M I N U T E S

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

August 27 and 28, 1975

Members Present

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

Staff Present

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

Others

Lloyd Hall, Kansas Association of Osteopathic Medicine, Topeka, Kansas
Dr. Arnold Levenson, Kansas Podiatry Association, Manhattan, Kansas
Cinda Vogel, Kansas Chiropractors Association, Topeka, Kansas
Judy Runnels, Kansas State Nurses Association, Topeka, Kansas
Donald Hoffman, Attorney General's Office, Topeka, Kansas
Ken Kline, Kansas Bar Association, Topeka, Kansas
Walt Biddle, Kansas Trial Lawyers Association, Topeka, Kansas
Dr. A. O. Tetzlaff, anesthesiologist, Prairie Village, Kansas
Joe Mackey, Hospital Administrator, Hutchinson, Kansas
David H. Fisher, Kansas Bar Association, Topeka, Kansas
Edwin Dudley Smith, Kansas Bar Association, Topeka, Kansas
Gerald L. Michaud, Kansas Trial Lawyers Association, Wichita, Kansas
Charles Fisher, Kansas Trial Lawyers Association, Topeka, Kansas
Henry Meiners, Blue Cross-Blue Shield, Topeka, Kansas

Dale Bonnett, Topeka, Kansas
Monty Bonnett, Topeka, Kansas
J. Eugene Balloun, Kansas Association of Defense Counsel
J. Harold Williams, Kansas Trial Lawyers Association, Wichita, Kansas
Frederick J. Knox, St. Paul Fire and Marine Insurance Company
David W. Wilson, Medical Protective Company
Paul Tompkins, Kansas Association of Independent Insurance Agents, Topeka, Kansas
Mark Bennett, American Insurance Association, Topeka, Kansas
Kenneth Cole, American Insurance Association
Fletcher Bell, Insurance Commissioner, Topeka, Kansas
For others who attended see the attached lists

The meeting was called to order by the Chairman, Senator Wesley H. Sowers. He informed the Committee that because of the number of groups asking to appear, the September meeting might start at 9:00 a.m. both days.

A motion was made and seconded to add "Surety Bond and Insurance" before "committee" on Page 6 for clarification and to approve the minutes of the July 22 and 23 meeting as amended. Motion carried.

Lloyd Hall, Executive Secretary and General Counsel, Kansas Association of Osteopathic Medicine, stated the malpractice insurance problem is acute for new doctors. For example, two new doctors, an obstetrician-gynecologist and a general practitioner, were given a combined premium quotation in excess of $8,000 to be paid in advance. New doctors must finance these premiums adding to the costs passed on to patients.

The Association feels the most significant factor to be considered is the statute of limitations. They recommend a two-year statute of limitations, providing for certain exceptions. Nearly all cases have the facts known by this time. He stated they basically subscribe to the recommendations of the Kansas Medical Society.

In answer to questions about lowering the statute of limitations, Mr. Hall stated that he meant for the two years to apply to personal injury cases only. This would make insurance available at a reasonable but probably not lower cost. He would get rate figures taking into consideration the two-year period and send them to the Committee. He also would send a recommended amendment changing the statute of limitations to the Committee.

In answer to other questions Mr. Hall stated that in the last two years there have been no cases against osteopaths in Kansas, but there have been nationally and this affects rates in Kansas. The Association is working to alleviate the problem by creating a peer review mechanism and by requiring their members to complete 150 hours (actual classroom hours) of graduate work every three years. The Association will be trying to make continuing education a part of the relicensing program.

He thought three osteopaths' licenses had been revoked by the Board of Healing Arts, but not for malpractice or negligence. Their Association supports the provisions for revoking, suspending or limiting a license included in H.B. 2008, and they favor a rehabilitation program for doctors. He noted cases can be reported to the Board of Healing Arts although there is no formal mechanism for doing so. There needs to be more legal protection for doctors reporting cases to the Board and for members of the Board.

In answer to a question about rates, Mr. Hall stated that under their national carrier, premiums are about $1,500 for $100,000-$300,000 for a general practitioner.

Dr. Arnold Levenson, Kansas Podiatry Assocation, stated most Kansas podiatrists carry insurance-underwritten by Lloyd's of London -- through their national organization. To date no Kansas podiatrist has been denied insurance, although some are having to change companies because their company withdrew from the market.

Kansas is in one of the lowest rate categories. However, ratings are on a month-to-month basis and premiums can change drastically. Podiatry premiums have increased approximately 300% in one year and will increase another 12% next year due to inflation. At the same time the company has reduced the coverage 50%, necessitating the purchase of an umbrella policy which further raises the total premium paid.

He noted that the same number of claims against podiatrists were filed nationwide from January 1 to August 20 of 1975 as had been filed during the same period in 1974.

Their Association has a peer review committee on Blue Shield programs. Legislation which became effective July 1, 1974, requires 54 postgraduate hours every three years for relicensing.

Their Association recommends a two-year statute of limitations, a re-evaluation of the contingency fee, a limitation of liability, and a peer review of claims in which the various specialities review their own members. Basically they endorse the recommendations of the Kansas Medical Association.

Cinda Vogel, Executive Director, Kansas Chiropractors Association, presented a written statement. (Attachment A)

In answer to questions, Ms. Vogel stated chiropractors' rates are low because they do not perform surgery. She thought annual premiums were about $200 to $250. She will try to get data on whether chiropractors participating in the experimental acupuncture program are covered.

Judy Runnels, Kansas State Nurses Association, presented a written statement. (Attachment B)

In answer to questions, Ms. Runnels stated that a few nurse anesthetists have had trouble getting insurance. Nurses pay an annual premium of $15.00 through the American Nurses Association. KSNA recommends all nurses carry their own malpractice insurance regardless of where they work because a nurse is a professional person and responsible for what she does. A nurse can question a doctor's order, and, if her conscience will not let her carry it out, can request that the doctor carry it out. KSNA does not object to mandating that nurses carry malpractice insurance. She did not have figures relating to the number of claims against nurses, because insurance companies did not wish to give them this information.

Dr. A.O. Tetzlaff, anesthesiologist, presented a written statement. He emphasized that he was appearing for himself and not for their Association. (Attachment C)

In answer to questions, he stated that two years ago nurse anesthetists paid an annual premium of $42.00, but the annual premium for their nurse anesthetist is now $750. He would like to see the number of procedures which a person is responsible for used as a basis for determining premiums. The present premium for doctors in their firm is $4,000 per physician for $100,000-$300,000 coverage, and about $2,500 for an umbrella of $2,000,000.

Donald Hoffman, Attorney General's Office and Attorney for the Surety Bonds and Insurance Committee, stated the committee submitted a manuscript policy for liability coverage for all state employees, individuals and agency as an entity, but had no bidders. They then began negotiations with brokers and companies. Figures quoted were in the neighborhood of $1.8 million for $1,000,000 per occurance coverage and a $25 million aggregate. A policy was not purchased because the cost seemed prohibitive and some agencies were not budgeted for their pro-rated portion. Medical malpractice was considered apart from the total liability package. The committee was assured by two companies they could provide the state with malpractice coverage. Cost was not specifically discussed, although it probably would have at least doubled the cost of the total package.

Companies bid on three levels of protection for a policy covering students at the KU Medical Center during their clinical phase of training. A contract providing $75,000 per student and $25,000 per occurrence was purchased from St. Paul Fire and Marine for something in excess of $8,000. These were the limits specified by the Medical Center in its original request, and apparently were satisfactory to the Insurance Commissioner who by statute was to set the limits.

In answer to questions, Mr. Hoffman stated that malpractice was considered separately because it could not be pro-rated to all agencies since all agencies do not employ physicians. Also in negotiations with companies, it was disclosed that many cases generally thought of as malpractice were actually errors and omissions claims and, therefore, covered by the negotiated liability policy. Most physicians at the KU Medical Center are members of

corporations which require their members to have coverage and purchase it for them. However, Mr. Hoffman indicated that the committee had heard conflicting statements about whether the corporation, the Medical Center or the State were covered. Physicians in other state agencies are on their own. His office has put these agencies on notice as to what the situation is.

In answer to a question, he stated the committee proved a liability policy could be written, but it did not solve the problem. Although there is no assurance that a policy can be written next spring after the Legislature meets, he felt there was a likelihood the company would be willing to bid again.

Staff submitted the following information furnished by Dr. Hill in a telephone conversation:

During the period July 18, 1970 through August 1975, the Board of Healing Arts conducted 47 disciplinary interviews; of these, 30 interviews resulted in a reprimand (the Board did not believe that the conduct merited suspension or revocation), in 16 cases no action was taken by the Board. During this period there were also 4 suspensions, 10 revocations and 12 reinstatements. At the present there are five cases pending prosecution, three of which involved Bureau of Narcotics and Dangerous Drugs issues and one in which a revocation may result. At the present time there are nine cases under investigation including the five noted as pending prosecution.

The meeting was recessed for lunch at 12:00 noon and reconvened at 1:30 p.m.

Joe Mackey, Hospital Administrator, Hutchinson, Kansas, spoke on behalf of 175 people from Reno County who appeared before the Committee and who had appeared before the Insurance Commissioner and the Governor earlier. He outlined the crisis in their community -- which had been brought to the attention of the Committee at a previous meeting -- noting malpractice is really a consumer problem. He thanked the Committee for its interest and efforts.

In answer to questions, he stated both the Governor and the Insurance Commissioner realized the seriousness of their situation. He felt Mr. Bell left the impression that if the recommendations of the Kansas Medical Society were adopted, insurance would be more available and the cost would be reduced.

Ken Kline, Kansas Bar Association, introduced David H. Fisher, Chairman of the Professional Relations Committee and Edwin Dudley Smith, Chairman of the Medical Legal Subcommittee, who presented written statements. (Attachments D and E) Copies of the "KBA Position Paper on Medical Malpractice" were also distributed to Committee members. (Attachment F)

In answer to questions, it was stated that generally the insuror cannot get subrogation for claims paid. The same discovery period would apply to all professions. Because of the time and expense involved, most attorneys will not become involved in

frivolous claims and some meritorious claims are not filed because they are too small. Limiting action against doctors would raise constitutional questions, as would reversing the collateral source rule. The conferees believed admitting evidence from panels in court could cause legal problems, especially if there was no opportunity for cross examination. KBA has not taken a stand on the issues of a defendant obtaining his defense costs or a claims made policy.

Walt Biddle, Director, Kansas Trial Lawyers Association, introduced Jerry Michaud who presented a written statement and a summary of their position paper. (Attachment G) He stated that more attention needs to be given to protecting the rights of the public and the person who is injured because of medical malpractice.

He stated they have been unable to find that insurance companies have given evidence to support the large increases in premiums. He referred to a letter received from Fletcher Bell in answer to their request for information about premiums paid in and claims paid out in Kansas. He stated that from 1971 through 1973 one company collected $1,985,056 in premiums and during this same period paid out only $295,663, noting the interest collected on the premiums would have covered the amount paid out. (Attachment H)

Mr. Michaud introduced Mr. Charles Fisher, Topeka Attorney, who stated that all cases appearing before a jury are being selected by the insurance companies because they settle the rest out of court. He presented the case of a three year old boy with a simple hernia in which the anesthesiologist, according to the court record, disconnected the monitoring equipment before surgery was completed. A few minutes later the boy turned blue. He was revived but was brain damaged as a result of the incident. Nine years later the father had a medical crisis and fearing his wife would be unable to provide for the boy and the rest of the family, went to an attorney. Mr. Fisher was contacted after the filing and accepted the case. Legal fees amounted to $25,000. The limit of the policy, $300,000, was awarded. They did not ask for more because of the doctors financial situation and the fact two other cases had been filed against him prior to this case. Mr. Fisher was later told that two additional cases were filed against this doctor after his case. The last he knew no disciplinary action had been taken against the doctor and he was still practicing in another community in Kansas.

An objection to the testimony was raised by Dr. O.A. Tetzlaff, who asked for time to present the true facts of the case. Mr. Fisher stated the facts he gave were a matter of court record. The Chairman ruled that since this Committee was not here to rule on the facts presented, time would not be granted but the objection would be noted in the minutes and a written statement could be submitted. For the statement submitted later see Attachment I.

Mr. Fisher was asked if insurance companies could pay a small sum each month or could put money in a trust fund instead of making a lump sum payment. He stated that in the case of a minor the law provided for a trust fund. He noted that in the case presented, $180,000 went into a trust fund and the rest was used to

pay attorney fees and medical bills. Mr. Michaud stated he favored the annuity type plan but a lump sum figure must still be determined.

Mr. Fisher interviewed Monty Bonnett, the boy involved in this case, and Dale Bonnett his father.

Mr. Harold Williams from the same law firm as Mr. Michaud, gave the following statistics about cases coming to them during the first 6½ months of 1975:

> 120 prospective cases came to them; 45 of these were rejected on the first call; 54 were rejected after interviews; 21 cases were filed and 5 of these were later discarded; some of the remaining 16 will be dropped after the medical records are examined.
>
> In the past 4½ years they have opened 190 files; filed 83 in court; settled 9 prior to filing the petition in court; settled 30 after filing the petition; withdrew from 5 after filing; dismissed 4 voluntarily; 11 were tried; 55 are still pending; 76 were rejected for other reasons.

He stated these figures represent about 50% to 75% of the malpractice business in Kansas and are probably representative of the whole state. They have noted no increasing trend in the number of cases during this period, but have noted a slight increase in the amount of money awarded.

In answer to questions, Mr. Michaud stated they would include all casualty companies and all companies writing health insurance in any joint underwriting pool. His firm tells people with meritorious claims under $25,000 that it is not economically feasible for them to take the case. He thinks arbitration might take care of some of these, but he also feels arbitration would not help the doctors. He favors level premiums because of interdependence between all categories of doctors. If all doctors paid $1,000 for $100,000-$300,000, limits, it would generate about twice the premium dollars collected last year. Level premiums would give every health care provider a personal and definite interest in what is going on in all segments of the medical enterprise. They suggested all licensed medical personnel be assessed for the "excess fund" if they wish to maintain their Kansas license. It was noted that not all licensed practitioners are practicing or practicing in Kansas.

The meeting was adjourned at 4:30 p.m.

August 28, 1975

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

J. Eugene Balloun, Kansas Association of Defense Counsel, presented their position paper. (Attachment J)

In answer to questions he stated they recommend that the review panel be made up of medical professionals but they had no objection to the recommendation of the Kansas Medical Society that it be chaired by an attorney. He felt a panel would be most valuable in screening small meritorious claims and getting the insurance companies to pay in these cases. He preferred to let the insurance commissioner tell the Committee what power he needed, but he thought it should be sufficient to set rates and to gather the statistics needed to set those rates. Views of panel members but not their conclusions should be admissible evidence in court, and members of the panel should be available to testify.

Frederick J. Knox, Vice-President, Actuarial, St. Paul Fire and Marine Insurance Company, noted that Kansas rates are about fourth from the bottom in their company. He then presented a statement and explained exhibits relating to rate setting. (Attachment K)

In answer to questions, he stated the insurance commissioner has all of the information presented. Also he has the right to call for detailed information regarding claims and to examine the claims file in their office. All the data is there if someone wants to take the time to understand it.

Administrative costs are in addition to cost figures shown in exhibits in the attached statement. (Attachment K) They pay commissions of 7½%.

All figures in the exhibits are based on $100,000-$300,000 limits. They do not have control on rates for excess coverage since they purchase it elsewhere. For hospitals they will write $300,000-$900,000 primary coverage and $1,000,000 in excess. In some states they are writing policies for new doctors coming from medical school or other states but not from other companies.

Mr. Knox felt that premiums would be higher if a no-fault concept were adopted.

In a claims made policy, if a doctor leaves practice because of death, disability or legitimate retirement, he may pay the three endorsements to keep his policy in effect in one payment. IRS has not been too clear but they have indicated the single payment would be deductible. Rates for the three year endorsements will be filed in the Insurance Commissioner's office this year and the rates for the single endorsement will be filed next year. Asked to give an example of a single endorsement, Mr. Knox said if you take a person at the highest rate in the highest classification who has been covered for five years, one payment for perpetuity for basic coverage and $1,000,000 umbrella would be approximately $11,214.

David W. Wilson, Assistant Vice-President, Governmental Affairs, Medical Protective Company, presented a written statement. (Attachment L)

In answer to questions, he stated the largest claim they paid in Kansas was $750,000 in 1974 on an occurrence policy. They are recommending a $100,000 total liability.

A question was raised regarding coverage and cancellation of policies. Mr. Wilson stated they do not cancel policies, but they did not renew six policies in 1974. A policy might be denied renewal on the basis of claims but not solely because the doctor had a claim against him. Based on his experience in Illinois, he felt cancellations were probably from companies in the non-admitted market. His company is writing policies for new graduates and those joining present policy holders. They do not exclude teaching.

Mr. Knox stated they have a surcharge program which is frequently considered in addition to the nature of the claim but they have not cancelled anyone.

Mr. Wilson stated he felt a claims made policy would do the most to stabilize the cost of insurance but what affect it would have on cost is an unknown. He believed the statute of limitations to be the most significant single factor contributing to increased costs. He did not answer a question relating to their experience in states having a two-year statute of limitation, except to say that in most states this is two years after discovery.

Answering a question, Mr. Wilson stated whether they preferred an arbitration panel over a jury would depend on how the panel was constructed and operated. Mr. Knox stated they favor a panel if it is binding.

At this point, Mr. Cole, representing the American Insurance Association, stated he would not make a presentation as planned, but would be willing to be included in the questioning.

The letter from Fletcher Bell, quoted yesterday, was referred to again. Mr. Knox stated he thought the figures quoted reflected accident year data and not calendar year data, and did not reflect what will be paid in later years on accidents occurring in that year. Mr. Cole referred the Committee to the total letter. (Attachment G)

Representatives of insurance companies present agreed they could furnish the Committee with data showing premiums received and claims paid out for each year from 1963 through 1974. This is not to include minors and is to be calendar year paid against calendar year premium.

Mr. Knox stated they do not send reports to the Board of Healing Arts. In states where they provide a total insurance program for a medical association, reports are sent to that association. Mr. Cole noted there is a legal problem if the law does not require them to report to the Board of Healing Arts.

All representatives agreed their companies would welcome other companies or groups coming into the malpractice insurance market.

In answer to questions, Mr. Knox stated that premium dollars collected minus payments made are put in reserve. The company has not earned any of this money until the coverage risk for that year has expired. Interest paid on these amounts are indirectly taken into consideration in determining rates. However, losses must be paid out of premium dollars and not interest money.

It was noted that questions of state or federal constitutionality might arise if limits of liability were placed on doctors only, if arbitration was mandatory and if the collateral source rule was changed.

It was pointed out that a contingent fee set by court rule or state statute is seen as a stabilizing factor in the future, but may not result in less cost to the taxpayer. The amount retained by individuals would be greater and it could indirectly reduce the amount paid out by insurance companies.

Mr. Wilson, in answer to a question, stated that a catastrophic fund to pay all in excess of $500,000 would encourage companies to come back into this field of insurance. Mr. Knox stated it would depend on the circumstances of the fund. Mr. Cole stated this would shift the burden of payments but would solve the price problem.

The representatives were asked if there would be any merit in an assigned risk like there is for auto insurance. It was pointed out companies such as Allstate for example, would not know what to do with this type insurance. If the pool included only those companies writing this type insurance, it would be unfair, create problems and mean companies would withdraw from Kansas.

Paul D. Tompkins, Independent Insurance Agents of Kansas, presented a written statement. (Attachment M)

In answer to questions, he stated that all non-admitted companies write only claims made policies. He has been able to get coverage for his clients, but know he will have to go to the non-admitted market to get excess coverage over $1,000,000 for special high risk groups. He feels adoption of the Kansas Medical Society's recommendations would reduce insurance premiums and help alleviate the practice of defensive medicine. He thinks the Blue Cross-Blue Shield programs of peer review improves the quality of care, but sees no evidence that it reduces the number of claims.

Henry Meiners, Vice-President for Professional and Institutional Affairs, Blue Cross-Blue Shield, presented a written statement. (Attachment N)

Fletcher Bell, Insurance Commissioner, presented a written report (Attachment O) stating the recommendations should be considered as a package.

In answer to questions Mr. Bell stated he did not think adoption of recommendation IV-1 would constitute an admission of guilt on the part of the insured. He feels they have the authority under the assigned risk statute to implement a Joint Underwriting Association, and he may exercise this authority before the next session of the Legislature. He views this as a temporary solution and believes it is still necessary for the legislature to pass a specific law pertaining to a JUA. If a JUA is formed before January 1, 1976, he envisions including only those companies currently writing malpractice insurance. However, when the Legislature adopts a law for a pooling mechanism, it could give the Commissioner the right to include all companies writing general liability in the state.

After reference to the letter from which Mr. Michaud quoted yesterday and a request for clarification, Raymond Rathert, Insurance Commissioner's Office, stated that for 1970-73, Medical Protective had an income of $1.7 million and a loss of $1.3 million for a loss ratio of 76.3%. St. Paul Fire and Marine had an income of $1.6 million and a loss of $1.047 million for a loss ratio of 65.4%.

Mr. Bell, in answer to further questions, commented that one state has requested detailed information relative to premiums received and claims paid. Such information should be available about mid-October. His office will have this type data by class for a one-year period at the end of this year.

If the Legislature provided immunity for persons furnishing information regarding doctors involved in malpractice claims, and required the Commissioner to send this information to the Board of Healing Arts, there would be no problem in complying with the directive.

It is correct that medical professionals in our state institutions must provide their own medical malpractice insurance. They are experiencing the same difficulty as others in obtaining coverage and the Commissioner assumes this creates a financial problem for them. He did not know if other states provide coverage for the medical professionals employed in their institutions.

He feels the limits in the occurrence policy purchased for students during their clinical experience are appropriate and were approved by the Medical Center. He would have to check his Memo to the Chairman to see if these limits are the same as he recommended during the last session of the Legislature.

Copies of the medical malpractice policy position adopted by the Intergovernmental Relations Committee of the National Conference of State Legislature were distributed. (Attachment P)

The next meeting will be September 23 and 24, 1975.

The meeting was adjourned at 4:00 p.m.

Prepared by Bill Wolff

Approved by Committee on:

9/23/75
(date)

Medical Malpractice
August 27, 1975

Please Print

Name	Address		Group
Wilma Naethy CRNA	1435 MacVicar	Topeka	Ks. Assn. Nurse Anesthetists
D. Barbara Moore CRNA	1924 Village Dr	Topeka	Ks. Assn. Nurse Anes
Mildred Rumpf CRNA	2917 West 20th	Topeka.	Ks. Ass'n Nurse Anesthetist.
Wayne Hird M.D. ✓	329 Mo St.	Lawrence 66044	
PHILLIP B. GODWIN, MD / Phillip B. Godwin, M.D.	346 MAINE ST	Lawrence 66044	- KAN SOC ANESTH
Jack Landreth	901 Ky.	Lawrence, KA 66044	
Robert H. Robinson M.D.	558 Stratford	Wichita	Kan Soc of Anesth
Arnold Greishnys, M.D.	7331 Plaza Ln.	Wichita	Kansas Soc. of Anesthesiology
John Braden	UPI		
Wlad. Hall	835 western	Topeka	Ks assn Ost Med
Donald E. [illegible] D.P.M. (print you clown!)	2308 Anderson	Manhattan,	Kans. Podiatry Ass.
JEREMY SLAUGHTER	KS. MED. SOCIETY	TOPEKA	
Wayne Prohasco	Ks Podiatry Assn	Topeka	
[illegible] Cornish	1st National Tower. 1	Topeka	(Ks assn of [illegible] Cos)
Mark L. Bennett	Ass Ins Assoc	Topeka Ks	
Cinda Vogel	Topeka, Ks.		Ks. Chiropractors Assn.
Edw D. Funk M.D.	Linwood Ks		Ks. St. Anes. Soc
J.V. BLISS, M.D.	Olathe, Ks.		Ks. Anes. Soc
Arch Tozlaff M.D.	Prairie Vill. Ks.		Kans. Soc. of Anesthesiologists
D. OKTAWIEC M.D.	FAIRWAY, KANS.		Kans. Soc. of Anesthesiology
[illegible] M.D.	Shawnee Mission Ks		" " "
A. KODANAZ, M.D	FAIRWAY, Kans.		Kans Soc of. Anesth.

August 21, 1975

ARNOLD GRUSHNYS, M.D.	Kansas Soc. of Anesthesiology	Wichita, Ks.
Joan M. Baker	Kans. Ins. Dept.	
GLEN E. EATON M.D.	KS. Soc. of ANES	Rt 3 SALINA, Ks
Melvin V. Holman, M.D.	Ks Soc of Anes	Merriam Ks
Druery R. Thorp MD	Ks Soc of Anes	Olathe Kansas
Helen Hash Jorg MD	Ks Soc of Anes	Merriam Ks
Hugh S. Mathewson, M.D.	Ks Soc. of Anes.	Kansas City
Carl C Schmitthenner	Kansas State Dental Assoc.	Topeka, Ks
David Moses	WASHBURN U.	Topeka, KS
Barbaralee Horejsi	State Treasurer	Topeka, Ks
Judy Runnels	Kansas State Nurses Assoc.	"
Cinda Vogel	Ks. Chiropractors Assn.	Topeka, Ks.
JOHN BLANK M.D	HUTCHINSON	K.M.S.
S. C. McCRAE, MD	SALINA	Ks.
L. M. CORNISH	Ks Assoc of Rep+Ca. Cos.	Topeka
Wilma Naethe, CRNA	Ks. Assn. Nurse Anesthetists	Topeka
D. Barbara Moore CRNA	Ks Assn. Nurse Anesthetists	Topeka
Mildred Rumpf CRNA	Nurse Anesthetists	Topeka
Earl Noyes CRNA	Ks assoc Nurse Anesthetist	KCK
KS Hdqrtrs.	Hutchinson	Ks.
Marilyn Chaney	Hutchinson	Ks.
PAUL E. FLEENER	KANSAS FARM BUREAU	MANHATTAN
Rosanne Winter	KTLA	Topeka
Carole Mansell	Hutchinson	Ks.
Lorene Graber	Hutchinson	Ks.
Marian Walter	"	Rt 2.
Helen Bittorf	"	"
Cayl McDowell	KTLA	Topeka
Jack Roberts	BLUE CROSS-BLUE SHIELD	"

August 27, 1975

Larry E. Davis D.O.	Overland Park Ks	Ks. Soc. of Anesthesiologists
Helen Hash Toro M.D	Merriam, Ks	Ks Soc of Anesthesiologists
MICHAEL E. ARONOFF, M.D	OLATHE	Ks Malpractice Comm.
JOHN BLANK M.D	HUTCHINSON	K.M.S.
Carl C Schmitthenner	Topeka	Ks Dental Association
Hugh S. Mathewson, M.D.	Kansas City	Ks. Soc. of Anesthesiologists
JOHN C ARTMAN M.D.	HAYS	KSA
[signature]	Wichita	KMS
George Brumbaugh	Wichita	Kan Council for Health Legislation
[signature] Walt Riddle	TOPEKA	Ks TRIAL LAWYERS ASSN
Adrian W. Mee, M.D.	Olathe	Ks Soc. of Anesthesiologists
Pedro L. Legaspi Jr.	Shawnee Mission, Ks	Ks. Soc. of Anesthesiologists
[signature]	Merriam Ks	Ks Soc of Anesthesiologists
Ruth Willson	Topeka	St. Rep.
[signature]	"	Ks. Insurance Dept.
[signature] Gary J Newman, DOS	Topeka	KSDA
Ken C. Hutchison, MD	Hays	Ks Soc of Anesthesiol

Medical Malpractice
August 28, 1975

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Name	Group	Address
[illegible]	Kansas St. Anesthesiologists Soc	Olathe Kansas
Melvin D. Holmandmd	" " " "	" "
Pedro L. Legaspi Jr.	Kan. Soc. of Anesthesiologists	Shawnee Mission, K
BERT HARNED, M.D.	Kan. Soc. of Anesthesiologists	OLATHE, KS.
D. OKTAWIEC, M.D.	" " "	Fairway, Ks.
Angela Nieval MD	" " "	Shawnee Mission Ks
J. Bliss, M.D.	Kan Soc. Anes.	Olathe, Kansas
Adrian W. Mee, M.D.	" " "	Olathe, Ks.
PHILLIP A. GODWIN MD	" " "	LAWRENCE KS
Hugh S. Mathewson, M.D.	" " "	Kansas City
GLEN E. EATON M.D	" " "	Salina
Glen C. HUTCHISON MD	" " "	Hays
ARCHIBALD O. TETZLAFF, M.D.	" " "	Prairie Village
Dale Patton	KMS	ICT
Jon Klein	Ks. Bar Assn.	Topeka
Dave Fisher	Chr. Professional Relations Ks Bar	Topeka
Mark T. Bennett	a J a	Topeka
Ken Cole	a J a	Dallas Texas
Don Jones	St Paul Cos	Kansas City
Fred Knox	" " "	St Paul
Edw D Funk MD	Ks Soc Anesthesiologists	Kenwood Ks
B. A. GILLEN, M.D.	" " "	PRAIRIE VILLAGE, KS.

