director, Kansas Medical Society, introduced Dr. John Travis, President, Kansas Medical Society, who stated the malpractice situation has led to the practice of defensive medicine, has caused a deterioration in the climate between doctor and patient which adversely affects the quality of care and may also limit the availability of service. Medical science has been oversold. There are unavoidable and irreducible complications and most suits are in these areas rather than negligence. He stated we are not talking about bad practice but about bad doctors.

Dr. Greg Snyder, Chairman, Commission on Professional Liability and Medico-Legal Affairs, Kansas Medical Society, stated physicians, attorneys, the insurance industry and patients are each a part of the problem and must each be a part of the solution. He felt factors contributing to the problem are a more active public, increasing opportunity for problems and active attorneys. He also noted that Kansas doctors present a small base and a small market for any insurance company.

Dr. Synder referred to a study conducted by the Kansas Medical Society which showed only 8 percent of the doctors are involved in two to four claims which other doctors would consider serious. One insurance company which studied cases in Kansas stated 80 percent of the doctors are highly reputable and qualified and would be acceptable as their doctor. He referred to one instance in which a premium was raised from $4,000 to $11,400 for one doctor and double that for his partner. Cases like this may eliminate a portion of doctor services in Kansas.

Dr. Stephan Bruner, who entered family practice alone in the Pittsburg area in July 1975, spoke from the point of view of a young doctor evaluating where he will practice. Because he had heard there were problems, he started inquiring about insurance at the end of January, 1975. He was told no company was writing insurance for those not already insured by them. He called Mr. Hayes in the Insurance Commissioner's Office who told him to

send applications to a list of companies and if he received rejections, the Commissioner's Office would help. Dr. Bruner sent in applications and by the middle of March had heard from only three -- all rejections. He never did hear from some companies. About April 1, Mr. Hayes notified him their office was working on finding a carrier who would insure him. On May 16, he contacted Mr. Hayes to tell him he had an offer from Hartford which he felt was reasonable -- $1,500 for $500,000 to one million for Class III.

During this time Dr. Bruner started looking at other places to practice and found he would have no trouble getting insurance in Colorado or Wyoming. A friend had no trouble in Nebraska. Another friend who considered going into practice with him accepted a position with a group in Missouri where he had no trouble getting insurance as long as he entered a group practice.

Dr. Bruner stated family practice is a highly competitive field and unless someone really wants to come to Kansas they will probably go where insurance is easier to obtain. He is trying to recruit a young doctor to join him next July but is not sure he can get him insured.

In answer to questions, Dr. Bruner stated he recalled having three lectures on medical-legal problems which were interesting but very remote. He became acutely aware of it during his residency and learned defensive medicine there. He stated the insurance companies gave no reasons for rejecting his application. He read some of the replies which were just a few sentences in length.

Dr. Tony Mahaffey, Baxter Springs, Kansas, stated that when his insurance company went to a "claims made" policy, he tried for several months to change companies. There are two other doctors in the community; one is considering retiring in January because of ill health; one would like to continue practicing but will retire next May if he has to go to the new "claims made" policy. If these doctors retire he could not pick up their load and would probably leave Baxter Springs because of the high probability of a lawsuit. He stated he sees it as a health service crisis rather than a malpractice crisis.

Dr. Dan Caliendo, Wichita Emergency Care, stated they had a policy with St. Paul with $100,000 to $300,000 limits for a premium of $1,100. They also carried a one to three million umbrella. St. Paul notified them they would not renew the policy. They wrote to insurance companies, thirteen of which did not answer even after several followup calls. Seven companies accepted their application which had to include a separate complete resume on each doctor and which was different for each company. They heard from two of these. They looked into being covered by Hartford as part of the Wesley Medical Center policy and found this was impossible. They contacted Mr. Hayes in the Insurance Commissioner's Office

about fifteen times and got very little help at first. He sent them information about CHUB which they had already investigated and found they did not fit. In the last week, Mr. Hayes did intervene with St. Paul who said they would reconsider extending coverage. They also received a letter from a company stating that if they wished coverage contact the local agent and tell him to contact the company. They contacted their local agent but never heard from the company. When St. Paul reconsidered, the coverage they offered was inadequate. Dr. Caliendo discussed quotes from other companies. The policy they were taking will cost $30,000 for the same coverage they did have for $1,500. This is just coverage for corporate liability in excess of individual liability which each member of the group carries. His company has notified him they will not review his individual policy but since he is a member of the American College of Emergency Physicians he can get coverage through their insurance. It will cost him $1,800 for $200,000 to $500,000 limits. The association has an umbrella policy approved in other states but not in Kansas. Their request for approval is on Mr. Bell's desk.

Dr. Caliendo agreed to leave copies of his correspondence with the staff. (The material is on file in the Research Department.)

Dr. John Morgan, Board of American College of Physicians and internist in a group practice in Emporia, stated the problem was one of availability. The company with which they have been insured for fifteen years notified them last October they were withdrawing from this class of insurance. They contacted seven companies between November and May and had repeated refusals. They were considering abandoning their practice when a local agent secured a "claims made" policy for them in June.

Dr. Jim Lefler, Wichita, Kansas pointed out this problem is all over the State of Kansas and is not yet as severe as it is in other states. We are just in the beginning of the price cycle with a doubling of premiums for which patients will have to pay. He mentioned a pediatrician and dermatologist who were unable to get insurance for a new person they were bringing in until Mr. Bell interevened and an ophthamologist whose premiums went from $1,800 to $9,000.

Dr. Synder pointed out that they have the figures from Mr. Bell's office to substantiate that this is a low profit area for insurance companies.

Dr. Phil VonRuden, Hutchinson, stated he was speaking for a clinic of twelve other doctors and for the Reno County Medical Society. One anesthesiologist in their community became aware of the problem early, did a lot of research into it and called it to the attention of others. They found they all could

get basic coverage but their was a gap between their basic coverage and their umbrella of about $300,000 or $400,000. They approached companies, got nowhere and called a meeting with the executive board of the hospital, area legislators, the Insurance Commissioner's Office and representatives of insurance companies. As a result, insurance is becoming available through several companies. Premiums for the group were $1,900 in 1974 and will be $41,000 in 1975.

The real problem for the group is the anesthesiologists. The one who works part-time was quoted a premium of $20,000 for next year which is probably more than she makes. One full-time anesthesiologist can get only a "claims made" policy and a one million umbrella which is too small. If he cannot get an umbrella of $2.5 million he may have to move.

Dr. VonRuden stated that all of them would like to quit even though they love medicine. He emphasized that it is more than a money factor. It is a need to get back to practicing medicine and reestablishing relationships with patients.

Dr. Daniel H. Roberts, Wichita, described the Regional Perinatal Care Program and the high risk of doctors who voluntarily participate in this program. They requested an opinion from the Office of the Attorney General clarifying whether or not they could be covered by the "Good Samaritan Act". The answer was noncommital.

A group of ten obstetrician-gynecologists, all of whom are fellows or associate fellows of the American College and who provide 35 percent of the service, are having trouble getting coverage. The first week in June, Lloyds of London informed them they were no longer writing malpractice insurance. They tried to get coverage elsewhere. Philadelphia Fire and Marine quoted them $19,100 for a single physician and $13,999 per person for those with no suits, however, teaching was excluded from this policy. After repeated discussions with an Los Angeles firm, they received a quote to cover teaching for a 50 percent increase. He emphasized the amount of time and effort taken away from the practice of medicine in order to get coverage.

Payne Ratner, Jr., Legal Counsel, Kansas Medical Society, stated the following concerns: lack of availability of insurance, increased premiums which will make a difference in the cost of health care, difficulty doctors have in getting insurance and the time it takes away from their practice, doctors having to use insurance companies they know little about and over which we have no control because they are not licensed in Kansas; problems between doctors and attorneys, and the climate and atmosphere in which the doctor is now practicing. He stated they are looking to the Insurance Commissioner's office and the legislature for help.

Copies of the position paper of the Kansas Medical Society were distributed. (Attachment K). The paper containing possible solutions which they are recommending is being finalized. Copies will be sent to Mrs. Correll to be distributed to Committee members. They asked for time to discuss this paper with the Committee after the members had had time to look it over.

In answer to a question, Dr. Travis stated the interpretation of "informed consent" is largely a matter of case law and does need clarification. He felt it should be based on what the doctor feels the patient is able to understand -- what he, as a prudent physician, feels is in the best interest of his patient.

Comments the Medical Society has received indicate that all but one of the surrounding states are presently a better place to go in terms of malpractice coverage but the problem is spreading. Although it is too early to tell the impact of legislation such as that in Indiana, it was pointed out that there are now seven carriers in Indiana. The Committee was urged to develop legislation without waiting to see what may or may not be working somewhere else.

In answer to a question, Dr. Lefler stated that in Missouri, Montana and Nebraska the state medical societies have an agreement with insurance companies to provide the bulk of the insurance and they are willing to take on new doctors. These are group plans.

It was pointed out that "claims made" policies cover the doctor only for the year of the insurance. Because of our ten and two statute, a doctor who dies or retires has to be covered after his policy expires. With a guaranteed endorsement one has to pay a premium of 180 percent of his mature premium rate for twelve years. The premium for the first year is less but increases for about five years until it hits a plateau. This type policy does let insurance companies predict more accurately.

In answer to a question, Dr. Travis stated he did not feel the Board of Healing Arts had adequate authority to do any housecleaning which might be needed nor do they have adequate resources to do it. The Board of Healing Arts says funds are not being released to them and they do not have an adequate staff. He cited a case in Topeka where the local medical society has removed a doctor from membership and he is now threatening them with legal action. They have asked the Board of Healing Arts to remove his license but the Board says it cannot take action. The Kansas Medical Society will be making proposals in this area.

Dr. Travis pointed out that for the first time the Kansas Medical Society has appointed an ad hoc committee on the disabled doctor. They feel it is important to identify this doctor without onus and rehabilitate him.

The Chairman recommended to the Committee that they consider a series of bills rather than one big bill trying to pinpoint the areas which they feel are most important.

Representatives of insurance companies and of the legal profession will be asked to appear before the Committee at the August meeting.

The meeting was adjourned.

Prepared by Emalene Correll

Approved by Committee on:

8/27/75
(Date)

Attachment 7
July 22, 1975

Testimony presented July 22, 1975, before the Joint Interim Study Committee of the Kansas Senate and House of Representatives on Medical Malpractice.

Lee J. Dunn, Jr.
Legal Counsel to the Medical Center
University of Kansas Medical Center

I would like to take this opportunity to discuss the effect of the "malpractice crisis" upon the University of Kansas Medical Center. Since approximately 23 percent of the licensed physicians in the state of Kansas practice at the Medical Center, and since the Medical Center is a unique institution in Kansas, the extent to which it is effected by and the methods it utilizes to react to the "malpractice crisis" are, I submit, of considerable interest to the Legislature and to the people of the State.

In the last two years 23 law suits alleging professional negligence have been filed against members of the medical and/or house staff of the Medical Center. Nine of these have included the Medical Center itself as a party defendant. Of these nine law suits, five are still pending with total amassed damages sought amounting to approximately $10.5 million. Given the approximately 300,000 out-patient visits and 19,000 in-patient admissions which the Medical Center experiences in a given year, this is an extremely small number of law suits. One could argue, and with considerable justification, that the small number of suits is reflective of the excellent care rendered by the physicians at the Medical Center. One could also argue that Kansans are not as litigious as the residents of other states, but, I submit to you that the primary reason why the number of law suits against the Medical Center and its physicians has been so low in the past was the existence of the doctrine of governmental immunity which, until June 9, 1975, rendered the Medical Center immune to suit on theories of negligence.

I think the existence of this doctrine had the effect of discouraging the filing of law suits against the physicians practicing at the Medical Center as well as against the Medical Center itself. With the decision in Brown v. Wichita State, however, the situation has changed dramatically. KSA 46-901 has been declared unconstitutional and, at the moment, the Medical Center has no statutory defense to malpractice actions. This does not mean that the Medical Center is defenseless. On the contrary, I think there are several defenses which could be raised, especially in those cases in which the cause of action accrued prior to June 9, 1975, but I do not think it appropriate to discuss pending litigation in detail at this time. For the future, however, I would think that some kind of a tort claims act, as suggested by the Supreme Court in the Brown case, or some other kind of statutory protection for valid governmental functions would be appropriate.

Some question has arisen as to the position of our medical students in the "malpractice crisis." When I first came to the Medical Center two and one-half years ago, we were confronted with a problem in Wichita in that several of the hospitals in which our medical students were training there felt that their exposure to liability was increased by the presence of our medical students. There was also concern about the liability of students serving in preceptorship programs throughout the state. In response to this, the Legislature, in its 1975 session, appropriated $15,000 for the purchase of malpractice insurance for medical students. It is hoped that this will provide a solution to the problem, if suitable coverage can be obtained at a total premium cost within the amount appropriated.

There is, however, an additional problem with individuals who have graduated from the Medical School, who have not yet begun their residencies, and work in a physician's office during the interim period. These individuals do not have

the protection of the statutes with respect to practicing medicine without a license and, I understand, are quite often left on their own by the physician/employer. This is a unique situation which, I think, will require legislation to correct.

One of the suggestions for dealing with the pending and expected malpractice suits against the Medical Center has been either to enter crossclaims against co-defendant physicians or to implead as third party defendants the professional corporations which employ these clinicians at the Medical Center. Up to the present time, when a law suit was filed against both the Medical Center and one or more physicians, we have never had to consider any counterclaims or cross-claims because of the existence of KSA 46-901. However, with the Supreme Court's decision in the Brown case, the possibility of doing so has become a real one. Let me deal first with the question of impleading a professional corporation as third party defendant.

I do not think that this would be a feasible tactic legally in that we could not successfully allege that the professional corporation was negligent in practicing medicine, since a professional corporation cannot practice medicine. Moreover, any allegation that the professional corporation was negligent either in hiring or retaining a particular clinician would fail, since before one can become an employee of a professional corporation at the Medical Center he must be admitted to the Medical Staff of the University and his retention on that staff is subject to review by the University and not the corporation.

The possibility of entering a crossclaim against co-defendant physicians is more real. However, it would cause tremendous difficulty in the running of the Medical Center and in the conducting of the defense of law suits.

At the present time, the defense of malpractice actions in which both medical or house staff members and the Medical Center have been named as co-

defendants is managed in a reasonably cooperative manner. Obviously, some of this cooperation stemmed from the fact that, under KSA 46-901, the Medical Center could be reasonably assured that it would not be held liable on any theory of negligence. With the Brown decision this assurance has vanished. However, if the Medical Center were to file a crossclaim against co-defendant physicians, we would be constructing a barrier which would make the practical defense much more difficult, would make it highly unlikely that the physicians involved would converse about the case with me or the administrators of the Medical Center without advice or presence of counsel, and, more importantly, would create a deep rift between our physicians and the Medical Center itself. Given the fact that Kansas civil procedure does not require that we file crossclaims and/or initiate indemnification proceedings immediately /the statutes, KSA 60-213 and 214, are permissive, not mandatory/ and given the fact that Kansas is consistent with the general rule that the cause of action for indemnification or contribution does not attach until the extent of one's liability is determined /see Annot. 57 ALR3d 867; Rexroad v. Kansas Power and Light Co., 192 Kan. 343 (1964)/, I see no legal reason for immediately utilizing this method and see numerous practical reasons for not doing so.

I understand that the Committee is also interested in what mechanisms exist within the Medical Center for reviewing the quality of care which our patients receive. As subcommittees to the Executive Committee to the Medical Staff, there are nine committees which monitor the quality of care from a number of different perspectives. A list of these committees would include the following:

1. Hospital Material Standards Committee
2. Audit Committee
3. Medical Records Committee
4. Operating Room Committee

5. Peer Review Committee

6. Tissue Committee

7. Utilization Review Committee

8. Medical Malpractice Committee

9. Physical Monitoring and Instrumentation Committee

If the members of the Committee wish information on any of these committees, I am prepared to give it to you, but, for the moment, I can assure you that the mechanism for close monitoring of the quality of care given by all levels of health care providers, of the equipment which they use, and of the conditions under which they render this care definitely exists.

In addition, I think one additional point should be made. Less than 50 percent of the 112 four-year medical schools in the United States offer any formal program in legal medicine. Legal medicine can be defined very broadly, but for my purposes let me say that legal medicine would include any exposure a medical student might receive to the interface between law and medicine. Of those medical schools which do have some formal course work in this field only one, to my knowledge, has legal medicine as a required part of its curriculum. In fact that one school has two required courses. That school is the University of Kansas Medical School. It is our hope that these two courses can be expanded and that certain programs already existing for making formal academic experiences available to medical and house staff, as well as to medical students, will be developed as well.

I would like to close by making a few observations on the "malpractice crisis." The crisis is multifaceted and it is difficult, if not imprudent, to pick out one or two facets as being primarily responsible for the crisis as a whole. However, from my vantage point, I see many of the attempts at resolving the crisis as treating only the symptoms and not the basic illness. Limitations on the amount of jury awards, shortening the statute of limitations, restricting

the extent of contingency fees, are all designed to treat simply the symptoms. The basic cause of malpractice litigation is medical injury, not all of which is the result of professional negligence. As long as medical injuries exist, medical malpractice suits will exist, and treatment of the symptoms alone will not alleviate the problem.

In the face of an industry which traditionally conducts loss prevention programs in the casualty field (especially with regard to industrial accident and fire insurance), I have been continually amazed at the virtual non-existence of carrier sponsored loss prevention programs in the medical malpractice area. One wonders how an industry can bemoan a crisis when it does little to alleviate it.

A recent study at Boston University showed that more than 80 percent of all the physicians surveyed were totally unaware of the laws that related to the treatment of minors. Although this study was written to emphasize how minors could have benefited from medical intervention of a knowledgeable physician, one can also look at it from the perspective of how can a physician expect to work within or be protected by the law when he is ignorant of it?

The fact is there is considerable ignorance in the medical profession about the law in general, and this situation is not being improved either by the insurance companies or by the medical schools. I would suggest that one positive method of dealing with the malpractice problem is massive education programs designed to educate physicians as to their legal responsibilities and the legal rights of the patients. This could be done on the state level through the Board of Healing Arts and the Board of Health.

Finally, I refer the Committee to remarkably successful records of the Cleveland Clinic and the Massachusetts General Hospital in virtually eliminating malpractice suits against their respective institutions. This has been

accomplished by a rigorous internal policing of the physicians and a strong patient advocacy program which nips problems in the bud and does not allow them to develop into litigation. This, I submit, is the best way to deal with the problem of medical malpractice.

Most of the proposals I have seen which are allegedly designed to deal with the malpractice problem do not come into play until after the injury has taken place. I would recommend that methods be developed for preventing the injuries from occurring in the first place.

My name is John McGee, I am an administrator of a twenty-five hospital in a small town, Kiowa, Kansas. We have two physicians who have been in our town over twenty years. However, one is leaving September first to go into teaching family practice. The problem of securing malpractice for new physicians may be quite a problem for us. In the small towns there is a great deal of pride in the hospitals and usually a great affection for the physicians practicing there. However, both the physician and the hospital are in the public eye in their care of patients and the practice of medicine is observed and known by all. We are able to tell a slight difference even in our small community in the doctors practice of medicine. There is more defensive medicine practiced.

We think the doctors are ordering more laboratory tests, we are certain they are ordering more X-Rays than they did ten or fifteen years ago. The hospital is forcing them to be more defensive by requiring more documentation as to the illness and/or injury. We also think the hospitals are being more defensive, we are requiring restraints be put on a type patient that ten or fifteen years ago we would have assumed we could watch to keep from climbing out of bed. Incidentally this does not do much for hospital-patient relationship for a patient who feels he is capable of not injuring himself by not climbing or falling from bed. The nurses are also becoming much more defensive minded because of the fear of being named in a suit against the hospital or physician.

Our county has five physicians and our two hospitals meet with those five physicians once a month for Utilization Review. Malpractice insurance has become a frequent topic of discussion. The doctors are getting approximately fifty percent increase as their renewal dates come up. At present it varies from $1,900.00 for the lowest to $2,800.00 for the highest. These men are all General Practitioners. On a forty hour week this figures out approximately $1.35 per hour for malpractice insurance. In a neighboring community the hospital malpractice insurance for a thirty-four bed hospital was $3,000.00, this went to $6,000.00 per annum and this hospital has had no claims nor have they ever had a suit filed. This same hospital has two physicians on it's staff, they have both quit doing surgery in order to keep down the increase in their malpractice insurance. This is going to affect the health care of that community.

Another hospital in the same county, also thirty-four beds, pays $1,500.00 per year for malpractice insurance, neither have they had any suits nor claims. Our hospital is currently paying $1,065.00 a year for our protection which is only twenty cents per patient day, which compares to $1.20 per patient day for the neighboring hospital in another county. Two other hospitals in the area said they would receive substantial increases on their premiums on their next renewal date. If these insurance costs continue to rise it is going to raise the cost of health care to the patient.

It seems to us that writers in magazines and perhaps some of the stories on T.V. have made it appear that any doctor is able to effect immediate cures irregardless of the disease or injury, on all of his patients. They make it seem that the doctor has only one patient to work with. This is not the way it is in the real world. In the small rural hospitals and in the rural physicians offices, all types of medicine must be practiced. Perhaps we get different types of emergencies than in the Urban hospitals. We have men injured on machinery, hunting accidents, cowboys thrown from horses and snake bites, then we also have the same things they have in the cities; ulcers, geriatrics with broken hips, occassional gun shot wounds, automobile accidents and poisonings. Sometimes we think there are not enough hours in the day to care for all these patients. The patient has come to think that absolutely nothing can go wrong in the treatment of their disease or injury. There is no way to always have perfect results, or results without some discomfort, so I presume patients will continue to sue when this "Utopian" type result is not achieved.

I do not know the perfect solutions, for I know the insurance companies are having problems also. It is estimated that somewhere between seventeen and twenty-two percent of the amount of premiums paid eventually reaches the patient in the form of a claims settlement. Some states are requiring

all insurance companies to participate in malpractice insurance, this seems rather unfair as some companies have no experience and therefore have no expertise in this type of insurance. "Claims made", approach requires the insurer to set the premium based upon the experience each policy year, and requires the insured to continue the coverage during any year that there might be any exposure for prior acts. Under the "Occurrence" type of policy the premium is set and paid and if the insured should wish to terminate coverage he still has insurance protection for the time the incident occurred, if it occurred during the period that he paid a premium.

It appears that several companies have considered the use of the "Claims Made" policy, but have had some reservations that the courts might judicially construe them to actually be an "Occurrence" policy. Some people are critical of the Claims Made approach, as they feel that the transition from one to the other will create a tremendous payment to the insurance companies the first year.

Some states are reducing statute of limitations from the date of the incidence without any provision to enlarge the statute from the date of discovery. They are limiting the time to two years after the sixth birthday, or some other age below majority plus two years.

Perhaps the arbitration panel mechanism might work in this state but irregardless some system must be developed to get malpractice insurance for physicians and hospitals in the rural areas at a reasonable cost or the health care of the majority of Kansans is going to suffer.

Attachment C

MEDICAL MALPRACTICE PROBLEMS OF THE STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Presented to the Medical Malpractice Committee studying Proposal No. 42.

The State Department of Social and Rehabilitation Services faces malpractice claims problems mainly in its Division of Mental Health and Retardation Services which includes the medical staffs of the state institutions operated by the department. The state and the department presently have no insurance coverage to protect any of these institutional employees or any other employees of the department from judgments or the litigation expense of civil suits.

It is estimated that only about 40 percent of the doctors employed by this department in institutional positions are covered by private malpractice insurance. Approximately 60 percent of these doctors have no insurance protection of any kind. The Superintendent of the Topeka State Hospital, who is a doctor, reports that malpractice insurance premiums have increased in the past year approximately 120 to 150 percent. Some staff physicians of that institution are now attempting to purchase malpractice insurance without success. Normal malpractice insurance rates for institutional physicians are now running approximately $250 per year without riders, especially riders for electro convulsive treatment. Riders for the electro convulsive treatment are now running at approximately $400 per year. Only one physician at the Topeka State Hospital is now carrying such coverage and his premiums are being shared by the other physicians at the Hospital at their personal expense.

The doctors and other employees of the department perform their duties as prescribed or resultant from statute and thus "act under the color of state law." This exposes the doctors and other employees of this department to civil rights actions as well as regular negligence, malpractice claims. Many suits are now combining civil rights and malpractice claims. Many of these suits presently seek claims of several millions of dollars, although none of these actions has yet resulted in a judgment.

Institutional doctors are not the only defendants to this type of action. Institutional superintendents, division heads, and the Secretary of Social and Rehabilitation Services are routinely named as additional defendants in these suits. Other persons who come in contact in any way with patients are also potential defendants and civil suits are now naming social workers as defendants.

The Legal Division of the State Department of Social and Rehabilitation Services has traditionally made its services available to the employees of the department for the defense of such civil actions. New problems have arisen, however, with the decision of the Supreme Court of the State of Kansas in the case of *Brown, et al. v. Wichita State University, et al.*, No. 47,363, which opens the possibility of the department and its institutions to become an additional defendant in negligence actions for which the department was formerly immune. The interests of the State Department of Social and Rehabilitation Services and of its employees are not necessarily identical in such litigation and cases may arise where it will not be possible for the Legal Division to represent the department employees when it must represent the state department and its institutions.

KSA 65-2836 to 2867 inclusive: Licenses, suspension or revocation, when;

Acts or offenses which constitute grounds for a disciplinary proceeding which may proceed to a full - blown adversay type administrating hearing are specifically detailed in KSA 65-2836 to 2867.

Prior to the 1972 session of the legislature, 65-2836 (b) listed, "immoral, unprofessional or dishonorable conduct, OR PROFESSIONAL INCOMPETENCY, as a cause for revocation or suspension of a license to practice a healing art, (65-2837 defines unprofessional conduct), but the three words, OR PROFESSIONAL INCOMPETENCY" were removed from the Act by the 1972 session through an amendment.

We offer no explanation for this removal because the Board of Healing Arts was neither consulted by the legislature about the removing amendment, nor was the Board notified that the removal was being considered.

Complaints against a licensee reach this Board through several avenues; some are referred to this Board by the State Medical Society, the County Medical Society, the State Association of Chiropractors, the State Osteopathic Association, or by the office of the Attorney General.

Such complaints are generally considered by the forwarding entity with decision that the matter has sufficient merit to justify requesting the Board of Healing Arts to make investigation and determine whether the matter should proceed to a disciplinary hearing which could result in suspension, or revocation of a license held by the licensee. Addiction to drugs, alcohol or both by the licensee, or a question as to the quantitative distribution of dangerous drugs by the licensee frequently are alleged in the complaint.

Some complaints reach this Board directly from a patient who deems himself, or a relative, or acquaintance, to have been agrieved by the conduct of the licensee. Complaints which originate in this matter generally come from areas in which the lay people are not familiar with the fact that there is a local society with whom the complaint can be lodged. Occasionally such a complaint will be referred to the State Society or Association by this Board, expecially if there appears to have been only a minor, and perhaps inadvertent breach of the rules of ethics of that particular branch by the accused licensee. This same type of referral has occured when the complainant was a licensee of the Board, but had lodged his own complaint individually instead of through his local or state organization. The complaint must be of a very minor nature to receive such a referral, and in no case is the referral made if the complaint contains allegations which, if based in fact, could result in any patient being exposed to sub-standard diagnosis and treatment, but the complaint could, for example, contain an allegation that the accused licensee was guilty of advertising or failing to affix to his signature the degree in which he was licensed to practice the healing art, or some similar lesser infraction of the provisions of the Healing Arts Act.

Upon receipt of an apparently meritorious complaint in the office of this Board, the complaint is routed to the Secretary of the Board, James E. Hill, M.D., who reviews the complaint to determine whether there is at least probable cause to believe that there has been a violation of one or more of the provisions of 65-2836 or 2837 by the accused licensee.

Having reached such a determination, Dr. Hill then forwards a copy of the file to the Boards investigator.

Because the nature of the complaints can be so widely varied in scope, it is not possible to set out a step-by-step chronology of the events as they occur in the investigation of the complaint, but, as a general rule, the first step in the investigation is to interview the complainant in person, in order to try to get a full and complete recitation of all events, conversations, acts, etc., as they transpired from the earliest date possible, right up to the time of the investigating interview.

No complaint is ever complete when it is received in the office, and additional information, generally highly pertinent or perhaps even crucial to the investigation, is developed from the initial interview; this may include ancillary complaints which were not mentioned originally, names of witnesses to conversations or communications, modalities employed, motivative factors for the original complaint, and many other items which no complainant ever includes in his communication of his complaint.

Usually the second step involves interviews with corroborating witnesses, which, incidentally, occasionally includes a licensee of the same healing art as the accused.

Hospital records, if indicated, are reviewed and in most cases the ranking officer of the local society or association of the branch of the healing arts in which the accused is licensed, is interviewed, both as to his knowledge of the present complaint and his knowledge of any other complaint against the accused. We are especially interested at this point in the investigation as to whether there is a repetitive pattern displayed, which is similar in nature to the present complaint.

When all known leads have been followed, the accused is then interviewed in his own office and asked to respond to the allegations made against him.

That interview may provide additional witnesses to be interviewed or leads to be followed, and this follow-up is just as diligent and objective as is the follow-up to the leads provided by the complainant, because the entire proceeding up to this point is purely investigatory, and not accusatory in nature, and the Board, through its investigator, maintains an entirely objective attitude in the matter until all the facts are in.

When the investigation has been completed, a report of the results and investigative findings is submitted to Dr. Hill, who then decides whether an ad hoc committee composed of one member from each of the three branches of the healing arts, should be appointed to review the findings, or whether the matter should be presented to the Board as a whole for their decision.

Whether the matter is reviewed by committee or by the entire Board, the matter may be handled in one of several ways. As an example, the decision may be to write the accused licensee, pointing out some corrections or changes which should be made in the practices of the accused.

More often than not in these cases, the accused licensee is requested to present himself to the Board at the next meeting, where he is interviewed by the Board members.

There have been occasions where it became apparent to the Board during such interview that the licensees needed to be placed on sort of a probationary status, with requirement for re-appearances before the Board at intervals in the future to report his progress in correcting deficiencies which have been pointed out to him by the peer group.

During the interim period between such re-appearances, the local society is advised of the action of the Board and requested to cooperate with the Board by observing the conduct of the accused, then advising the Board of the results of their observations.

There are times when a strong "father image" projected by the Board serves a positive function in these cases, and deficiencies are corrected through this approach.

If, after the initial interview before the Board, or at any subsequent interview, it becomes apparent to the Board that revocation proceedings must be commenced, the office of the Attorney General is so advised and provided with all the information known to the Board, and directed to file revocation proceedings.

Formal petition is then drafted and presented to the Secretary of the Board by the Attorney General, at which time the Secretary makes an order fixing the time and place for a hearing. The time should be not less than thirty (30) days, nor more than forty-five (45) days from the date of such filing. A copy of the petition is served upon the accused at least twenty (20) days before the date set for the hearing.

During the hearing, the Board as a whole sets as a trier of the facts, not bound by technical rules or procedure or rules of evidence, but grants the respondent reasonable opportunity to present his evidence and to be heard in the matter.

The Board has power to subpoena witnesses the same as any district court, and deposition may be used by either the plaintiff or the respondent.

Suspension of a license must be for a specified period of time fixed by the Board and the license must be renewed at the expiration of that period of time, if renewal fees are paid.

A revocation is for all time, but, at the end of one year from revocation, application for reinstatement may be filed with the Secretary of the Board by the licensee, then the Board may promulgate such rules and regulations as they deem necessary concerning notice and hearing for the application.

If the respondent does not prevail in any of the disciplinary hearings, the costs can be taxed against him, but if he prevails, the costs are the expense of the Board.

Withinn thirty (30) days after a hearing, either party can file an appeal in the district court in which the licensee resides, and if such an appeal is taken, the Secretary of the Board must forthwith file a certified copy of all pleadings upon which the cause was tried, with the clerk of the district court of the proper county.

Court must place these cases ahead of all other cases on the docket, except workmens compensation or criminal cases, and appeals to the supreme court are handled the same as in other civil cases.

Actions in injunction or quo warranto maybe brought to enjoin or oust from the unlawful practice of the healing art any person who so practices without proper licensure, but such injunctive relief does not preclude the bringing of a criminal action for the unauthorized practice of a healing art.

Criminal action can also be brought against a licensee for filing or attempting to file any false or forged diploma, certificate affidavit or identification or qualification, or any other written or printed false representation.

It is also a misdemeanor to falsely impersonate a holder of a license to practice the healing art, or to swear falsely in any affidavit or oral testimony made or given by virtue of the provisions of this Act.

The Board has the authority, by statute, to make all necessary investigations relative to this Act.