Please Print

Name	Group	Address
GERALD L MICHAUD	KS TRIAL LAWYERS	Clown Wichita
Harold Williams	"	Wichita
Darby Patten	KMS	Wichita
Charles S Foster Jr	lawyer	Topeka
Dale Bonnett	citizen	Topeka
Monty Bonnett	citizen	Topeka
Ken Klein	Ks. Bar Assn.	" "
JOHN E SHAMBERG	KTLA AND PUBLIC	KANSAS CITY, KAS
WALT RIDDLE	KTLA	TOPEKA.
H. R. DRAEMEL	SALINE CO. M.S.	SALINA KANSAS
Jerry L. Mathis	Physician-Citizen	Salina KS
Adrian W. Mee, M.D.	Kans. State Society Anesthesiologists	Olathe, Ks.
J.V. Bliss, M.D.	Ks. Soc. Anes.	Olathe, Ks.
Wesley Pruett	AJA	Topeka
KEN W. COTE	AJA	DALLAS
Pedro L. Legaspi Jr.	Ks. Soc. of Anesthesiologists	Shawnee Mission, Ks
ARCH TETZLAFF, M.D.	Kans. Soc. of Anesthesiologists	PRAIRIE VILLAGE
J.B. Barbee	United Transportation Union	Wichita
Frank L Gestry	Kans. Hosp. Assoc	Topeka
George Donnald	Kansas Council for Health Legislation	Wichita
M Snyder MD	KMS	Wichita
Dudley Smith	Kan Bar Assn	Topeka
T.C. Anderson	Kansas Bar Assn	Topeka
Jack R Euler	" " "	TROY
Cathy Tebow	KTLA	Topeka
Robert H. Robinson M.D	Kansas Soc of Anesth	Wichita

Cathy Talbert	KTLA	Topeka
[illegible]	Ks. Med. Soc.	[illegible]
[illegible]	KMS	Wichita
George Trumbold	Ks Council for Health Educ	Wichita
Barb Rather	KMS	Wichita
L M Cornish	Ks Assoc	Topeka
DAVID WILSON	MEDICAL PROTECTIVE	FT. WAYNE, IN
[illegible]	✓	✓
A.O. TETZLAFF, M.D.	KANS. SOC. OF ANESTHESIOLOGISTS	PRAIRIE VILLAGE
Robert Zand Joy Hustead	Kans Soc of Anesthesiologists	Wichita, Kans
Glen C. Hutchison M.D.	" " "	Topeka
Hugh S. Matheson, M.D.	" " "	Kansas City
Mildred C. Rumpf	Ks. Assn Nurse Anesthetists	Topeka
Wilma Naethe, CRNA	Ks. Assn Nurse Anesthetists	Topeka
Carl C Schmitthenner	Ks State Dental Assn	
JOAN BAKE	Ks. INSURANCE DEPT.	
Bert Harned, M.D.	Kans. Soc. of Anesthesiologists	OLATHE
Melvin V. Holman, M.D.	Ks Soc of Anes	Olathe
Pedro L. Legaspi JR.	" " "	Shawnee Mission
Henry R. Thorn M.D.	Kan. Soc of Anesthesiologists	Olathe
Bob Nichol	Ks Ass Osteopathic Medicine	Topeka
Judy Runnels	Ks State Nurses Assoc.	Topeka
Paul E. Fleener	Kansas Farm Bureau	Manhattan
JACK ROBERTS	BLUE CROSS - BLUE SHIELD	TOPEKA
HENRY MEINERS	"	"
J.V. Bliss, M.D.	Ks. Soc. Anes.	Olathe, Ks
Adrian W. Mee, M.D.	" "	" "

James O Wallace	Ks. Indep Insurance Agts	Topeka
Paul Tompkins	"	"
Cinda S. Vogel	Ks. Chiropractors Assn.	Topeka, Ks.

H

Presentation
to the
Special Committee on Medical Malpractice

August 27, 1975

Mr. Chairman and members of the Committee, I am Cinda Vogel, Executive Director of the Kansas Chiropractors Association. We appreciate your invitation to appear before this Committee to present our position.

The majority of the doctors of chiropractic in Kansas carry their professional liability insurance with two insurance companies which are affiliated with the two national chiropractic organizations -- the National Chiropractic Mutual Insurance Company and the International Chiropractors Insurance Company. As far as we have determined at this point in time, availability of liability insurance for chiropractors is not a problem.

Information from one of the national companies indicates that claims made in Kansas since January 1, 1970, total seven with a total pay-out of less than $5,000.00. However, both companies have increased premiums since the first of this year by no less than 100%, which is a strong indication that, nation-wide, the problems in the malpractice issue are affecting not only the medical profession but other health professionals as well.

For the past several years, the Kansas Chiropractors Association has strongly supported the Healing Arts Board in maintaining the requirement of mandatory post-graduate education for relicensure of chiropractors each year in Kansas, and has worked with the Board in maintaining a high standard of continuing education programs.

Furthermore, at the annual 1973 spring convention, the Association established by resolution a peer review system. Accordingly, the profession's peer review goals were set forth:

(1) To assure high quality health services at reasonable cost;

(2) To assure high standards of professional conduct and ethics by objective evaluation of chiropractic peers;

(3) To provide educational assistance to the doctor of chiropractic in rendering his service; and

(4) To assure that chiropractic review procedures remain the responsibility and the privilege of the profession.

We feel that our peer review program has been quite successful in fulfilling these goals.

The chiropractic profession is very much concerned with the problems surrounding malpractice as they exist now and in line with other health professions, the Association favors preventive legislative action to avoid future crises.

In cooperation with other health professional groups, the Legislature and likewise, with the office of the Insurance Commissioner, the Kansas Chiropractors Association will work toward and support common solutions to both immediate and potential malpractice problems.

B

Notes submitted to the Special Committee on Medical
Malpractice of the Kansas Legislature on August 27, 1975
by Judy Runnels, Lobbyist, Kansas State Nurses' Association

Mr. Chairman:

Professional Liability Insurance for Nurses is no longer a "Ho-Hum, Maybe I will someday" situation. The professional nurse today who has no personal liability insurance is flirting with financial disaster. It wasn't always this way. Not too many years ago the average professional nurse often ludicrously dubbed as a "good soldier in the bedpan brigade", discharged mostly ministerial functions. She dutifully, albeit sometimes apprehensively, executed medical orders and that was that! In recent years much of this has changed. The advent of degree programs in nursing education, coupled with liberalized Nurse Practice Acts have given a true meaning to the word PROFESSIONAL in the title of "Registered Professional Nurse." However, nurses everywhere have come to realize that with more professional recognition, there comes a greater measure of separately-identifiable legal liability.

It is not unusual for a nurse to find herself on the receiving end of a block-buster malpractice suit today. This can happen as a result of the efforts of an Attending Physician to extricate himself from liability. For example, a typical doctor's defense in a malpractice suit today arising out of the death of a coronary patient might take the following form: (1) my diagnosis was right; (2) my treatment orders were correct; (3) at the time of death, my patient was under the care of ICU nurses; (4) if there was negligence, it wasn't mine but may have involved the failure of such nurses to properly execute my orders and the standing orders of their Unit. This kind of affirmative medical defense might present a personal liability problem for a nurse. Even if employed by a "covered" hospital at the time of the alleged negligence, she might still need personal liability coverage.

Therefore the Kansas State Nurses' Association supports the Kansas Medical Socities' recommendations that all health care providers must show financial responsibility by carrying liability insurance.

There are approximately 10,000 Registered Professional Nurses and 3,500 Licensed Practical Nurses currently employed in Kansas. At the present time, few R.N.'s have had difficulty obtaining malpractice insurance. R.N.'s can obtain malpractice insurance from St. Paul Insurance Company for $50.00 for a three-year premium. They can also be covered through the American Nurses' Association's insurance program for as little as $15.00 per year. Nurse anesthetists, however, are experiencing rapidly rising rates. In 1975 the cost was $770.00/year and their rate will be even higher in 1976.

Should this Committee elect to write comprehensive malpractice legislation, we in KSNA feel that nurses should also be included.

Nurses have empathy for the difficulties being experienced by some physicians and are supportive of their efforts to see that comprehensive legislation is inacted.

Nurses are also concerned about the patient or consumer. We have confidence that the committee will keep their needs in mind as well.

We are generally supportive of the KMS proposal. However at this time, KSNA does not have any official position.

Therefore, Mr. Chairman, we will wait to react to specifics until we see what legislation the committee chooses to draft.

Thank you.

ANESTHESIOLOGY, CHARTERED
PRACTICE LIMITED TO ANESTHESIA AND INTENSIVE CARE
A. O. Tetzlaff, M.D., Harold Esrig, D.O., A. Aytekin, Kodanaz, M.D.

A. O. TETZLAFF, M.D.
6525 Granada,
Prairie Village,
Kansas, 66208

August 27, 1975

The Honorable
Senator Wesley Sowers, Chairman
The Kansas Legislature
Special Committee on Medical Malpractice

Mr. Chairman:

I am submitting two letters from R.G. Evans Underwriting Service. The first letter is dated May 24, 1974; it contains in paragraph three the quote of a premium for $ 2,000,000 umbrella insurance, namely $ 4,287 for our group of three physicians. That is $ 1,429 per physician for the above umbrella insurance with an underlying limit of $ 100,000/300,000 covered by a basic policy.

The second letter is dated July 9, 1975. It informs us that the umbrella insurance might be extended for two new physicians in our group, provided their underlying limits would be increased to $ 250,000/500,000, and then for an annual premium estimated to be between $ 60,000 and $ 70,000 per physician.

If we disregard the request for the increased "basic" limits, we come to the conclusion that in only 411 days the umbrella premium increased from $ 1,429 to at least $ 60,000, that means it multiplied by a factor of fourty-two! In other words, the rate of growth of our premium is exponential, at 332 per cent per year compounded instantly. If continued at that rate, it will reach $ 1,275,000,000,000 on or about August 8, 1980, that is, the annual premium per physician would then equal the GNP (Gross National Product) of the year 1973.

However, by July 29, 1976 the premium for $ 2,000,000 umbrella insurance would amount to $ 2,000,000. It implies that by that time next year the probability of losing $ 2,000,000 in a malpractice claim equals very nearly 1, or certainty. Nobody, of course, would pay a premium which is higher than the amount for which he wants to be insured.

To make our fees commensurate with the risk of malpractice litigation losses, they should rise at the same rate. If we charged $ 100 for a procedure in May of last year, we should now be charging $ 6,623 and by July of next year $ 139,455.00.

However, if we merely want to meet the anticipated expense in one year, we have to charge our patients $ 43.00 per anesthesia in addition to our usual fee. We have submitted these increased charges to Blue Shield of Kansas City, only to be told that the public could not endure such a rate increase at this time.

In the meantime, we have been quoted a premium of $ 27,000 for $ 1,000,000 umbrella insurance, with basic limits required to be 300,000/900,000. The latter request rapidly rose to $ 500,000/ 1,000,000. Today that company does not offer umbrella insurance at any price, we are told. The information comes from Mr. R.G. Evans, the company is "American Universal".

Our legal counsel advises us that we cannot dare practice our profession without umbrella insurance in addition to the "basic" limit coverage. Our renewal date comes up January 1, 1976. It appears the insurance companies may revoke our license to practice medicine at that time, unless emergency legislative relief is forthcoming.

Without a solution to this crisis, we may be out of work as of that date. We will not be on "strike", merely unable to practice. If the same situation develops in other areas in Kansas, and we have information to the effect it already has developed, the situation could deteriorate very rapidly. Hospitals may have only 40 to 50 percent of their usual occupancy, they would soon be headed for bankruptcy, many employees would lose their jobs, and patients would go without care. All would suffer.

From a report by a group of Michigan doctors (The Kansas City Star, Monday, August 25, 1975),which we are hereby submitting to the Committee, we learn that anesthesiologists have about the same number of suits filed against them as pediatricians, yet anesthesiologists are asked to pay much higher malpractice premiums.

Dentists and oral surgeons pay only a few hundred dollars a year for malpractice insurance, yet they bring those patients into our operating rooms which they consider to be too poor a risk to be taken care of in the office.

Therefore, we recommend that all medical malpractice premiums should be of the same level, regardless of specialty. Otherwise, we may see some medical specialties lose what little manpower they have today.

From the same report cited above we also learn that a disproportionate amount of our premium dollars end up in the hands of lawyers, and very little goes to the injured parties. In fact, only those injured parties with high claims seem to be able to find legal counsel willing to help them.

The contingent fee system is supposed to be the "key to the courthouse" for all but the very rich. But that key does not fit for those with claims of $ 5,000 or less. Is that not a lot of money for a poor person?

We submit an article from FORBES, dated September 1, 1975, page 63, with a solution to the problem which will channel the money directly to the injured parties without subjecting physicians to the 19th century procedures of tort law: Pattern the compensation for therapeutic misadventure along the lines of the workmen's compensation law, in a "no fault" fashion. Why should an identical injury result in a tenfold or higher claim when it results from a medical misadventure as compared to an injury at work?

To the best of my knowledge, the contingent fee is judged to be unethical and illegal in all but two countries in the world. Why should attorneys in these two countries cling to a privilege which has been outlawed in all other countries?

Before closing, I would like to point out that the so-called "claims-made" malpractice insurance should also be declared illegal in our State. It has been compared to buying a house with a 25-year mortgage, and to be told after 23 years how much the total price of the mortgage is going to be.

We hope the Committee agrees that we have a crisis on our hands and that decisive steps have to be taken as rapidly as possible to provide relief.

Very truly yours,

Archibald O. Tetzlaff, M.D.

Archibald O. Tetzlaff, M.D.
President, ANESTHESIOLOGY, CHARTERED

C-1

R. G. EVANS UNDERWRITING SERVICE

Professional Insurance Facilities

May 24, 1974

Office of
Robert G. Evans

15 West 10th Street
Kansas City, Mo. 64105
816-421-5155

Anesthesiology Chartered
7500 West 95th Street
Overland Park, Kansas 66212

Attention: A. Aytekin Kodanaz, M.D.

U.S. Fire - Umbrella #DCL 08 65 61

Dear Dr. Kodanaz:

Gerald Franksen has indicated that you folks are interested in knowing of the amended annual premium for optional higher umbrella liability limits.

As indicated to you folks in our letter of May 17, it is necessary that your existing $1,000,000 professional personal umbrella liability policy be endorsed to reflect new underlying limits of $100/300 and the amended annual premium for the $1,000,000 will be $3,062 with pro-rata additional premium from July 1, 1974 until anniversary date January 1, 1975 of $416.

Alternatively, annual premiums for $2,000,000 umbrella would be $4,287* and for $3,000,000 umbrella, would be $5,052. Of course, if we increase the limit of liability at this time or as of July 1, 1974 when the new proposed Atlantic Insurance Company policy and limits become effective, there would merely be a pro-rata additional premium from that time until next anniversary billing date, January 1.

Please advise if I can be of any assistance concerning your inquiry or if you do desire one of the optional higher umbrella limits to be placed into effect. Incidentally, higher umbrella limits up to $5,000,000 are readily available by simple endorsement to your existing policy or, even $10,000,000 limit is available on special submission to the umbrella insurance carrier.

Sincerely,

Robert G. Evans

cc: Mr. Gerald J. Franksen

* for three physicians

R. G. EVANS UNDERWRITING SERVICE

Professional Insurance Facilities

July 9, 1975

Office of
Robert G. Evans

15 West 10th Street
Kansas City, Mo. 64105
816-421-5155

A. O. Tetzlaff, M.D.
c/o Anesthesiology Chartered
Providence Health Center
1818 Tauromee,
Kansas City, Kansas 66102

→ Residence: 6525 Granada Dr.
Prairie Village, Ks.
66208

Chicago Insurance Company - Professional
Personal Umbrella Liability Insurance Policy-
#2 55 U 026268

Dear Dr. Tetzlaff:

This will supplement and confirm our several telephone discussions during the past two weeks concerning your request to extend the captioned umbrella liability insurance policy to reflect the exposure of two employed Anesthesioligists by your professional corporation and for the individual umbrella liability of those two proposed employees, Larry Edward Davis, D.O., and Danuta Oktawiec, M.D., effective July 1, 1975.

The purpose of this letter is to confirm to you certain restrictions and changes in Chicago Insurance Company underwriting approach during the several months since their initial inception of the captioned umbrella policy on January 1, 1975, such current restrictions and changes relayed to me by telephone from the Chicago, Illinois office of the company following receipt of your request to now include these folks under the captioned umbrella policy.

While the Chicago Insurance Company was able to accept as new business your professional liabillity umbrella policy captioned above, following the maximum available underlying professional liability limits of $100/300 afforded by your primary insurance carrier, Atlantic Insurance Company of Gulf Insurance Group, I am informed that within two or three months thereafter, because of pressures and restrictions imposed

upon Chicago Insurance Company by their re-insurers, minimum underlying professional liability limits for Anesthesiologists to qualify for their professional umbrella liability program were increased first to a level of $200/600 then, just a few weeks later were increased to higher levels of $500/1,000,000 and then I believe $1,000,000/1,000,000 and then finally, no new or renewal professional umbrella liability available on any business through Chicago Insurance Company.

Thus, when our office approaching Chicago Insurance Company with your request to extend the captioned umbrella policy to both cover the exposure of the professional corporation as employer of the two proposed employees as well as the individual professional umbrella coverage for one of those employees, Dr. Davis, they indicated that, at first, it was their underwriting requirement insofar as the policy coverage and conditions were concerned to include the individual exposure of all physicians associated with the firm, either as principals or employees, so therefore, our request to increase the captioned policy in any manner immediately presented a major underwriting obstacle to the company.

Within the negative climate of Chicago Insurance Company not accepting any new or renewal professional umbrella coverage for any Anesthesiologist, the company underwriter was able to obtain tentative offer to extend the captioned policy as requested but only if underlying professional liability limits for these two employees was increased to a level of $250/500 and then, tentative premium indication for each doctor on an annual basis was estimated to be between $60,000 and $70,000 each and, of course, this proposed premium range would be pro-rated from effective date of coverage until policy expiration on January 1, 1976.

Furthermore, the underwriter indicated Chicago Insurance Company would definitely not be a market for renewal of the captioned policy beyond January 1, 1976.

Since the absolute maximum underlying professional liability limits available through Atlantic Insurance Company of Gulf Insurance Group are and always have been $100/300, we obviously reached an impasse.

July 9, 1975

The underwriter for the insurance company indicates that while they were willing to continue the captioned umbrella policy until its normal expiration based upon the exposure contemplated at inception, January 1, 1975, the proposed employment of two additional Anesthesiologists on or about July 1 reflected a major change in exposure at a time when that company's acceptability of professional umbrella liability coverage for Anesthesiologists had changed materially reportedly because of restrictions placed upon them by their re-insurers, the captioned policy would have to be terminated in mid-term if the current underwriting considerations were not met.

It is, therefore, my understanding that based upon our various telephone conversations concerning this unfortunate matter that the professional corporation's contract of employment to the proposed employees has been terminated for the present time and the status of Anesthesiology Chartered remains the same as that originally contemplated.

While I believe this letter completely outlines the status of this matter to date, please do not hesitate to contact me if you should require further clarification relative to this situation.

Thanks again for your patience and understanding in this difficult situation.

Sincerely,

Robert G. Evans

cc: Mr. Chuck Doubler,
Liability Department
Interstate National Corporation
55 East Monroe Street
Chicago, Illinois 60603

C-3

14 THE KANSAS CITY STAR
Monday, August 25, 1975

Michigan Doctors Criticize Medical Malpractice System

By Lawrence K. Altman
New York Times News Service

New York—The medical malpractice system is costly, out of control, not serving the public interest and benefiting just a small percentage of lawyers, a Michigan doctors' group charges on the basis of its study of 1910 malpractice suits filed in the metropolitan Detroit area between 1970 and 1974.

The survey of court dockets for all malpractice suits filed in one geographic area is believed to be the first of its kind. It was financed by the Physicians' Crisis Committee, a group of 1,578 Michigan doctors who, suddenly confronted with soaring malpractice premium rates, sought data about key factors leading to the crisis that has struck across the country.

Apparently only the Michigan group organized a research team to obtain basic facts about why malpractice litigation was rising so sharply.

Detroit patients, the study found, paid an estimated $70 million in legal fees for malpractice cases to a small number of law firms. Though the average settlement was $78,148, the plaintiffs received fewer dollars than the attorneys, the doctors' report said.

Another finding—that doctors do not win the vast majority of cases—refuted a contention advanced by many lawyers. Trial lawyers particularly have argued that because doctors win most cases, lawyers need a high contingency fee to make malpractice litigation profitable.

Money was awarded Detroit plaintiffs in more than four out of five medical malpractice cases surveyed.

The overwhelming majority of malpractice cases never go to trial and attorneys settle many cases for reasons that seldom relate to the merit of the malpractice charges, the report said in charging that "the vaunted American jury clearly makes the decision in less than one out of every 10 cases."

Still another surprising finding was that doctors of osteopathy were defendants in malpractice cases in a disproportionate number of cases, compared with doctors of medicine.

Another finding in the study of Wayne, Oakland and Macomb circuit courts in Greater Detroit was evidence of a clear relationship between the advent of no-fault automobile insurance and the growth of the malpractice crisis in Michigan. Three times as many malpractice suits were filed in 1974 than in 1970. A relatively gradual increase occurred through 1973, at which time there was a sharp rise when no-fault automobile insurance became effective.

John F. Dodge, attorney for the committee, said in a telephone interview that law firms that once had concentrated on automobile litigation cases had entered the malpractice field recently and were largely responsible for the precipitous rise in malpractice claims.

Serious questions about the insurance industry's rating practices were raised in the doctors' minds because, they said, "our information suggests that at least some ratings are based on total ignorance, completely haphazard guessing—or worse."

The survey "disclosed an immense discrepancy between" the very high rates charged anesthesiologists and the relatively low number of suits filed against these specialists. One suit per 10.7 anesthesiologists and one suit per 9.6 pediatricians were filed. Yet the insurance carriers charged the anesthesiologists the highest and the pediatricians the lowest rates among all types of specialists. Neuro-surgeons had the highest ratio—one suit per 0.8 brain surgeons.

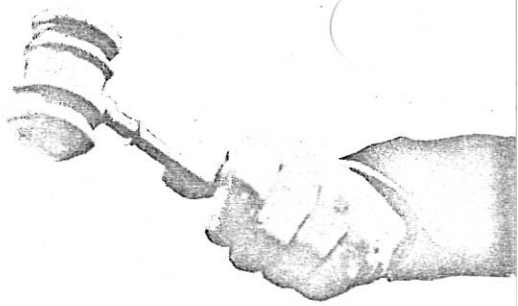
Anesthesiologists have been among the leaders of the doctors' work slowdowns in California and elsewhere over proposed doubling and tripling of their malpractice rates.

Accordingly, the Michigan group urged that greater regulatory control be placed over insurance carriers and that they be made to report more stringently facts about malpractice suits.

The writer is a doctor and science specialist for the New York Times.

SPECIAL INSURANCE REPORT 1975

Sue! Sue! Sue!



The insurance company isn't the only one that loses from a fat damage award. So does the insured public. But there's a sensible alternative.

The absolutely latest wrinkle in litigation: Sue your son. Let's suppose the boy is chauffeuring the family up to Lake Hollyhock and rearends the car in front at a stoplight. Some lawyers are encouraging the old man to sue the kid for negligence. Good clean fun, and maybe you can collect enough cash from the insurance company to make up for your next seven insurance rate increases, and then some.

Or, try this: Sue your husband for breach of fiduciary duty if he put too much of the family's nest egg in New York City bonds. Or sue the city itself for selling him the bonds in the first place, as one lawyer did last month, to the tune of $19 billion in asked-for damages.

Ridiculous extremes? Ridiculous, maybe, but not so extreme. The newspapers are full of stories about litigation these days. Doctors are a prime target, but far from the only target. The prevailing attitude is: Make 'em pay; they're insured, aren't they?

Jury awards to victims of all sorts are skyrocketing—and with them insurance rates. Last month, superlawyer F. Lee Bailey asked for $4.6 *billion* for some 120 victims of an airplane crash.

As plaintiff lawyer Jacob Fuchsberg asked (he had more than a dozen $1-million accident verdicts to his credit before he became a judge): "Can't we afford it?"

The answer is almost certainly: No.

Take the insurance companies. No matter how fast they push premiums up, they keep losing money on their underwriting business. Teledyne's Argonaut Insurance Co. dropped $80 million on medical malpractice insurance alone last year. Meanwhile, the companies are reaping a bitter harvest of public scorn with each rate increase, with each refusal to renew. The lawyers and a minority of victims reap the money. The insurance companies reap the blame. The nation's bill for nonauto liability insurance hit $1 billion in 1961, $2 billion in 1970, $3 billion last year. Counting in autos, the bill soars to $14 billion. It could go as high as $30 billion by 1980. Indeed: *Can we afford it?*

Fortunately, history offers some ways out.

The "malpractice crisis" is actually one of the most durable sagas around. Just like *Gone With The Wind*, it plays to a new audience every decade or so.

Think back for a moment. When the focus was on on-the-job injuries some 80 years ago, this scenario ended happily with the passage of workmen's compensation laws—what we would call no-fault laws today. Call them "no-lawyer laws," since that was their effect. The legislature fired the legal free-lancers who had been defending workers' right to sue, and the lancers moved on. The result: cheaper insurance for more employers, a smooth stream of profits for insurers, better industrial safety and a prime source of labor-management friction done away with. The price? The doing away with a lot of plush legal practices.