7/22/75

Testimony

Before the Special Interim Committee
on
Medical Malpractice
of
The Kansas Legislature

I am Dean Collins, a physician and staff psychiatrist at The Menninger Foundation. I appear before you to speak on behalf of the Kansas Psychiatric Society, a 240-member specialty component of the Kansas Medical Society. I, as Legislative Representative, and Joe Kurth, as Councillor, appreciate the opportunity to present testimony on Proposal 42 to the Special Interim Committee on Medical Malpractice.

Psychiatrists in Kansas share the deep concern of the rest of the medical profession and of the broader citizenry about the growing crisis in liability claims and insurance protection. Although we have no accurate data available, it is our impression that claims and awards in the area of psychiatric practice have not been in large numbers or amounts. However, the aspects of our practice subject to claim have increased in recent years. Adverse or unwanted reactions to drugs, infringement on patient's freedom and civil rights, erroneous prediction of dangerousness to self or others -- all these are daily risks we must take in our practices, even when in the interest of the patient. These issues are also becoming the subject of suits against psychiatrists. We share the view that legislation is urgently needed to guarantee high

quality medical care, to assure redress for justified patient complaints, to provide for compensation for injury and to specify the mechanisms for punitive measures -- all this in such a way that the effects and costs are not indiscriminately distributed to all physicians and all patients. As in other insurance programs, medical liability insurance should be financed in accord with actuarial experience of the field of practice and the experience of the individual practicioner.

The Kansas Psychiatric Society strongly supports the elements of legislative proposals already formulated -- a system of medical review panels to evaluate claims, reduction of the statue of limitations, limitation on injury compensation, and the requirement of the profession to exercise strictly its authority to monitor and control the practices of its members. We are convinced that such a legislative package would offer greater protection to the patients and to their physicians than the present system does, and at the same time the medical profession would be held accountable for its own responsibilities.

We are aware that many current claims are signals of a breakdown in communication in the doctor-patient relationship. For that reason every effort should be made to facilitate a meeting of the parties to reestablish communication, and, if possible, resolve the complaint in its nascent stages before any court action

Secondly, we are aware that some physician errors in judgment or technique are the result of a disabling condition of the physician -- physical or mental --- perhaps in its very early stages. The American Medical Association has urged the enactment of a model Disabled Physicians Act in all states. We join in urging that legislation be enacted in Kansas to protect the public, to protect the profession, and to assure corrective treatment or other measures for a disabled physician.

Finally, we strongly support the efforts of the legislative proposals before you to separate compensation for injury and punitive actions. Every patient should have guaranteed the right to be compensated for injury; however, the punitive action for a physician's negligence should not be in the form of money paid by all patients in fees to all physicians in his specialty category. We urge the requirement of effective disciplinary actions by peer review committees at the appropriate level. The Credentials Committees of hospital medical staffs, the Boards of Censors of local medical societies, the Ethics committees of specialty societies, the Peer Review Committees of Professional Standards Review Organizations, and the State Board of Healing Arts each has individual disciplinary actions within its authority. Credentials Committees control hospital privileges, society committees control membership in the society,

and the Board of Healing Arts controls licensure to practice medicine. All these bodies must exercise a range of reprimand and remedial educational recommendations as well as ultimate suspension or revocation of privilege, membership or license. Legislation must extend to all these bodies, the immunity of their actions and freedom from subpoena of their records in order to assure strong, effective policing of the profession by the profession.

Dean T. Collins, M.D.
Legislative Representative
Kansas District Branch of
The American Psychiatric Association

DTC/vm

Attachment F

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE 312-645-9400

July 11, 1975

TO: Allied Hospital Association Executives

SUBJECT: Bulletin #3--Malpractice Insurance Activities

Attached you will find the latest survey results on malpractice activities in the various states. Please recognize that this information was obtained from a variety of sources, and while we have attempted to verify it as closely as possible, there may be some inaccuracies. We would appreciate your keeping us posted on any major changes in the situation in the states or on any inaccuracies in the attached document.

In the brief summary that covers the detailed tables there is reference to an issue of some importance--the fact that even though some states have enacted legislation, the new laws have little or no immediate impact on the cost problem. As you might expect, the insurance industry has been very reluctant to make any commitments on premium reductions or even on tempering premium increases. This reluctance is based on a substantial number of unknowns at this time, especially in any projections of where and to what extent major cost reductions can be achieved based on tort system and other changes in the malpractice area. In addition, once substantive changes have been made at the state level, there will be a period of time before any hard data are available on actual claims experience with the new system. One of the keys to minimizing this problem is to make sure that there is careful monitoring of the actual claims experience once legislation has been enacted. Accumulation of such information on a state-by-state basis will provide a lever for use against private insurance carriers shown to be overcharing on malpractice premiums.

We sent both Jim Ludlam and Jim Groves to the recent national meeting of the National Association of Insurance Commissioners in Seattle to not only monitor the proceedings and participate in the discussions on the new malpractice reporting form developed by NAIC, but also for the express purpose of raising with the insurance commissioners from the 50 states the premium reduction issue outlined in the above paragraph. We had the opportunity both in private sessions and from the platform at the full meeting to indicate our concerns in this area, and the response from the insurance commissioners was positive.

I will be sending you a further report on NAIC activities soon. Also, the next set of materials for the malpractice manual is currently going through editing and should be ready for distribution shortly. If you have any questions on the malpractice survey, please call Jason Doskow (312) 645-9515.

Paul W. Earle
Vice President

attchs.

Attachment 1

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE 312-645-9400

July 11, 1975

State Survey on Malpractice

The summary below and the tables attached report the results of a 50-state survey of activities related to malpractice conducted recently by the AHA. Some updating of the information has been done through review of news reports, articles, and the like. This information has been verified to a degree but should be considered only as a broad indication of the many activities at the state level that are focusing on the malpractice problem. The information reflects activities through June 19; actions taken in several states since then are not included.

1. Summary of Legislative or Administrative Malpractice Activities at the State Level

As indicated in table 1, as of June 19, 1975, 27 states had some malpractice legislative or administrative procedure already in effect; 9 other states were expecting something to be put into effect by the end of 1975; and one other was anticipating some action in 1976. As a consequence, it can be projected that 37 of the 50 states will have taken some specific action to deal with the malpractice crisis by the end of next year.

In reviewing the specific kinds of legislative and administrative actions at the state level, it is clear that a substantial number of states are moving in the areas of creating special study commissions and/or developing joint underwriting associations. A far smaller number of states (only 7 of 27 through June 19) have developed more comprehensive and substantive legislation. This is an important point, in that real impact on the problem of the cost of malpractice insurance can be achieved only through comprehensive and substantive legislative programs at the state level. It is projected that by the end of 1976 slightly less than half of the 37 states that have acted in the malpractice area will have made substantive changes.

In those states that have already enacted or are moving toward more comprehensive programs, the prevailing kinds of actions are changes in the statute of limitations, informed consent, and patient compensation or liability funds. Several states also are placing limits on liability or damages. As highlighted in table 1, many other kinds of malpractice legislation or administrative regulations also are being developed in the various states.

2. Summary of State Malpractice Insurance Market Conditions

The market for hospital malpractice insurance has been volatile, especially for the past six months. Twelve states, for example, have reported at least one major carrier cancellation in recent months. In addition a number of states are reporting problems in various segments of coverage even though malpractice insurance may be generally available. For example, there are difficulties in certain states in obtaining middle and upper level reinsurance.

While a market for hospital malpractice insurance still exists, market conditions in a number of states are becoming tight. For example, 7 of the 50 states have only one carrier still offering some hospital coverage, and 11 other states have only two. Less than one-third of the states seem to have a number of carriers offering this coverage on a fairly competitive basis.

Another way to judge the degree of market problems is in the total number of carriers currently writing hospital malpractice insurance. We currently count approximately 39 carriers across the country that are offering some form of coverage to hospitals, reflecting at least some fairly substantial interest in this market on the part of private carriers. A number of major carriers continue to withdraw, however, and 27 of the 39 carriers have indicated that in certain states no new business will be written. Thus, if major cancellations continue and the existing carriers do not pick up this new business, market conditions could tighten considerably.

As for the rate situation, exact information is not available but almost every state has reported premium increases of at least 100 percent this year and many have reported requests from carriers for rate increases of up to 600 percent. It should be noted that availability is in part a function of price, especially when prices increase significantly, and the continuation of these rate increases could well have the same effect as a full market withdrawal by the carrier. Many states also are reporting severe problems in the availability and cost of malpractice coverage for physicians. Moreover, even where state legislatures have acted, so far there have been no indications of premium reductions, because many of the laws will probably be tested in the courts, and because it will take several years to develop a data base that can provide a more exact measurement of the actual impact on premiums of a particular state law or laws.

Paul W. Earle
Vice President

attchs.

SUMMARY OF LEGISLATIVE OR ADMINISTRATIVE MALPRACTICE ACTIVITIES
AT THE STATE LEVEL AS OF JUNE 19, 1975

Attachment 2/1

Table 1A

ACTION	NO. OF STATES	STATE
AD DAMNUM	2	Florida, Tennessee (Limited)
COLLATERAL SOURCE	2	Nevada, New York
CONTINGENCY FEES	4	Idaho, Indiana, New Jersey, Tennessee
INFORMED CONSENT	6	Florida, Idaho, Indiana, Nevada, New York, Tennessee
LIMITATION ON LIABILITY	3	Florida, Idaho, Indiana
JUA OR MUTUAL INSURANCE COMPANY	15	Arkansas, Florida, Idaho, Maine, Maryland, Massachusetts, New Hampshire, New York, North Carolina, North Dakota, Rhode Island South Carolina, Tennessee, Texas, Wisconsin.
PATIENT COMPENSATION FUND OR LIABILITY FUND	5	Florida, Indiana, Maryland, Nevada, New York
SCREENING PANELS OR REVIEW BOARDS	6	Florida, Indiana, Massachusetts, Nevada, New York, Tennessee
STATUTE OF LIMITATION	10	Florida, Indiana, Maryland, Massachusetts, Nevada, New York, South Dakota, Tennessee, Texas, Utah.
STUDY COMMISSION*	12	Connecticut, Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New Mexico, Rhode Island, South Carolina, Texas, Virginia Wyoming.

* Indicates a separate entity or act from those contained in JUA functions.

JND/7/75

STATE MALPRACTICE INSURANCE ACTIVITIES

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF JUNE 19, 1975	CURRENT LEGISLATIVE PROPOSALS			NO ACTIVITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
REGION 1					
Connecticut	Study commission				
Maine	JUA Study commission				
Massachusetts	JUA; Statute of limitations; screening panel. Study commission				
New Hampshire	JUA Study commission				
Rhode Island	House established Study commission; Governor's Blue Ribbon Commission. JUA established out of Governor's office - will not need leg. action.			Freeze rates; no ad damnum in suits; statute of limitations; dollar limit on claims, arbitration.	
Vermont					X
REGION 2					
New Jersey	Study commission; contingency fee limits (judiciary).	Dollar limits on claims			
New York	JUA & Med. Society JUA, Statute of Limitation, Informed consent, collateral source, professional review.				
Pennsylvania				Approach similar to Indiana; JUA	

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF JUNE 19, 1975	CURRENT LEGISLATIVE PROPOSALS			NO ACTIVITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
REGION 3					
Delaware					X
District of Columbia					X (some discuss)
Kentucky	Study commission (governor appointed)				
Maryland	Insurance company for physicians, not hospitals; prof. liability fund, statute of limitations.				
North Carolina	JUA				
Virginia	Study commission				
W. Virginia			Arbitration; dollar limits on claims; elim. or limits on punitive damages		
REGION 4					
Alabama		Dollar limits on claims; statute of limitations; compensation plan; arbitration			
Florida	Joint underwriting assn.; statute of limitations, ad damnum, limited liability for provider, patient comp fund, medical practice reviews, mediation panels				

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF JUNE 19, 1975	CURRENT LEGISLATIVE PROPOSALS			N ACTIV... REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
Georgia					X
Mississippi			Dollar limits on claims; statute of limitations; elim. or limits on punitive damages.		
Puerto Rico					X
South Carolina	Study commission JUA - Can be invoked for any category; physicians participating, hospitals eminent; exclusive right to issue ins. to each category.				
Tennessee	Statute of limitations, review board, burden of proof on claimant, contingency fees. JUA.				
REGION 5					
Illinois		JUA; dollar limits on claims; statute of limitations; arbitration; limits on punitive damages.			
Indiana	Limitation of recovery; limitation of liability for indiv. provider; statute of limitations; patient compensation fund; screening panel admissible as evidence in court proceedings.				

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF JUNE 19, 1975	CURRENT LEGISLATIVE PROPOSALS			NO ACTIVITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
Michigan	Risk insurance pool	Statute of limitations; arbitration; collateral source; affadavit of merit.			
Ohio		JUA; statute of limitations; binding arbitration (if M.D. & patient agree) (parts have chance)			
Wisconsin	Joint underwriting assn.	Statute of limitations (passed House, in Senate); "claims made" provision.			
REGION 6 Iowa		Bill awaiting Governor's signature; Informed consent; statute of limitations; JUA; review panel; collateral source, contingency fee limits, elim. of ad damnum			
Kansas	Annual insurer reports on suits; inclusion of phys. assts. under Good Samaritan Act.		Statute of limitations; arbitration; certain med staff records privileged.		
Minnesota			Screening panel; dollar limits on claims; statute of limitations; contingency fee limits.		
Missouri		Authorization to estab. mutual assessment Ins. Co.			

STATE	LEGISLATIVE OF ADMIN. ACTIONS ALREADY IN EFFECT AS OF JUNE 19, 1975	CURRENT LEGISLATIVE PROPOSALS			NO ACTIVITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
Nebraska					X
North Dakota	Mutual Insurance Company for physician coverage				X
South Dakota	Statute of limitations				
REGION 7					
Arkansas	High risk pool or JUA, dollar limits on premiums issued by JUA, arbitration				
Louisiana	Elim. or limit on punitive damages.	High risk pool or JUA: dollar limits on claims; statute of limitations; arbitrations.		Compensation plan; collateral source; burden of proof; 60-day advance notice of claims.	
Oklahoma				Statute of limitations; elim. or limits on punitive damages; collateral source.	
Texas	JUA, Regulation of rates, Study commission, statute of limitations.				
REGION 8					X
Colorado					
Idaho	Dollar limits on claims; elim. or limits on punitive damages; informed consent, licensure, contingency fee maximum, JUA - exclusive for phys. not for hospitals				

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF JUNE 19, 1975	CURRENT LEGISIATIVE PROPOSALS			NO ACTIVITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
Arizona		Arbitration (admin. program similar to Illinois' under consid)			
Montana					
New Mexico	Study commission (House appointed)				
Utah	Statute of limitations			Arbitration; contingency fee limits	
Wyoming	Study commission				
REGION 9					
Alaska		JUA		Dollar limits on claims; elim. or limits on punitive damages.	
California		High risk pool or JUA; compensation plan; collateral source rule; periodic payments; contingency fee limits.	Statute of limitations; no-fault; arbitration		
Hawaii		Contingency fee limits and insurance pool (passed House & Senate -- awaiting governor's signature)			
Nevada	Insurance pool, statute of limitations; compensation plans; screening panel; Good Samaritan law; collateral source; standards of evidence; (Cont'd on next page)				

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF JUNE 19, 1975	CURRENT LEGISLATIVE PROPOSALS			NO ACTIVITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
Nevada (Cont'd)	informed consent; physician licensure; ability of legally disabled to bring suit.				
Oregon		Dollar limits on claims; statute of limitations; physician licensure; contingency fee limits; informed consent.			
Washington		Statute of limitations; arbitration (admin.); physician licensure.			

6/75
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Table 2A

SUMMARY OF STATE MALPRACTICE INSURANCE MARKET CONDITIONS
AS OF JUNE 19, 1975

NUMBER OF CARRIERS STILL OFFERING SOME HOSPITAL COVERAGE	NUMBER OF STATES	STATE
1	8	Alaska, Arkansas, California, Colorado, Florida, Kentucky, North Carolina, Tennessee
2	11	Hawaii, Iowa, Maryland, Minnesota, Nevada, New Mexico, Rhode Island, Oregon, Utah, Vermont, Virginia.
3	9	Idaho, Massachusetts, Montana, North Dakota, South Carolina, South Dakota, Washington, West Virginia, Wyoming.
4	4	Arizona, Maine, New Hampshire, Texas
More than 4	11	Kansas, Illinois, Indiana, Michigan, Missouri, Nebraska, Louisiana, New York, Ohio, Oklahoma, Wisconsin.
Information not available	7	Alabama, Connecticut, Delaware, Georgia, Mississippi, New Jersey, Pennsylvania.