Or remember when public attitudes toward divorce changed after World War II that the story was about the same. No-fault divorce—after 30 years' resistance by the lawyers—was the answer, and most states now have it. Where there is mutual consent to divorce, there is no more need to prove adultery or alienation of affection. No more breach of promise. No more need for photographers and private detectives to burst in on love nests. Some lawyers lost out, but the public as a whole benefited.

And no-fault auto laws, as Daniel Moynihan has pointed out, were "the one incontestably successful reform of the 1960s."

Why not the same answer when the spotlight suddenly shifts to medical malpractice, where a steadily increasing number of legal warriors have set up shop? Why isn't the insurance industry taking advertisements telling people that no-fault is the answer? Why do companies rely almost single-mindedly on the old-time religion of more rate increases? That's a good question. And the probable answer is: Inertia.

Despite stop-gap legislation in many states, the bill for medical malpractice has just begun to be paid. A record 103 suits were filed in Cook County, Ill. alone in July—just in time to beat a possibly unconstitutional law that seeks to hold down damages on them to no more than $500,000. Doctors and hospitals are just starting to pass on their insurance rate increases to patients: Day rates in some hospitals have climbed $12 a day in just eight months (to $144!).

It isn't just doctors, either. Lawyers, accountants, architects, consultants, directors and homebuilders have all been watching their premiums soar. No one seems immune: Utica Mutual, the nation's largest insurer of insurance brokers and agents, says that malpractice claims filed against its 11,000 policyholders climbed 40% last year. The indicated rate increase: 60%! But will even that be enough? "Who knows?" says Vincent T. Ehre, Utica chairman.

Accountant's Nightmare

The accounting profession is especially beleaguered by malpractice claims against its members. So the American Institute of Certified Public Accountants is taking the extraordinary step of trying to bar member CPAs from working on a contingency-fee basis for lawyers who bring class-action suits—the professional equivalent of trying to kill the messenger who brings you the bad news. (They haven't succeeded yet.)

Just imagine the chaos when some clever attorney finds a way to make stick malpractice charges against economists and journalists.

Product liability is the next "crisis area," comparable to medical malpractice, according to Iowa Insurance Commissioner William Huff III, president of the National Association of Insurance Commissioners. Already, consumer suits—over everything from exploding frying pans to mislabeled birth control pills—are causing a "serious profit hemorrhage," according to expert Irwin Gray. Product-liability suits have increased from 50,000 in

1960 to 500,000 in 1970 and to more than a million today. Tomorrow, the bill for all that will be passed on to the consumer.

You can pay through the nose on your tax bill, too. The deep-pocket theory goes double for government. A year ago, 78 lawyers in New York City's legal department were slogging away at 55,000 suits stemming mostly from flaws in streets and sidewalks. After the fiscal crisis, there may be fewer lawyers—but there will certainly be more suits.

Sidewalk falls. Exploding frying pans. The twist-too-much of an oxygen valve in an operating room. What these have in common with the workman's severed finger, the failed marriage and the bent fender is that each was once considered a dirty deed rather than an accident. All were originally a rich field for litigation.

But where the 19th century saw a tort—and sued—the 20th century sees an accident and settles. That is what no-fault is all about. It may be an abridgement of the rugged individual's right to win big if he can, but it is also a civilized necessity. In a society that believes in protection for all—not just for the rich and the lucky—the protection must be delivered at a reasonable cost, and only no-fault can do it.

No-fault insurance simply short-circuits tort law. You give up your right to sue. You give up the need to argue who did what to whom. But you also give up the fear of coming away with nothing. You collect your out-of-pocket losses from your insurance company—but no pain and suffering money—immediately. Without argument. Without fail. This is the principle that underlies workmen's compensation.

Can no-fault be made to work against the liability litigation boom? Almost certainly. But there are some big obstacles.

The Association of Trial Lawyers of America claims that *any* extension of the no-fault principle would have "stratospheric costs, since there are literally hundreds of medical injuries for every person who now receives payment in a fault claim." But the ATLA is not precisely a disinterested party.

In fact, the tort system is horribly inefficient in medical cases. One attorney who has studied the medical malpractice business estimates that only 16 cents of every premium dollar ever gets to patients. The rest goes for lawyers, brokers and overhead. That's compared with 66 cents for no-fault auto insurance and 74 cents for workmen's compensation.

There are a few simple ways to begin no-fault medical. One of the most appealing has been advanced by Professor Jeffrey O'Connell, the author (with colleague Robert E. Keeton) of the idea of auto no-fault in the 1960s.

Why can't certain types of tort liability be abolished by contract? O'Connell has asked. A man entering a hospital could sign a contract with his doctor for insurance that would cover his expenses—automatically—if certain things (like his heart stopping unexpectedly), all specified in the contract, went wrong. The patient's incentive to sign? The guarantee of being taken care of immediately if something did turn sour, rather than waiting for four or five years to find out whether he had struck it rich or failed to collect a penny. And he could still take the surgeon to court if he woke up with a pair of scissors in his belly.

Take the guarantee a step further. What if your purchase of a saw was conditioned on your e[illegible] into a warranty contract with the maker? If it cut off your hand or shocked you to death, his insurance would pay a certain amount, no matter whose fault it was. You, in turn, would give up your right to sue him.

It takes no law to get this started. (Remember: the lawyers are still fighting a rearguard action against auto no-fault.) It can be applied where it works and ignored where it doesn't. An accurate check on costs and benefits can be kept at each step of the way. And above all, it would reestablish some basis for mutual trust between seller and buyer. In other words, smaller but realistic awards for more people with less argument. A beautiful idea, right? O'Connell is understandably the lawyers' *bête noire*; indeed, the California Bar Association's *Journal* just killed rather than publish a special malpractice symposium with an article by him in it. The reason given: "hysterical antilawyer pamphleteering."

Yet why is O'Connell the *insurance* industry's Solzhenitsyn? An acknowledged genius with whom no one wants to be seen? "Don't quote me," says an executive, "but my committee might meet with O'Connell next year." Can the industry afford to wait to extend the principle of no-fault? Do executives really expect to wheedle rate increases out of state commissioners fast enough to keep up with astronomical jury awards during a time of inflation?

Part of the trouble already, of course, is the fact that the insurance industry has been under the stifling hand of state regulation for more than 50 years. Innovative ideas are so difficult to feed through the regulatory process that after a while whole industries stop trying, witness the railroads. Marketing fears play a part also. For example, the "Chicago Group" of insurance companies held out against no-fault auto insurance for years after the "Hartford Group" of the American Insurance Association embraced it. The Chicagoans' attitude was: Maybe this product makes sense on the whole, but where would *we* come out on it?

The right to sue is deeply cherished by Americans, but remember this: It is a zero-sum game. What some people win, everybody else loses. In the end, you cannot soak the insurance company—or you can only soak it until it is stripped of assets and of the ability to write insurance. In the end, the insurance company is simply an agent for *us*, the insured. So why are we litigating ourselves into a paranoid society? ■

"Trial By Jury": Writing 100 years ago, Gilbert and Sullivan satirized the legal profession's sometimes excessively mercenary bent. Sang the judge, recalling his days as a lawyer: "All thieves who could my fees afford relied on my orations. And many a burglar I've restored to his friends and his relations." Today some attorneys successfully use their orations to mulct large fees from insurance companies—and in the end, the general public.

SPECIAL INSURANCE REPORT 1975

Fire & Casualty: Is The Worst Over?

The only answer we can give is: Maybe.

LAST YEAR was bad, but this year, so far, is even worse for the fire & casualty insurance industry. Inflation is slower but continuing, and the litigation epidemic rages unabated (*see p. 63*). The ponderous state rate commissions simply are not coming through with fast enough and big enough rate increases in the critical personal lines.

Cycles are nothing new in this business; they are a fact of life. But this is a rough one. In the first half alone, FORBES estimates that the auto insurers had losses that could be as high as $1 billion from insurance operations (before investment income). Government Employees Insurance Co., a onetime stellar growth company, sank into the red overall and eliminated its dividend. And the No. One auto insurer, State Farm Mutual, went from a $94-million underwriting profit to a $76-million loss.

International Telephone & Telegraph's Hartford Fire subsidiary was one of the hardest hit. The Hartford had operated on the principle that if it could break even on insurance operations, it could produce an enormous positive cash flow for its parent. When you shaded price to get volume the way Hartford did (as did many other competitors), it was a disaster. The company lost $123 million pretax on underwriting last year; another $70 million in 1975's first half. And that was after inclusion of $11 million in catastrophe reserves back into earnings. The Financial Accounting Standards Board recently required all fire & casualty companies to do away with their catastrophe reserves. So, for many, the miserable results shown are really even worse.

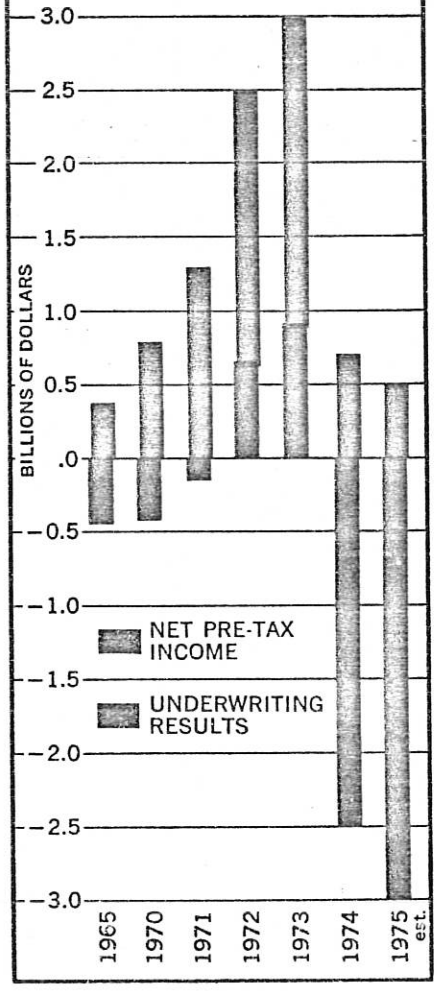
Even a conservative company like Philadelphia's INA Corp., which is less dependent on personal lines, took a beating. INA had to increase its loss reserves by $16 million because of the spectacular New York Telephone Co. fire in the spring. For the six months INA ended up paying out 12% more in claims and policy dividends than it took in in premiums.

Will the cycle turn as it has in the past, rewarding those smart enough to buy at the bottom? There were a few hopeful signs. INA's property casualty operation went into the black in June, its first black ink in eight months. "We're crossing our fingers," says INA's CEO Ralph Saul.

At the halfway mark, the industry was an estimated $2 billion in the hole on underwriting operations after paying out policyholder dividends. The second half should be a bit better, thanks to sizable rate increases. But how *much* better? "I shudder," says Saul, "at the thought of a major storm. That would be all we would need." In short, rates have not yet caught up enough to leave a margin for acts of God. Nor for a resurgence of inflation caused by acts of man.

UNDERWRITING LEVERAGE.

If the fire and casualty companies can break even on insurance operations, they can make a substantial overall profit. In recent years they earned $2 billion—$3 billion from investments on top of underwriting profits. But in disaster years like 1974-75, insurance underwriting losses almost wash out investment income.



At least the stock market helped this year. Last year's bear market tore huge chunks out of the skin of an industry now doubly dependent on capital and on investment income. This year's smart rally restored some of it. The fire & casualty insurers have sold stock on balance so far this year, seeking to lock in the recovery. "Who knows," lamented one executive, "whether the market won't collapse again if interest rates soar again and inflation takes off. We'll just have to miss out on the shot at future capital gains in order to avoid the risk of getting clobbered by the stock market as well as by everything else."

In a way it was an old story. The stronger companies have not had to sell stock, because they were fortified against adversity. New York's Continental Corp. has, for every $1 of premiums it writes, 75 cents of capital to back it up, and thus can sit out a severe bear market. Others, with less capital, have seen their premium-to-capital ratios balloon to 3.5-to-1 and even higher.

Houston-based American General was doing relatively well, too. Its life insurance and mortgage banking was taking up some of the slack caused by fire & casualty losses. As a result, its earnings were off only 3%, with some assistance from a reduction in shares outstanding.

Under a new management team, once troubled Chicago-based CNA Corp. has cut underwriting losses, while its capital position has been bolstered by $40 million from its new controlling stockholder, Loews Corp. "The old management," says CNA's new top man, Edward Noha, "got distracted with diversification. They lost control of the bread-and-butter business, insurance." With its real estate subsidiary, the Larwin Group, written down to zero last year, CNA doesn't have those losses hanging over its head in 1975.

Despite a few bright spots for the industry as a whole, many basic problems remain. Rate increases are subject to being held down by angry customers and politically sensitive rate commissions. But there is nothing the industry can do about inflation and litigation, both of which continually increase claims. As things now stand, companies heavy in auto

Stock Fire & Casualty Companies

Rank	1974 RESULTS ($ millions) Total Assets	Total Revenues	Fire & Casualty Premiums	Net Investment Income	Net Income	Company	PROFITABILITY Return on Equity 5-Year Average	Return on Equity 1974	Combined Loss & Expense Ratio 5-Year Average	Combined Loss & Expense Ratio 1974
1	**$4,079**	$1,798	$1,430	$147.4	$91.9	Continental Corp	8.2%	6.5%	99.6%	105.3%
2	**1,874**	949	926	52.5	46.8	United States Fidelity & Guaranty	9.7	8.2	98.0	101.6
3	**1,441**	859	802	60.9	27.1	Crum & Forster	10.1	6.9	100.1	105.1
4	**1,049**	391	373	42.4	32.3	General Reinsurance*	15.7	13.1	98.8	105.7
5	**817**	569	565	32.3	26.1	Government Employees Insurance	22.4	15.8	97.7	101.5
6	**700**	445	394	29.2	14.5	Kemper Corp	15.3	9.6	99.3	105.6
7	**541**	250	230	21.3	—4.4	American Re-Insurance*	11.8	def	101.3	119.9
8	**534**	236	165	22.1	12.5	ERC Corp*	12.2	11.0	99.8	105.3
9	**475**	316	298	18.7	22.4	Ohio Casualty	21.0	16.4	92.8	97.2
10	**377**	200	185	13.1	7.3	Hanover Insurance Cos	13.1‡	9.4	99.2	103.7
11	**312**	212	173	11.7	4.2	NN Corp	9.8	4.5	97.0	101.9
12	**310**	153	144	8.8	7.4	Republic Financial Services	18.8	10.9	93.4	100.4
						Averages	14.1	9.4	98.1	104.4

Note: All 1974 results are based on "generally accepted accounting principles." Where regulators have granted exemptions from GAAP, results show only periods when GAAP applied. * A reinsurance company. † 4 years. ‡ 4 yr. av. P-D—Profit to deficit.

Stock Multiple Line and Diversified Companies

Rank	1974 RESULTS ($ millions) Total Assets	Life Insurance In Force	Total Revenues	Total Insurance Premiums	Net Income	Multiple Line Insurers	GROWTH (5-Year Compounded Rate) Total Assets	Life Insurance In Force	Total Revenues	Total Insurance Premiums	Earnings Per Share*
1	**$13,881**	$84,243	$5,173	$4,210	$151.6	Aetna Life & Casualty	7.9%	8.0%	8.9%	7.8%	25.1%
2	**9,842**	69,516	4,605	4,054	147.9	Travelers Corp	7.9	5.7	10.3	9.9	13.1
3	**8,350**	45,333	2,654	2,098	126.0	Connecticut General Ins Corp	8.5	7.1	10.3	9.2	16.9
4	**4,437**	22,270	1,827	1,538	—207.6	CNA Financial Corp	5.0†	5.7	8.6	6.3	P-D
5	**4,299**	34,631	1,265	1,014	76.1	Lincoln National Corp	6.9	8.4	10.5	11.1	5.6
6	**3,895**	10,657	2,247	1,834	79.8	INA Corp	10.9	20.2	18.2	15.2	11.1
7	**3,592**	22,149	1,168	1,008	57.5	American General Group	10.5	18.2	11.7	11.5	11.3
8	**1,868**	3,270	886	782	38.5	St Paul Companies	11.7**	15.8**	15.6**	14.3**	2.8**
9	**1,499**	3,853	732	682	4.9	Chubb Corp	9.3	9.3	16.3	15.3	—26.1
10	**1,457**	4,011	817	628	65.0	American International Group	16.2	22.3	18.0	16.9	23.4
11	**1,440**	2,342	784	602	—13.9	Reliance Group	4.9	11.5	11.1	11.0	P-D
12	**1,241**	5,150	615	539	14.8	Safeco Corp	13.4	21.9	12.8	11.7	—4.9
13	**909**	7,070	243	191	23.6	Gulf Life Holding	7.5	5.8	11.0	11.5	9.7
14	**434**	1,797	226	192	—11.4	Centennial Corp	35.8	42.2	40.4	27.0	P-D
15	**374**	5,653	123	99	5.8	Integon Corp	13.3	13.1	12.7	11.3	11.2
16	**350**	867	293	250	37.1	Colonial Penn Group	36.8	10.6	33.4	37.0	39.2
17	**322**	2,250	120	93	1.4	Beneficial Standard Corp	NA	15.6	1.4**	—0.7**	NM
						Diversified Companies					
1	**$5,471**	$8,803	$2,675	$2,425	$70.8	International Tel & Tel Hartford & Financial Services	18.3%	18.0%	17.0%	17.1%	8.4%
2	**4,352**	17,666	2,845	2,661	156.0	Sears, Roebuck Allstate Insurance	11.0	15.9	14.3	12.9	20.9
3	**2,930**	37,900	1,299	1,024	62.1	Transamerica Occidental & Transamerica Ins	7.4	8.6	11.2	10.9	11.9
4	**2,576**	1,689	1,342	1,231	64.9	American Express Fireman's Fund American Cos	8.1	3.5	9.7	9.4	22.3
5	**1,894**	3,316	971	894	36.8	City Investing The Home Insurance	4.4	4.8	8.4	8.1	2.6
6	**1,483**	5,086	712	641	—56.4	Teledyne Unicoa & Argonaut	16.4	20.5	10.0	18.6	P-D
7	**935**	1,054	616	555	38.9	American Financial Corp American Financial Ins Group	NM	NM	NM	NM	NM
8	**883**	5,570	277	232	36.5	Avco Paul Revere (& other Ins Oper)	7.2	11.5	8.9	8.3	14.0
						Averages	12.1	13.5	14.2	13.0	9.5

Note: All 1974 results are based on "generally accepted accounting principles." Where regulators have granted exemptions from GAAP, results show only periods when GAAP applied. * In the Diversified Companies section, the results are for net income. † 3 years. ‡ 3 yr. av. ** 4 yrs. †† 4 yr. av. P-D—Profit to deficit. NA—Not available. NM—Not meaningful.

GROWTH (5-Year Compounded Rate)				TREND (Change 1974 vs 1973)			STOCK DATA				
Total Assets	Total Revenues	Fire & Casualty Premiums	Earnings Per Share	Total Revenues	Fire & Casualty Premiums	Earnings Per Share	1974 Earnings Per Share	Recent Price	Price/ Earnings Ratio	1974-75 Price Range	Indicated Dividend
4.4%	6.5%	4.6%	11.1%	8.9%	9.7%	—33.7%	$3.46	36½	10	46⅛-23⅛	$2.60
4.8	9.2	8.0	8.2	8.4	0.8	—15.5	2.88	30¾	12	38½-18½	2.48
8.8	12.3	11.4	11.3	10.6	8.3	—43.7	2.15	22	11	27 -12⅜	1.40
16.3	14.6	13.7	15.4	11.3	15.8	—15.5	5.93	148	27	221 -99	0.40
16.8†	17.1†	14.9†	14.5†	7.9	5.8	—17.8	1.48	20⅝	—	42½-14⅝	Nil
16.4	17.6	15.8	15.5	23.1	20.8	—31.0	2.61	12½	9	20½-11	0.80
9.4	10.8	8.8	P-D	21.4	15.3	P-D	—0.80	16½	—	30¾-10	0.60
13.3	11.2	9.7	10.6	—0.6	—6.9	—19.8	2.47	16	8	42 -10½	0.56
11.7	13.0	10.9	16.7	4.3	3.9	—13.7	3.91	34½	11	45¼-15⅝	1.32
9.8†	8.8	7.5	30.3†	12.5	12.0	—30.6	2.22	8½	4	13¼- 5½	0.50
9.0	12.5	9.5	—4.7	11.2	8.9	—62.0	1.30	13¼	41	21½- 9¼	1.20
19.6	13.0	16.3	27.5	4.4	14.5	—36.1	2.09	10⅛	6	17¼- 8	0.80
11.7	12.2	10.9	13.0	10.3	9.1	—26.6					

Combined ratio: For practical purposes, a combined ratio under 100% indicates an underwriting profit, over 100% a loss. Companies also earn investment profits. Combined ratio includes ratio of losses and loss-adjustment expense plus policyholder dividends to premiums earned and ratio of underwriting expenses to premiums written. P/E based on latest 12 mos. EPS.

TREND (Change 1974 vs 1973)		PROFITABILITY Entire Company Return on Equity		Life Operations Yield on Investments		F & C Operations Combined Ratio		STOCK DATA				
Total Revenues	Earnings Per Share*	5-Year Average	1974	5-Year Average	1974	5-Year Average	1974	1974 Earnings Per Share	Recent Price	Price/ Earnings Ratio	1974-75 Price Range	Indicated Dividend
9.9%	—22.1%	11.0%	9.8%	6.0%	6.6%	100.2%	102.7%	$2.85	22⅝	12	39¼-15⅛	$1.08
10.1	—15.3	9.3	9.5	5.9	6.1	102.3	109.2	3.33	23	13	35½-15¼	1.08
9.9	—6.3	12.6	13.5	6.3	7.0	99.0	102.8	4.61	36¼	8	55⅜-22¼	0.96
3.6	P-D	NA	def	5.8	6.2	103.0	114.3	—6.35	6⅜	—	11⅛- 2¼	Nil
8.0	—18.2	10.1	8.7	6.1	6.7	97.2	102.8	3.19	27⅝	10	43½-19	1.60
18.6	—26.1	9.8	7.9	6.2	6.6	100.7	106.8	3.48	34	11	40⅜-19¼	2.10
20.8	—10.2	9.0	8.5	5.7	6.4	100.1	104.2	2.20	11⅜	5	16 - 7	0.60
15.8	—32.6	11.7††	8.1	5.9	6.4	96.2	104.5	1.84	28¼	15	46 -15⅜	0.72
13.3	—89.3	9.3	1.2	5.7	6.3	97.7	109.8	0.40	29¾	NM	50⅞-17⅞	1.40
21.9	21.1	20.1	24.0	6.6	7.7	96.2	97.3	2.58	53¼	19	65½-24	0.24
7.4	P-D	6.5	def	5.9	6.2	98.4	102.9	—2.99	7⅜	—	11⅞- 4¼	Nil
8.8	—60.4	12.1	4.2	6.6	6.9	96.3	108.3	1.13	28¾	24	45 -18	1.00
7.3	—20.7	14.2	10.4	7.7‡	7.8	91.9	92.5	1.30	7⅜	7	12 - 5⅞	0.50
7.1	P-D	28.6	def	6.2	6.7	96.9	116.4	—1.62	3¼	—	31½- 2½	Nil
19.0	—23.6	12.3	10.0	5.9	6.1	97.4	106.5	0.97	6⅝	7	9⅝- 3⅞	0.28
32.2	25.0	37.4	34.1	6.1	6.5	91.5	91.0	2.30	31⅝	13	57⅞-12⅝	0.40
0.9	—55.8	NA	2.3	NA	5.6	111.2	104.5	0.38	3⅝	12	6¾- 3⅛	0.20
7.1%	—31.5%	11.8%	7.5%	5.6%	6.3%	101.8%	107.4%	$3.45	20⅞	6	29½-12	$1.52
7.8	—9.8	14.7	14.3	6.3	7.0	98.0	100.3	3.18	61⅜	23	90⅜-41½	1.85
5.4	—2.2	10.9	10.8	5.7	6.5	101.1	104.0	0.61	8⅝	12	10⅜- 5⅜	0.59
7.5	—17.7	11.5	11.9	7.1	7.4	99.4	103.8	2.04	36⅛	18	48⅜-17¾	0.80
5.5	—38.1	13.2	9.2	5.6	6.4	99.6	106.3	1.29	7	25	14 - 4	0.66
18.4	P-D	11.8	def	NA	NA	105.9	128.6	1.29	19⅝	8	25¼- 7⅜	Stock
7.9	—0.4	NA	14.9	NA	7.6	NA	99.4	1.58	11½	7	13¾- 7⅛	0.04
13.6	12.7	10.0	12.6	6.0	6.8	96.5	92.4	—1.64	5	—	8⅞- 2	Nil
11.5	—16.9	13.5	9.3	6.1	6.7	99.1	104.7					

Combined ratio: For practical purposes, a combined ratio under 100% indicates an underwriting profit, over 100% a loss. Companies also earn investment profits. Combined ratio includes ratio of losses and loss-adjustment expense plus policyholder dividends to premiums earned and ratio of underwriting expenses to premiums written. P/E based on latest 12 mos. EPS.

SPECIAL INSURANCE REPORT 1975

and homeowner lines probably won't get big enough increases to get into the black until sometime next year, at the earliest. Meanwhile, what happens if inflation speeds up again? It is in the homeowner and auto lines where political pressure is most felt. Look at the situation in New Jersey on auto rates. The insurance commissioner has had requests for auto rate increases before him since the year's end totaling close to $90 million. So far there have been few approvals. Many companies are getting ready to ask for badly needed additional rate increases. It will probably take a threatened pullout by insurance writers to break the bottleneck, as was the case in 1970.

It's well to remember that auto premiums account for over 40% of all premiums. As auto lines go, so go much of the industry's underwriting results.

Unfortunately, there is no assurance that the underwriting cycle will soon turn decisively upward. Listen to Robert J. Schraeder, a top executive at A.M. Best Co., the industry's rating service: "It would be wishful thinking to look at current underwriting losses as a short-term phenomenon." He tends to regard the current problems as secular rather than merely cyclical. The long-term seriousness of the situation was masked for a long time, he says, by rising investment income, a product of a strong stock market, and higher rates of return on fixed-income investments. But with the stock market crash and losses brought on by disastrous diversification for many companies, capital has been severely eroded. They no longer have a strong shield against continuing underwriting losses. The A.M. Best organization has significantly cut its ratings of almost half of the 65 fire & casualty companies which account for 85% of all of the premiums written.

An added problem is consumerism. At its extreme, consumerism regards large corporations as fair game. "Don't raise insurance rates," goes the slogan, "take it out of the big companies' hides."

The trouble is that the hides aren't all that thick anymore.

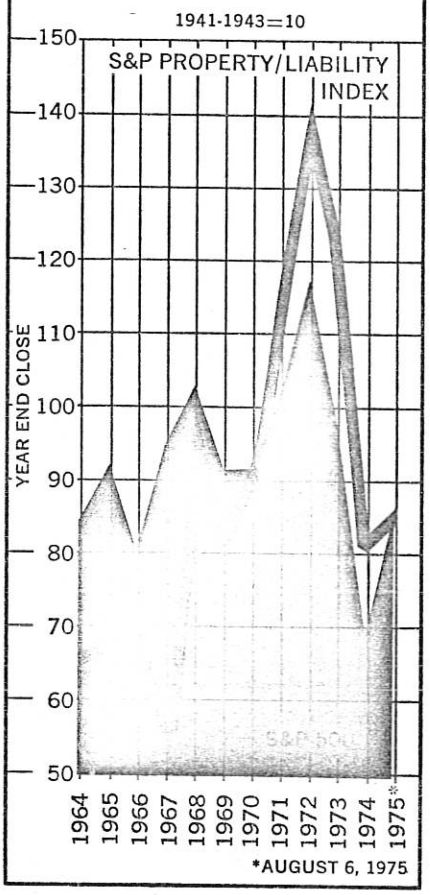
Related to consumerism is the uncertainty surrounding federal no-fault legislation. It's quite conceivable that next year the Congress will enact a federal auto no-fault bill, according to several observers. The industry is split over its desirability. Those who favor it say that it will standardize coverage and result in reduced claim costs for the industry.

Others fear that a sharp in would keep costs growing bu the Government will be under great pressure to keep rates frozen. And they worry that federal regulation will mean more and more control over the insurance business, possibly impairing its long-term profitability.

We will end, however, on an encouraging note. Ralph Saul, INA's new CEO, sees the problems as manageable. "I came," he says, "from the securities business, which isn't all that dissimilar to the fire & casualty industry. [Saul was once head of the American Stock Exchange and later a top executive at New York's First Boston Corp.]

"Both industries are heavily dependent on the securities market, on governmental regulation and both are very vulnerable to inflation." In the end, he says, the smart and well-financed companies will work their way out of the mess. The survivors will emerge stronger, the weak will not survive. Saul has a point, but he and his colleagues have their work cut out for them. ■

Swinging with underwriting cycles as well as with the stock market as a whole, fire and casualty stocks are extremely volatile.



But The Other Side Wasn't Greener

Life insurance is a nice, quiet, lucrative business —unless you start looking over the fence.

"LIFE INSURANCE," says Allstate Chairman Archie Boe, "is like shooting fish in a barrel."

What could be simpler? No inventory problems to worry about. No foreign-exchange problems. No patent problems. No styling changes of any consequence. No money-raising problems.

Better still, the product is not particularly price-sensitive. Comparison-shopping for life insurance policies requires a degree of patience (masochism?) and a fondness for mathe-

Stock Life Insurance Companies

	1974 RESULTS ($ millions)						PROFITABILITY			
							Return on Equity		Yield on Investments	
Rank	Total Assets	Life Insurance In Force	Total Revenues	Life Insurance Premiums	Net Income	Company	5-Year Average	1974	5-Year Average	1974
1	$2,643	$13,688	$470	$321	$79.7	NLT Corp	9.9%	10.5%	5.3%	6.1%
2	1,954	12,987	438	307	58.1	Jefferson-Pilot Corp	11.9	13.3	6.7	7.3
3	1,856	12,957	364	257	35.3	American National Financial Corp	7.8	10.3	5.9	6.5
4	1,837	17,013	450	285	46.3	USLIFE	16.6	17.2	6.3	7.1
5	1,712	10,326	308	197	37.7	Franklin Life Insurance	NA	14.6	5.7	6.3
6	1,634	12,702	352	255	48.8	Capital Holding Corp	11.5	12.3	5.8	6.5
7	1,411	7,444	276	189	25.4	Southwestern Life Corp	11.1	12.8	5.8	6.3
8	1,360	7,699	267	199	40.6	Liberty National Life Insurance	12.6	12.6	6.0	6.4
9	1,302	8,287	328	143	26.7	Richmond Corp	11.0	9.5	6.1	6.8
10	1,233	12,974	346	268	19.5	Nationwide Corp	8.6	9.1	5.9	6.6
11	1,147	17,251	700	646	34.8	Provident Life & Accident	14.6	17.7	5.7	6.2
12	1,114	3,433	151	79	10.1	Equitable Life Insurance of Iowa	9.2	8.8	5.8	6.3
13	1,015	11,379	223	167	15.9	United Benefit Life	NA	10.4	5.5	6.2
14	1,004	4,922	181	84	20.0	Monumental Corp	12.7	13.2	5.9	6.6
15	855	8,758	350	296	18.2	Washington National Corp	9.5	8.5	6.1	7.0
16	802	3,632	424	391	13.2	Bankers Life and Casualty††	NA	NA	3.9	4.2
17	774	7,321	185	126	—6.9	BMA Corp	7.3	def	5.7	6.3
18	768	4,714	156	104	15.4	Southland Financial	NA	13.0	5.7	6.1
19	721	3,755	110	71	13.4	Kansas City Life Insurance	10.1†	11.6	5.8	6.3
20	689	4,832	176	140	17.4	Life Insurance Co of Georgia	13.2†	13.8	5.6	6.2
21	646	2,715	90	46	11.9	Great Southern Corp	11.5	13.7	6.0	6.5
22	619	4,434	140	80	14.9	Liberty Corp	10.7	11.0	5.9	6.6
23	542	3,214	359	338	48.6	Combined Insurance Co of America	21.3	21.9	4.3	5.4
24	522	6,726	105	81	16.7	Farmers New World Life	14.5	15.1	6.0	6.6
25	512	1,999	115	90	11.5	Monarch Capital	NA	6.8	5.5	6.1
26	502	11,162	288	270	9.2	Republic National Life Insurance	NA	12.4	4.4**	4.5
27	499	3,589	194	160	18.6	Independent Life & Accident	NA	16.9	5.4	5.6
28	487	6,474	153	123	14.1	Philadelphia Life	16.1	15.9	5.9	6.5
29	481	2,319	181	141	8.5	Pennsylvania Life	10.3	5.3	NA	6.1
30	473	3,224	99	73	13.3	Home Beneficial Corp	12.0	11.7	5.8	6.6
31	435	4,326	87	69	14.3	Fidelity Union Life Insurance	NA	16.0	6.1	6.7
32	416	3,440	84	65	1.4	Manhattan Life	5.8	5.0	5.1	5.4
33	329	2,701	58	40	10.9	Northwestern National Life‡‡	11.0	12.7	6.0	6.8
34	318	2,680	82	57	8.1	Durham Life Insurance	NA	9.0	5.6	6.0
35	291	1,277	141	132	2.5	National Liberty Corp	20.9	2.2	6.1	7.6
36	287	2,939	72	58	8.0	Kentucky Central Life	13.3	14.0	6.2	7.0
37	265	1,295	39	25	7.2	Equitable General Corp	11.2	11.7	5.8	6.3
38	244	2,453	45	32	4.4	United Services Life Insurance	18.3**	17.5	5.7	6.0
39	220	3,871	77	66	5.2	Protective Life	10.2†	14.2	5.6	6.2
40	217	1,479	43	31	1.3	Continental American Life Insurance	15.8	16.7	5.1	5.4
41	204	2,897	45	36	3.6	National Old Line	NA	10.0	5.2	5.7
						Averages	12.2	12.0	5.7	6.3

Note: All 1974 results are based on "generally accepted accounting principles." Where regulators have granted exemptions from GAAP, results show only periods when GAAP applied.

matics well beyond normal human capacity.

Then, of course, the "risk" being underwritten—*i.e.*, the chances of policyholders dying young—is tediously predictable and growing more tolerable by the year, thanks to significant advances in health care.

During a period of rising interest rates, the longer policyholders' money stays on the books, the fatter become the margins of the insurance companies, as 3.5% corporate bonds bought back in the Fifties are rolled over into 9.5% or 10% bonds today. For stock life companies, the difference flows right into earnings.

Indeed, last year that pretax investment margin rose more sharply (from 5.88% in 1973 to 6.25%) than in any prior year in the history of the life insurance industry. The improvement will certainly continue over the next few years as more of the old low-interest loans drop off the books and are replaced by newer loans at higher rates of interest.

Now you might think that the 12.2% inflation the U.S. experienced last year would have caused a significant decline in the sale of new life insurance policies. Looking ahead, who knows how drastically inflation will erode the purchasing power of

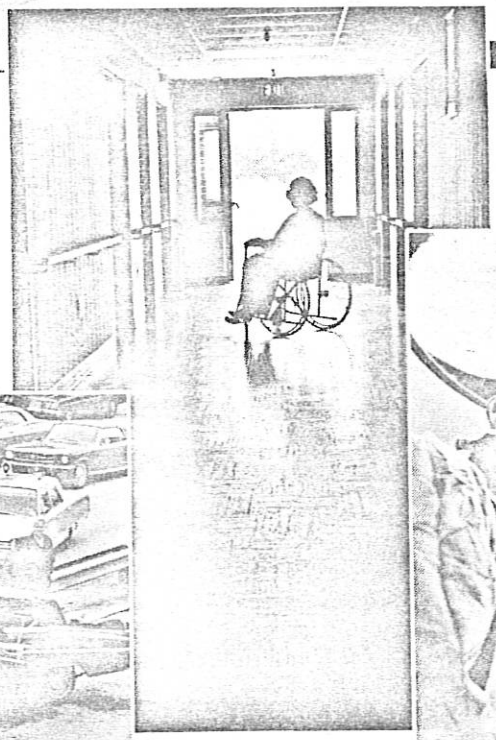
that coverage in the years to come?

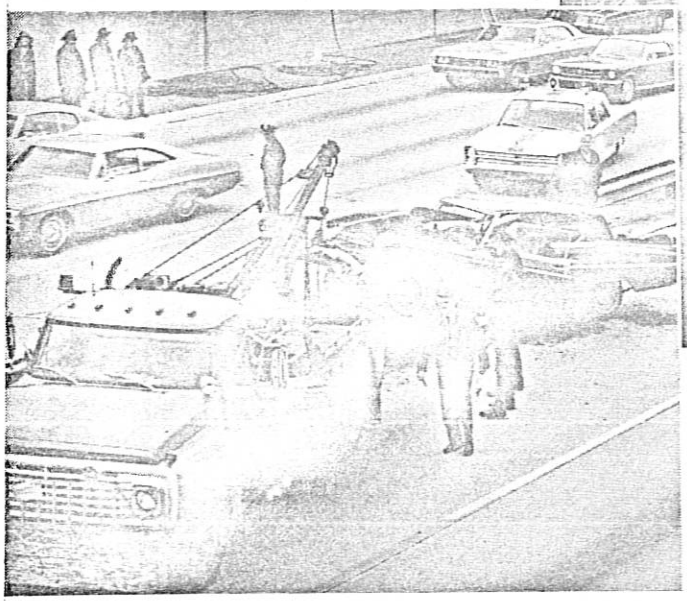
But your life insurance agent is ready for that one. If you think inflation will continue, he argues, then you should buy a *larger* amount of coverage. After all, it won't cost you any more in the long run. You'll be paying your fixed premiums with ever cheaper dollars.

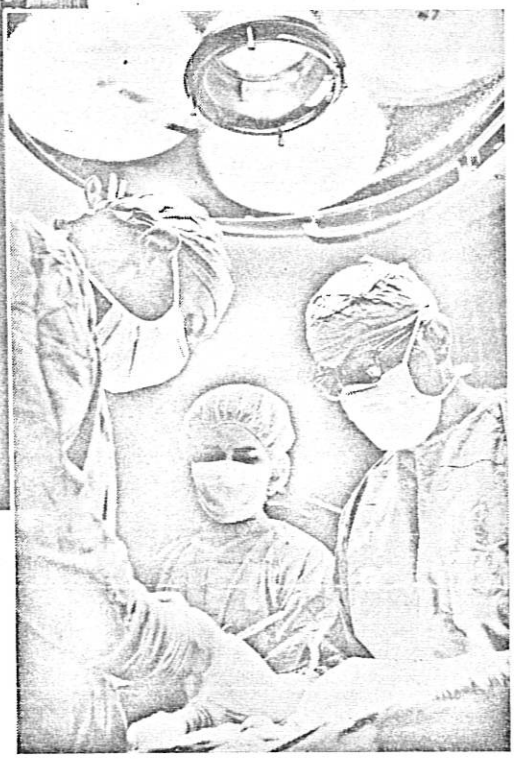
That approach has worked like a charm. The size of the average ordinary life insurance policy has about

GROWTH (5-Year Compounded Rate)					TREND (Change 1974 vs 1973)			STOCK DATA				
Total Assets	Life Insurance In Force	Total Revenues	Life Insurance Premiums	Earnings Per Share	New Life Insurance Written	Total Revenues	Earnings Per Share	1974 Earnings Per Share	Recent Price	Price/ Earnings Ratio	1974-75 Price Range	Indicated Dividend
7.0%	6.4%	7.7%	5.7%	12.4%	—1.0%	10.4%	12.0%	$2.33	14⅝	6	21¼ - 8¾	$0.60
6.7	9.1	9.4	10.5	16.4	9.0	10.6	13.1	2.41	30⅞	13	38¾ - 20½	0.72
5.1	4.6	4.7	3.6	22.4	42.5	7.7	25.0	1.10	7½	6	8⅜ - 5⅜	0.42
14.4	13.2	14.8	14.0	18.7	48.8	39.0	—5.9	2.07	12	6	31⅜ - 7¼	0.30
6.7	6.1	7.1	5.5	NA	7.5	9.0	7.8	1.79	17⅝	10	26⅜ - 11⅝	0.84
9.8	10.9	11.4	10.2	14.3	—1.0	3.7	12.6	1.70	22	12	31 - 13⅝	0.34
5.9	7.8	4.3	6.5	12.6	—1.0	6.8	6.5	2.46	25	10	40½ - 16¾	0.92
9.5	10.1	10.9	10.1	13.1*	15.5	13.5	6.8	2.03	22¾	11	38⅛ - 17¾	0.60
6.2	8.7	11.3	6.3	8.0	27.3	6.8	—20.4	2.03	12½	7	20¼ - 9⅛	0.80
8.2	9.4	12.8	12.0	13.6	2.4	5.0	—8.2	1.91	6¼	4	13½ - 5	0.30
13.2	11.3	14.9	14.7	19.3	—2.9	13.4	23.4	3.53	22½	7	50⅝ - 18	0.68
3.5	5.8	4.4	4.0	7.2	4.5	4.3	9.8	2.02	11½	5	15¾ - 8¼	0.50
7.5	10.2	10.1	9.4	NA	36.6	12.2	14.1	22.06	100	5	185 -100	2.40
9.9	6.1	9.9	3.8	14.1	12.2	9.3	5.3	1.39	9⅝	7	17 - 7¼	0.48
7.8	11.8	9.9	10.3	4.7	36.5	10.0	—12.6	2.64	10⅞	6	16½ - 7½	0.80
13.0	13.3	12.7	12.3	NA	16.9	13.1	NA	NA	Not Available—Privately Held			
12.2	8.2	10.8	6.9	P-D	15.5	—4.6	P-D	—1.15	10⅝	—	22 - 7⅛	0.58
7.3*	5.9	9.2*	7.3*	14.1	40.6	8.2	—9.6	1.22	10	10	23¼ - 9⅛	0.30
4.9	10.9	10.6*	11.2*	13.4*	35.9	18.2	24.3	4.35	25¾	6	29½ - 14½	1.20
7.5‡	7.6	8.3	6.8	14.3‡	8.9	4.8	8.2	2.90	13¼	5	18¼ - 11⅜	0.68
6.7	7.7	7.1	4.4	16.2	27.2	11.7	14.4	2.46	11½	5	15½ - 7¾	0.52
12.0	10.5	10.9	10.8	9.9	0.3	14.8	—2.6	2.24	10	5	15⅝ - 7⅛	0.40
15.8	39.3	13.2	12.9	12.1	11.0	13.6	12.3	1.82	10	5	12¾ - 5¼	0.60
8.9	12.8	9.8	9.0	19.2	17.2	9.3	9.1	2.53	36	13	61½ - 23	0.16
NA	4.3	5.2	4.1	NA	5.0	6.0	—11.6	1.29	9⅝	7	12⅝ - 8⅛	0.76
12.2	10.1	17.9	18.6	NA	—21.7	—3.9	4.3	0.98	3¾	4	8¼ - 2	Nil
11.0	11.3	8.7	7.1	NA	16.9	4.0	—14.4	1.90	7½	4	17 - 5¼	0.56
9.3	13.9	14.6	14.9	13.8	46.9	17.7	8.4	1.60	11	7	20⅝ - 6⅞	0.48
17.1	20.9	15.3	13.8	—9.5	2.2	13.1	—23.5	0.39	1⅜	20	2¼ - ¾	Nil
7.5	8.8	7.9	6.2	12.7	23.6	6.8	—1.4	4.17	18½	4	30 - 12½	1.00
12.1	11.4	10.9	10.5	14.0	35.2	12.1	12.0	2.81	17½	6	27 - 11½	0.85
2.8	5.7	—0.1	—1.4	1.6	46.1	3.4	17.6	0.40	3⅜	7	5⅜ - 2⅛	0.20
5.6	12.1	8.3	8.0	10.1	—2.9	8.7	14.4	3.10	15	5	20⅛ - 7¾	0.55
7.4	9.4	9.9	9.6	NA	12.4	12.9	8.7	3.26	22½	7	23¾ - 10	0.80
26.2	—0.7	24.1	25.7	—17.1	12.7	8.7	—82.7	0.18	3⅜	14	5½ - 1	Nil
6.2	10.1	6.1	5.0	19.7	—25.9	8.7	25.6	1.67	5⅞	4	7⅜ - 3⅞	0.20
5.5	6.1	6.6	5.1	11.8	10.8	5.3	11.9	2.17	11	5	13¾ - 7	0.44
9.9	6.7	7.3	5.5	9.9‡	178.4	10.7	1.9	1.62	7½	4	10⅝ - 4⅝	0.40
4.9*	12.4	5.1*	4.6*	25.7*	69.1	5.5	22.5	2.07	12¼	6	12¾ - 8⅛	0.60
4.9	4.9	4.7	3.2	10.2	12.2	3.8	10.3	1.72	16½	10	17 - 10¾	1.00
4.1	16.3	10.6	11.2	—1.9‡	—2.9	4.0	—27.5	0.66	3⅛	5	6¼ - 2⅜	0.26
8.9	**10.0**	**9.7**	**8.8**	**11.0**	**20.2**	**9.2**	**3.0**					

* 4 years. † 4 yr. av. ‡ 3 yrs. ** 3 yr. av. †† "Statutory" figs. ‡‡ Stock dept. only. NA—Not avail. P-D—Profit to deficit. P/E based on latest 12-mos. EPS.







Woe to the life insurance companies with property and casualty or health and accident lines. Caught short by auto-repair costs that have been rising twice as fast as inflation and health care costs that haven't been lagging far behind, insurers got hit with heavy underwriting losses. Despite recent rate hikes, many analysts predict even worse underwriting losses this year.

doubled, to $26,500 over the past ten years (keeping pace with disposable income). And last year Americans bought 27% more life insurance than in 1973—almost $300 billion of it. To be sure, nearly half of last year's increase resulted from broadened military group coverage, but even without that surprised bonus, the industry would have survived inflation comfortably with a 14% sales gain.

But what happens when sales growth slows? Surely, then, life insurance earnings slow with it. Not necessarily. Even in this respect, life insurance is a very good business. From February through May of this year, life insurance sales showed a decline, the worst one for decades. What happened, of course, was that with many prospects out of work and others squeezed by inflation, the salesmen had a tough row to hoe. Even that was cushioned for this extraordinary industry.

Here's why: Too much growth is not good for life insurance earnings. A slowdown can actually help, because the acquisition cost of new insurance—the salesmen's commissions, the bookkeeping costs, the risks of early lapse—fall heavily in the first year. (The agent alone rakes in anywhere from 55% to 90% of the first year's premium, but only about 10% of subsequent years.) Every new policy booked, therefore, tends to penalize earnings at first. Gradual growth, where the acquisition costs get diluted by the profits from insurance already in force—by an "old book"—is the best kind of growth. Even no growth at all can help for a while.

Several years ago, for example, Provident Life & Accident of Chattanooga, Tenn. fired an independent agency by the name of Financial Service Corp. of Atlanta, Ga. because it was writing too many new policies and too many of them were lapsing before they became profitable.

Chairman Henry C. Unruh explains it this way: "They were writing so much business, we just couldn't digest it. It was taking our statutory surplus down too fast, and the proportion of our overall business written by a group over whom we had absolutely no control was more than we could take. In ordinary life policies, if you write a lot of business you lose money!

"When they started out for us they were writing $35 million of ordinary a year. And we thought, 'Well, maybe they'll build it up to $75 million.' In the first eight months with us they wrote $80 million, and the next year $160 million and they wanted to go to half a billion, you know. That was just too much. Besides, they were invading our own general agents' territories, and that got a lot of people upset."

Provident parted company with Financial Service Corp. in 1970, and

its gain in individual insurance in force dropped from $489 million in 1969 to $202 million by 1972. Interestingly, however, Provident's earnings increased at a much faster pace after the sales slowdown.

As Allstate's Archie Boe says, life insurance is almost a can't-lose business. If you grow, you make money; if your growth slows down, you make money. But we have to emphasize the word *almost*. The fact is that a good many major stockholder-owned insurance companies have suffered severe profit setbacks this year. In the first half, Travelers was off 61%; Aetna, 67%; Lincoln National, 23%; BMA, 62%. The list goes on and on.

What happened? It wasn't the slowdown in sales that was to blame. It wasn't that life insurance had become inherently less profitable. It was their nonlife ventures that caused the declines. Inside the insurance Pandora's box there are several monsters. The most troublesome: property and casualty insurance, health and accident insurance and real estate. That, of course, explains why the earnings of the big multiple-line companies like CNA, Travelers and Connecticut General were among the hardest hit. Their life insurance profits held steady, but they were clobbered in fire & casualty.

Climbing Claims

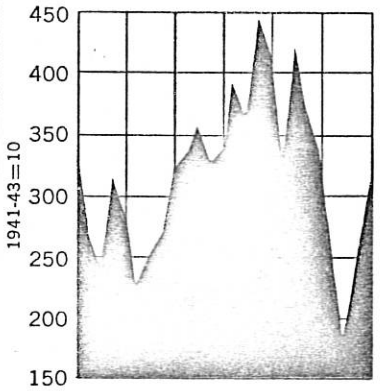
In dramatic contrast to life insurance, where inflation doesn't increase death-benefit obligations one iota, inflation greatly increases the dollars insurance companies are called upon to pay out for repairing smashed automobiles and ailing human bodies.

The gory details of what promises to be the worst in a lengthening string of bad years in fire & casualty insurance are given starting on page 68.

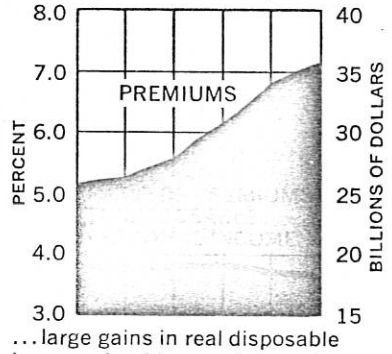
As for health and accident insurance, it is a marginal business at best for most companies. Typical is the attitude of BMA, for example. Says Executive Vice President Oscar R. Klein: "We have the objective of just trying to break even in the group-health area so that we can create markets for individual sales. We won't sell a group-health policy now unless there's a group *life* combined with it."

Not surprisingly, as health-care costs skyrocketed, starting last year, most of the field sank quickly into the red. "Three or four things happened," explains Chairman Henry C. Unruh of Provident Life & Accident, whose main business is health and accident insurance. "First, the [price] controls were taken off health-care costs and then there was talk of re-

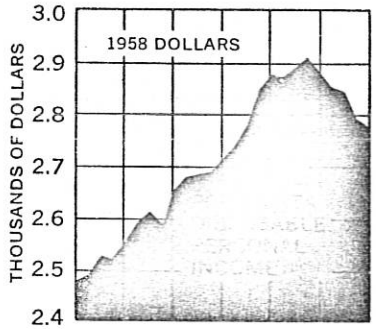
When should you buy shares in stock life companies? Two favorable indicators, say analysts, are when disposable income is rising and when interest rates are stable or declining.



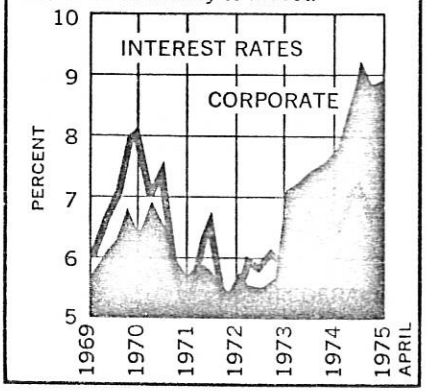
Since Americans tend to devote the same amount of disposable income to life insurance premiums...



...large gains in real disposable income should mean large gains in premium income.



And since rising interest rates mean more cash-draining policy loans and fewer mortgage prepayments, thus reducing insurance company cash flow, stable or declining interest rates mean more money to invest.



instating controls, so everybody [illegible]d up their prices. Secondly, you [illegible] malpractice situation. And [illegible], people who thought they might lose their jobs decided to get their operations before they lost their insurance."

Even so, Provident's earnings are only off 8.8% so far this year, far less than most, and the company has shown consistently superior growth and profitability in recent years. Remarkable, in a field competitors treat as a loss leader. What's the secret?

"Our average group is 500 lives," Unruh replies, "which is probably two or three times the average size of other companies. Our biggest problems are in the smallest accounts—less than 100 lives. Secondly, we're a little bit blessed by geography. We just don't have as many accounts in the big, big cities where pressures and costs are greater. Finally, we know the state of every account every month by the sixth working day. A lot of other companies don't even have it on a quarterly basis."

Believe it or not, Unruh has just decided to enter the property and casualty business. Does he have a death wish or something?

"Everybody gets all uptight about that," he answers. "Look, I'm not enamored of it, but, after all, we've been in the medical business for years and that isn't any fun either!"

Then why take the plunge? *This* year, particularly?

"I think we *have* to," he says. "If you're a group company, you have to get into it because a few years down the road it's going to be a negotiable item between labor and management, and we're looking to the day when management treats it as another fringe benefit. That's our only reason for going into it. We're not going to have an individual business at all. It's all got to be a payroll deduction, management-sponsored thing."

But that is the way trouble often begins in the life insurance industry. It was just that kind of small, seemingly prudent step that led many insurance firms down the primrose path into real estate ventures, mainly in the late Sixties. Even today, owned real estate constitutes just 3.2% of life insurance company assets. But, oh what a 3.2%!

"It started out with mortgage lending, which most of them have been doing for years," says analyst Robert Brokaw of Mabon, Nugent. "Unless you take only the best risks, you're going to get *some* real estate over time through foreclosures! But what really got them into the field was basically a response to what the mortgage market would bear. If you charge 15%, say, you've pretty much

guaranteed that the developer is going to fail. So you charge a lower rate and take an equity participation. It was really an investment decision."

Not a very wise investment decision, as it turned out.

It was real estate, of course, that played a major role in CNA Financial's well-publicized fall from grace. Says Brokaw: "The mistake was in branching out beyond mortgage banking. . . . I mean, someone who's an expert in real estate just isn't going to work for insurance companies at the salaries they pay!

"Along with nursing homes, CNA went into college dormitories. Their dormitories started losing money as early as 1971. They didn't anticipate the change in lifestyles—that in many areas students didn't want to live in noncoed dormitories. Another classic blunder was to build an office building in downtown Los Angeles. . . . They wound up with a big building in a bad location. What they had their sights on was not the building itself but rather the tax advantages. That's the kind of mistake that's probably general throughout the industry."