JND/7/75

Attachment 1

Table 2B

LIST OF CARRIERS ISSUING HOSPITAL MALPRACTICE INSURANCE COVERAGE

Aetna

Allstate

Ambassador

Appalachia

Argonaut

Bellefonte

Comm. Union

Continental
* Buckeye

Chubb & Son
* Federal

Employers Mutual of Wausau

Farmers
* Truck

Fireman's Fund

Glacier Nat. (Ltd.)

Hartford

Home

Imperial

INA
* Calif. Union

Ind. Fund Hazard

Kemper
* Lumbermans

Lloyds of London

N.H. Group

Med. Soc. Captive (New York)

Ohio Casualty

Professional Mutual

Reliance

Royal Globe

Shelby Mutual

St. Paul

Travelers

U.S.F. & G.

U.S. Fire

Western Casualty & Surety

Total Carriers: 32

* These companies are essentially the same as the parent company.

JND/7/75

Attachment 3/3

Table 2C/1

SURVEY OF STATE MALPRACTICE INSURANCE MARKET CONDITIONS

STATE	CARRIER	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
REGION #1						
Connecticut						Contracts expire 1977
Maine	Hartford Comm. Union St. Paul U.S.F. & G.					JUA 6/75.
Massachusetts	Hartford Argonaut St. Paul Lumbermans Traveler's		X	 X X	100-500%	JUA 7/75
New Hampshire	Hartford St. Paul U.S. Fidelity Argonaut N.H. Group	 X X 	X	 X 		Not good. JUA 6/75
Rhode Island	St. Paul Aetna Travelers	 X		X	420%	Upper limit umbrella problem, not basic. JUA
Vermont	St. Paul Hartford Continental Argonaut		 X X 	X X	200 - 500%	No viable market.
REGION #2						
New York	Argonaut Med. Soc. Captive Glacier Nat.(Ltd.) Federal St. Paul Hartford Continental		 X X X X X X	X		July 1, 1975 JUA's operative.

STATE	CARRIER	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
New Jersey						Considering captive. Prices up especially umbrella coverage.
Pennsylvania						Coverage available through 1975.
REGION #3						
Delaware					Part of N.J. Program.	
D. of C.	St. Paul				179 - 652%	Influx from Maryland due to dropped physician coverage may cause problems.
Kentucky	Ambassador*				250%	Stable
Maryland	U.S.F.& G. INA				U.S.F.&G. Not yet announced rates. Seem to be O.K.	Coverage available through 1975. JUA.
North Carolina	St. Paul* Employer's Mutual*			X	Not significant.	Talk of switching to "claims made" with increases averaging 280% JUA 10/75
Virginia	Continental* St. Paul*	X X			300%	Coverage available through 1975.

STATE	CARRIER	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
West Virginia	Aetna* Buckeye* Ambassador*				50%	Coverage available through 1975.
REGION #4						
Alabama					200%	Limited Market
Florida	Glacier Nat.		X		100%	JUA 7/75
Georgia						
Mississippi					250 - 400	
Puerto Rico						
S. Carolina	U.S.F. & G. Hartford Employers of Wausau St. Paul - Phys.	X X		X	60%	JUA 6/75
Tennessee	Bellefonte	X			Up to 600%	JUA 7/75
REGION #5						
Illinois	INA Argonaut Continental Hartford Ambassador Bellefonte Aetna St. Paul Employers of Wausau	 X X	X X X X		440%	Companies shrinking size of umbrella coverage. Increased premiums but coverage available.

STATE	CARRIER	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
Indiana	Argonaut		X		200 - 300%	Enacted malpractice law. Law probably will be tested in courts, could create confusion.
	St. Paul		X			
	U.S.F. & G.		X			
	Continental		X			
	Aetna		X			
Michigan	Argonaut		X		600%	Coverage available throughout 1975.
	Continental		X			
	All State					
	St. Paul					
	INA					
	Royal Globe					
	Aetna					
	Hartford					
	Chubb & Son					
Ohio	Buckeye		X		300 - 400%	Increased premiums, but coverage available through 1975.
	St. Paul					
	Shelby Mutual					
	INA					
	Ambassador					
	Royal Globe					
	Aetna					
	U.S.F. & G.					
	Home					
	Travelers					
	Continental					
	Hartford					
	Ohio Casualty					
	Western Cas.					
Wisconsin	Employers of Wausau*				100%	Coverage available through 1975. Excess Hospital coverage may be problem. JUA 6/
	Continental					
	St. Paul					
	Aetna					
	Travelers					
	Hartford					
	INA					

STATE	CARRIERS	NO NEW BUSINESS	NEW BUSINESS	CANCELIATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
REGION #6						
Iowa	St. Paul*	X			500 - 600%	Depends on actions of St. Paul
	Prof. Mutual	X				
Kansas	St. Paul		X		300%	Coverage available through 1975.
	U.S.F. & G.		X			
	Aetna		X			
	Continental		X			
	Western Cas.		X			
	Surrity		X			
Minnesota	St. Paul*	X			300 - 600%	Coverage available through 1975.
	Argonaut*	X				
Missouri	St. Paul		X		300%	Coverage available through 1975.
	Argonaut		X			
	Kemper		X			
	Continental		X			
	Aetna		X			
	Hartford		X			
	Prof. Mutual		X			
Nebraska	Hartford	X			300 - 350%	Coverage available through 1975.
	St. Paul*	X				
	Continental*		X			
	Lloyds*		X			
N. Dakota	St. Paul*		X			Mutual Ins. Co. for physicians.
	Continental*		X			
	Ins. Co. NA		X			
S. Dakota	St. Paul		X		400%	Coverage available through 1975.
	Continental		X			
	Employers of Wausau		X			

Attachment 3/8

Table 2C/6

STATE	CARRIERS	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
REGION #7						
Arkansas	St. Paul		X	X	Depends on Reinsurance Act.	Depends on reinsurance Act. JUA.
Louisiana	St. Paul			X	100 - 400%	Available through 1975.
	Hartford			X		
	Ambassador*					
	Continental					
	Calif. Union					
	Bellefonte		X			
	Ind. Fund		X			
	Hazard		X			
	INA		X			
	Aetna		X			
	Appalachia		X			
	Reliance		X			
	Travelers		X	X		
	Argonaut			X		
Oklahoma	St. Paul	X				
	Continental	X		X		Coverage available through 1975.
	Travelers	X				
	U.S.F. & G.	X				
	Aetna	X				
	INA	X				
Texas	Argonaut		X		300 - 400%	Problem may be getting basic to go up to lower umbrella limits. JUA 8/75.
	U.S. Fire		X			
	Hartford					
	St. Paul					
REGION #8						
Arizona	Farmers	X			120%	Potential probl if urban hospita lose coverage.
	St. Paul	X				
	Travelers	X				
	Imperial	X				

Attachment 3/9

Table 2C/7

STATE	CARRIERS	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
Colorado	St. Paul	X				Coverage available through 1975.
Idaho	Argonaut		X		300%	Coverage available through 1975. JUA 6/75
	Farmers		X			
	Aetna					
Montana	Farmers		X		80 - 100%	Coverage available through 1975.
	Aetna		X			
	Argonaut		X	X		
	U.S.F. & G.		X			
New Mexico	St. Paul		X		75 - 100%	Leg. Study Committee
	Aetna					
Utah	INA	X			150 - 200%	
	Aetna	X				
Wyoming	U.S.F. & G.	X				Study Committee
	Hartford		X			
	St. Paul	X				
REGION #9						
Alaska	Fireman's Fund		X		37% ↓	Coverage available through 1975.
California	Farmers		X		150 - 185	Coverage available through 1975.
Hawaii	Argonaut*				300%	Phys. not renewed at end of year. Hospital coverage available through 1975.
	Truck (Kaiser)		X			
Nevada	Argonaut - Phys.,		X			Coverage ava able through 1975.
	Truck - Hosp.		X			

Table 2C/8

STATE	CARRIERS	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
Oregon	Farmers St. Paul		X		170%	Coverage available through 1975.
Washington	Farmers Aetna (Phys) Continental		X	 X	300%	Coverage available through 1975. Premium on monthly basis.

Note:
* Identified as a major carrier.

Information obtained from State Hospital Association Survey, update 6/19/75

JND

Aetna malpractice insurance rates jump 271 percent; severe losses cited

A.O.A. News
June 15, 197.
Page 1.

(St. Louis, MO) Optometric malpractice insurance premiums from Aetna insurance company—stable at $16 from 1960 to 1974 when they were raised to $28—will take a 271 percent jump to $104 effective June 16.

Aetna Life and Casualty, which handles the majority of all optometric malpractice insurance and the AOA endorsed professional liability package, further announced that their malpractice coverage will no longer be available to non-AOA members.

According to D. John Pecorino of Aetna, the rate hike is due to "the increase costs Aetna has sustained in providing optometric malpractice coverage."

Although Pecorino was unable to make public the number of malpractice suits filed during the past year and the amount of awards granted plaintiffs, he did say that there have been "several severe losses." One optometric malpractice suit, he said, resulted in an award of over $100,000 to the plaintiff.

Pecorino explained the optometric malpractice situation by saying that "this is the age of consumerism. If Mr. and Mrs. John Q. Public are not satisfied, they do not hesitate to bring a lawsuit. In addition, as optometrists become more knowledgeable and assume new roles of responsibility, they are exposed to additional hazards which bring about lawsuits."

Concerning Aetna's new policy toward non-AOA members, Pecorino said "as laymen, we have no way of judging professional competence of optometrists, so we rely on AOA to do this. In other words, we (Aetna) will not knowingly insure an optometrist who is not a member of AOA."

In an effort to educate optometrists to the malpractice menace, Pecorino explained the present situation and offered advice on how optometrists can avoid the "chilling experience of a malpractice suit." The situation, he said, "is fast becoming more and more precarious" for doctor and insuror alike.

Pecorino, an attorney, explained that insurance companies face one of four situations when a claim is presented against a doctor they insure.

If the insurance company feels that the doctor is liable for damages sustained by a patient claimant, the company will try to get the insured doctor's consent and try to settle the case for

(Continued on page 14)

AH

[No. 42775. En Banc. MAR 14 1974

MORRISON P. HELLING et al., Petitioners, v. THOMAS F. CAREY et al., Respondents.

[1] Physicians and Surgeons--Malpractice--Standard of Care--Standard of Profession--Insufficiency--Effect. A physician may be guilty of negligence, even though he adheres to that standard of care and skill expected of the average practitioner in the class to which he belongs, if reasonable prudence requires a higher degree of care. In determining whether reasonable prudence requires care not ordinarily exercised by the average practitioner, the court will consider the complexity and cost of the additional care, its risks if any, its reliability, and the consequences of failure to exercise the care.

[2] Physicians and Surgeons--Malpractice--Standard of Care--Standard of Profession--Glaucoma. A skilled and qualified ophthalmologist is negligent in not routinely giving a test for glaucoma to all persons suffering any eye discomfort, notwithstanding that the standard of the profession does not require the routine giving of such test to persons under the age of 40, since although glaucoma is found in only one out of every 25,000 persons under the age of 40, the test is simple, inexpensive, and harmless, and the consequences of the disease going undetected is irreversible

blindness.

Utter, Finley, and Hamilton, JJ., concur by separate opinion.

Review of a decision of the Court of Appeals, February 5, 1973, 8 Wn. App. 1005. Reversed.

The Court of Appeals affirmed, by unpublished opinion, a judgment of the Superior Court for King County, No. 714089, Howard J. Thompson, J., entered December 18, 1970. The appellant (plaintiff) petitioned the Supreme Court for review.

Action for medical malpractice. The plaintiff appealed to the Court of Appeals from a judgment entered on a verdict in favor of the defendants.

Attachment 4

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

MORRISON P. HELLING and BARBARA HELLING, his wife,	)	NO. 42775
Petitioners,	)	EN BANC
v..	)	
THOMAS F. CAREY and ROBERT C. LAUGHLIN,	)	
Respondents.	)	Filed MAR 14 1974

This case arises from a malpractice action instituted by the plaintiff (petitioner), Barbara Helling.

The plaintiff suffers from primary open angle glaucoma. Primary open angle glaucoma is essentially a condition of the eye in which there is an interference in the ease with which the nourishing fluids can flow out of the eye. Such a condition results in pressure gradually rising above the normal level to such an extent that damage is produced to the optic nerve and its fibers with resultant loss in vision. The first loss usually occurs in the periphery of the field of vision. The disease usually has few symptoms and, in the absence of a pressure test, is often undetected until the damage has become

extensive and irreversible.

The defendants (respondents), Dr. Thomas F. Carey and Dr. Robert C Laughlin, are partners who practice the medical specialty of ophthalmology. Ophthalmology involves the diagnosis and treatment of defects and diseases of the eye.

The plaintiff first consulted the defendants for myopia, nearsightedness, in 1959. At that time she was fitted with contact lenses. She next consulted the defendants in September, 1963, concerning irritation caused by the contact lenses. Additional consultations occurred in October, 1963; February, 1967; September, 1967; October, 1967; May, 1968; July, 1968; August, 1968; September, 1968; and October, 1968. Until the October 1968 consultation, the defendants considered the plaintiff's visual problems to be related solely to complications associated with her contact lenses. On that occasion, the defendant, Dr. Carey, tested the plaintiff's eye pressure and field of vision for the first time. This test indicated that the plaintiff had glaucoma. The plaintiff, who was then 32 years of age, had essentially lost her peripheral vision and her central vision was reduced to approximately 5 degrees vertical by 10 degrees horizontal.

Thereafter, in August of 1969, after consulting other physicians, the plaintiff filed a complaint against the defendants alleging, among other things, that she sustained severe and permanent damage to her eyes as a proximate result of the defendants' negligence. During trial, the testimony of the

medical experts for both the plaintiff and the defendants established that the standards of the profession for that specialty in the same or similar circumstances do not require routine pressure tests for glaucoma upon patients under 40 years of age. The reason the pressure test for glaucoma is not given as a regular practice to patients under the age of 40 is that the disease rarely occurs in this age group. Testimony indicated, however, that the standards of the profession do require pressure tests if the patient's complaints and symptoms reveal to the physician that glaucoma should be suspected.

The trial court entered judgment for the defendants following a defense verdict. The plaintiff thereupon appealed to the Court of Appeals, which affirmed the judgment of the trial court. Helling v. Carey, No. 1185-41918-1 (Wn. App., filed Feb. 5, 1973). The plaintiff then petitioned this Court for review, which we granted.

In her petition for review, the plaintiff's primary contention is that under the facts of this case the trial judge erred in giving certain instructions to the jury and refusing her proposed instructions defining the standard of care which the law imposes upon an ophthalmologist. As a result, the plaintiff contends, in effect, that she was unable to argue her theory of the case to the jury that the standard of care for the specialty of ophthalmology was inadequate to protect the plaintiff from the incidence of glaucoma, and that the defendants, by reason of their special ability, knowledge and

information, were negligent in failing to give the pressure test to the plaintiff at an earlier point in time which, if given, would have detected her condition and enabled the defendants to have averted the resulting substantial loss in her vision.

We find this to be a unique case. The testimony of the medical experts is undisputed concerning the standards of the profession for the specialty of ophthalmology. It is not a question in this case of the defendants having any greater special ability, knowledge and information than other ophthalmologists which would require the defendants to comply with a higher duty of care than "that degree of care and skill which is expected of the average practitioner in the class to which he belongs, acting in the same or similar circumstances." Pederson v. Dumouchel, 72 Wn.2d 73, 79, 431 P.2d 973 (1967). The issue is whether the defendants' compliance with the standard of the profession of ophthalmology, which does not require the giving of a routine pressure test to persons under 40 years of age, should insulate them from liability under the facts in this case where the plaintiff has lost a substantial amount of her vision due to the failure of the defendants to timely give the pressure test to the plaintiff.