CNA has had plenty of company. Connecticut General last year took a $21.4-million writedown on its losing joint venture in Columbia, Md.; Travelers took a $16-million writedown on two big real estate ventures; National Liberty is still in the courts trying to settle claims arising from the purchase of condominiums in 1973 from now-bankrupt Kassuba Development (FORBES, *Oct. 1, 1974*) and Kansas City's BMA Corp. has wagered $152 million—roughly one-fifth of its assets—in real estate ventures like hospitals, shopping centers and condominiums. And that's *after* a $19-million writeoff in the fourth quarter of last year, which drove BMA itself $7.4 million into the red for the entire year.

If only the rest of Allstate Insurance was as easy to manage as are its life insurance operations, says Chairman Archie Boe, who is having more than his share of headaches in automobile lines.

"Several of our joint-venture partners were getting into financial difficulty," says BMA Executive Vice President Klein, "so we had to step in and take over a number of those projects. In hindsight, I think we should have watched some of our partners a little closer to make sure they were capable of weathering adverse economic situations."

Sadly, in an industry already shaken by the Equity Funding scandal, another major stock life insurance company, Republic National of Dallas, Tex., has been charged with fraud—this time in real estate. In March 1974 the Securities & Exchange Commission charged t[illegible] public was attempting to avoid [illegible] sive writedown of its approximately $110-million investment in troubled Realty Equities. What Republic did, the SEC says, was to buy real estate from Realty Equities at enormous markups and not properly disclose such transactions to shareholders. Shortly thereafter the Texas Insurance Commission took over the management of Republic's investment operations, demanding changes in top management. The company has since consented to the SEC injunction, and now faces lawsuits and possible further real estate losses.

In sum, there is little doubt that life insurance companies have fared poorly on balance when they stepped outside of writing life insurance and lending money. In recent years, at least, they would clearly have been better off sticking to their traditional insurance business and fixed-income investments. To be fair, some companies, like Aetna, Travelers and State Farm, started out in the fire & casualty business and had the good sense to diversify into the more comfortable pastures of life insurance. Not enough good sense, however, to phase out of their original lines altogether. But insurance companies are as enamored of size as are other industries.

Life insurance sales are picking up again; in June they were 2.5% over the June 1974 performance. But that isn't what will make the difference. Until real estate straightens out and until fire & casualty and health insurance underwriting losses drop, insurance company earnings will be penalized. Life insurance, after all, is not like shooting fish in a barrel. Not anymore it isn't. ■

A Salesman Who Was Too Successful

HIGH LAPSE RATES are nothing new in the life insurance industry. Lapses have been rising steadily for many years, to the point where now one out of every five new policies sold doesn't even stay on the books two years. The fault lies mainly with insurance salesmen, eager for large first-year commissions, who urge people to buy more insurance than they can afford.

"Unless perhaps there are blood stains all over the premium payments, insurance companies simply don't care how the policy is sold," says Harold Somer, an independent Manhattan insurance agent.

Such indifference does occasionally backfire. In April 1974 Aetna Life & Casualty fired its top salesman, Bert Kreisberg, who had written over $100 million in new policies in 1973 alone (roughly 5% of Aetna's new business that year). Kreisberg was selling multimillion-dollar face-amount policies with high first-year cash value and then offering to pay the premiums on that policy himself in exchange for the cash-value rights. By borrowing on the cash value and then adding in his commissions and expenses, Kreisberg wound up with 140% of the first-year premium. To be sure, he would have netted more than 40% by simply writing those policies in the ordinary manner, but the market for life insurance policies of such size is exceedingly thin. (Unless, of course, they're "free" like Kreisberg's.) The catch, however, is that to make it worth his while, Kreisberg would have had to keep increasing his policy sales geometrically. Although cash values rise in the second year of a policy, commissions fall sharply and interest payments must be made.

The California Insurance Department suspended Kreisberg's license to sell insurance.

Unlikely as it may seem, a spokesman for Aetna says that losses to date on Kreisberg's business have been minimal.

The point is that, even in such comparatively unusual situations (Connecticut General faced a similar problem several years ago, but it doesn't happen often), lapses are treated as a sales expense. As long as the growth rate in the sale of new policies far outweighs the increase in lapses, there is little incentive for insurance companies to dampen the enthusiasm of their sales force.

The Mutuals

THESE ARE the real giants of the insurance business. The biggest, Prudential, with nearly $36 billion in assets alone, outweighed the combined assets of the 41 stock life insurance companies covered in this survey.

When it comes to earning a return on these investments, the mutuals do about as well as the stockholder-owned companies. The average return on investment last year was 6.3% for both. Among the mutuals, Bankers Life does an exceptional job: 7% on investments last year. Teachers Insurance & Annuity did even better. Prudential, in spite of its huge size, is no slouch; its return (6.4%) was above average for all life companies.

Last year the average return on assets went up a full three-tenths of a percentage point, as newer, high-interest loans replaced older, low-interest loans on the books. This year, even with interest rates down a bit, the return should go up again as the industry further works off its inventory of old 4% and 5% loans. ■

Mutual Life Insurance Companies

Rank	1974 RESULTS ($ millions) Total Assets	Life Insurance In Force	Total Insurance Premiums	Net Investment Income	Net Gain From Operations	Company	PROFITABILITY Yield on Investments 5-Year Average	1974	GROWTH (5-Year Compounded Rate) Total Assets	Life Insurance in Force	TREND 1974 vs 1973 New Life Insurance Written
1	$35,819	$218,270	$5,446	$1,962.4	$91.1	Prudential	6.0%	6.4%	5.2%	8.3%	29.8%
2	32,728	215,901	4,673	1,901.3	—83.3	Metropolitan	5.8	6.3	4.1	6.5	39.5
3	17,558	108,995	3,018	927.9	—27.0	Equitable Life Assurance	5.7	6.2	4.6	9.0	23.2
4	13,002	69,971	1,690	722.2	30.5	New York Life	5.5	6.0	4.7	8.7	33.2
5	11,822	81,350	1,770	627.0	58.8	John Hancock Mutual	5.5	6.0	4.0	7.5	15.9
6	7,344	28,679	763	422.8	44.4	Northwestern Mutual	5.8	6.2	4.4	9.5	18.2
7	5,397	27,009	759	308.8	19.8	Massachusetts Mutual	6.0	6.4	5.8	8.1	14.6
8	4,397	21,530	584	241.9	3.8	Mutual Life of New York	5.6	6.0	3.8	7.9	12.8
9	4,261	19,407	550	233.0	13.2	New England Mutual	5.7	6.1	4.4	6.6	13.0
10	3,813	3,325	461	261.8	28.5	Teachers Insurance*	6.7	7.6	13.5	8.8	—5.5
11	3,375	14,418	386	185.7	—1.0	Connecticut Mutual	5.6	5.9	5.2	8.3	2.6
12	3,105	20,677	496	171.3	1.0	Mutual Benefit	5.5	6.0	4.4	11.2	44.4
13	2,928	16,727	627	175.7	21.5	Bankers Life	6.1	7.0	9.1	12.2	14.6
14	2,779	11,741	288	161.5	2.1	Penn Mutual	5.7	6.2	3.2	6.4	24.2
15	2,212	11,729	272	122.2	13.3	Western & Southern	5.6	6.0	4.5	5.3	6.5
16	1,742	7,571	190	90.8	7.4	National Life	5.2	5.6	4.9	7.9	20.2
17	1,682	14,699	302	88.3	6.6	Phoenix Mutual	5.4	5.9	4.8	19.6	4.4
18	1,487	10,150	237	82.3	6.5	State Mutual Life	5.7	6.1	4.6	8.5	—1.2
19	1,370	20,144	275	84.7	23.6	State Farm Life†	6.6	7.2	14.9	19.9	28.2
20	1,336	7,315	163	73.7	2.4	Provident Mutual	5.4	5.9	3.6	7.4	33.2
21	1,199	8,436	350	65.8	8.0	Pacific Mutual	6.0	6.5	6.4	9.8	—29.1
22	1,184	9,166	236	69.6	16.5	Guardian Life	6.0	6.5	6.0	12.4	34.4
23	1,126	8,724	191	67.6	9.3	Home Life	6.2	6.7	8.1	9.8	20.1
24	971	6,603	141	48.2	6.3	Union Central	4.9	5.3	1.8	10.1	21.9
25	840	18,566	202	47.2	3.0	Minnesota Mutual	6.2	6.9	8.0	14.3	19.1
						Averages	5.8	6.3	5.8	9.8	17.5

Note: Data is based on "statutory" accounting required by state insurance regulators, not on the "generally accepted accounting principles" used by stock companies (shown on pp. 68-73). Assets and premiums include "separate accounts" of pension plans segregated from the main insurance operations, but investment income does not. * A stock company held by trustees of T.I.A.A: run for the benefit of policyholders. † A stock company 100% owned by State Farm Mutual Automobile Insurance Co.

Mutual Fire & Casualty Companies

Rank	1974 RESULTS ($ millions) Total Assets	Premiums Written	Net Investment Income	Net Income	Realized Capital Gains	Company	PROFITABILITY Combined Loss & Expense Ratio † 5-Year Average	1974	GROWTH (5-Year Compounded Rate) Total Assets	Premiums Written	TREND 1974 vs 1973 Premiums Written
1	$3,959	$2,893	$190.7	$197.4	$2.2	State Farm Mutual Auto	94.6%	99.0%	14.8%	11.3%	7.9%
2	2,271	1,067	105.6	16.6	—2.3	Liberty Mutual	104.6	108.4	9.0	3.7	6.0
3	1,167	686	52.2	48.9	0.3	Nationwide Mutual	95.9	98.7	13.2	6.6	3.2
4	1,091	569	59.6	—19.9	—0.3	Employers Ins of Wausau	107.8	114.0	9.8	7.6	7.1
5	794	424	35.6	2.1	—3.4	Lumbermens Mutual	101.8	109.6	8.3	9.7	9.5
6	649	170	32.4	40.4	—3.9	Allendale Mutual	NA	147.7	NA	NA	14.8
7	538	321	23.9	6.7	—2.3	Sentry Insurance Group	99.1	105.3	12.2	4.7	10.9
8	304	212	17.0	1.8	—7.4	American Mutual Liability	107.2*	107.6	0.7	0.6	—3.6
9	276	223	12.6	—15.3	—1.6	Unigard Insurance Group	104.2	113.3	10.2	13.2	—3.5
10	271	152	11.6	—1.2	—1.6	Atlantic Companies	NA	110 9	NA	NA	9.0
11	221	183	10.8	10.7	—0.8	American Family Group	93.3	98.8	15.0	17.6	7.6
						Averages	100.9	110.3	10.4	8.3	6.3

Note: Data is based on "statutory" accounting required by state insurance regulators, not the "generally accepted accounting principles" used by stock companies (shown on pp. 68-73). † For practical purposes, a combined ratio under 100% indicates an underwriting profit, over 100% a loss. Companies also earn investment profits. Combined ratio includes ratio of losses and loss-adjustment expense plus policyholder dividends to premiums earned and ratio of underwriting expenses to premiums written. NA—Not available. * 3 yr. av.

SPECIAL INSURANCE REPORT 1975

Long Distance Runner

IN A VERY REAL SENSE, Shelby Cullom Davis, now 66, was the man who discovered insurance stocks. They made him very rich. A Ph.D in political science, a former broadcast journalist (CBS), financial analyst and a friend and cohort of the great Ben Graham, Davis worked for Governor Thomas E. Dewey's unsuccessful Presidential campaign in 1944. Afterward, Dewey made Davis First Deputy Superintendent of Insurance for New York State. A scholarly man but a practical one, Davis set about learning the ropes. "I also got to know who were the bluffers and who were the people who were really professionals," he recalls.

That experience led to the formation of the investment firm of Shelby Cullom Davis Co., whose capital, most of it belonging to Davis, is now over $30 million. A few years back when insurance stocks were riding high, it was closer to $60 million.

Davis started the firm in 1947, when he was 38, with the purchase of a small insurance investment business and $100,000, part of it borrowed. Insurance stocks were very much of a backwater in those days. Nobody wanted them. Insurance was considered an unexciting business. The fire & casualty companies were suffering huge underwriting losses as a consequence of claims increased by the post-World War II inflation.

Public Need

"I realized," Davis says, "that rates would have to be raised to maintain the solvency of the industry." He was right. Then followed what was one of the greatest bull markets ever in fire & casualty stocks during the years 1948 through 1950.

"I mean stock like Aetna, Travelers, Hartford and Continental went up threefold, and others ran up even more. Those stocks had been selling at around two times earnings and around a third of book value in many cases."

At the bottom of the late Forties cycle, Davis plunged hard. He used his $100,000 and borrowed from banks to buy more stocks. By the time the firm was four years old it had $1 million in capital.

There has long been a cycle in this part of the insurance industry, a cycle accelerated by inflation. First, claims rise, putting the companies into the red and depressing the stocks. Then, as rate increases work their way through the sluggish insurance commissions, the companies go back into the black and the stocks go up.

Shelby Cullom Davis

Shortly after his discovery of fire & casualty companies, Davis began getting interested in life insurance. There was a bit of institutional investment in the biggest companies, Aetna, Travelers and the like, and they were selling at a nice, steady ten times earnings. But the smaller companies attracted no investment interest at all.

Davis was making regular monthly trips to Peoria, Ill. to visit his ailing father, and one day in 1951 he stopped off in Fort Wayne, Ind. to visit the annual meeting of Lincoln National, a smallish, obscure life company. "They were so startled to see an outsider at the annual meeting that the directors invited me to lunch. I spent a whole day with them and I learned a lot. They were growing at a fantastic rate of about 20% to 25% a year and selling at three times earnings. It was ridiculous when other insurance companies growing half as fast sold for three times as much."

Davis immediately invested a few hundred thousand dollars in Lincoln National stock. However, he did more than just become a passive investor. As an analyst he realized that the faster growing life companies were penalized by the fact that the cost of putting new insurance on the books was making their earnings look bad even though they were storing up earnings for the future. The way it works is that the agent's commission mostly comes out of the first year's premium, which, therefore, produces a loss for the company; but if that new policy stays on the books, it would be producing earnings for as long as a quarter of a century or more.

"To me," Davis says, "it was all backwards. It took me a while, but I finally worked out a better formula. By this formula, we adjusted statutory earnings to reflect the real earnings growth that was going on. I made an adjustment for the *increase* in insurance in force, giving so much a dollar of individual life, so much for a dollar of term and so much for a dollar of group life. This enabled an investor to see what was really happening to smaller companies like Lincoln National."

Using his own formula, Davis picked out other life insurance growth stocks like Illinois-based Franklin Life. Into these stocks went some more of Davis' growing pool of capital, supplemented with borrowed cash.

Davis didn't sit around and keep his formula to himself. He traveled the country, educating analysts and institutions on his formula and persuading them to draw the logical conclusion: There were many solid buys among smaller life insurance stocks.

As the new gospel spread, stocks that had sold for three times adjusted earnings soared to 15 times earnings. By the late 1950s, the Davis firm's capital was over $15 million.

Foreign Fields

There were other worlds to conquer. In the late Fifties, Davis visited Japan. "Oh, I visited the temples, of course, but my main object was to get to know the Japanese fire & casualty business. Then, in late 1962, the Financial Analysts Federation took a large group of analysts for a 2½-week tour of Japan. This time I really got to meet with the fire & casualty companies and study them. In those days the fire & casualty stocks sold on the basis of yield and had nothing to do with earnings. Growth hadn't been heard of. Giant companies like Tokio Marine & Fire, Sumitomo, Yasuda and Taisho were selling for two or three times earnings, and the Japanese economy was really taking off." The Japanese insurance companies would certainly benefit. Since the country's life companies had been nationalized after World War II, this made the fire & casualty companies the logical beneficiaries.

By 1963 Davis had established major positions in those stocks. He then set about convincing the Japanese institutions that these companies should be bought on the basis of growth, not yield. His business boomed and so did his Japanese investments. By the second half of the Sixties, U.S. institutions wanted a piece of the growth in Japan. Davis gave it to them [illegible]mending Japanese fire & [illegible]ty stocks. For the third time, Davis had succeeded in pushing along a major insurance stock surge.

In 1969, Davis, a life-long Republican, got appointed U.S. ambassador to Switzerland. There he stayed for six years, leaving his firm in a partner's charge. During his ambassadorship the insurance stock market collapsed. Davis, who stayed with most of his long-term positions, saw his capital cut approximately in half. But you don't worry too much about that when you still have $30 million worth of stocks, all owned outright. "Yes, I got clobbered," he says, "but you don't make money trading in and out of stocks. You make money buying good stocks when they are cheap and holding them. Remember, I won't have to worry about when to get back in."

What Davis learned in his New York political job also came in handy —such as how to tell a good insurance man from what he calls a "bluffer." This ability to discriminate is what got him out of Continental Insurance in 1964 when it got new management and changed its name to CNA. The whole thing struck him as a bluff.

Right now he's getting back into CNA. "The man the Tischs [Laurence and Preston Tisch of Loews Corp.] brought in from Allstate, Edward Noha, is serious and knows the business. No bluffer. The Tischs aren't bluffers, either. They take chances, but well-calculated chances. They can't turn CNA around in one year, but thay are making noticeable progress. It's a company to watch."

As a pro himself, Davis recognizes another pro when he sees one.

At Shelby Cullom Davis Co., Davis runs a tight ship. He has only 20 employees and two minority partners to run the country's largest insurance stock specialist firm. He has only one serious competitor, Hartford's Conning & Co., which has only about 60% as much capital as Davis has.

Davis declares himself bullish on fire & casualty stocks today. "Their situation," he says, "is very similar to just after World War II. They have suffered heavily from inflation and underwriting losses. Now they are starting to get sizable rate relief. It should start showing up next year. The leverage is considerable in a swing from a loss ratio of 10% to break even."

Of course, history doesn't *always* repeat. In fact, financial history has been rather fickle in recent years. But if logic prevails, Davis will probably turn out to be right. Can we, logically, permit the industry to sink into chronic low profitability and so hamper its ability to insure a growing economy? ■

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THE KANSAS BAR ASSOCIATION POSITION FOR CONSIDERATION BY THE SPECIAL COMMITTEE ON MEDICAL MALPRACTICE OF THE KANSAS LEGISLATURE ON AUGUST 27, 1975

David H. Fisher, of Topeka, Kansas, Chairman of the Professional Relations Committee of the Kansas Bar Association, and Edwin Dudley Smith, of Topeka, Kansas, Chairman of the Medical-Legal Subcommittee, make the following presentation:

1. INTRODUCTION.

The Kansas Bar Association appreciates the opportunity to appear before this Committee to discuss the question of medical malpractice in Kansas.

Of course, if there were no medical malpractice we would not be here today.

Medical malpractice is a difficult problem; difficult because it is highly emotional and it involves basic human rights. It is the liability of a health care provider for his negligence in performing, or the lack of performing, medical services. Without attempting to define in minute detail the responsibility of a health care provider to a patient for negligence it generally rests on a determination that the acts or omissions in providing said health care is below the standards expected in the community or other similar communities. The difficulty is compounded because of the shortage of doctors; in providing doctors and health care providers.

It is further complicated by the apparent high cost in providing medical and health care providers with adequate insurance protection against claims made by patients for medical malpractice.

We have no magic formula or suggestion as to how to outlaw or do away with medical malpractice. As long as human beings perform services and make decisions

with regard to health care there will always be results which are not completely satisfactory, and there is always a chance of human error.

We realize there are many new advances in medical science, both from education and new learning experiences, new drugs, new operative procedures, new discovery as to the causes of diseases. Brain surgery, open heart surgery and transplants are all relatively new as acceptable treatment. Publicity points out that the laser beam may open many and new exciting and beneficial operative treatments.

The Legislature cannot legislate the amount of education or re-education required in the medical field to meet the changes of a medical society. There is no question but what, with the advances in medicine, continued medical education is desirable if the standards of medical treatment are to keep up with the demands. I know that the Legislature has repealed most of the average lawyer's education since he graduated from law school. The standards of continued medical education in order that physicians and surgeons can keep up with new methods and new treatment procedures is within the province of the medical society. We encourage the continuation and concentration in this regard. Any methods adopted by the medical society requiring continuing medical study and education should help in disseminating advances in medicine to all practitioners. We would encourage the licensing authorities and the medical society itself to adopt requirements of continuing medical education. This certainly should result in a reduction of medical malpractice claims.

I believe that physicians, hospitals and medical vendors should be encouraged to review methods of treatment of patients in the hope that this will result in improving conditions of treatment and in determining better methods of treatment, and review by the physicians and hospital staffs should not be curtailed in any way. By this peer review it is generally hoped that claims of medical malpractice will be greatly reduced and the causes of medical malpractice can be lessened or greatly improved.

The professional review of specific claims of medical malpractice should be encouraged. It is recognized that in reviewing a specific claim the facts, hospitalization and all records pertaining to said treatment will be reviewed by other professionals qualified in the field involved. The professional review of these claims should be encouraged and not discouraged, and the fact that a professional review of a specific claim has been made and studied should not be admissible in the trial of a malpractice action which has been filed, or is later filed. In the hope that more frequent and more in depth reviews are made of medical malpractice, we believe that the results of such professional review and the opinions of doctors and physicians who participate in the same should not be admissible in the trial of a malpractice action.

Naturally, the hospital records and all specific findings which are considered and upon which any claim is reviewed, must still be available to the patient in order that his rights may be fully served.

The standards of care in treatment of patients is established by the health care providers themselves. It is only when the treatment a patient receives falls below the standard of care that a valid claim for medical malpractice arises. If all treatment and all services rendered met the standard of care, there would, of course, be no basis for a medical malpractice claim. As long as there are differing opinions there will, of course, be medical malpractice claims, but a successful medical malpractice claim can only result in an award where expert medical testimony shows that the treatment had not met the standard of care.

2. THE DOCTRINE OF INFORMED CONSENT.

It is impossible to legislate the standard of care that a physician or surgeon must use in treating a patient. These change with each new accepted surgical procedure, each new drug that comes upon the market, and each new learning which is generally accepted within the medical profession. The duty of a physician as to

what he must disclose to his patient at the time of treatment and prior to surgery is well defined by the Kansas courts. That duty being limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. Disclosures of possible results of medical or surgical procedures are to be made to a patient which are ascertainable, and expert medical testimony is ordinarily necessary to establish that they were insufficient to accord with disclosures made by reasonable medical practitioners under the same or similar circumstances. (Charley v. Cameron, 215 Kan. 750, Page 756.) This rule seems ultimately fair, as again the standard is set by the medical practitioners themselves, and protects to them the accepted opinions of the profession as to what is necessary under the same or similar circumstances. An attempt to legislate the exact rule to be followed would result in too much or too little, as this must be determined by the known problems, the reasonably known results, and taking into consideration the patient himself, whose rights we must ultimately preserve. The emotional problems of a patient about to go under surgery must be considered and the law as it presently exists does not require that each infinitesimal, imaginative or speculative element must be included in such informed consent. We do not see how it is possible that the Legislature could define any rule of thumb that would fit any and all circumstances or anticipate the changing advancements or medical science.

3. The emergency treatment by medical and health care providers has long been the concern of the medical profession.

Kansas has a Good Samaritan Act, which permits the treatment by a physician or surgeon in case of an emergency determined by the circumstances, and he is not held to the same standard as in the hospital, where the doctor has available to him nurses, equipment, laboratories, X-Ray machines, sophisticated diagnostic equipment, specialists and other facilities which can assist in the proper treatment. This is a good rule which makes possible emergency treatment to a patient without undue exposure to the person who renders such treatment. An extension of this rule

to the doctors' office, to the emergency room or to the hospital itself would not be in the best interests of the patient who is entitled to the expertise of the examining physician or surgeon who can have available at his elbow or telephone the benefits of modern medical science.

4. We do not see a medical malpractice crisis in Kansas, but we do believe that several considerations should be made in alleviating the medical malpractice claims which are made, and medical malpractice insurance should be made available to all health care providers. We must not lose sight of protecting the rights of the public--the patient, nor can we escape the responsibility of the medical provider to the patient. The Bar Association is anxious to see improvements in the present system, which will avoid a medical malpractice crisis as other states have encountered. We do not believe that socialized medical care, such as Great Britain's state-run national health service is, is the answer, as it now appears that this is breaking down, and predictions are that the system is broke.

Certain malpractice claims can be handled without resorting to litigation. Dudley Smith will later speak on the questions of limitations of recovery, arbitration of medical malpractice claims, the Ad Damnum clause and the Collateral Source Rule. These may in some part assist this Committee in determining the rights of the patient and procedures which will save the doctors anxiety.

The rights of the patient to redress should at all times be protected, and this includes the right of a patient to present his medical malpractice claim. For 200 years the tort system, through our judicial processes, has worked, and such plans as will streamline the presentation of a medical malpractice claim, or the adjudication of the claim, should at all times be voluntary on the part of the patient. Mandatory plans take away from an individual his otherwise right to trial by a jury.

A screening panel, or impartial medical-legal plan to which medical malpractice claims can be submitted by patients or by the physician or health care provider, if voluntary, can work to eliminate small claims or nuisance claims and will shorten

the time in which determination can be made as to whether the claim is valid. The panel should consist of a ratio of lawyers and doctors which is substantially equal in number from both professions. The patient should be permitted to present a claim with the assistance of his attorney. The results of the screening panel should not be admissible in evidence in the trial of a malpractice action, but all matters pertaining to evidence to support or disprove a malpractice act should be admissible under present evidentiary procedures. The panel should agree to furnish one or more physicians to testify on behalf of the prevailing party. It should not be mandatory that all medical malpractice claims be presented to the medical-legal review plan. There are many similar plans across the country which can be considered and still retain to the private citizen--the patient--his rights to a judicial determination. This should not be confused with the arbitration plan.

There is no logic to a health care provider being encouraged to perform his services in a willful, wanton and reckless manner. Therefore, punitive damages should not be eliminated from malpractice cases any more than they would be eliminated in any other case involving willful, wanton and reckless misconduct. It should be reiterated that this misconduct can only be found upon proof by competent expert witnesses.

5. The cost of medical malpractice insurance is of concern to all of us. It appears that premium charges by insurance carriers have jumped beyond the normal inflationary trend. The cause of this is not known. Insurance companies have indicated that it is due in part to more claims, larger awards, and uncertainty in the time in which claims may be made, which requires reserves to be held for long periods of time. As we see the problem the number of doctors, and particularly in Kansas, is rather small as far as the risk involved. Therefore, a fewer number are required to carry the expense for all concerned. It appears that the obtaining of medical malpractice insurance has not reached the crisis stage in Kansas, but specialists have found their premiums to be greatly increased. Perhaps some of the criteria on which medical premiums are charged is not known. It does appear, however, that the specialist is being charged on a much different basis than the

general practitioner. There are many less specialists than there are practitioners, and therefore the nucleus used in determining the rates of specialists grows even smaller. Perhaps a study should be made as to whether all health care providers should be involved in the cost of malpractice insurance as an over-all picture. Our Insurance Commissioner does not have adequate means of determining the basis on which malpractice insurance premiums are determined. There does not appear to be statistics on which a determination can be made as to the number of claims or the exposure of such claims. The malpractice problem has multiplied so fast in recent years that insurance companies apparently do not have the history on which th properly reserve for claims. We believe that legislation is in order to assist the Insurance Commissioner in obtaining additional information with regard to the basis upon which insurance companies set their premiums.