The defendants argue that the standard of the profession, which does not require the giving of a routine pressure test to persons under the age of 40, is adequate to insulate the defendants from liability for negligence because the risk of

glaucoma is so rare in this age group. The testimony of the defendant, Dr. Carey, however, is revealing as follows:

> Q. Now, when was it, actually, the first time any complaint was made to you by her of any field or visual field problem? A. Really, the first time that she really complained of a visual field problem was the August 30th date. [1968] Q. And how soon before the diagnosis was that? A. That was 30 days. We made it on October 1st. Q. And in your opinion, how long, as you now have the whole history and analysis and the diagnosis, how long had she had this glaucoma? A. I would think she probably had it ten years or longer. Q. Now, Doctor, there's been some reference to the matter of taking pressure checks of persons over 40. What is the incidence of glaucoma, the statistics, with persons under 40? A. In the instance of glaucoma under the age of 40, is less than 100 to one per cent. The younger you get, the less the incidence. It is thought to be in the neighborhood of one in 25,000 people or less. Q. How about the incidence of glaucoma in people over 40? A. Incidence of glaucoma over 40 gets into the two to three per cent category, and hence, that's where there is this great big difference and that's why the standards around the world has been to check pressures from 40 on.

The incidence of glaucoma in one out of 25,000 persons under the age of 40 may appear quite minimal. However, that one person, the plaintiff in this instance, is entitled to the same protection, as afforded persons over 40, essential for timely detection of the evidence of glaucoma where it can be arrested to avoid the grave and devastating result of this disease. The test is a simple pressure test, relatively inexpensive. There is no judgment factor involved, and there is no doubt that by giving the test the evidence of glaucoma can be detected. The giving of the test is harmless if the physical condition of the eye permits. The testimony indicates that although the condition of the plaintiff's eyes might have at times prevented the defendants from administering the pressure test, there is an absence of evidence in the record that the test could not have been timely given.

Justice Holmes stated in Texas & Pac. Ry. v. Behymer, 189 U.S. 468, 470, 47 L. Ed. 905, 23 S. Ct. 622 (1903):

> What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not.

In The T. J. Hooper, 60 F.2d 737 (2d Cir. 1932), Justice Hand stated on page 740:

> [I]n most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.

(Italics ours.)

Under the facts of this case reasonable prudence required the timely giving of the pressure test to this plaintiff. The precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the opthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma.

We therefore hold, as a matter of law, that the reasonable standard that should have been followed under the undisputed facts of this case was the timely giving of this simple, harmless pressure test to this plaintiff and that, in failing to do so, the defendants were negligent, which proximately resulted in the blindness sustained by the plaintiff for which the defendants are liable.

There are no disputed facts to submit to the jury on the issue of the defendants' liability. Hence, a discussion of the plaintiff's proposed instructions would be inconsequential in

view of our disposition of the case.

The judgment of the trial court and the decision of the Court of Appeals is reversed, and the case is remanded for a new trial on the issue of damages only.

WE CONCUR:

HALE, C.J.

ROSELLINI, J.

STAFFORD, J.

WRIGHT, J.

BRACHTENBACH, J.

No. 42775

UTTER, J. (concurring)--I concur in the result reached by the majority. I believe a greater duty of care could be imposed on the defendants than was established by their profession. The duty could be imposed when a disease, such as glaucoma, can be detected by a simple, well-known harmless test whose results are definitive and the disease can be successfully arrested by early detection, but where the effects of the disease are irreversible if undetected over a substantial period of time.

The difficulty with this approach is that we as judges, by using a negligence analysis, seem to be imposing a stigma of moral blame upon the doctors who, in this case, used all the precautions commonly prescribed by their profession in diagnosis and treatment. Lacking their training in this highly sophisticated profession, it seems illogical for this court to say they failed to exercise a reasonable standard of care. It seems to me we are, in reality, imposing liability, because, in choosing between an innocent plaintiff and a doctor, who acted reasonably according to his specialty but who could have prevented the full effects of

this disease by administering a simple, harmless test and treatment, the plaintiff should not have to bear the risk of loss. As such, imposition of liability approaches that of strict liability.

Strict liability or liability without fault is not new to the law. Historically, it predates our concepts of fault or moral responsibility as a basis of the remedy. Wigmore, Responsibility for Tortious Acts: Its History, 7 Harv. L. Rev. 315, 383, 441 (1894). As noted in W. Prosser, The Law of Torts § 74 (3d ed. 1964) at pages 507, 508:

> There are many situations in which a careful person is held liable for an entirely reasonable mistake. . . . in some cases the defendant may be held liable, although he is not only charged with no moral wrongdoing, but has not even departed in any way from a reasonable standard of intent or care. . . . There is "a strong and growing tendency, where there is blame on neither side, to ask, in view of the exigencies of social justice, who can best bear the loss and hence to shift the loss by creating liability where there has been no fault."

(Footnote omitted.) Tort law has continually been in a state of flux. It is "not always neat and orderly. But this is not to say it is illogical. Its central logic is the logic that moves from premises--its objectives--that are only partly consistent, to conclusions--its rules--that serve each objective as well as may be while serving others too. It is the logic of maximizing service and minimizing disservice to multiple objectives." Keeton, Is There a Place for Negligence in Modern Tort Law?, 53 Va. L. Rev. 886, 897 (1967).

When types of problems rather than numbers of cases are examined, strict liability is applied more often than negligence as a principle which determines liability. Peck, Negligence and Liability Without Fault in Tort Law, 46 Wash. L. Rev. 225, 239 (1971). There are many similarities in this case to other cases of strict liability. Problems of proof have been a common feature in situations where strict liability is applied. Where events are not matters of common experience, a juror's ability to comprehend whether reasonable care has been followed diminishes. There are few areas as difficult for jurors to intelligently comprehend as the intricate questions of proof and standards in medical malpractice cases.

In applying strict liability there are many situations where it is imposed for conduct which can be defined with sufficient precision to insure that application of a strict liability principle will not produce miscarriages of justice in a substantial number of cases. If the activity involved is one which can be defined with sufficient precision, that definition can serve as an accounting unit to which the costs of the activity may be allocated with some certainty and precision. With this possible, strict liability serves a compensatory function in situations where the defendant is, through the use of insurance, the financially more responsible person. Peck, Negligence and Liability Without Fault in Tort Law, supra at 240, 241.

If the standard of a reasonably prudent specialist is, in

fact, inadequate to offer reasonable protection to the plaintiff, then liability can be imposed without fault. To do so under the narrow facts of this case does not offend my sense of justice. The pressure test to measure intraocular pressure with the Schiotz tonometer and the Goldman applanometer takes a short time, involves no damage to the patient, and consists of placing the instrument against the eyeball. An abnormally high pressure requires other tests which would either confirm or deny the existence of glaucoma. It is generally believed that from 5 to 10 years of detectable increased pressure must exist before there is permanent damage to the optic nerves.

Although the incidence of glaucoma in the age range of the plaintiff is approximately one in 25,000, this alone should not be enough to deny her a claim. Where its presence can be detected by a simple, well-known harmless test, where the results of the test are definitive, where the disease can be successfully arrested by early detection and where its effects are irreversible if undetected over a substantial period of time, liability should be imposed upon defendants even though they did not violate the standard existing within the profession of ophthalmology.

The failure of plaintiff to raise this theory at the trial and to propose instructions consistent with it should not deprive her of the right to resolve the case on this theory on appeal. Where this court has authoritatively stated the law, the parties are bound by those principles until they have been overruled.

Acceptance of those principles at trial does not constitute a waiver or estop appellants from adapting their cause on appeal to such a rule as might be declared if the earlier precedent is overruled. Samuelson v. Freeman, 75 Wn.2d 894, 900, 454 P.2d 406 (1969).

WE CONCUR

FINLEY, J.

HAMILTON, J.

Attachment L

THE HELLING DECISION: DAMNED IF YOU DO AND DAMNED IF YOU DON'T!

This new court ruling says you better take tonometry tests on all patients, regardless of age. And that can spiral your fees.

By Harry J. Doyle, LL.B.

■ **Should you perform tonometry** tests on all patients, regardless of age?

■ Can a court in a malpractice proceeding require a higher standard of care and practice from a doctor than those standards established by the doctor's own profession or specialty?

■ Is it possible for a doctor, without proof that he was negligent, to be liable for injuries suffered by a patient?

A recent decision by the Supreme Court of Washington State, which has been widely discussed in health and legal circles, clearly answered "yes" to all these questions. The six-judge majority of the Washington Court* held that ophthalmologists are liable for injuries caused by glaucoma which went undetected because the patient, during the ages between 23 and 32, was not administered a tonometry test. In a concurring decision, a three judge minority of the Court broke new legal turf by holding that ophthalmologists are "strictly liable" -- that is, liable without proof of fault — for failure to perform tonometry tests on any patient, even though the standard of a "reasonable prudent specialist" existing within the profession of ophthalmology did not require such a test.

*Helling vs. Carey, 519 p. 2d. 981 (Wash. 1974)

Precedents Merit Attention

Although the Court's decision is binding only on ophthalmologists practicing in the State of Washington, it deserves close attention from all optometrists and, indeed, all health practitioners, no matter where they practice. The precedents enunciated by the majority and minority in *Helling v. Carey* have received sizable legal attention. They will invariably find their way into plaintiff complaints and briefs and, as a result, will have to be weighed and could be adopted by other state courts.

The Facts

In 1959, Barbara Helling, then 23 years old, consulted partners who practiced ophthalmology and was fitted with contact lenses for myopia. During the next nine years she consulted with the same ophthalmologists ten times concerning visual problems, which were considered to be complications connected with her contact lenses. On her eleventh visit, in October of 1968, one of the partners tested her eye pressure and field of vision for the first time.

The tests indicated primary open angle glaucoma. Miss Helling, then 32 years

old, had lost her perpheral vision and her central vision was reduced to 5 degrees vertical by 10 degrees horizontal. She brought suit against the M.D.s, maintaining that they had breached their duty of care by failing to administer a tonometry test in time and that, as a result of such failure, she had sustained permanent damage to her eyes and, as a consequence, incurred economic loss.

The ophthalmologists countered by arguing that they had not breached the standard of care and skill ordinarily possessed and exercised by ophthalmologists acting in the same or similar circumstances. They established, through expert testimony, that the standards of the profession of ophthalmology do not require the giving of a routine pressure test to persons under 40 years of age, since the incidence of glaucoma under age 40 is 1 in 25,000. They pointed out that, since they are entitled to be judged according to the tenets of their specialty, they were not guilty of negligence.

The trial court entered judgment for the ophthalmologists. Miss Helling then appealed to the Washington Court of Appeals which affirmed the judgment of the trial court. But the State Supreme Court overruled them both.

The High Court accepted the expert testimony that a tonometry test for glaucoma was not given by ophthalmology as a regular practice for patients under age 40. However, the Court stressed, "it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma". It added that the administration of the test is relatively simple and inexpensive, requiring minimal judgment and that a consequence of not giving the test is often blindness or severe impairment of vision. It ruled that a reasonable standard of care required the giving of a tonometry test, that the ophthalmologists were negligent for not performing the test and that, since their negligence resulted in the injuries sustained, they were therefore liable.

A New Precedent

The Court, in effect, ran roughshod over a sacred legal cow that had allowed health practitioners to document through expert testimony the standards of care established by their respective professions and specialties and, in doing so, to prevent many cases from being subjected to the emotions of the jury. The Court produced a 1932 decision written by one of the lions of American law to support its authority to set higher standards for any calling. It quoted from Learned Hand's opinion in the T.J. Hooper case, a case in which liability was imposed upon tugboat operators for failing to employ radio sets to receive storm warnings, even though such sets were not commonly used in maritime circles. Hand concluded: ". . . A whole calling may have unduly lagged in the adoption of new and available devices . . . Courts must in the end say what is required . . ."

It is, admittedly, a big leap from a two-way radio in a tugboat to a tonometer in an ophthalmologist's office. Courts, however, are not beyond such leaps when the results are consistent with emerging

"As a result of Helling, optometrists may be damned if they do and could be damned if they don't", says Attorney Harry J. Doyle of Philadelphia, Pa. Mr. Doyle was formerly Director of Federal Relations for the American Optometric Association. He is a lecturer at the Pennsylvania College of Optometry on Jurisprudence. He also practices law in Philadelphia and in Washington, D.C.

social policy. Clearly, the decision in *Helling* is indicative of the legal and social concern over the freedom of health professions to set their own standard of conduct. This trend is evidenced in cases dealing with hospital malpractice, where courts have gone beyond hospital accrediting standards and codes of practice and have imposed higher standards. The State of Washington has now extended that trend to health practitioners.

Though *Helling v. Carey* is applicable only in the State of Washington, it can be assumed that the holding will find its way into other states. It is also clear that optometrists fall well within the orbit of the Helling decision.

Application to Optometry

Helling v. Carey can be reduced to the following areas for optometrists:

1) *Tonometry tests should be performed on all patients, regardless of age, unless the physical condition of the patient's eyes or the lack of cooperation by the patient preclude the administration of the test.*

Helling did not specify any age limitation for the administration of a tonometry test. The sweep of the holdings indicate that every patient, however young, should be tested. The Court implied an exception when the physical condition of a patient's eyes precluded the test. The lack of cooperation by a patient during the test might be another exception. It would be wise to document such exceptions in the particular patient's

records. Presumably, the test should be employed routinely.

The scope of *Helling,* with its emphasis upon defensive care, seems to require, at minimum, other relevant tests, especially a visual field, if the tonometry reading appears suspicious in any way. The safest route would include a tonometry and visual field test on every patient, regardless of the tonometry reading. It is assumed that any added costs resulting from the administration of these diagnostic tests can be applied to the practitioner's fee. Any optometric organization negotiating with third party programs should demand reimbursement for all relevant services and diagnostic tests relating to detection of glaucoma.

2) *Whenever a patient persistently complains of distress, be on notice to engage in defensive care by utilizing all appropriate diagnostic tests to determine the problem.*

Although the *Helling* decision did not turn on this issue, the Court was influenced by the numerous complaints of the patient. *Helling* is clear in pointing out that, unless an attempt is made to determine the problem through appropriate diagnostic tests, the practitioner will run the risks of any adverse consequences suffered by the patient. In a time when each patient is a possible claimant, caution should be the rule.

3) *The Court has a duty to determine the standard of care for a health profession either directly by requiring a higher standard of care or indirectly by accepting the profession's standard and holding the practitioner strictly liable for not practicing beyond that standard.*

This is the most far-reaching precedent in *Helling.* For an evolving and expanding profession such as optometry, the precedent could create increased vulnerability.

One scenario comes to mind. An understanding of hypertension and the cardiovascular system, with the resultant ability to administer a blood pressure test, is now an accepted component of an optometry student's curriculum and could become part of his diagnostic procedures as an optometrist. Assume a case arises in 1980 where a patient dies of a stroke as a result of an optometrist's failure to perform a blood pressure test. A court could, accepting optometry's pronouncements as a primary profession and its educational standards, find that such a test was effortless, definitive and inexpensive and, even though such a test was not pervasive among optometrists, could impose, under *Helling,* a higher standard of care on the profession. It's clearly not improbable.

Part of Consumer Movement

Helling is a product of a Court with a moderate image, one not especially known for breaking new legal ground. Their holding is, at bottom, a consumer decision, moored to the times, based upon an awareness that, given liability insurance, the practitioner and not the patient, should bear the loss. It serves to augment the trend towards defensive

care and to feed the inflationary spiral of health services, especially the rising cost syndrome of liability insurance.

Helling is underlined by many social factors. The times urge us to second guess any authority figure, whether they be politicians, corporate executives or health providers. Such currents will lead a moderate Court to arrogate to itself the standard of care of health practitioners.

The consumer movement breeds distrust towards any supplier, including suppliers of health services. Professional licensing boards are considered mere restraints of trade which enable providers to control and increase costs. Professional standards of care are minimal strictures tied to the economics of practice and not to the care of patients. The patients only access to genuine peer review is through malpractice actions where the provider should appropriately bear the loss. Fueled by the diminishing purchasing power of the wage earner's salary, consumerism has translated these indictments into instant rhetoric and political clout.

Fee Considerations

Yet, the health provider is being pressured from all sides—public and private—to hold the line on fees. And the pressure is changing from mere words to possible actions. Many states are considering legislation to obtain a handle on hospital and provider costs. The eventual National Health Insurance program will certainly include strong mechanism for the control of provider fees, as will private third party programs.

It is interesting to assay the increased cost to an optometrist as a result of *Helling*. He will now have to perform tonometry tests and possibly visual fields on all patients. This will increase the time of numerous examinations anywhere from ten to twenty minutes. Active practices may require the employment of a new office assistant. What's more, numerous optometric malpractice actions result from injuries sustained in the administration of a tonometry test. Thus, as a result of *Helling*, optometrists may be damned if they do and could be damned if they don't! Its holding will require optometrists to spend more time with patients and engage in more diagnostic tests, and will increase their vulnerability to liability and probably increase their insurance premiums. The end product is an increased cost in the conduct of their practice.