The Insurance Commissioner should seriously consider pooling arrangements created by the insurance companies doing business in Kansas, whereby the insurance industry makes available coverage for medical malpractice claims.

There has been considerable publicity in all the news media concerning the sky-rocketing costs of medical malpractice insurance, and there has been testimony before this Committee of the unavailability of this type of insurance to physicians and surgeons who desire to commence practice in this state. Consideration should be given to a plan which would permit a professional person (and this problem is not one for the medical profession alone, but involves all professional persons who are experiencing the same problem with regard to professional liability insurance) to carry a limited amount of malpractice coverage, with any judgment in excess of that amount to be paid out of a state fund. The fund should be supported by the particular professional group adopting this plan. A study should be made as to whether this fund would provide for malpractice coverage at a reasonable premium rate, but the professional group involved should contribute toward the excess fund in order that there would be funds available to pay any catastrophe or extremely high judgments that might occur. If the professional person is to be relieved of his personal

liability for any excess over and above a statutorily limited coverage, the fund must be sufficient in order to satisfy the judgments against an individual professional person.

6. The contingency fee system has been under considerable attack. The contingent fee system does not cause malpractice, nor does it contribute to the problem of the availability of medical malpractice insurance. No evidence has been presented that the size of the contingent fee bears any logic or factual relationship to the size of a jury verdict. On the contrary, the jury is asked to bring in an award fairly compensating the plaintiff for injuries sustained. It receives no instructions on attorney fees, and few, if any, jurors have any idea that a contingent fee (if such be the case) is involved in the case they are hearing. The size of settlements are not logically or in fact affected by the contingent fee.

Clients who pay the contingent fee after a verdict or a settlement rarely, if ever complain about the amount of the fee.

If the client who pays the fee does not complain, and if the size of the award or settlement is not affected by the amount of the fee, then the true source of complaint regarding contingent fees must be the doctor, who may be influenced by professional jealousy. Certainly the regulation of lawyers' fees is subject to challenge by the courts, and very recently the highest court of the land has held that fee schedules are unconstitutional. Statistics show that two-thirds of malpractice cases tried by plaintiffs are lost, in which case the lawyer receives nothing for his time and often nothing for expenses incurred. It is the contingency fee system which funds the handling of similar cases. This is the risk the lawyer assumes when he files any tort case on which he has agreed to represent the plaintiff on a contingent fee basis.

The genius of the contingent fee plan is not only that it gives his client access to a lawyer whom he could not otherwise afford, but it gives the lawyer the

impetus to handle the suit. The consequence of lowering the fee by a significant amount will be to discourage competent lawyers from handling malpractice cases and open the handling of malpractice cases to a less well-trained bar. Surely this is not behind the proposal by organized medicine to do away with or limit the contingent fee.

In any study made by this Committee the contractual rights of the insurance companies must be considered, in that legislative requirements for handling malpractice claims may be unattractive to private insurance carriers and may actually controvert the terms of the insurance contract itself, leaving the health care provider without any source of insurance protection.

liquidated damages in a precise amount in the event of certain breaches of contract, and, in effect, work out the contract to the satisfaction of both parties. Where a tort is involved, the victim of a future tort has no way of knowing the type of injury that may be inflicted upon him, the ultimate consequences of such injury, whether he will incur a temporary injury, a permanent injury, or be totally disabled for the rest of his life to the extent that he is unable to participate in any gainful activity whatsoever. It seems only reasonable in such a case to permit the injured victim, after the injury occurs, to have time to reflect upon the proposed method of settling his dispute, whether by arbitration or established court procedures, which would be permitted under the existing law. Changes which are proposed would require the injured person to make such a decision on the spur of the moment when he does not have time to reflect and knowingly waive his constitutional and statutory rights to present his case to a jury of his peers.

In talking with many lawyers over the past several years who have defended physicians and hospitals in medical malpractice cases, it is clear that in almost 100 per cent of the malpractice cases which are defended, the hospital or physician asked for a jury trial. The lawyers feel that the physician or hospital will get a fair trial before a jury, and that the individual prejudices which all persons have, including an arbitrator or a judge, can be avoided by presenting the case to a jury of 12 persons of various backgrounds and disciplines, with the result that a fair decision will be made for all parties concerned.

In the event that this committee is considering recommending amendment of the existing arbitration statutes to allow written agreements to arbitrate future tort controversies, a study should be made as to the effects such a requirement would have on the availability of malpractice insurance for physicians and hospitals, and whether such agreements made in advance by physicians and hospitals would violate the provisions of their malpractice insurance policies. Many attorneys, and, in fact, most plaintiff's attorneys, if I am not mistaken, feel that the awards entered by arbitration will be higher in malpractice cases than the same cases would have obtained if submitted to a jury under the existing court procedures. If this is true, it certainly will not help the medical malpractice situation in Kansas.

A comment should be made about existing arbitration agreements such as found in the Ross-Loos Clinic in California. The Ross-Loos Plan does not contemplate a situation where ill, diseased and injured persons present themselves for the first time to a physician, a hospital emergency room, or a clinic, in need of immediate medical care. On the contrary, all patients who are treated by the physicians in the Ross-Loos Clinic are there because they are members of a pre-paid medical plan, and all of their medical treatment has been contracted to the clinic. In other words, those patients have had an opportunity to make a determination, in advance of their illness or injury, as to whether or not they desire to enter into the medical contract with the clinic,

ARBITRATION OF MEDICAL MALPRACTICE CLAIMS.

The Kansas statutes, K.S.A. 5-401 et seq., are titled The Uniform Arbitration Act. It provides for arbitration by written agreement of any controversy other than a claim in tort thereafter arising. In other words, agreements can be made to arbitrate any existing controversy whether in tort or in contract, and an agreement to arbitrate future contractual disputes can be made, but the statute does not permit the arbitration of a future tort.

There appear to be several basic reasons behind the limitation on arbitration of future torts, which will be mentioned.

The Kansas Bar Association endorses voluntary arbitration as now exists under the Kansas law. Compulsory arbitration of any dispute is opposed.

There appear to be several reasons supporting a restriction upon permitting agreements to arbitrate torts which may arise after entering into the arbitration agreement. Since we are concerned with the medical malpractice issue, consideration should be given to the particular facts involving persons who are injured, ill, or otherwise in need of medical treatment. A person who presents himself at the emergency room of a hospital, for instance, with a serious injury and in need of immediate medical care, is certainly in no position to make a voluntary and informed decision with regard to the signing of a proposed agreement to arbitrate in the event a claim might arise against the hospital or the physicians as a result of treating such person. The patient may be unconscious, and a relative may be asked to waive the rights to submit future disputes to a court and jury, which the injured patient would not agree to if he had time to consider all of the ramifications of signing such an agreement.

In many cases, a person who needs immediate medical care may be incoherent or otherwise incompetent to understand the nature and extent of such an agreement, but might be required to sign such an agreement as a condition to obtaining medical treatment. This certainly is not in the best interest of the patient and cannot be considered as a voluntary agreement to arbitrate.

Another reason that comes to mind for maintaining the existing Kansas law involves the problems a patient might have in trying to evaluate in his own mind the particular injuries that might result from the proposed treatment. When parties enter into a written contractual agreement involving the construction of a building, for example, it is not too difficult to imagine what the total extent of any loss might be as the result of a breach of the contract by one of the parties. The parties to such a contract can take as much time as necessary to work out all of the details of the contract, provide for

injury. Thus, when a gas valve is negligently installed in a house, there is no substantial injury until the explosion occurs, and the statute of limitations does not begin to run until such substantial injury occurs, which could be many years after the negligent installation took place. In one Kansas case, the explosion occurred ten and one-half years after the installation, and the injured party had two years thereafter to bring a lawsuit.

The Kansas statute also provides that where substantial injury has occurred, but the fact of the injury is not reasonably ascertainable until sometime thereafter, then the period of limitation does not begin to run until such injury becomes reasonably ascertainable, but in no event shall the period be extended more than 10 years beyond the time of the act giving rise to the cause of action. In other words, the injured party has 10 years to discover that he has been injured. (Ruthrauff, Administratrix v. Kensinger, 214 Kan. 185, 519 P.2d 661 (1974)).

The Kansas Bar Association endorses amendment of this statute of limitations to reduce the 10-year discovery period to 6 years, on all professional liability tort claims. Such a change would involve shortening of the discovery period as to all professional persons, not only physicians. It is believed that some logical classification of persons subject to the shortening of the discovery period must be made, and that inclusion of all professional liability tort claims would be a proper classification.

With regard to malpractice claims involving physicians and hospitals, an example might be helpful. Where a physician during surgery causes injury to a patient, there is usually substantial injury at that point in time. However, the patient may not discover the injury until sometime thereafter. The present statute of limitations provides for a ten-year discovery period. It is proposed that the discovery period be reduced to six years.

It is believed that the statistics show most medical malpractice claims are brought within a six-year period of time, and that patients would not be adversely affected by such a change to any significant extent, but that insurance companies would be in a better position to set up their reserves knowing their claims were over after six years, as opposed to ten years.

LIMITATION ON RECOVERY.

We propose no limitation on the amount of recovery in medical malpractice actions, or in any other civil action. The present law should be maintained. It is difficult to conceive any rational basis for limiting the amount of recovery if a person is injured as the result of medical malpractice,

or be part of a group plan which has contracted with the clinic for medical services to members of the group. The patient has had an opportunity to understand the nature and extent of the waiver of rights, and to submit their future controversies to arbitration. Possibly this type of arrangement is already legal in Kansas under the present Uniform Arbitration Act. If it is not, amendments can be made if and when such pre-paid group medical practice becomes prevalent in this state. This plan is not an example of the situation that would occur if the Kansas arbitration statute was changed to permit arbitration of future tort controversies as a condition to obtaining medical care.

AD DAMNUM CLAUSE.

The Kansas Bar Association is in favor of elimination of the ad damnum clause, that is, the clause which sets out the prayer or amount claimed against the defendant, from the petition or complaint at the time it is filed. It is recommended that provision be made for immediate disclosure of the prayer upon motion by the defendant, or by interrogatory. It is obviously necessary to know the amount of the prayer, since in many cases the defendant's insurance policy limits will not be sufficient to indemnify him if judgment were entered in the amount of the prayer, and the insurance company must notify him that he has been sued in excess of his policy limits. It is also necessary to know whether damages which are not covered by the insurance policy, such as punitive damages, are claimed, and the amount thereof, so that the insured may be advised and so that he may retain his own attorney and otherwise take appropriate action for his own defense. Of course, it is necessary for any attorney defending a lawsuit to know the amount of the prayer, but it is not necessary that this be included in the petition or complaint at the time it is filed, as this is a mere formality. It is understood that the Supreme Court of Kansas is presently studying the elimination of the ad damnum clause from petitions, by Supreme Court rule.

STATUTE OF LIMITATIONS.

It must be understood that any statute of limitations is determined on an arbitrary basis by its very nature. The present tort statute of limitations, applicable to negligence actions, including but not limited to medical malpractice actions, is K.S.A. 60-513, which provides for a two-year statute of limitations where the claim is based upon negligent tort. The statute of limitations begins to run when the tortious act first causes substantial

satisfaction of the judgment to the extent that his medical insurance paid for your medical bills.

The doctrine involves other areas, as well, such as gratuitous nursing benefits provided by the injured person's wife, or relatives. The theory is that reducing the recovery by the amount of benefits received by the plaintiff would be a windfall to the defendant who should properly pay the reasonable value of those benefits.

The Bar Association supports the existing collateral source doctrine under Kansas law. When you purchase an accident and health policy to provide medical benefits if you are injured, you pay for that policy with your hard earned money, and you are entitled to the benefits of the insurance contract. To allow the tortfeasor in a medical malpractice case, or any other negligence case, to reap the benefits of such a collateral source is basically unfair. Proposals to do away with the collateral source doctrine will affect not only those injured in medical malpractice situations, but also every person who is the injured victim of a negligent tort in Kansas. Insurance contracts to pay medical expenses are not taken out for the benefit of the tortfeasor, but solely for the benefit of the insured who pays the premium, with the hope that he is never injured, but with the knowledge that he will have some means of paying his medical bills from his own sources in the event he is injured through negligence or otherwise. On the other hand, the negligent tortfeasor pays no portion of his victim's insurance premium, which may amount to a substantial sum over a period of years, and should not be able to claim the benefits of that contract. The Kansas Bar Association opposes any change in the existing collateral source rule in Kansas.

whereas he could recover fully for his loss if it resulted from the negligence of any other person including professional persons. If a highly skilled surgeon were to injure a patient by negligence during surgery, causing the patient to lose his livelihood, and become entirely dependent on others for care and support, a limitation on recovery would subject the injured patient to a maximum recovery of, say, $200,000.00 or $500,000.00, for example. If a few days after the operation, the surgeon were to be similarly injured in an automobile accident, he would have no limit on his recovery against the negligent driver who caused his disability. Limitation on recovery in medical malpractice actions will not serve the public or the citizens of Kansas. Once a limitation on recovery is allowed in one area, such a medical malpractice, certainly other professional groups, and non-professional groups, will seek similar limitations on recovery. Large damage actions against any person, whether he be a physician, lawyer, engineer, plumber, or automobile driver, are equally devastating to the individuals against whom such judgments are rendered.

There have been very few judgments or settlements of medical malpractice actions in the state of Kansas in excess of $500,000.00. That is not to say that there are not cases which may arise in the future which would justify settlements or judgments in excess of that amount. However, a dollar limitation on the amount of recovery must by its nature be arbitrary, and will probably be inadequate in a few years as the result of inflation. We all recognize the problems over the past years involving the limitation in wrongful death actions in Kansas. It was at one time, $10,000.00, then, $15,000.00, then, $25,000.00, then, $50,000.00, and last year, the legislature saw fit to remove all limitations on pecuniary loss in wrongful death actions. The same reasoning behind the removal of the limitation on recovery in death actions applies to the problem of determining whether a limitation should be placed upon recovery in malpractice actions. The Kansas Bar Association supports the present law which allows an injured party to recover a judgment against the person who negligently injured him, to the full extent necessary to compensate him for his loss.

COLLATERAL SOURCE RULE.

The collateral source doctrine is a rule of damages which provides that benefits received by a plaintiff from a third party cannot be deducted by the defendant from a judgment entered in favor of the plaintiff against the defendant. In other words, if you are the plaintiff, and have purchased medical insurance, which pays some of your medical bills, and you obtain a judgment against a defendant who negligently injured you, the defendant cannot reduce his judgment by the amount of the medical benefits which you obtained through your own insurance policy. The rule only applies to benefits received from third parties who are not connected with the defendant. Therefore, if the defendant's medical insurance pays for your bills, the defendant would be entitled to claim

studying handling the elimination of Ad Damnum clauses from petitions for damages at the time of filing by Supreme Court rule.

7. Contingent fees - The contingent fee system is not a contributing factor to the problem of availability of medical malpractice insurance, nor is it a factor in the high damage awards which are recovered in some cases. The availability of legal services to persons otherwise unable to pay for them is substantial justification for the contingent fee system. The current problem involves the availability of malpractice insurance coverage at a premium rate which is reasonable, and it is our belief that the contingent fee is not a factor in the determination of either the availability of medical malpractice insurance nor in the premium rate charged. The Bar Association opposes legislative regulation of contingent fees. The matter of lawyers' fees is subject to review by the courts.

8. Punitive damages - The Bar is opposed to the elimination of punitive damages in cases involving willful, wanton and reckless misconduct.

9. Informed Consent - The present Kansas law on informed consent is supported, and legislative action should not be taken to change present case law.

10. Good Samaritan Act - Kansas law in its present form is supported, and it is recommended that any change in the Good Samaritan Act should be opposed.

11. Statute of Limitations - The present statute covering limitation of actions should remain as is, except that the ten-year period of extension beyond the time of the act giving rise to the cause of action should be reduced to six years on all professional liability tort claims.

12. Limitation of Recovery - There should be no limitation on the amount of recovery in medical malpractice actions, and the present law should be supported.

13. Malpractice insurance premium rates - Legislation to permit the Insurance Commissioner to obtain additional information with regard to the basis upon which insurance companies set their premium rates should be supported.

14. Collateral source rule - Any change in the existing collateral source rule in the State of Kansas is opposed.

15. Pooling arrangement created by insurance companies - Support should be given to the arrangement whereby the insurance industry, through pooling arrangements, makes available coverage for medical malpractice claims.

16. Limitation on amount of insurance coverage carried by professional persons - Support should be given to a plan whereby a professional person would be permitted to carry only a certain limited amount of malpractice coverage, any judgment in excess of that amount to be paid out of a state fund, which would be

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KANSAS BAR ASSOCIATION POSITION PAPER ON MEDICAL MALPRACTICE

The Executive Council of the Kansas Bar Association has authorized the Professional Relations Committee of the Bar to publish the following position paper on certain matters relating to the medical malpractice problem:

1. Continued medical education - This is within the province of the Medical Society.

2. Peer review, in the sense that physicians, hospitals, or other medical vendors periodically or generally review methods of treatment, and medical malpractice - The Bar Association should not make general recommendations with regard to peer review.

3. Professional review of specific claims of medical malpractice - Professional review of specific claims of medical malpractice is approved in principal. The extent to which said proceedings and records should be discoverable in subsequent litigation involving medical malpractice should be subject to further study. The fact that such proceedings were held and the results of such proceedings, and the evidence contained in such proceedings, should not be admissible in the trial of a malpractice action.

4. Screening panel, or impartial medical-legal review plans - The principal of a screening panel to which medical malpractice claims can be submitted by attorneys and/or physicians and hospitals is supported in principal, subject, however, to the following conditions:

   a. That it be a voluntary proceeding, and not mandatory.

   b. That the results of the screening panel procedure would not be admissible in evidence in the trial of a malpractice action.

   c. That the panel agree to furnish one or more physicians to testify on behalf of the party prevailing in the screening panel procedure.

   d. That the panel consist of a ratio of lawyers and doctors which is substantially equal in number from both professions.

5. Arbitration of medical malpractice claims - Voluntary arbitration is now available under existing law. Compulsory arbitration is opposed, and the existing law on voluntary arbitration is supported. Any study with regard to compulsory arbitration should include the effect such a requirement would have as to a violation of the insurance contract of the physician or hospital.

6. Ad Damnum clause - The elimination of the Ad Damnum clause from the petition or complaint at the time it is filed is supported, with the recommendation that such information be disclosed immediately upon motion by the defendant. It is our understanding that the Supreme Court of Kansas is presently

supported by the particular professional group involved. This would permit a professional person to carry a stated amount of malpractice insurance, at a reasonable premium rate, and contribute toward an excess fund to pay any catastrophe or extremely high judgments that might occur. However, the fund must be sufficient to satisfy the judgments if the individual professional person would be relieved of personal liability for such excess over and above his statutory malpractice coverage.

DAVID H. FISHER, Chairman
Professional Relations Committee,
Kansas Bar Association.

KANSAS TRIAL LAWYERS ASSOCIATION

POSITION PAPER ON MEDICAL PROFESSIONAL NEGLIGENCE

Presented to

The Kansas Legislature

Special Committee on Medical Malpractice

August 27, 1975

AD DAMNUM CLAUSE

We feel that this is not necessary and should be eliminated.

PUNITIVE DAMAGES

Punitive damages are rarely asked for in medical negligence cases, but should be available when necessary.

SCREENING PANELS

We support voluntary screening panels composed of an equal number of doctors and lawyers, with a non-lawyer, non-physician as chairperson.

ARBITRATION

We support arbitration:

a. mandatory, non-binding arbitration for claims under $10,000;

b. mandatory, non-binding arbitration or voluntary, binding arbitration for claims over $10,000.

COLLATERAL SOURCE RULE

We advocate that the present law be maintained.

INFORMED CONSENT

The necessity of such consent is just and reasonable.

PEER REVIEW

Peer review of the competence and level of performance of health care providers will not be effective without vigorous implementation of the authority to discipline now vested in the Board of Healing Arts and other liscensing authorities.

CONTINUING MEDICAL EDUCATION

We favor continuing education for all professions, including the medical profession.

GOOD SAMARITAN ACT

We do not favor liberalizing the Good Samaritan Act at this time.

FURTHER STUDY

We recommend an ongoing study of all areas of the medical negligence insurance issue.

PROPOSED

KANSAS STATE FUND FOR MALPRACTICE AWARDS
IN EXCESS OF $100,000

PRO FORMA ANNUAL INCOME PROJECTION

Assessments of licensed health care providers:

Physicians and Surgeons (M.D.'s and D.O.'s)	5,500		
Chiropractors	900		
Podiatrists	67		
Dentists	1,800		
	8,267	@ $100	= 826,700.
Registered Physical Therapists	400	@ $50	= 20,000.
R.N.'s	17,000	@ $20	= 340,000.
L.P.N.'s	5,000	@ $10	= 50,000.
Laboratory technologists and technicians	777	@ $20	= 15,540.
X-ray technicians	405	@ $20	= 8,100.
Inhalation therapists	180	@ $20	= 3,600.
Hospital beds (including bassinets, but not including long term care beds)	13,900	@ $30	= 417,000.
			1,680,940.

NOTE:

$100 per year is less than 28¢ per day.
$ 30 " " " " " 9¢ " "
$ 20 " " " " " 6¢ " "
$ 10 " " " " " 3¢ " "

KANSAS TRIAL LAWYERS ASSOCIATION
POSITION PAPER ON MEDICAL PROFESSIONAL NEGLIGENCE

The problem before us is one of availability of medical professional negligence insurance at a reasonable cost to all health care providers. This problem, if indeed such a problem does exist, can and must be solved without denying the person injured by the medical negligence the right to comprehensive compensation. If this so-called medical malpractice insurance "crisis" was manufactured, those responsible should be exposed.

Kansas Trial Lawyers Association is an organization of trial attorneys who specialize in representing individuals rather than corporations and institutions, and who most often represent the side of the plaintiff or claimant. Only a small precentage of our members handle medical professional negligence claims, but most medical professional negligence claimants in the State of Kansas are represented by lawyers belonging to our Association. The philosophy of our organization encompasses obtaining adequate compensation for injured persons. We feel that persons injured by the negligence of others represent a small, unorganized and even undetermined group. They have no spokesperson or organization except for the Kansas Trial Lawyers Association. We hope to represent these individuals and their rights in our position paper.

Two issues that have been discussed in testimony before this committee are the statute of limitations and the

contingent fee. In order to better understand these concepts, we will discuss them in relation to a hypothetical set of facts. Mrs. Smith is a housewife. Mr. Smith is an engineer. They have two children, aged 10 and 12. In 1970, Mr. Smith was negligently overexposed to radiation during treatment at a local hospital while under the supervision of his family doctor and a radiologist. In 1975, Mr. Smith developed leukemia, caused by that overexposure.

STATUTE OF LIMITATIONS

Mr. Smith is understandably concerned about the future support of his wife and young children, as well as payment of his mounting medical bills. He is also concerned that more care be taken in the future to prevent these needless types of injuries. For these reasons, the Smiths seek the advice of an attorney.

An attorney is governed by certain professional ethics. Before accepting a case, he must be certain that he is not knowingly accepting a false or groundless claim, and that he can practically afford to accept the case and carry it through trial if necessary.

If the statute of limitations has run, a good claim cannot be filed. The five-year period before Mr. Smith's leukemia developed is not a far-fetched example. Under the present Kansas statutes, the claimant has ten years during which discovery of an occult injury can be made, and two years after such discovery to file an action. Thus, the

Smiths' case can be filed.

The insurance industry and the health care providers favor a reduction in the statute of limitations. They feel the "long tail" created by the discovery period of ten years, and the tolling of the statute of limitations for a minor until he reaches the age of majority, burdens the insurance industry in planning reserves for future losses, and retiring doctors by leaving them open to suit after retirement. Adequate evidence has not been presented by either group that the existing statute of limitations has any substantial effect on the problem under study -- availability of insurance at a reasonable cost for all health care providers.

We realize, however, that a practical decision is going to be made as to where to draw the lines that ultimately place the opportunity for a victim to recover his losses secondary to the collective capacity of society to supply that protection. With this in mind, as a balance between the rights of claimants and the needs of the health care providers and insurance companies, we do not oppose a reduction in the statute to a period of six years from the date of the negligent act in which all claims must be filed. Such claims would thereafter be cut off in the absence of fraud, concealment, or alteration of records. Where fraud, concealment, or alteration of records is discovered, we advocate criminal sanctions. We agree to the

elimination of the discovery rule and the exception for minors in light of the longer filing period, and in light of the further proposals we make later in our paper. We emphasize that anything less than a six-year statute would seriously impair the rights of injured persons to just compensation for their injuries. Our proposal simplifies the law, and cuts down the "long tail" without doing away with the rights of minors and other injured persons. Although our proposal applies specifically to medical negligence, we do not at this time oppose applying it to all professional negligence claims.

CONTINGENT FEE

The usual method by which a victim of alleged medical negligence finances a claim is the contingent fee system, whereby an attorney and his client agree that upon winning a recovery in the case, the client will pay the attorney a specified percentage of that recovery. The client's portion of the recovery is tax free; the attorney's fee is subject to state and federal taxation as income. If the claim is lost, not only does the attorney receive nothing for his time and effort, but in reality the client is unable to pay all or most of the expenses of prosecuting the suit; as a consequence the attorney must absorb the expenses. This system is an effective means of reducing the number of claims, by forcing the attorney to be discriminating in accepting only valid cases.

The contingent fee system is the necessary "key to the courthouse" for all but the very rich. Even a family such as the Smiths, Mr. Smith being a professional man with a good income, would find it impossible to finance their medical negligence case in any other way. By their very complex nature, medical negligence cases are difficult and time consuming. Expenses for such a case can and do run extremely high. For example, expert medical witnesses often charge $500-$1,000 per day plus expenses, from the time they leave their offices until they return. These facts already deter competent attorneys from handling medical negligence cases with a potential recovery of less than $25,000. Any limitation on the present contingent fee system would lead to a claimant being unable to obtain an attorney unless his case had a potential of $100,000 or more.

We oppose any change in the present system. We do not feel that what attorneys charge for their services is any more relevant to the problem of availability and cost of insurance than is what doctors charge. Medical negligence verdicts do not include anything for attorneys fees and are not increased thereby. Juries are not told the amount, if any, the attorney may receive from the recovery; in fact, they are prohibited from considering it. It is most interesting to note that it is not the client -- the injured party -- who is complaining about the contingent fee system, but rather the health care providers and the in-

surance industry. What reason can they have for attempting to change a system whereby injured persons at every economic level can obtain top-flight attorneys? The only possible reason is that they hope to make medical negligence cases economically unfeasible for attorneys to handle. To deny a claimant opportunity for an attorney to take a case on a contingent fee is to deny an equal opportunity for recovery to those who are least able financially to withstand the economic loss occasioned by the injury.

We acknowledge that there is some fault with the contingent fee system. The injured party may not receive the full compensation due him, but he usually receives a larger net recovery under the present system than in other situations. For those who insist on limiting or abolishing the contingent fee system as a solution to this problem, we offer the alternative of an add-on attorney fee, to be collected by a successful plaintiff, based on an amount equal to a specified percentage of the recovery, an hourly rate or as otherwise determined by the court. The manner of compensation would be prearranged and court approved. This alternative assures an equal opportunity for all to be justly compensated.