Clearly, *Helling* does not reflect sound social policy. Its precedents will not create efficiency and quality care within the health delivery system. Even the consumer movement, with its cost consciousness, is beginning to acknowledge that defensive care is expensive to the patient and disruptive to the delivery system. It is time for each of the respective health professions, in conjunction with government, the bar and consumer groups, to address the malpractice issue and to create approaches which are equitable to the providers and consumers of health services.

A few more *Hellings* and the opportunity may have passed! OM

Attachment 3

KANSAS OPTOMETRIC STANDARDS

9600 - VISUAL ACUITY TESTING

A. Standards of Care -

(1) Distance visual acuity determined for each eye separately and both together with or without any prior prescription worn by the patient.

(2) Near distance visual acuity determined for each eye separately and both together with or without a prior prescription.

The following procedures may be included:

a. Color discrimination testing.

b. Confrontation fields.

c. Other visual efficiency tests such as the D.B. series, etc.

B. Standards of Equipment -

(1) Instrumentation or charts necessary to accurately determine visual acuity that may be converted to Snellen standards at distance and near. For color discrimination tests, Ishihara or comparable color plates, or other comparable color tests shall be used.

C. Standards of Records -

(1) Recording of Snellen equivalent for distance and near according to Standards of Care.

9601 - EXTERNAL EXAMINATION

A. Standards of Care -

(1) Observation of pupil size, shape, equality, color and responses; direct, consensual, and accommodative.

(2) Conjuctival inspection including injection, tearing, debris, growths and cysts.

(3) Palpebral inspection including Cilia, Meibomion glands and Punctum.

(4) Tactile inspection: The palpation of the globe for freedom of movement, internal tension, and obvious growths.

(5) Voluntary eye movements (versions).

The following procedures may be included:

a. Blink habits including rate and strength.

b. Iris color

B. Standards of Equipment -

(1) Proper illumination and magnification equipment as necessary.

C. Standards of Records -

(1) Recording of normal or the deviations from normal.

9602 - REFRACTION

A. Standards of Care -

(1) Objective testing: Accurate objective determination of the refractive status.

(2) Subjective testing: Determination of the refractive status of each eye separately. It is performed at a test distance of both far and near.

B. Standards of Equipment -

(1) Adequate retinoscope or other equipment.

(2) Trial frame, lenses, or phoropter and visual acuity charts, projected or real.

C. Standards of Records -

(1) Recording of any objective and subjective findings and resulting acuity.

9603 - COORDINATION TESTING

A. Standards of Care -

NOTE: This involves a subjective far point balance test and a subjective near point balance test and an investigation of functions of accommodations and convergence. It is usually concerned with binocular testing; but, may in restricted versions, or one eye conditions, be concerned with only one eye.

It may include all or some of the following procedures:

(1) Balance at far distance (Duochrome, equal prism, Turville, Stereo, etc.)

(2) Plus and minus acceptance at near to blur.

(3) Cross cylinder tests.

(4) Phoria tests at far and near.

(5) Vergencies (blur, break, recovery) far and near.

(6) Stereopsis.

(7) Cover test-objective and subjective.

B. Standards of Equipment -

(1) Adequate trial frame, prisms, lenses, or phoropter and charts, projected or real.

C. Standards of Records -

(1) Recording of findings.

9604 - OPTHALMOSCOPY EXAMINATION

A. Standards of Care -

(1) Examination of the cornea, anterior chamber, lens, vitreous body, optic disc, fundus vessels, and fundus with the ophthalmoscope.

B. Standards of Equipment -

(1) Any self-illuminated operable ophthalmóscope.

C. Standards of Records -

(1) Recording of findings.

9607 - OPHTHALMOMETRY OR KERATOMETRY

A. Standards of Care -

(1) The examination and measurement of the anterior reflecting surface of the eye with the ophthalmometer or keratometer.

B. Standards of Equipment -

(1) Any operable ophthalmometer or keratometer.

C. Standards of Records -

(1) Recording of findings

9608 - BIOMICROSCOPY EXAMINATION

A. Standards of Care -

(1) The examination of the anterior segment of the eye including the lids, cornea, anterior chamber, iris, and lens with the biomicroscope.

B. Standards of Equipment -

(1) Any operable biomicroscope.

C. Standards of Records -

(1) Recording of normal or the deviations from normal.

9610 - Tonometry

A. Standards of Care -

(1) A determination of the intraocular pressure of the eye.

B. Standards of Equipment -

(1) Any operable tonometer or electronic device to determine the intraocular pressure.

C. Standards of Records -

(1) Recording of the intraocular pressure.

9612 - MULTIPLE PATTERN FIELDS OR VISUAL FIELDS SCREENING

A. Standards of Care -

(1) A "Screening" test in order to quickly appraise the ability of a patient to perceive extra-foveally.

B. Standards of Equipment -

(1) Any operable equipment.

C. Standards of Records -

(1) Recording of normal or the deviations from normal.

9613 - PLOTTED FIELDS

A. Standards of Care -

(1) A careful evaluation and plotting of the ability of a patient to perceive extra-foveally.

B. Standards of Care -

(1) Any operable equipment.

C. Standards of Records -

(1) The field chart and testing conditions must be included with the case records.

9614 - ORTHOPTIC OR VISUAL TRAINING EVALUATION

A. Standards of Care -

(1) Orthoptic evaluation means the objective and subjective determination of the failure of the two eyes of a patient to consistently point to the object of regard. It includes the measurement and direction of the deviation. It further includes the probable cause of the failure and the prognosis with any indicated treatment.

(2) Visual Training evaluation means the work up of a visual training problem which will lead to rehabilitation of the visual process. This includes the evaluation of a developmental vision case.

B. Standards of Equipment -

(1) Instrumentation or equipment to execute the procedure prescribed.

C. Standards of Records -

(1) Recording of any objective or subjective findings made in this evaluation.

(2) Recording of any indicated treatment or visual training routine prescribed and probable prognosis.

(3) Subsequent recording of progress from training or treatment.

9615-9616-9617 - VISUAL TRAINING THERAPY

A. Standards of Care -

(1) In-office training of a patient in the expectation of increased visual efficiency. This includes developmental vision training as well.

B. Standards of Equipment -

(1) Instrumentation or equipment to execute the procedures prescribed.

C. Standards of Records -

(1) Individual records of each training session.

9618 -DIAGNOSTIC CONTACT LENS EVALUATION

A. Standards of Care -

The following procedures are assumed completed.

a. 9600 Visual Acuity Testing
b. 9601 External Examination
c. 9602 Refraction
d. 9603 Coordination Testing
e. 9604 Ophthalmoscopy Examination
f. 9607 Ophthalmometry or Keratometry
g. 9608 Biomicroscopy Examination

Diagnostic Contact Lens Evaluation specifically includes:

a. Measurement of eye variables such as corneal diameter, palpebral fissure, pupil size, etc.
b. Application of known diagnostic lenses to each eye.
c. Refraction with lenses on the eye.
d. Fluorescein pattern evaluation with the "black light" and/or biomicroscope, or Keratometry measurement of a flexible lens on the eye.
e. Evaluation and calculation of probable success with contact lenses.
f. Prescription.

B. Standards of Equipment -

(1) Adequate equipment to perform the necessary procedures outlined in Standards of Care.

C. Standards of Records -

(1) Recording of objective and subjective findings made in this evaluation. This includes records of all physical characteristics of the lens. (See Standards of Care).

9619-9624 - CONTACT LENS ADAPTATION PROCEDURES (Includes 6 months care)

A. Standards of Care -

NOTE: It will be necessary to train the patient and examine the patient a sufficient number of times in the 6 month period to assure proper adaptation.

The following tests are conducted at each visit as deemed necessary.

Lenses on the eye:

a. 9600 Visual Acuity Testing
b. 9602 Refraction and Resultant Visual Acuity
c. 9625 Fluorescein Pattern (or) 9607 for Flexible Lenses

Lenses removed:

d. 9626 Contact Lens Analysis
e. 9601 External Examination
f. 9602 Refraction and Resultant Visual Acuity
g. 9607 Ophthalmometry or Keratometry
h. 9608 Biomicroscopy Examination

(This 6 months care includes all lens modifications that may be necessary).

B. Standards of Equipment -

(1) Adequate equipment to perform the necessary procedures outlined in Standards of Care.

C. Standards of Records -

(1) Recording of objective and subjective findings made in this evaluation.

9625 - FLUORESCEIN PATTERN STUDY (Independent of other testing)

A. Standards of Care -

(1) With the contact lens on the eye, fluorescein is allowed to color the lacrimal lens and an analysis of bearing and clearance made. The instrument may be the "black light" and/or biomicroscope.

B. Standards of Equipment -

(1) Instrument to provide "black light" evaluation of the fluorescein pattern.

C. Standards of Records -

(1) Records of findings by sketch or description.

9626 - CONTACT LENS NEUTRALIZATION

A. Standards of Care -

(1) Each contact lens is analyzed. The following specifications, at least, are noted: base curve, power, diameter, optic zone, widths of peripheral curves, tint, thickness, edge treatment, surface quality.

B. Standards of Equipment -

(1) Necessary instrumentation and equipment.

C. Standards of Records -

(1) Records of all physical characteristics of the lens.

9633-9635 - CONTACT LENS REPLACEMENT

A. Standards of Care -

(1) Ordering and refitting a contact lens replacement lens involves contact lens analysis and the following tests as necessary: 9600-9601-9602-9604-9607-9608.

B. Standards of Equipment -

(1) Necessary instrumentation and equipment.

C. Standards of Records -

(1) Records of procedures performed as previously outlined in Standards of Care.

9636 - CONSULTATION

A. Standards of Care -

(1) It is assumed that with the average patient visit, the consultation necessary is considered as a part of each procedure. This procedure is applicable when consultation is needed over and above that which is necessary with normal examination procedures.

B. Standards of Equipment - Not applicable.

C. Standards of Records -

(1) Records of the problems involved in the consultation.

9640-9653 - DISPENSING

A. Standards of Care -

(1) Aid in patient selection of a new frame if necessary.

(2) Determination of frame size, shape, lens centration, ordering and verification of manufacturer's and fabricator's work.

(3) Fitting and adjustment of completed prescription.

B. Standards of Equipment -

(1) Necessary instrumentation and equipment.

C. Standards of Records -

(1) Records of all lens and frame specifications.

STANDARDS OF RECORDS - MISCELLANEOUS

1. Vital statistics -

a. Name, given and family.
b. Address.
c. Phone.
d. Birthdate or age.
e. Occupation.
f. Sex.
g. Social Security, Medicare, Title XIX numbers and case name when necessary.

2. Case History -

a. Date of last visual examination and by whom, if required.
b. Previous visual prescription and date.
c. Health history.
d. Statement of patient's complaint.

STANDARDS FOR CONTINUING EDUCATION

Each optometrist must present satisfactory evidence that he has attended at least two days of the annual education program as conducted by the Kansas Optometric Association or its equivalent each calendar year upon demand.

NOTE: Equivalent means all educational meetings conducted by a national, regional, or state optometric organization, or a college of optometry.

4-13-73

STANDARDS OF FACILITIES

A. Adequate space for files and records. This facility shall be adequate to produce procedural and financial records upon demand.

B. Adequate office space to perform any procedures that are performed as outlined in Standards of Care.

C. The office must be professional in appearance, location and overall decor. Adequate facilities for heating, ventilation and cleanliness must be provided.

STANDARDS OF PERFORMANCE OF CARE

NOTE: These are minimum procedures for the vinocular and average patient. Other objective and subjective tests should be used when indicated to adequately determine the visual status and eye health. (The age brackets are approximate.)

(1) Pre-schooler (age 0-5)

9601 - External Examination

9602 - Refraction (objective)

9603 - Coordination Testing (objective)

9604 - Ophthalmoscopy

(2) Youth and Adult (age 6-39)

9600 - Visual Acuity Testing

9601 - External Examination

9602 - Refraction (objective and subjective)

9603 - Coordination Testing

9604 - Ophthalmoscopy

(3) Presbyope (age 40-65)

9600 - Visual Acuity Testing

9601 - External Examination

9602 - Refraction (objective and subjective)

9603 - Coordination Testing

9604 - Ophthalmoscopy

In addition, one or more of the following tests shall be performed for the purpose of glaucoma screening:

9610 - Tonometry

9612 - Multiple Pattern or Vision Field Screening

9613 - Plotted Fields

(4) Geriatric (age 65 and over) Same as item three wherein possible.

Attachment K

rofessional Liability Problem

KMS Position Paper

(Ed. Note: Resolution No. 75-18 established the KMS Commission on Professional Liability and Medico-Legal Affairs. Resolution No. 75-26 directed the Commission to prepare a comprehensive medical injury compensation study to be presented to the Kansas Legislature.

The Legislative Planning Committee, under the chairmanship of M. Martin Halley, M.D., Topeka, submits the following position paper for consideration in the Kansas Legislature.)

Introduction

The medical profession, as well as the entire health care industry, is deeply concerned that patient care is suffering because of progressive deterioration of the malpractice situation, recently brought into sharp focus by the crisis in cost and availability of liability insurance.

Comprehensive legislation is essential for a long-term solution of this complex problem, which involves most importantly the patient—the primary beneficiary of health care—who must be assured the highest quality of care, protection from injury, and compensation for injury when it occurs. The combined resources of all health care professions, the legal profession, the insurance industry, and government must be applied to this public purpose.

The Kansas Medical Society has identified, and herein presents, the major areas of concern, and supports the enactment of a comprehensive remedial legislative program. It is hoped that our Legislature will address itself to these critical issues at an early time.

1. Health care practices are adversely affected by the impact of a steadily rising volume of claims and lawsuits. This unhealthy climate for health care delivery must be improved.

The increasingly aggressive legal environment surrounding health care practitioners has had a profoundly negative effect upon provider-patient relationships, and has resulted in undesirable modifications of patient care through compensatory changes in medical practices.

One aspect of this deplorable phenomenon is that the fundamental physician-patient relationship, already weakened by changing patterns of health care delivery, has been further compromised by provider responses to a hostile environment. Here, the additional consideration of legal risks has assumed increasing importance as providers have attempted to minimize legal problems with the consideration of each patient also as a potential plaintiff. This intrusion of the adversary process into relationships requiring trust and harmony, a disruptive paradox in an era of ever-improving health care, has been a causative factor of current malpractice problems, and continues to cloud the health care environment.

Another aspect of the same phenomenon has been the widespread practice of defensive medicine. Substantial and undesirable effects upon patient care have resulted from such medical practice alterations for the purpose of avoiding or defending possible lawsuits. These effects involve the quality of health care, the risks of procedures, the convenience of the patient, and the total cost.

Positive defensive medicine involves the performance of procedures not medically indicated. Specific examples are additional laboratory tests, additional diagnostic procedures, additional x-rays, additional office visits, additional or extended hospitalizations, or additional medical consultations.

Negative defensive medical practices occur when an indicated procedure is not performed for fear of legal consequences. Examples of negative practices are avoidance of specific surgical procedures, refusal or referral of certain cases, refusal of certain emergencies, and strict limitation of practice. Negative practices may further limit the availability of care since legal risks are a factor in physicians' choice of specialty, choice of practice locations, and in decisions for early retirement.

A third form of defensive medicine, fully as serious in potential consequences, has been an apparent reluctance of some physicians to publish scientific material or otherwise communicate professional information for fear of possible unfavorable legal results.

These undesirable effects and practices, as well as resulting increases in health care costs, are inexorable consequences of the current medical malpractice problem. The comprehensive remedial legislation supported by the Kansas Medical Society is designed to effect overall improvement in this complex and unhealthy climate.

2. The professional liability insurance market is unstable. A program for long-term stabilization is mandatory.

Physicians and hospitals, as well as other providers, are presently faced with crises in the area of professional liability insurance precipitated by dramatic in-

creases in insurance premiums, difficulty in availability of insurance at any price, and the withdrawal of insurers from the field. The patient again is the ultimate loser, since health care cannot continue without adequate insurance coverage, and since cost increases are ultimately passed on to the consumer. The instability of the insurance market, which serves as a sensitive barometer of the legal risks of medical practice, intensifies the adverse impact of the total complex situation upon patient care.

In Kansas, the situation is not yet as acute as in some other states, but great potential for crisis exists. Two insurers write the major share—86%—of medical liability insurance, and all available companies have indicated reluctance to increase their participation in the Kansas market under present circumstances. This reluctance is the direct result of steadily increasing malpractice claims settlement costs and claims frequency potential, the latter related to the "long tail" of malpractice insurance, made possible by the present lengthy statute of limitations in Kansas.

Health care providers in Kansas, as elsewhere, are experiencing substantial increases in premiums. New physicians are encountering difficulty in obtaining coverage and some have located insurance only through the intervention of the insurance commissioner. Established physicians are required to accept the relatively unsatisfactory provisions of claims-made policies, which pass the insurers' actuarial uncertainties to the insured providers' future years.

Thus, although the short-term insurance market in Kansas appears controlled at present, long-term stabilization as to availability and cost is essential to assure the uninterrupted delivery of health care. This will require legislative action.

Programs under consideration include Joint Underwriting Associations, and physician-owned insurance companies supported by national reinsurance sources. The Kansas Medical Society is presently supporting comprehensive legislation, including the following proposals: limitation of individual provider liability; a state managed patients' compensation fund for awards above the individual limits; a stronger role for the insurance commissioner in management, and in the accumulation of statistical data relative to claims; a risk management program for insuring health care providers unable to locate insurance in the regular market; a shorter statute of limitations to eliminate the disastrous actuarial effects of the "long tail" of malpractice claims; expeditious claim determination; and elimination of the collateral source rule to permit consideration of other payments or benefits received by claimants.

3. Health care costs are increasing due to the malpractice problem.

The increasing volume and severity of claims and lawsuits, the resulting increases in insurance costs, and the medical defensive practices are manifesting an inflationary effect upon total health care costs, which will reach an estimated $115 billion in 1975. The precise cost increase due to the malpractice problem is not known, but substantial effects are caused by increases in hospital or other institutional rates due to rising hospital insurance costs and costs of institutional defensive practices, as well as the increasing costs of physicians' and other providers' defensive practices, and the increasing cost of physicians' liability insurance. Cost containment is a major problem of the health care industry, and is an important benefit of the proposed comprehensive legislative program.

4. Quality assurance in health care is essential, but is not a solution to the malpractice problem.

Patient injuries, real or imagined, or other adverse effects of treatment, are primary causative factors of the malpractice problem, and are increasing as volume and complexity of patient care increase. Many such occurrences cannot be prevented, short of termination of medical practice, since they result from unavoidable treatment complications, accidents and ever-present human error, by otherwise competent practitioners.

This increasing incidence of adverse results—a side effect of modern medical practice—has occurred even though the medical profession has long labored for better and safer patient care through a high degree of self-evaluation and self-regulation, and through constant emphasis on the highest professional standards throughout the long years of physicians' training as well as in the subsequent years of practice.

There is general agreement that even more and even better education is desirable, that maintenance of professional competence through continuing education should be encouraged, that incompetent practitioners should be rehabilitated or removed, that hospital privileges should be limited to the scope of providers' competence, and that ethical principles in practice and in research must be rigorously enforced. There is, however, no evidence, statistical or otherwise, that any one of these areas has been a significant causative factor in the increasing frequency or cost of malpractice claims. Therefore, however inherently beneficial the intensification of such programs may be, these efforts will not significantly ameliorate the medical malpractice problem.

Nevertheless, programs for quality assurance which have long been an integral part of the health care industry must be intensified and extended. Such programs should include evaluation of medical practice by peer review mechanisms, recertification of specialists, re-registration of health care providers based upon proof of participation in continuing medical education, reporting of malpractice claims to the licensing authorities for evaluation and appropriate action, rehabilitation of marginal practitioners, and expanded accident prevention programs. Proposals to this effect are included in the legislative proposals of the Kansas Medical Society.

5. The present system for compensating injured patients is inadequate. Procedural law must be modified to enable expeditious claim determination and fair compensation.

The patient's claim, following an injury, must be promptly evaluated and adjudicated, without undue delay and without the hardships and expenses of prolonged litigation. Claim determination must also occur without unreasonable interference with the continued operation of the health care system, so that providers will not be diverted physically or emotionally from their primary task of patient care. Reasonable, but not excessive compensation must be permitted for the attorney, so that the injured parties' final recovery will not be unduly diminished by large contingent fees. It is submitted that these objectives are not readily attained at present in medical malpractice controversies.

The comprehensive legislative program supported by the Kansas Medical Society encompasses the entire complex medical malpractice problem. It provides a therapeutic approach for total correction, rather than a less effective palliative effort for symptomatic relief. It accomplishes the objectives of substantial justice to the parties, expeditious determination of claims and fair compensation for the injured with a minimum expense, and additionally provides major beneficial effects for health care delivery, health care costs, and liability insurance.

The legislative program in this regard includes the following provisions: Mandatory medical screening panels chaired by an attorney, to evaluate all malpractice claims and provide evidence and testimony at trial if settlement does not occur; expeditious and realistic compensation for claimants undiminished by excessive attorneys' fees; advance payments to claimants with meritorious claims or even to those with doubtful claims; insurance market stabilization as previously discussed; clarification or modification of certain rules of law; consumer protection through quality assurance in health care delivery.

If enacted, the provisions of the program will result in great improvement of all aspects of the health care environment, and will assure uninterrupted delivery of high quality care without the danger of future crises.

6. Substantive law modification should be considered as an alternative approach.

In the event that the requested procedural remedies do not provide an adequate solution for the malpractice problem, legislative modification of substantive law must be considered, perhaps to completely abolish the concept of fault for injury leading to compensation in an approach similar to workmen's compensation law. The comprehensive legislative proposal will include a provision for a legislative study commission to review malpractice data on a continuing basis, and to consider the implementation of pilot studies in no-fault patient injury insurance.

AWSUITS: A GROWING NIGHTMARE FOR DOCTORS AND PATIENTS

It's not only doctors who pay the cost of malpractice suits. The added expenses are passed on to patients, and that's just the start.

MALPRACTICE SUITS against doctors and hospitals are multiplying so rapidly and growing so costly that they are significantly altering the practice of medicine in the U. S.

Rising medical costs are already attributed in some measure to the surge in malpractice suits. From all evidence, even higher bills are in the offing.

In the past five years, malpractice claims have more than doubled in frequency. Size of claims is skyrocketing. A $100,000 suit is not unusual. In California last year there were about 30 awards of more than $300,000 each—and half of those were for more than 1 million dollars.

One consequence: The cost of malpractice insurance for doctors and hospitals has risen astronomically—by almost tenfold in many places since 1969.

Such insurance is even becoming unobtainable at any price in more and more places. In Texas, New York, Maryland, North Carolina and Michigan, for example, many insurance firms are going out of the malpractice business or limiting coverage to "low risk" groups.

Alarm is widespread—at top Government levels and throughout the medical profession—over a situation that is creating a nightmare for doctors and patients alike. Besides cost problems, the spread of malpractice suits poses other dangers—

- Doctors increasingly are reluctant to try any procedure which, while it might provide a cure, could be risky. This may stultify medical progress, scientists warn.
- More and more doctors say they are practicing "defensive medicine"—keeping patients in hospitals longer, insisting on more lab tests. This development may drive up medical bills far faster than the rise in malpractice insurance premiums.
- The doctor shortage may increase. Many physicians, particularly aging ones, are talking of quitting practice rather than risk suits that could hurt them financially and ruin hard-won reputations. Others are refusing to take on new patients.

Caspar Weinberger, Secretary of Health, Education and Welfare, voices Government concern in these words:

"The increasing difficulty physicians have in obtaining malpractice insurance—at any price—has reached crisis proportions in the United States. . . . The loss of insurance coverage for physicians would have an immediate impact on the public's access to quality health care. It would most certainly drive up the cost of medical care even further and it would increase the number of tests and procedures ordered by physicians solely to protect themselves."

All told, Secretary Weinberger estimates that "high malpractice insurance premiums and the defensive medicine that results cost the public between 3 billion and 7 billion dollars a year."

The doctors' dilemma. Across the country, physicians and surgeons agree with Dr. Russell B. Roth, former head of the American Medical Association, who says of the increased malpractice premiums: "There's only one place a doctor can get this kind of money, and it's from his patients."

Dr. Roth suggests the premiums run from $1.50 to $2 for each office visit.

In Florida, where malpractice premiums are high, Dr. Pedro J. Greer, an internist who heads the Dade County Medical Association in Miami, asserts:

"If the increase is 5 to 10 per cent of the doctor's gross income in premiums—that is probably the cost increase that should go to the patient."

Dr. Irwin J. Cohen, of the New York County Medical Society, feels it would be "unrealistic" to expect doctors not to pass on their premium costs.

Dr. Kenneth Lehman, of Topeka, Ind., is solving the malpractice dilemma by quitting. After 27 years of practice, he says:

"I am getting out because I do not want to be in the untenable situation where a jury rules on my medical competency. A malpractice decision should be made by individuals who know medicine, and there should be some limits as to what damages belong with a certain kind of case."

Pounds of prevention. Can malpractice suits be avoided? Dr. Cohen believes that many suits result from bad

(continued on next page)

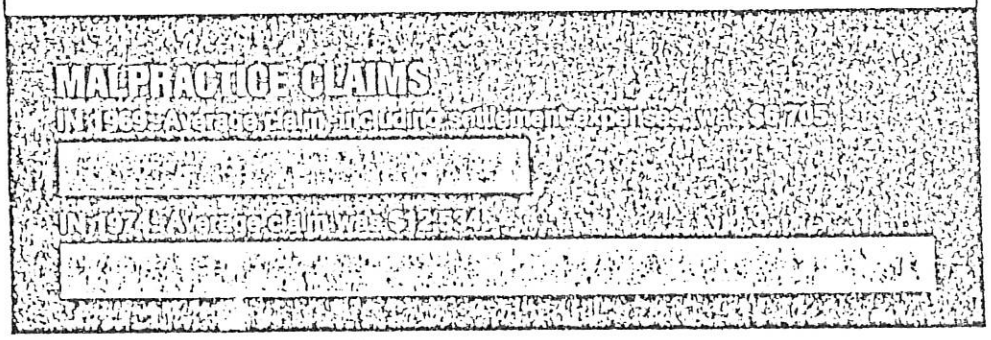
MORE DOCTORS ARE BEING SUED—AND FOR MORE MONEY

Based on experience of St. Paul Fire & Marine Insurance Company, which insures 48,000 physicians and surgeons around the country—

MALPRACTICE SUITS

IN 1969: 4 per cent of doctors had suits pending against them.

IN 1974: 10 per cent of doctors had suits pending.



L... SUITS FOR DOCTORS

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communication between doctor and patient. As he sums it up:

"If a patient feels you have his best interest at heart and that you are genuinely concerned, that you'll do everything possible to treat the complications that have occurred, and you answer all his questions—then he'll be more likely to face a bad result with his physician rather than against him in court."

Still, many doctors prefer not to take high risks. According to Dr. William R. Cast, chairman of the committee on malpractice of the Indiana State Medical Association:

"Physicians are practicing defensive medicine in case they have to justify themselves to a jury. They hospitalize patients who could be home. They keep patients in hospitals longer than is necessary. They order tests and X rays that are not needed, and they order second tests and X rays when the first ones have already shown adequate results.

"These costs are a thousand times greater for patients than what is added to their bills because of premium increases for malpractice insurance."

A San Francisco internist says he might merely bandage a friend's son who was hurt in a football game.

"But if he were a stranger, I'd have him get every kind of X ray, might hospitalize him for observation. In questionable cases I'd call in a consultant. It's the only way a doctor could have a reasonable chance to defend himself against charges of inadequate treatment and negligence."

As the chief surgeon of a large New York City hospital sees it:

"It's sad to state that a careful, clinical evaluation is no longer acceptable today. You have to reinforce it with a lot of lab tests and X rays. And these cost money—a lot of money."

In Savannah, Ga., Dr. William H. Lippitt, past president of the Georgia chapter of the American College of Surgeons, comments:

"I have had a number of doctors tell me they look on every patient as a potential suit, and that's so sad."

Problem for hospitals. Until about five years ago, hospitals by law were usually exempt from malpractice suits. That has been changing, and today most hospitals carry malpractice liability insurance and pass a portion of the cost along to patients.

In addition, hospital staffs are under orders to be generous with lab tests and X rays—to protect the hospital from suits based on negligence.

Some good side effects are reported. An internist in Marin County, California, echoes the feelings of some doctors about the specter of lawsuits:

"It's probably helpful in that it forces doctors to be more careful, and many doctors need to be more careful."

The American Hospital Association has issued a "Patient's Bill of Rights," which spells out the duty of doctors to be completely frank and explicit in outlining to a patient all possible risks. Next to negligence, the most common basis for a malpractice suit is lack of "informed consent" on the patient's part to treatment that might be risky.

"Hospitals and doctors are far more efficient and careful now because fear of lawsuits has forced them to avoid negligence," says Denver attorney Jim R. Carrigan, who handles a lot of malpractice litigation.

Some doctors blame lawyers for part of their problems. A San Francisco physician comments:

"The people who bring malpractice suits are either broke and need money or hate their doctor. In either case, they find a sympathetic helper in some lawyer anxious for a big fee."

In Atlanta, neurosurgeon Dr. William W. Moore, Jr., fears medical malpractice "is becoming a source of legal practice that's maybe looked on as a new-found oil field."

Solutions ahead? Federal authorities and some States are now considering actions aimed at a solution of the malpractice problem. California's legislature, for example, has come up with these recommendations:

- Empower hospitals to require doctors to carry adequate malpractice insurance—so that those with bad practice records can be screened out.
- Develop screening procedures to eliminate "nuisance suits."
- Appoint ombudsmen to investigate claims and make informal adjustments.

At the federal level, there are plans to consider Government-backed malpractice insurance and to set guidelines for new laws on malpractice.

But time is short, warns Dr. Jordan S. Brown of New York University Medical Center. He says:

"The malpractice situation is in the process of destroying medicine. The people who are ultimately going to lose are the patients themselves."

UP, UP GOES THE COST OF MALPRACTICE INSURANCE

Annual premiums for malpractice insurance, coverage of $100,000 per claim and up to $300,000 per year for all claims—

	Five Years Ago	Now
PORTLAND, OREG.		
General practitioner, no surgery	$181	$484
Thoracic surgeon	$684	$2,420
Neurosurgeon	$847	$3,023
HOUSTON		
General practitioner, minor surgery	$216	$1,895
Ophthalmologist	$371	$4,063
Orthopedic surgeon	$711	$6,772
MINNEAPOLIS-ST. PAUL		
General practitioner, minor surgery	$89	$611
Cardiac surgeon	$198	$1,756
Anesthesiologist	$231	$2,196
ATLANTA		
General practitioner, major surgery	$185	$1,080
Ear-nose-throat doctor	$206	$1,348
Gynecologist	$206	$1,530
BOSTON		
General practitioner, no surgery	$119	$469
Proctologist	$357	$1,760
Plastic surgeon	$622	$3,060

Source: St. Paul Fire & Marine Insurance Co.

WHO GETS SUED FOR MALPRACTICE?

Of all malpractice suits—

SURGERY	**57.2%**
Orthopedic	19.0%
Gastrointestinal	11.5%
Gynecological	10.3%
Obstetrical	5.1%
Cardiovascular	1.8%
Other surgery	9.5%
MEDICAL TREATMENT	**20.5%**
Psychiatric	1.5%
Cardiovascular	1.4%
Other medical	17.6%
RADIOLOGY	**6.1%**
Diagnostic	5.2%
Other radiology	0.9%
PATHOLOGY	**1.6%**
Anatomic	1.1%
Other pathology	0.5%
ALL OTHER TREATMENT	**14.6%**
Emergency	5.8%
Vaccinations	1.2%
Other treatment	7.6%

Source: U. S. Dept. of Health, Education and Welfare

MALPRACTICE CRISIS

How It's Hurting Medical Care

A strike of doctors in California . . . hospitals threatened with bankruptcy . . . reports of doctors leaving medical practice . . . higher costs for patients. . . .

These are just a few of the far-reaching effects of a crisis in malpractice insurance that is still gathering steam.

A major part of the problem: The number of suits against doctors and hospitals—and the size of settlements—is climbing so rapidly that premiums for malpractice insurance are soaring. In some areas, doctors can't buy malpractice insurance at any price.

One State after another is rushing through stopgap measures. Congress now is considering a dozen bills to cope with a problem that is becoming a nightmare for doctor and patient alike.

Here, from authoritative sources, are answers to major questions that people are asking:

Is the malpractice crisis affecting the quality of health care?

Signs are that it is starting to do so, or soon will.