PROCUREMENT OF RECORDS

It is extremely important that there be other legislation that would allow the patient and his attorney to immediately obtain complete and full copies of medical

records to expedite the early evaluation of a medical negligence claim. It is now common to be forced to wait three to four months, or longer, to receive copies of patient records. A statute is needed that requires doctors and hospitals to provide copies of the patient's records within ten days of receiving claimant's request. A penalty should be provided for lack of compliance. Delays are harmful to all parties involved.

AD DAMNUM CLAUSE

At present, the petition filed in court on behalf of the plaintiff includes what is known as an ad damnum clause, which means "to the damage". This is the part of the complaint where the claimant asks for a certain amount of money to cover his losses. We feel that this is not necessary and should be eliminated. In the American system of justice, the jury has always been, and should continue to be, the sole decider of damages.

PUNITIVE DAMAGES

In Kansas, as in most jurisdictions, punitive damages are allowed where misconduct is gross, wanton or wilfull. Punitive damages are rarely asked for in medical negligence cases, but should be available when necessary. For example, punitive damages would be proper in a suit of a claimant injured by a drunk driver. They would also be equally proper in a suit of a claimant injured by a drunk doctor. Indeed, an attorney would be professionally neg-

ligent if he did not ask for punitive damages in such cases.

It is alleged that punitive damages are asked for to frighten doctors into settling non-meritorious claims because punitive damages by law must be paid out of the doctor's own pocket, rather than by the insuror. We are presently undertaking a survey to determine how frequently punitive damages are asked for by claimants in medical negligence cases, how frequently these cases are settled, and how frequently punitive damages are granted.

SCREENING PANELS

We favor settlement of disputes wherever possible. It is hoped and anticipated that screening panels and arbitration will facilitate settlements, reduce costs, and make it more feasible to accept cases involving only a small claim. We support voluntary screening panels composed of an equal number of doctors and lawyers with a non-lawyer, non-physician as chairperson. The panel members should be selected by the parties with district court supervision. The panel should make findings supported by reasons. Such findings should not be admissible in evidence. The panel, instead, should agree to furnish a doctor from the panel to testify where the findings of the panel are unanimous. The choice of the doctor who will be testifying should be made by the prevailing party.

ARBITRATION

We also support arbitration, with the question becoming

one of form. We propose that if the existing law is inadequate, mandatory non-binding arbitration be instituted for claims under $10,000. Past experience indicates that insurance companies have not used arbitration; thus, in small cases, the public would better benefit if arbitration were required. For cases over $10,000 we favor the options of mandatory, non-binding arbitration or voluntary, binding arbitration. The value of mandatory, non-binding arbitration is found in its potential for facilitation of settlements. Mandatory, binding arbitration is a denial of the basic right to a trial by jury. Following the recommendation contained in a U.S. Deparment of Health, Education and Welfare report on medical malpractice[1], we support lay public involvement in any arbitration system.

We are opposed to arbitration being at the option of the doctor and patient at the inception of their relationship. The negotiating power of the parties is not equal at that point, and such discussion can only be detrimental to the doctor-patient relationship. Such a small percentage of doctor-patient contacts end in negligence claims that it is an undue burden on both parties to cause them to consider it at that point.

COLLATERAL SOURCE RULE

For those cases that do not come to trial, there are

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[1]Report of the Secretary's Commission on Medical Malpractice, DHEW Publication No. (05) 7388 (1973).

several legal doctrines to which there have been objections. One is the collateral source rule. What this rule presently states is that the jury may not be informed of any collateral source of income (ex: medical insurance), which claimant may receive to offset his damages. Allegedly, the possibility of double recovery stimulates non-meritorious claims.

We advocate that the present law be maintained. If a prudent individual takes out an insurance policy and pays his monthly premiums to protect himself and family, while a second individual does not, and both are injured, should the tortfeasor, the wrongdoer, receive the windfall? One who is prudent, works hard and protects his family should have the fruits of his labor; one who negligently injures another should compensate him for that injury.

Objections might be raised where the collateral source is payment, such as Medicare, by some federal agency. However, most federal agencies have the right of subrogation to the claim of the injured in such cases. This means, in short, that the federal agency may be paid back from the amount recovered that which it has already paid the claimant for the same injury.

INFORMED CONSENT

The other legal doctrine objected to by the health care providers and the insurance industry is that of informed consent. This doctrine is established by case law and states that in the absence of emergency or legitimate

medical reasons, a physician has a duty to inform his patient fairly and honestly as to the risks of the procedure or treatment about to be undertaken so that the patient can make an informed decision as to whether or not he wishes to submit his body to the procedure or treatment. The necessity of such consent is just and reasonable. Insofar as we can ascertain, we know of no Kansas case in which lack of informed consent was the sole theory of recovery.

Any attempt to force this established doctrine of fairness into the rigid language of a statute will benefit no one, for the flexibility of court-made rules will be destroyed.

LIMITATION ON RECOVERY

In the event of a judgment against a health care provider, we realize his need for financial protection. However, we oppose any limit on the right of recovery. Financial recovery of persons injured by medical negligence should be commensurate with the injuries sustained. Any limit would be arbitrary, unfair and unjust to the injured party due to the unpredictability of circumstances in individual cases. It would also be unfair to allow health care providers limited liability, while the liability of other citizens remained unlimited.

INSURANCE COVERAGE

We favor a spreading of losses among all persons involved in the enterprise of medical care by requiring

all health care providers in each catagory (ex: medical doctors, chiropractors, dentists, etc.), be provided basic coverage of $100,000/$300,000 at uniform premium rates. Provision should be made for an assigned risk category for those unable to obtain insurance elsewhere. A state-managed excess coverage fund should be created with provisions for funding through annual assessments of all license holders and all hospitals on a per bed basis.

The fund should be maintained at a minimum of 2.5 million dollars and a maximum of 5 million dollars. All insurance companies writing casualty coverage in Kansas should be required to carry part of the medical negligence insurance burden. The Insurance Commissioner should be required to obtain additional information necessary for establishing equitable rates. Public hearings must be required by statute for all rate adjustments. The insurance companies should be required to prove to the public their need for rate increases with complete factual disclosures.

Legislation is also needed to prohibit claims made policies. Such policies are completely unnecessary if the statute of limitations is reduced. They are unfair and detrimental to health care providers, and create a special hardship for the retiring health care provider. Most importantly, no facts have been given as evidence of actual need of the insurance companies for claims made policies.

PEER REVIEW

Another means of protection for health care providers is peer review. The phrase "peer review" does not have a standardized meaning, but we understand it to mean intra-professional surveillance. Past history appears to indicate that litigation of medical negligence is a more effective tool than peer review or license renewal proceedings for deterring medical malpractice. Peer review of the competence and level of performance of health care providers will not be effective without vigorous implementation of the authority to discipline now vested in the Board of Healing Arts and other licensing authorities. It should be required that all malpractice claims be reported to the respective Board. The Board should be required to make an annual report to the Governor of, among other relevant matters, the number of claims and complaints made, the number of health care providers disciplined and the nature of the discipline.

CONTINUING MEDICAL EDUCATION

We favor continuing education for all professions, including the medical profession. We favor the development of a comprehensive medical injury prevention program. We invite the medical profession to join with us in developing a mechanism to encourage the sharing of information between doctors and lawyers. Such sharing can help both professions to better understand and work together.

GOOD SAMARITAN ACT

We do not favor liberalizing the Good Samaritan Act in Kansas at this time. The act presently provides for the protection from civil damages for acts or ommissions of any physician, practitioner of the healing arts, or dentist licensed in any state, or any registered nurse or person who has successfully completed an approved emergency service program who renders emergency care at the scene of an accident, with good faith, and without gross negligence or wilfull and wanton acts or omissions. We find that the present act serves the public well. We oppose extension of the present act to hospitals and doctors' offices because we fear health care providers will not be held responsible for their negligence in dealing with a medically created emergency.

FURTHER STUDY

Finally, we recommend an ongoing study of all areas of the medical negligence insurance issue, including:

1) insurance available at fair rates to all health care providers,

2) fair underwriting practices,

3) diminution of medical injuries, and

4) comprehensive compensation for all persons injured by medical professional negligence.

EXHIBIT I

INCURRED LOSSES

ACCIDENT YEAR 1969
(1000 OMMITTED)

(1) Year	(2) Paid	(3) %	(4) Known Claims	(5) %	(6) Unknown Claim Cost
1969	$ 108	.9	$ 2,174	18.1	$ 9,826
1970	489	4.1	6,625	55.2	5,375
1971	2,013	16.8	11,084	92.4	916
1972	3,978	33.1	12,752	106.2	(752)
1973	6,041	50.3	13,811	115.0	(1,811)
1974	8,361	69.7	13,301	110.8	(1,301)
6/75	9,187	76.6	12,812	106.8	(812)
Ultimate	12,000	100.0	12,000	100.0	----

EXHIBIT II

INCURRED LOSSES

ACCIDENT YEAR 1969
(NUMBER)

(1) Year	(2) No Claim	(3) Paid	(4) O/S	(5) Total	(6) %
1969	9	64	424	497	28.2
1970	260	153	550	963	54.7
1971	475	244	647	1,366	77.6
1972	743	338	569	1,650	93.8
1973	888	439	382	1,709	97.1
1974	992	518	231	1,741	98.9
6/75	1,015	544	201	1,760	100.0
%	57.7	30.9	11.4	100.0	

PURE PREMIUMS

CLASS I

Exposure Year	Reported Year of Claims 1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	Total	% Increase
1966	3												
1967	7	5											
1968	20	10	9										
1969	34	29	14	13									
1970	26	38	38	19	18							139	
1971		28	48	49	25	24						174	25.2
1972			36	64	60	32	31					223	28.2
1973				49	87	71	40	39				286	28.3
1974					67	117	82	49	48			359	25.5
1975						90	154	93	59	58		448	24.8
1976							118	198	104	70	69	544	21.4
1977								151	249	115	82		
1978									189	307	126		
										232	372		
Totals	90	110	145	194	257	334	425	530	649	782	929		
% Increase		22.2	31.8	33.8	32.5	30.0	27.2	24.7	22.5	20.5	18.8		

EXHIBIT III

EXHIBIT I - KANSAS

INCURRED LOSSES

ACCIDENT YEAR 1969

(1) Year	(2) Paid	(3) %	(4) Known Claims	(5) %	(6) Unknown Claim Cost
1969	0	0	51,750	34.5	98,250
1970	0	0	40,500	27.0	109,500
1971	11,940	8.0	98,190	65.5	51,810
1972	25,185	16.8	124,935	83.3	25,065
1973	67,879	45.3	121,129	80.8	28,871
1974	69,707	46.5	157,457	104.9	(7,457)
6/75	70,630	47.1	159,130	106.0	(9,130)
Ultimate	150,000	100.0	150,000	100.0	----

Note: Earned Premium for 1969 is $168,623.

EXHIBIT II - KANSAS

INCURRED LOSSES

ACCIDENT YEAR 1969

(1) Year	(2) No-Claims	(3) Paid	(4) O/S	(5) Total	(6) %
1969	0	0	8	8	29.6
1970	7	0	5	12	44.4
1971	8	2	11	21	77.8
1972	14	3	8	25	92.6
1973	17	5	5	27	100.0
1974	16	5	6	27	100.0
6/75	15	5	7	27	100.0
%	55.6	18.5	25.9	100.0	----

SECTION L

PROJECTED STATE PURE PREMIUMS

General

For states that exhibited a high degree of stability of experience over time by passing critical statistical tests, the trending procedure fits the state's data for each (reported) time period and each (accident) lag period to the corresponding countrywide estimates to arrive at a state's set of lag functions. However, the data for this state does not pass these tests. As a result, trending based solely on the state's data could produce unreliable estimates.

To deal with this problem, it was assumed that the state's trend pattern parallels the countrywide pattern. To make use of the 5 years of state data, current cost adjustment factors were developed from the fitted (smooth) countrywide data. The current cost factors are developed below. Unity represents cost levels for the second half of 1974. These factors were then applied to each state's actual pure premiums by reported period to bring them up to current levels (see next page). An average of the ten adjusted pure premiums is then calculated. This average is then divided by the countrywide pure premium for the second half of 1974 to produce a factor K. If K is less than one, it indicates that, on the average, the state's pure premium is less than countrywide, while if K is greater than one, the state's pure premium is greater than countrywide. Once the proportionality constant has been determined for the state, it is multiplied by the countrywide estimates for all time periods and all lags to produce the corresponding state estimates. (i.e., $\overline{PP}(T,L)_S = K*\overline{PP}(T,L)$)

Reported Period	Countrywide Pure Premiums	Current Cost Factors
1st half 1970	86.824	3.1629
2nd half 1970	93.361	2.9415
1st half 1971	103.481	2.6538
2nd half 1971	117.182	2.3435
1st half 1972	134.466	2.0423
2nd half 1972	155.332	1.7679
1st half 1973	179.780	1.5275
2nd half 1973	207.810	1.3215
1st half 1974	239.423	1.1470
2nd half 1974	274.617	1.0000

SECTION L
(CONTINUED)

KANSAS

Calculation of K

(1) Reported Period	(2) Current Cost Factors	(3) State's Pure Premium	(4) Column (2) x Column (3)
1st half 1970	3.1629	64.813	204.997
2nd half 1970	2.9415	75.184	221.154
1st half 1971	2.6538	41.220	109.390
2nd half 1971	2.3435	98.634	231.149
1st half 1972	2.0423	74.297	151.737
2nd half 1972	1.7679	132.222	233.755
1st half 1973	1.5275	128.038	195.578
2nd half 1973	1.3215	229.042	302.679
1st half 1974	1.1470	290.705	333.439
2nd half 1974	1.0000	94.167	94.167
5 Year Current Cost			207.805
K - Factor			.7567

As of this date, September 29, 1975, Mr. David W. Wilson had not submitted a corrected copy of his testimony. In the absence of that revised statement, these comments made by Mr. Wilson have been included in the minutes.

In my case only 6

KANSAS MEDICAL EXPERIENCE

The Medical Protective Company appreciates having this opportunity to participate in your investigation of the medical malpractice situation in Kansas. We hope our comments will aid your efforts in producing a climate more equitable for the practice of medicine and for the general public in its quest for quality care at feasible costs.

The Medical Protective Company has continuously provided professional protection for physicians and dentists throughout most of this century. During that time, the Company has witnessed a number of ~~cyclical~~ changes in the field. The situation which confronts us today is different from earlier conditions in both the extent and the depth of the problem.

The twin specters of increasing incidence of claims being brought against physicians and the dollar value of individual cases rising at even greater rates have combined to present society with a most severe problem. The problem is sufficiently widespread and sufficently deep-rooted in various professional disciplines as to require the public directly addressing the problem through its elected representatives.

The cost and availability of professional liability insurance has been the topic of innumerable discussions over the past decades. For several years the problem of availability of coverage has been

discussed as being primary over the cost of the coverage. However, now that the cost of traditional protection reaches into five figures for a significant minority of surgeons throughout the country, it becomes clear that the cost of the coverage is quite as important as its availability, for availability at unmanageable or unpayable premiums is no availability in practice.

Dollar Control

To combat the problems which exist today, controls must be exerted to control the dollars being paid, and these controls must be placed at the proper points. When prominent physicians from across the country formed The Physician's Guaranty Company, a direct predecessor of The Medical Protective Company, the doctors created a service organization. The functions of that first professional liability Company were twofold. First, the defense of doctors against malpractice claims. Second, the collection and dissemination of information which could aid the doctors in avoiding claims. Concern with loss prevention has directed the Company's attention to three areas: Injury Prevention, Claims Prevention and Dollar Loss Prevention.

Physicians turned over the administration of The Medical Protective Company to laymen familiar with the complexities of insurance and the law within a decade of the firm's organization. By then, it was

recognized that a professional liability carrier was an uncommonly inefficient mechanism for policing the profession. Before an incident is reported to the Company, an evaluation secured, and the claim resolved, several years will have elapsed, on the average. Indeed, rather than the carrier awaking the profession to a marginally adequate practitioner, it is normally the other way around. Doctors know, long before the malpractice carrier, whether or not a particular doctor needs disciplinary action or additional training. It is our belief that injury prevention is most properly and effectively programmed through the profession itself...the malpractice carrier's slim information being too little and too late to be effective in specific cases.

In claims prevention, however, the professional liability insurance company can provide practical advice and experience-based information. Throughout its 76 year history, The Medical Protective Company has gathered and analyzed facts uncovered during the course of defending its doctor-policyholders. The Company has publicized the resulting information for the benefit and protection of its clients. Case files have been examined to determine why particular situations resulted in lawsuits; what types of injuries were involved, what procedures were being done, what equipment was used, the age of patients, of doctors, the doctor's specialty, schooling. The fundamentals of malpractice law and the changing emphasis of legal doctrines have been published, also.

We find, for example, that while the majority of malpractice claims involve real injuries, most of these injuries are not the result of medical malpractice--either as to cordial relationship or a failure to meet the standard of care. Further, the injury most often is not the triggering factor. The patient's dissatisfaction may be the fee, a snippy nurse, a doctor's cold and impersonal attitude, misunderstood directions, or less-than-perfect results. MAL PRACTICE IS MAL OCCURRENCE

Influencing the atmosphere conducive to malpractice are often-cited legal and social factors. Included here are the extension of legal bases upon which successful legal actions may be brought; the "informed consent" approach; the "res ipsa loquitur" assault. There is ~~the questionable influence of attorney contingency fees,~~ the admitted deterioration of physician-patient relationships, the error potential attendant to a multiplicity of health care providers, increased sophistication of treatments with heightened injury potentials, publicity about malpractice, publicity about the cost of care, the fact of increased cost of care, publicity of "miracle" cures, pre-trial screening panels, the image of the professions as self-centered--more interested in profits than patients, the trend to demand compensation for injury from the most visible target, whether or not negligence exists, THE QUESTIONABLE INFLUENCE OF ATTORNEY CONTINGENCY FEES. E.E. NEW JERSEY COURT RULING.

To a greater or lesser degree, these factors have been at work for many years. The question before us today is what has caused the

dramatic change in the past few years. We believe there is one prime cause. It relates to dollar loss prevention.

DOLLAR LOSS PREVENTION

To compete and successfully earn its way, The Medical Protective Company must control losses, loss adjustment expenses, and other expenses. The Company is proud of its record in recent years, using over 85% of the premium dollar in direct policyholder benefits of claim resolution. It is estimated that approximately two-thirds of the premium dollar collected by The Medical Protective Company is paid to patients and their attorneys. The Company vigorously dissents from the widely quoted but unsubstantiated claim that only 16 or 17 cents of the premium dollar ever finds its way to the injured patient. (A)

The Company is aware, acutely aware, of the need to exert firm control over loss adjustment expenses. Strong efforts made in recent years have resulted in holding the line on average expense per claim resolved. Loss adjustment expenses and other expenses are well under control.

There has been a continual upwards surge each year in loss payments required to resolve the claims. Control over these dollars is increasingly difficult and presents the major issue confronting the public today: unlimited awards.

The dollars risked and lost are the central problem today. The damages paid have, indeed, become a problem which overwhelms and

dwarfs all others. Paid losses assume such proportions today that all of our efforts in claim prevention, injury prevention, and alternate methods of handling litigation, in underwriting, in loss adjustment control, in professional upgrading - all of our combined efforts in all of these areas will be fruitless unless we can resolve the fundamental issue of unlimited losses.

Dollar awards made or encouraged by courts, juries or panels are without restraint. Individual doctors are subject to damage awards as great as may be assigned against major industries. Unless awards can be capped, there will shortly be no insurance company capable of insuring doctors for rates which a doctor can afford. This is not to suggest that there should not be appropriate compensation for injury, negligently come by or not. If society believes that compensation limits cannot be equitable and that every less-than-perfect result should entail compensation to the patient, THE MAL OCCURRENCE THEORY a responsible and efficient method for funding such a program should be devised. Professional liability insurance is not intended, nor could it ethically attempt, to administer a patient compensation program. Such a program could and perhaps should, exist side-by-side with the traditional negligence system.

Loss prevention today means putting a ceiling on malpractice awards.

This is a simple matter of economics. The medical profession does not earn enough money to pay multi-million dollar awards. Responsible insurance companies cannot subsidize the catastrophic risk of a "run" of such awards. A lid must be placed upon this problem. (B)

CLAIMS FREQUENCY

There has been a vicious upturn in the incidence of claims in Kansas in recent years. By using five-year increments and overlapping these time periods to show the trends, we have noted that there has been an incidence of 1.9 claims per hundred doctors during the first five-year period of 1960 to 1964. This level of incidence held relatively constant through the next periods, but climbed to 3.1 between 1968 and 1972. Between 1970 and 1974, the incidence again increased up to 4.4 per hundred. Compare this with the rate in 1974 of 6.1 and the dramatic nature of the upward curve becomes apparent.

At the same time, the Company has managed to achieve a technical legal victory for its policyholders in approximately the same percentage of cases throughout the past 15 years. The average for the entire period is only 1% greater than that in 1974, and the 1974 average is higher than that in the first period of 1960 to 1964. The point to be

made is that the Company has been successful in achieving jury verdicts for the doctor, dismissals or summary judgments in about the same percentage of cases throughout the years. The Company still fights hard for the rights of its policyholders. The trend of cases resolved for nuisance value has followed a course diametrically opposed to street opinion. The percentage of cases which have been resolved for a nuisance settlement is less than half the percentage in 1974 that it was during the period of 1960 to 1964. There has been a constantly dwindling percentage of cases in this category. Of even greater importance is the fact that the dollars used to pay these nuisance value claims has also diminished. Whereas the nuisance value cases required 5% of the loss dollars paid in 1960 to 1964, they required only 1% of the 1974 dollars. Fewer cases of nuisance value and a smaller valuation. Obviously, the nuisance claim is not the reason for the increase in premium. It would apparently be a savings today of only one dollar out of a hundred if all of these cases were to have vanished without any cost whatsoever.

The substantial change that has occurred and that is causing the premiums to increase is in the area of claims requiring five or six-figure amounts to resolve. Such cases amounted on only 3% of the files resolved 15 years ago and cost but 14% of the dollars paid in losses at that time. Those cases have now increased to 33% of the total

requiring five or six figure amounts to resolve.

number of cases resolved and require 86% of the dollars. When this figure is correlated with the loss trend of the five-year periods under consideration, it becomes obvious why the premiums have increased as they have. The trends have shown increases between the five-year segments studied of 58%, 60%, 80%, and 95% as we move from the earlier years to the present time.

The problem is the case of possible or probable liability with a severe injury. We must recognize this as being the core of the cancer which has spread throughout this industry.

Kansas Medical Experience m.d. only
15 year

	Periods					
	1	2	3	4	5	6
Incidence/100 DRs	1.9	1.8	1.8	3.1	4.4	6.1
# Claims						
Technical Legal Victory	24%	28%	31%	27%	25%	26%
✓ Nuisance value	31%	19%	22%	24%	18%	15%
Moderate value	52%	43%	31%	29%	32%	26%
Substantial value 10,000+	3%	10%	16%	20%	25%	33%
Defense verdicts	3	3	3	5	7	1
Plaintiff verdicts	1	1	0	2	4	1
Loss Payments.						
✓ Nuisance value	5%	3%	3%	3%	2%	1%
Moderate	81%	43%	29%	26%	19%	13%
Substantial 10,000+	14%	54%	68%	71%	79%	86%
Loss Trend		up 58%	up 60%	up 80%	up 95%	

Period 1 - 1960-64
2 - 1962-66
3 - 1965-69
4 - 1968-72
5 - 1970-74
6 1974

"Nuisance" dollar cutoff
1960-62 - $500
1963-65 - $1000
1966-68 - $1500
1969-71 - $2000
1972-74 - $2500

The Medical Protective Company believes that amounts recoverable from doctors should be limited, and that those limits should be in the vicinity of $100,000. The experience of The Medical Protective Company would indicate that limitations in this amount would have a moderating effect upon the number of claims being filed, upon the risk exposure of the insurance carriers, upon the losses incurred and paid, upon the premiums required from health care providers and upon health care costs of the general public. We believe that the problem of the increasing incidences of claims can be tied to the mushrooming of verdicts and loss evaluations at increasingly high levels. At the same time, the Company believes that a firm Statute of Limitations is appropriate for protecting the citizens of the state. Studies made by the Department of Health, Education and Welfare demonstrate that more than half of the claims brought against doctors are recognized as claims-worthy by patients within one month of the incident. Over 90% of the claims were recognized by patients within 6 months and only an insignificantly small percentage went unrecognized beyond one year. It is clear that the delays in reporting cases result from, as the HEW study states, "..... a propensity on the part of the attorneys to delay filing action at law until the Statute of Limitations is about to expire." The Medical Protective Company would recommend a two year Statute of Limitations be adopted, a Statute without exceptions as to discovery of injury. The Company believes that this limitation is in the best interests of the public, providing a greater good than the exception for discovery permits. (C)

KANSAS S of L > 2 yrs. from discovery
MAX. 10 years from ~~date~~ of occurrence
minors - one year from date of reaching // majority.

The Company believes that further court reforms which would be helpful in bringing equilibrium to the situation today would include elimination of the mention of the ad damnum in the filing of a lawsuit and the admissibility of collateral sources of recovery so as to eliminate double-windfall recoveries by the plaintiff.

To assure the public that health care will remain available, it is reasonable that a back-up plan be adopted to provide coverage for doctors or other health care providers who find coverage unavailable to them on the voluntary market. It is the consideration of The Medical Protective Company that the reforms regarding limitations on awards and on the Statute of Limitations, combined with the other reforms mentioned would probably induce other insurance carriers to return to the market, thus reducing unavailability to a minor factor.

Even though reforms may be made, and even though unavailability of coverage may be reduced as a problem, the cost of the protection will continue to vex the physicians, the insurance industry and the public unless limitations are placed upon amounts recoverable from doctors in professional liability cases.

The Medical Protective Company supports the thrust of the legislation proposed by the Kansas Medical Society. We believe that is imperative to keep foremost in our minds the overriding importance of limitations on awards, however, and recognize that the sacrifice of all other elements would be less hazardous than the elimination or watering down of the limitation feature.

(A)

THE MEDICAL PROTECTIVE COMPANY

BREAKDOWN OF PREMIUM DOLLAR

RETAINED $ VS. COLLECTED .59 .66

	1970	1971	1972	1973	1974
Payments to Claimants	49.84	64.30	54.82	56.77	59.63
Cost of investigating and processing claims	6.24	4.65	4.30	4.47	3.18
Cost of defending claims	27.20	16.75	24.22	21.63	23.93
Other administrative expenses	15.15	13.58	13.69	15.00	13.53
Profit and (Loss)	1.57	.72	2.97	2.13	(.27)
Total Premium Dollar	100.00	100.00	100.00	100.00	100.00

(A)

Installe[d] new officers at the NAMIC convention were, from left: Harold I. Mohle[r] Johnson County Mutual, Warrensburg, Mo., chairman; Earle L. Forthma[n] Guilderland Mutual Re, Delmar, N.Y., vice chairman; Robert O. Noel of State Farm Mutual, Bloomington, Ill., chairman-elect; Alden Ives of Patrons Mutual, Glastonbury, Conn., past chairman; and Harold W. Walters, president and general manager.