The strike in May of anesthesiologists in San Francisco is an example. They were protesting a whopping boost in malpractice premiums. Though emergency surgery was performed while the strike was on, "elective" surgery at the hospitals involved was put off—including a number of cancer operations that could turn out to be vital.

Officials of some hospitals with large numbers of empty beds talked of facing bankruptcy.

And beyond that?

There are longer-range dangers, too.

Many doctors are becoming reluctant to perform hazardous operations, or to try any procedure that might provide a cure but could be risky. Medical authorities warn that this eventually could stultify progress.

Some doctors, rather than risk suits that could hurt their professional reputations or financial standing, are retiring early or going into research, teaching or other related fields. The number, according to the American Medical Association, is still small but is likely to grow—and thus exacerbate the shortage—if the malpractice crisis is not resolved.

Localized doctor shortages are in prospect in many communities, or even whole States, where doctors are unable to renew their malpractice insurance and thus might move their practices.

Dr. Max Parrott, president-elect of the AMA, is concerned that skilled specialists—a common target of suits, and payers of the highest premiums—might limit their practice to non-risk-producing procedures. This could leave patients with fewer trained people to handle their special problems.

Newcomers to an area, in particular, may have trouble arranging for doctors to take their cases. Physicians, it is said, might be prone to stick with patients they have known for a long time, and turn down new patients.

Are doctors changing their medical procedures in other ways?

More and more say that they are practicing "defensive medicine"—ordering more X rays and lab tests, keeping patients in the hospital longer. This is occurring all over the country as physicians try to ward off later claims of negligence or lack of thoroughness.

That, too, has its dangers, say medical experts who worry about an excessive amount of radiation from multiple X rays. "Defensive medicine" also drives up medical bills for patients.

What's behind the rapid increase in malpractice suits?

A combination of factors is cited by medical and other authorities:

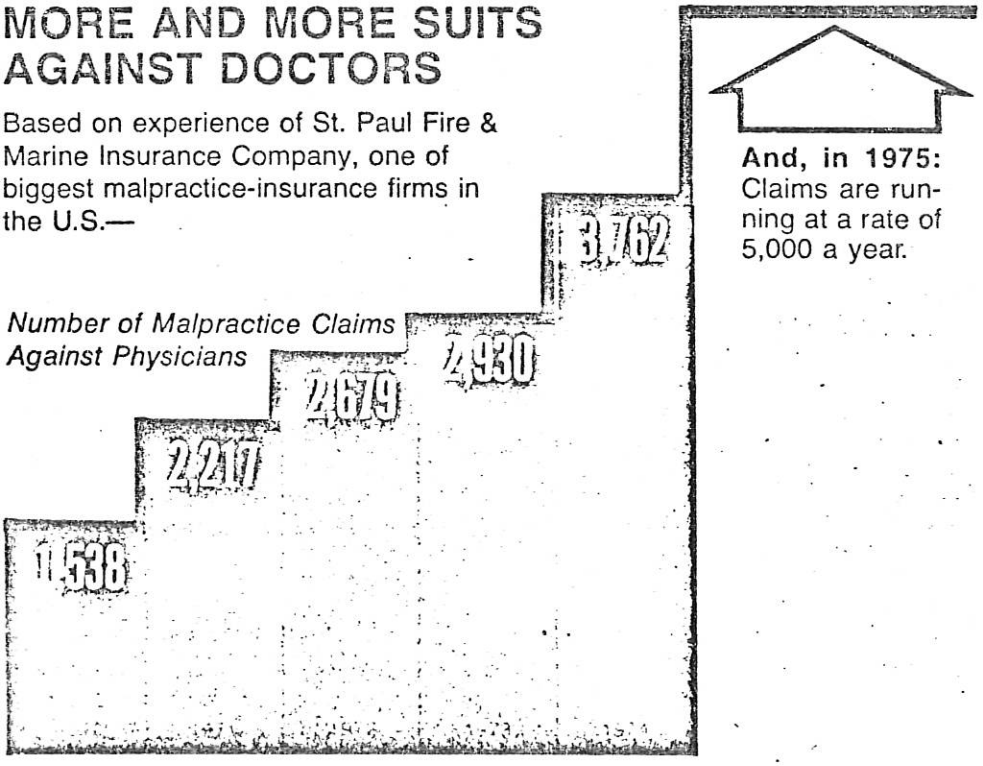
- "A changing attitude in our society about litigation" is one, according to Dr. Roger O. Egeberg, the Department of Health, Education and Welfare's expert on malpractice. He notes that people nowadays are more likely to sue whenever they feel they have been injured—whether by doctors, auto companies or other manufacturers.
- A growing interest among lawyers in seeking out medical malpractice suits, for which fees are usually collected on a contingency basis.

Lawyers take a different view. Says Robert Cartwright, president of the Association of Trial Lawyers: "The cause of the malpractice crisis is malpractice on the part of doctors."

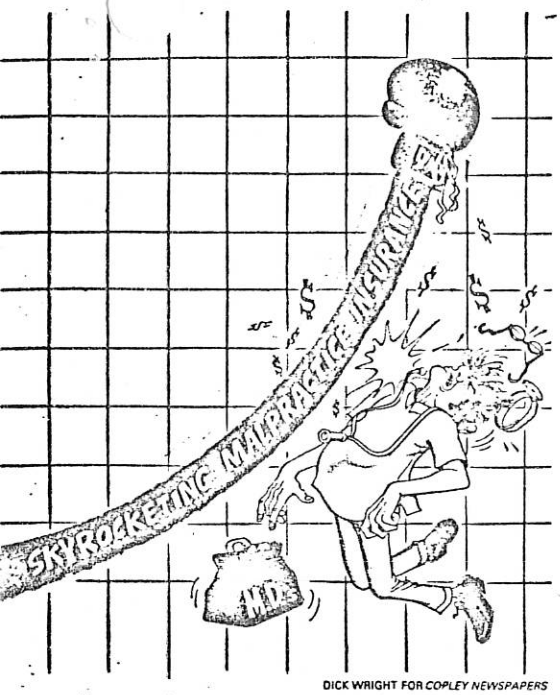
- Weakening of personal relationships between patients and physician, which has accompanied the trend toward use of specialists. "When the doctor was a family friend," says Kent Shamblin, an official of the St. Paul Companies, Inc., "there was less inclination to sue."
- What is called by doctors and insurance companies the "Marcus Welby syn-

MORE AND MORE SUITS AGAINST DOCTORS

Based on experience of St. Paul Fire & Marine Insurance Company, one of biggest malpractice-insurance firms in the U.S.—



And, in 1975: Claims are running at a rate of 5,000 a year.



DICK WRIGHT FOR COPLEY NEWSPAPERS

drome." Many people expect their doctors to be like the kindly, nearly infallible doctor in the television series, and a real doctor who fails to live up to such standards may be the target of wrath—and lawsuit.

Just how fast have malpractice suits increased?

The number of claims has about doubled in the past five years to a level, HEW estimates, of 18,000 to 20,000 annually. An insurance-industry official says that 90 per cent of all the malpractice suits ever filed in the U.S. have come since 1964.

Has the size of claims gone up, too?

Even faster than the number. A $100,000 suit is not unusual these days. Last year there were 15 suits for more than 1 million dollars in California alone.

How often are suits successful?

About 5 per cent reach the courts, according to Dr. Egeberg, and, of those, an estimated 70 per cent are won by doctors or hospitals. Win or lose, the costs can be large for insurance companies because of legal fees and court costs. Insurers frequently will settle out of court for $1,500 or $3,000 just to avoid the legal costs.

How much has the cost of malpractice insurance increased?

Roughly 600 per cent in the past three or four years. Right now, the cost of such insurance is running at about 1 billion dollars a year—350 million in premiums paid by doctors, 650 million by hospitals. In the next year, the cost could rise to more than 2 billion dollars, according to HEW officials.

Doctors tell of paying 10 to 20 per cent of their gross income in premiums. Dr. Parrott, who is an obstetrician-gynecologist, says that his personal premium is being raised from $3,600 to $11,700 a year.

Is there any truth to reports that sharp losses in the stock market before this year had something to do with boosts in premiums?

Dr. Parrott thinks so. His view, expressed in an interview on radio station KPOK, Portland, Oreg.:

Insurance companies, required to maintain big reserves against potential litigation, invest considerable amounts in the marketplace.

"The market went to pot last year, so that reserves were depleted by a decline in the stock market," he said.

The result, according to Dr. Parrott: "The companies had to raise more money for the reserves, and the only way they could do it was to raise the premiums precipitously."

Are the higher premiums passed on to patients?

In the great bulk of cases. Says Dr. Malcolm Todd, current president of the AMA:

"There is absolutely no way that a doctor can pay $20,000 to $35,000 in insurance without raising fees. Although the insurance is a business deduction [for tax purposes], a doctor must generate twice the amount of business to pay for it."

A routine office visit, where the risk of a malpractice suit is small, is reported to be costing an extra $1.50 to $2 to cover such insurance in many places.

In Chicago, hospitals now are adding $10 to $12 a day to a patient's bill for malpractice insurance.

Cases are reported of surgeon's fees being raised 10 to 20 per cent—and sometimes more in the case of high-risk specialties.

All told, according to Caspar Weinberger, Secretary of HEW, higher premiums and "defensive medicine" cost the public between 3 billion and 7 billion dollars a year.

With premiums soaring, are insurance-company profits rising?

Most companies assert that they are losing money at a rapid clip, and would like to get out of the malpractice-insurance business.

The number of firms that handle the bulk of malpractice insurance has dropped from about 25 companies five years ago to a half dozen now. Many of these will not write insurance for a doctor in California or New York "at any price" because of the rising number of suits filed in those States.

Don't malpractice suits keep medical practitioners on their toes, particularly the worst doctors and hospitals?

In some cases, perhaps, but it often works the other way, in practice. Dr. Egeberg notes that some of the best doctors and best hospitals are s the most, because they get the hardest cases and handle the most risky operations.

Do doctors see any need for tougher policing of their profession?

That has been suggested by AMA officials. Dr. Todd said in a recent interview in *U.S. News & World Report:*

"There certainly is room for improvement [in the policing of doctors by review committees], and I think it's going to be demanded of us to do a better job in this regard."

Are hospitals taking any steps to deal with the malpractice crisis?

Members of the American Hospital Association have voted to set up an insurance company of their own to provide malpractice insurance to those hospitals who are unable to get it through regular channels. The plan is to finance the new company with a per-bed assessment on member hospitals, then get a group of large insurance companies to "reinsure" the policies.

What are the States doing to deal with the malpractice crisis?

A variety of approaches is now being tried:

• State-backed insurance programs to provide doctors with malpractice in-

(continued on next page)

A DECADE OF SOARING PREMIUMS

Typical annual premiums for malpractice coverage of $100,000 per claim and up to $300,000 per year for all claims—

	1965	Now
MICHIGAN		
General practitioner	$101	$ 1,471
Urologist	$364	$ 6,001
Neurosurgeon	$364	$12,002
VIRGINIA		
General practitioner	$ 68	$ 758
Urologist	$245	$ 3,092
Neurosurgeon	$245	$ 6,185
CONNECTICUT		
General practitioner	$ 62	$ 454
Urologist	$222	$ 1,856
Neurosurgeon	$222	$ 3,712
TENNESSEE		
General practitioner	$117	$ 383
Urologist	$422	$ 1,564
Neurosurgeon	$422	$ 3,128

Source: Insurance Services Office

ALPRACTICE CRISIS

[continued from preceding page]

surance where private companies withdraw—or threaten to do so—are being planned by Maryland and New York. Michigan and Indiana have already acted on such measures.

• Statutes of limitation on the liability of a doctor or hospital—which can run up to 20 years or more in some places—have been shortened in a number of States. Maryland's legislature, for example, has voted to limit liability to five years from the date of incidence. In South Dakota, it is six years; Florida, four years; Missouri, two years.

• Lawyers' contingency fees in malpractice cases would be limited by legislation under consideration in Ohio and Tennessee. Idaho already has passed such a bill.

• The amount of damages that may be awarded in malpractice suits in specific cases would be limited in bills now being considered by Florida, Alaska, Georgia and Texas. Idaho and Indiana have enacted such laws.

Is the Ford Administration considering a role for the Federal Government?

Not at this time. A ranking HEW official explains it this way:

"This is something that the Federal Government should stay out of, if at all possible.

"It is the States that have the prime responsibility for doctors and health care. They license them, set standards, and generally regulate the medical profession. So, unless the situation becomes completely unmanageable, the States should be allowed to take whatever action is needed."

What about Congress—is it likely to step in?

Not in the immediate future, but perhaps later on.

More than a dozen bills to help doctors cope with skyrocketing malpractice-insurance premiums have been introduced recently in Congress.

Among the proposed remedies: the creation of a federal fund to reinsure doctors; a national no-fault malpractice-insurance system; establishment of federal arbitration guidelines that would allow disputes between doctors and insurance companies to be worked out at local levels.

Hearings have begun on such proposals in a Senate Health subcommittee headed by Senator Edward M. Kennedy. A House subcommittee expects to start hearings within another month.

The prospects, according to one congressional authority:

"These bills probably will get low-priority treatment, depending on how much the situation gets out of hand. If it gets much worse, though, Congress may have to move more rapidly than it wants to now."

WHEN DOCTORS WENT OUT ON STRIKE—

SAN FRANCISCO

A strike of doctors here in northern California showed what can happen as a result of the malpractice crisis.

Faced with rate hikes for malpractice insurance of about 240 per cent, anesthesiologists in San Francisco's 12 private hospitals quit work May 1. The strike spread quickly to nearby areas.

Anesthesiologists are licensed medical doctors who specialize in administering anesthetics.

All "elective" surgery—the type that can be delayed—was immediately postponed at the affected hospitals. The strikers agreed to continue handling "life or death" cases. But they declined to become involved in operations for cancer, or in normal childbirths.

Wide support. Officials of the San Francisco Medical Society said many surgeons, hit with similarly steep insurance increases, backed the boycott. Executive Director Jack Collins said the strike had the full support of the medical society.

While their operating rooms—a major source of revenue—were idle, the 12 San Francisco hospitals said they were losing up to $300,000 daily. Three of the 12 said in mid-May that they would have to close their doors and file for bankruptcy if the crisis was not settled "within a few days." The dozen institutions laid off 3,000 employes during the first two weeks of the month as occupancy rates dropped sharply.

At the Marshall Hale Medical Center, for example, Administrator Dale Morgan closed one of four hospital floors and dismissed a third of the 300-worker staff in an attempt to reduce a growing deficit. Only 45 per cent of the center's beds were in use in mid-May. Mr. Morgan said he had moved 10 patients to emergency centers that were manned by the San Francisco Medical Society. There were six such centers.

As the private hospitals emptied, public institutions, such as San Francisco General Hospital and the University of California Medical Center, became increasingly jammed. The public hospitals pay the insurance premiums for their medical staffs and were not involved in the strike.

Authorities said there had been no reports of deaths attributed to a lack of proper treatment. Medical care generally was said to be only moderately affected by the boycott.

But Frances Spector, a registered nurse at San Francisco's Mount Zion Hospital, said patient care had been endangered by the lack of workers and that "many patients have been discharged too early." Further, she said, health care at the U.C. Medical Center and at San Francisco General was deteriorating because the hospitals were accepting too many patients—a charge denied by officials at both institutions.

At the U.C. Medical Center, Dr. Joseph Kitterman, director of the intensive-care nursery, said, "things have gone very smoothly, better than expected," even though the unit was operating at 200 per cent of capacity.

The walkout began when the Argonaut Insurance Company of Menlo Park, Calif., which writes the malpractice insurance for doctors in this area, raised its rates on May 1 from $5,377 a year to $18,184 a year for anesthesiologists, gynecologists and orthopedic surgeons.

Incomes for anesthesiologists in the San Francisco area are said to average $40,000 to $45,000 a year.

"It would be very easy," said Mr. Collins of the medical society, "if the doctors could pay the higher premium rates and pass along the added costs to the consumer, but they are convinced the increase is not justified. All they have to do is look at the insurance companies and see that they lost more than 6 billion dollars last year on the stock market. They are convinced the increased rates aren't coming because of malpractice suits."

Proposals for relief. The doctors are looking to the State for relief in some type of legislation governing rates. Governor Edmund G. Brown, Jr., called legislators to a special session on May 19 to consider a variety of proposals including one of his own that he said would provide "fundamental reform."

Insurance rates have not yet changed in southern California although there are many reports of pending increases.

Doctors in Los Angeles and San Diego staged one-day walkouts on May 6 in sympathy with the San Francisco strikers but there was no prolonged boycott.