Congressional Aide

Aug 22 National Underwriter

For Now, Feds Content To Let States Handle Malpractice

For now Congress is content to wait and listen regarding the medical liability problem, according to Spencer C. Johnson, an administrative aide to U.S. Rep. James F. Hastings of New York.

But the actions of the individual states in the first year of this crisis are not terribly impressive up to this point, in the opinion of Mr. Johnson.

The Congressional aide told the annual meeting of the National Assn. of Mutual Insurance Companies that the prevailing thought in Congress seems to be to allow the states some time to attack this problem. Borrowing from some research by the American Hospital Assn., Mr. Johnson said that 27 states have taken legislative action on the malpractice problem as of June 19, but only seven had passed what are considered comprehensive bills, that is, bills which include a number of legal and medical reforms in addition to the establishment of a joint underwriting association.

He said the Indiana law is considered by many to be the best attempt at comprehensive legislation.

"Four key elements make the Indiana law effective in stabilizing premiums and creating a competitive environment for insurers: a relatively short statute of limitations; a limitation or cap of $100,000 on physician-insurer liability; a state insurance fund for doctors who cannot get coverage elsewhere; and arbitration in the form of a mandatory nonbinding screening panel before a malpractice suit can go to court," Mr. Johnson reported.

Again, using information obtained by the AHA, Mr. Johnson said that it is projected that by the end of 1976 about 37 states will have taken some kind of action relative to the malpractice crisis. But he said that less than half of the 37 "will have made substantive changes."

"It is the relatively limited response of the states to a problem that is so enormous and growing so rapidly, that is forcing a critical reevaluation of the position that this is entirely a state issue," Mr. Johnson told the convention.

He reported that the American Insurance Assn. visited Rep. Hastings' office recently with a proposal for a Federal program of reinsurance. Mr. Johnson said that earlier this year AIA was advocating JUAs for each state but because reserves of the established JUAs are not sufficient, AIA member companies are concerned that these new pools may threaten their own revenues.

Mr. Johnson explained the national legislation which Mr. Hastings pro-

Cont'd on Page 22

Mutual Companies Told:

ALL VOTING MEMBERS ARE MD's & THEY ARE LOOKING AT LIABILITY FROM A MEDICAL VIEW.

Washington May Take Over Health Care On Piecemeal Basis

There probably will not be a national health insurance bill during the next three years, according to an educated guess by an Illinois Congressman. But he also guessed that the Federal government may eventually take over the country's health care system on a piecemeal basis over a period of years.

Rep. Philip M. Crane (R.-Ill.) said that both the present Federal deficit and the prospective deficits of the next two years have even made liberal Congressmen reluctant to pass a health care bill which would add a lot to the deficits.

Speaking at the 79th annual convention of the National Assn. of Mutual Insurance Companies, Rep. Crane insisted that the nation's health care problem is not nearly as severe as many of his peers have made it out to be. He accused many of his fellow Congressmen of calling it a "crisis" when a crisis does not really exist.

'Misconceptions'

For example, regarding the doctor-patient ratio, the speaker said the United States has one of the best ratios in the world. In fact, he said there is a good chance that there will be an oversupply of doctors within 10 years.

Regarding the country's alleged "terrible infant mortality rate," Rep. Crane accused the proliferators of this message of failing to tell the people that each nation measures infant mortality in different ways so that a comparison among all countries is not possible. For example, he said that in countries where there are frequent abortions the infant mortality rate is quite low because of the lesser incidence of births.

But when measuring the United States against countries of similar background and practices, it is a leader in infant mortality statistics, Rep. Crane asserted.

And the United States' distribution of doctors is also not nearly as bad as critics make it out to be, the speaker said. Referring to what he described as the only major comprehensive study of this issue, Rep. Crane reported that of the nation's 3,084 counties, 132 of them are with-

Cont'd on Page 17

NAMIC Annual Meeting

U.S. Rep. with newsmar radio station convention.

(B)

FLETCHER BELL

COMMISSIONER OF INSURANCE

July 10, 1975

Mr. David H. Fisher
Law Offices of Fisher,
Patterson, Sayler & Smith
520 First National Bank Tower
Topeka, Kansas 66603

Dear Mr. Fisher:

This will acknowledge your letter dated June 30, 1975, regarding information pertaining to medical malpractice insurance in the state of Kansas.

I also wish to acknowledge your recent telephone conversations with Mr. R. D. Hayes of my staff regarding the availability of the information you have requested. As a matter of record, I will respond to your specific requests in the same order set out in your letter.

1. My department does not maintain a record of pending and closed cases pertaining to medical malpractice or any other line of insurance. In view of the requirements of Senate Bill No. 353, information regarding medical malpractice cases or files closed will be maintained in the future.

2. Premium dollars paid to insurance carriers in Kansas for a five-year period is contained in Table 5, page 8, of my March 14, 1975 Report on Medical Malpractice and Professional Liability Insurance in the State of Kansas. I am also currently prepairing a questionnaire to gather 1974 medical malpractice premium and loss information, the results of which should be completed and available in late August.

3. I am not able to provide a detailed breakdown of the disposition of past medical malpractice claims settled in this state; however, I am attaching an exhibit to this letter which provides the premium and loss experience for the years 1971 through 1973 for the major writers of medical malpractice insurance in the state of Kansas.

I am also enclosing photocopies of my March 14, 1975 report, the June 25, 1975 update and a copy of my remarks to the Kansas Legislature's Special Committee on Medical Malpractice Insurance.

Hopefully, this information will be of assistance to you; however, if you should have any additional questions or comments, please do not hesitate to contact my office.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

FB:llc
Enclosures

EXHIBIT ON MEDICAL MALPRACTICE INSURANCE PREMIUMS AND LOSSES

A. THE MEDICAL PROTECTIVE COMPANY: Provides insurance for approximately 50 percent of the Kansas physicians and surgeons.

Year	(1) $25,000/$75,000 Basic Limits Earned Premiums	(2) Basic Limits Actual Losses Paid	(3) Basic Limits Losses Incurred and Outstanding
1971	$680,056	$130,710	$236,210
1972	651,688	114,794	282,794
1973	653,312	50,159	94,659
	$1,985,056	$295,663	$613,663

NOTE: These years shown in the above schedule reflect only the claims cost paid or incurred for known reported claims. No attempt has been made to include the claim which has been incurred but not reported to the company.

B. ST. PAUL FIRE AND MARINE INSURANCE COMPANY: Provides insurance for approximately 35 percent of the Kansas physicians and surgeons.

Year	(1) $25,000/$75,000 Basic Limits Earned Premiums	(2) Basic Limits Actual Losses Paid	(3) Basic Limits Losses Incurred and Outstanding	(4) Basic Limits Losses*
1971	$560,107	$41,292	$403,542	$425,945
1972	606,577	33,986	196,736	459,956
1973	668,179	1,441	447,691	1,019,184
	$1,834,863	$76,719	$1,047,969	$1,905,085

*NOTE: The last column includes the company's projection for the incurred-but-not-reported claim.

EXPLANATION OF TABLES A AND B

Table A reports only the known loss data in column (2) and (3). Since the Kansas Statutes of Limitations have not yet run, the insurance company can expect an unknown number of claims to be filed against its insureds in the future. Table A does not contain any projection for these

incurred-but-not-reported (IBNR) claims; however, column (4) of Table B includes this projected figure which has been computed based past experience. The reason for utilizing these two tables (one pany's experience without the IBNR projection and one company's experience with the IBNR projection included) is to demonstrate why many people reach the conclusion that medical malpractice insurance is profitable for the insurance companies. That is, although recent years do indicate an apparently favorable ratio of premiums to losses paid, the fact of the matter is that a significant portion of the losses sustained in those years have not yet been reported and are unknown because of the long tail of medical malpractice claims due to the current Statutes of Limitations in this state.

2

ARCHIBALD O. TETZLAFF, M. D.
6525 GRANADA DRIVE
PRAIRIE VILLAGE, KANSAS 66208

PHONE (913) 432-8841

August 27, 1975

The Honorable
Senator Wesley Sowers
Chairman,
The Kansas Legislature
Special Committee on Malpratice

Dear Sir:

The gentleman who testified before your Committee about 4:00 PM on August 27, 1975, used distortions of fact and a sickening display of an emotional appeal which were typical for the 19th century tort law to which physicians are sometimes subjected in our otherwise civilized society.

I objected to his remarks for the following reasons: I recognized the case he was describing as BONNETT vs. CHALIAN, which had been filed in the District Court of Topeka several years ago.

The gentleman stated that the anesthesiologist stepped away from the patient and left the operating room before the procedure was finished. I do not remember any witness testifying to these facts in any of the proceedings of this case. I therefore believe the above statement to have been untrue.

The gentleman further stated that the anesthesiologist is still practicing his profession in a hospital less than one hundred miles from Topeka. I happen to know that the anesthesiologist in question is in retirement and has not been in active practice for some time.

The parading of a brain-damaged patient in front of a jury may easily result in a finding of guilt of negligence against the physician, no matter how carefully he performed his services. It should not persuade anyone of the merits of the contingent fee system. Without the contingent fee system, and with a Workmen's Compensation type of malpractice law, it would not have taken nine years to settle this case to the satisfaction of the plaintiff and his parents.

Sincerely,

Archibald O. Tetzlaff M.D.

Archibald O. Tetzlaff, M.D.

J

KANSAS ASSOCIATION OF DEFENSE COUNSEL

POSITION PAPER ON MEDICAL MALPRACTICE

The Kansas Association of Defense Counsel is a voluntary organization composed of attorneys whose legal practice is largely concerned with litigation, and who primarily represent defendants in lawsuits.

We recognize that physicians, attorneys, insurance companies and patients are all concerned with the availability of protection for persons who suffer injury as the result of medical malpractice. It is our position that the Public's interest should be considered paramount and the interests of physicians, attorneys and insurance companies should be adjusted to promote the rights of the public to compensation in appropriate cases.

We believe the root causes of the so-called "malpractice problem" are found within the medical profession. Perhaps stricter licensing, peer review, improvement of public relations, and strengthening of physician-patient relationships are among the possible methods of improving the situation. But, doctors, like all persons, must continue to respond in damages for negligence. They should not be persecuted, but neither should they be exempted from their responsibilities. The key to improving the malpractice situation must be a product of the efforts of the medical community to reduce malpractice itself. At the same time, the function of the courts and legislature should be to create a climate that will lend itself to fair and expeditious settlement of claims.

At the same time, we firmly believe the judicial system is a cornerstone in the protection of the right of the public to compensation for injuries as a result of medical malpractice. Changes in the judicial structure should not be undertaken lightly, and a system that has proved itself over hundreds of years should not be altered to remedy an otherwise soluble problem. On the other hand, if vigorous action is appropriate, the Kansas Association of Defense Counsel will support it.

In general, we support the implementation of medical review panels and some changes in the existing legal structure. Legislation that will strengthen the power of the insurance commissioner should be undertaken. Implementation of changes in the types of insurance policies issued which will allow companies to continue to provide medical malpractice insurance coverage should be undertaken. Our belief is that a state fund program is not needed and that insurance companies can meet the needs of the doctors and public. Insurance coverage should be available to all doctors at rates that are subject to scrutiny and regulation by the insurance commissioner. It is our firm conviction that complete availability of insurance coverage must be our goal to achieve protection of both physicians and the public.

The Kansas Association of Defense Counsel wishes to make its position known concerning the major proposals that are being considered by this Committee.

MEDICAL REVIEW PANELS

We agree in principle with the position of the Kansas Bar Association that screening panels to which medical malpractice claims may be submitted should be implemented. Such panels should be on a voluntary basis, and the decision of the panel should not be admissible in evidence in the trial of any resulting malpractice action. We further believe the panel should be required to furnish expert medical testimony on behalf of the prevailing party. The use of such panels would allow the parties to determine at an early stage whether the claim is meritorious. If it is not, most patients and certainly their attorneys, would not be interested in proceeding further. If the claim is valid, the responsible people will be interested in attempting to resolve the claim. Most cases would be disposed of as a result of the early screening. The introduction of the panels decision in a subsequent court proceeding, however, would give undue weight to the conclusion of a non-judicial group.

LIMITATION OF RECOVERY

The Kansas Medical Society has proposed legislation limiting recovery in malpractice actions to $500,000. Such legislation must be opposed, since there may be cases in which a larger recovery is appropriate. To allow unlimited recovery to persons injured by negligent motorists, but to deny it to those damaged by negligent physicians, is to deprive one group of injured individuals the equal protection of the law. If in rare cases, verdicts are excessive under the facts of the case, such awards can and should be reduced by reviewing courts.

PATIENT'S COMPENSATION FUND

Basically, we do not feel that the institution of a state administered Patient's Compensation Fund is necessary. Excess liability can be best handled by insurance companies who have existing facilities and organizations. In essence, the Kansas Medical Society proposal for a Patient's Compensation Fund would merely make the State an "excess insurer" of liability above $100,000. We believe such action is not necessary, but if such a plan is instituted, it should be paid for by assessments against health providers, and not through the use of state funds.

INSURANCE COMMISSIONER

The position of the Insurance Commissioner in the medical malpractice field should be strengthened. Reporting of claims, losses paid, and other data should be compulsory. Present data concerning the insurance companies' losses, reserves and future exposure is inadequate. Vigorous studies in the malpractice area should be undertaken. The Insurance Commissioner's powers in establishing insurance rates for medical malpractice insurance companies issuing policies in Kansas should be clarified and strengthened. Likewise, the Insurance Commissioner should have broad powers to require pooling arrangements to make coverage available. He should also have the power to require insurance companies doing business in Kansas who offer medical malpractice policies in other states to offer them in Kansas also.

"CLAIMS MADE" INSURANCE POLICIES

Authority to issue "claims made" insurance policies in Kansas would do much to eliminate the problems created by claims being filed over a period of years under the "occurrence" policies. We understand St. Paul Fire and Marine Insurance Company has had their policy approved by the Insurance Commissioner. Data compiled by the Insurance Commissioner seems to indicate many of the present reserves made for future claims by insurance companies are speculative. The use of claims made policies will allow the Insurance Commissioner a clear role in establishing rates that will allow companies a premium assuring a reasonable profit, and the availability of medical malpractice insurance for all doctors.

STATUTE OF LIMITATIONS

We support the position of the Kansas Bar Association concerning changes in the Statute of Limitations. At the same time, we believe the utilization of claims made policies will minimize the difficulties previously encountered. We do not believe the severe limitations on the rights of minors to recover as suggested by the Kansas Medical Society are appropriate. There has been no proof submitted that any substantial number of claims are presented as a result of the extensions of the Statute of Limitations by the date of discovery of the wrongdoing or the fact of injury. A balancing of the interests involved supports the position of the Kansas Bar Association.

INFORMED CONSENT

We do not believe that the Kansas case law on informed consent should be altered. The Kansas Medical Society suggestion that a written document should be conclusive unless clear and convincing evidence is introduced that the writing was fraudulently obtained would represent an unwarranted change in the law. Consents to health care procedures are obtained by physicians in a fiduciary capacity, and the patient should be free to explain the circumstances in any malpractice action. The circumstances surrounding the giving of consents to medical procedures should not be subjected to any different standard of proof than other factual issues.

ARBITRATION

We do not believe the existing Kansas Law concerning arbitration should be changed. It would not promote good relationships between physicians and patients to have persons required to sign agreements to arbitrate disputes as a condition of securing medical treatment. This could well be the result of a change in the law.

THE GOOD SAMARITAN ACT

The present Good Samaritan Act in Kansas provides adequate protection to providers of medical care. We particularly oppose a change in the standard of care required in hospital emergencies.

MISCELLANEOUS CHANGES IN LAW

The following five changes in Kansas law have been suggested. We do not believe any of the points involved have a substantial effect on the malpractice situation. Some change may be appropriate, as noted, but the Kansas Association of Defense Counsel believes the various changes proposed in these areas do not directly relate to the problem with which this Committee is concerned.

A. Collateral Source Rule. A change in the collateral source rule is unnecessary. This would not make a substantial difference in medical malpractice awards. If the collateral source rule is changed, defendants and insurance carriers should not be the beneficiaries of the plaintiff's diligence in providing medical and other coverages for himself. The defendant should be required to pay to the plaintiff an amount sufficient to reimburse the plaintiff for premiums he has paid for such coverage.

B. Contingent Attorney Fees. We do not believe contingent fees are either a cause of or contributor to the malpractice problem. Persons having substantial malpractice claims will be represented regardless of what the fee arrangements may be. Those without financial resources may be deprived of the right to be represented if contingent fees are not available. We do believe contingent fees should be subject to court review in any case, even though they are provided by contract between attorney and client. If attorney fees are to be regulated, then likewise fees should be assessed against defendants when they refuse to pay claims without just cause or excuse, as is provided in some cases under K.S.A. §40-256.

C. Burden of Proof. Existing law concerning burden of proof should not be altered in medical malpractice cases. The application of the doctrine of res ipsa loquitor in malpractice cases arose as a result of the reluctance of doctors to testify as experts against other doctors. It is a rule of law that applies in many types of cases and an exception should not be made in the case of malpractice claims.

D. Punitive Damages. We agree with the Kansas Bar Association position on punitive damages in cases involving willful, wanton, and reckless misconduct. We do believe a preliminary determination should be made by the court concerning whether punitive damages may be appropriate in the case, to eliminate any testimony that might otherwise prejudice the defendants' rights.

E. Ad Damnum Clause. We believe that the ad damnum clause should be eliminated from the petition at the time it is filed, since it is not uncommon that prejudicial publicity results from the filing of actions with large prayers for damages.

Respectfully submitted,

KANSAS ASSOCIATION OF
DEFENSE COUNSEL

K

FOR THE SENATE COMMITTEE

ON THE STUDY OF MALPRACTICE INSURANCE

STATE OF KANSAS

BY:

Frederick J. Knox

Vice President - Actuarial

St. Paul Fire & Marine
Insurance Company

August 29, 1975

Last year at this time, the malpractice crisis was recognized and talked about almost completely within the insurance industry and the medical profession. Now it's a household word as is evidenced by the fact that most of the popular cartoonists have done something on malpractice. The scope and the impressive speed with which this problem became a public issue has resulted in the involvement of almost every state legislature in the search for solutions. There have been suggestions from state regulators; there has been close attention from the Department of Health, Education and Welfare; there have been congressional hearings by Senator Kennedy; there have been introductions of several bills in Congress; there have been the inevitable study commissions established by interested groups all over; statements about the nature of the problem have come from various insurance companies, including ourselves; Position Papers from organized defense attorneys, from plaintiff attorneys, from insurance agents and the American Medical Association, plus thousands of stories from the general press and medical press publications.

Through all of this, there has been a great deal of finger pointing. Doctors accuse lawyers of abusing the contingency fee system and promoting malpractice suits. Lawyers, in turn, charge doctors for not doing a better job of policing their profession and say that there are more malpractice suits simply because there is more malpractice on the part of America's doctors.

The insurance industry has not escaped this fault finding symdrome either. The major emphasis of attacks on malpractice insurers is to question the credibility of their statistical information...the facts on which they base their requests for increased rates.

Critics of the insurance industry intimate that malpractice insurers are actually doing well in this business. They picture these companies as squirreling away profits while reporting deficits. Some critics loudly proclaim that there is need to "cause the insurance industry to open their financial books."

The question of credibility of information or financial figures is compounded by the special nature of Professional Liability Insurance and medical malpractice insurance in particular. Later, I will present some specific exhibits to demonstrate why medical malpractice loss data is misunderstood and frequently questioned, and you will see that the type of risk being insured is quite different from the concept that most people have of insurance. However, before demonstrating that fact I would like to point out the insurance industry is a highly regulated industry. Our financial and statistical information is punched, prodded and probed by more regulatory agencies than almost any other business. We are subject to regulation from every state in which we write business. Annually, we file a statement with each state in accordance with the requirements of the National Association of Insurance Commissioners, including any specific requirements that a state may have. This information becomes a matter of public record and any person can visit an Insurance Department and examine this annual statement.

In addition, every three years insurance companies are examined by a team of experts representing the National Association of Insurance Commissioners.

Periodically, the Internal Revenue Service audits our tax returns and the process of their audit are quite concerned with our loss reserves.

Our own Certified Public Accountants monitor and audit our records that they may certify the accuracy of our figures.

In addition, within our own Company outside directors have their own audit team to be sure they understand what's going on within our Company and are not just accepting what management tells them.

So you can see that the call for openness of insurance company records is a call for something that's already being done to a greater degree than is prevalent in the profession issuing such a challenge.

Another important point to remember is that insurance companies are profit oriented organizations. A shareholder of The St. Paul Companies, Inc., the parent firm of St. Paul Fire & Marine, expects its operations to be profitable. While our shareholders are interested in the long term future of the Company, they are also quite concerned about short range profits. Shareholders want profits now and they are becoming impatient with our continual losses from medical malpractice insurance. Given this shareholders concern for profits, it's ludicrous to accuse us of squirreling away profits or juggling any of our financial figures, including claims reserves.

As an industry that's regulated in every state in which it does business, insurance companies must keep accurate statistical records on all premium and loss transactions because this statistical information is the data which we must use to make rate filings in each state.

As chief actuary of St. Paul Fire & Marine Insurance Company, I am responsible for developing and maintaining the statistical records for all lines of Property Liability Insurance. I have confidence in the statistical

information that we have developed for medical malpractice insurance, contrary to what critics may allege.

However, I would like to show you, through the use of exhibits, why insurance regulators and others have problems in understanding loss data for medical malpractice insurance.

Exhibit 1 shows our loss history for the year 1969. This is a look at malpractice insurance we wrote in 1969 and the losses that developed from that one year's book of business.

What I will be demonstrating is the fact that our loss experience for one year's business cannot be known completely for many years into the future... what's commonly called the long tail of medical malpractice.

The first column of this exhibit shows the calendar years, the second column shows losses paid out and loss adjusting expenses, both in thousands of dollars. The third column shows the percent of these losses and loss expenses paid at any point of time as a percentage of what we ultimately expect to pay out. The fourth column combines these paid losses with the known claims which are an obligation of the company yet to be paid, and the fifth column shows these known and paid claims as a percent of what we believe to be the ultimate claims cost, and finally the sixth column shows the value of the claims that are yet unknown but which will be reported at some time in the future...this is the notorious IBNR

I selected 1969 as my example because it is the most recent year in which our complete loss cost is known. The fact that accident year 1969 is the

latest year I can use already demonstrates part of the problem. In medical malpractice insurance, it takes many years for all claims to be fully known and many more years for all claims to be fully paid.

As you can see, at the end of 1969 only 18.1% of all estimated ultimate losses were known. If our ultimate loss cost turns out to be $12,000,000, this would have required us to carry a loss reserve for unknown claims of $9,826,000 when we prepared our Financial Statement for 1969.

At the end of 1970, only 4% of the losses were paid and 55% of the losses were known, leaving an unknown loss cost of over $5,000,000. As more and more losses are reported to us, our known claim value becomes larger and larger. Since a claims adjuster puts a value on each reported claim at the time it becomes known, it is not surprising to find the sum of all such claims values would very seldom equal what ultimately will be paid out. It isn't realistic to expect that claims values established one, two, three or more years before will coincide with the amount at which claim is settled. It is our hope, that the sum of all these individual reserve values will exceed what we ultimately pay out. This becomes evident for years 1972 through 1975 showing that known claims values exceed slightly what we believe our ultimate loss cost will be.

If I were to stop at this point, it would be assumed that I have just proven our critics to be correct that insurance companies do over reserve for losses.

However, remember that the 1969 example reflects just one year's business. We have malpractice business written in every subsequent year that must carry reserves for unpaid losses. When you add the amounts needed for unknown claims for more recent years of business, these amounts dwarf the small redundancies for reserves on reported but unpaid losses. Also, when we establish corporate reserves for the medical malpractice business, these redundancies for known claims are used to offset amounts needed for unknown

claims.

These redundancies are reflected in our rate filings and are used to reduce the actual reported losses that form the basis for the claims experience used in rate making.

For the last five years as chief actuary of St. Paul Fire & Marine, I have had the accountability of establishing adequate corporate claims reserves. In retrospect, I failed in that responsibility because for each year 1970 to 1973 I grossly understated the required reserves. It is too early to say how our 1974 reserves will develop, but all indications today do not lead to any strong feeling of optimism on my part.

Recently, The St. Paul filed a Claims-Made Malpractice Insurance Contract to replace our present Occurrence Contract for insuring doctors. Claims-Made contracts provide coverage for reported and known losses only, as opposed to the Occurrence Contract that provides coverage for incurred but unknown claims. The Occurrence Contract requires us to guess at what the unknown claims will be (see the last column in Exhibit 1) for setting our loss reserves and future prices. The Claims-Made Contract deals with only known losses and does not involve any speculations as to future losses.

Exhibit 3 demonstrates the basic difference between the Claims-Made Policy and the Occurrence Policy. There are two major distinctions for losses, the accident year (or professional year of service) and the year the loss is reported. The left column shows the accident year and the top row shows the reported year. The loss cost figures in each box correspond to each combination of accident year and reported year. The sum of any vertical column would yield the cost of Claims-Made Contract and the sum of any horizontal row would give the cost of an Occurrence Contract.

You can see that it is easier to project the cost for the next reported year (column) than to project a whole row of figures into the future for the next accident year. Thus, it is easier to accurately price the Claims-Made Contract as opposed to the Occurrence Contract.

This is precisely the reason why The St. Paul has decided that an Occurrence Contract (accident year projections) is no longer a viable policy. We believe that loss cost for the next reported year can be projected in order to adequately price the Claims-Made Policy. In addition, Claims-Made pricing can be more responsive to any changes affecting Malpractice claims.

The loss cost that will be reported to state regulators and medical societies each year will be an accurate statement of the so-called malpractice crisis in that state. Under the Occurrence Contracts, so little is really known at the end of the year that no one really knows how well or how poorly the situation is developing. Under Claims-Made there will be less discussion of questionable figures and a greater stimulous to take corrective action.

As a case in point, some states have adopted legislative programs aimed at correcting the malpractice problem. Without getting into a discussion as to the value of such legislative programs, I can say that where these programs are effective in halting malpractice claims, the progress will be more quickly reflected in the premium paid for Claims-Made Contract than could ever be accomplished under an Occurrence Contract.

The St. Paul is no longer writing Medical Malpractice Insurance for doctors on occurrence basis. Its switch to Claims-Made is complete, for all intents and purposes, in this line of business. A similar effort is under way for hospital malpractice and should be completed by mid or late September.

Up to now my discussion has been related to our companywide experience. What does the experience of Kansas look like? Attached is an Exhibit I and II for Kansas. Exhibit I-Kansas shows a slower development than companywide data and a much smaller percentage of losses paid. However, for accident year 1970 Kansas had a high percentage of the losses paid and for years 1971 throught 1974, the percentage of losses paid to total known losses was not significantly different from our companywide pattern. Exhibit II-Kansas shows that the percentage of no-claims are not too different from our companywide figures.

Attached are pages 20 and 21 of our rate filing for Kansas. Also attached is page 21 for Iowa that can be used for comparison. Page 20 explains how St. Paul arrived at the pure premiums (claim per doctor) for low volume states. Examining page 21 for Kansas and Iowa, it is obvious that neither state has a clear half-year by half-year claim pattern. Even on a claims-made basis, determining future pure premiums (claim cost) for states with small volume is very difficult. To try to determine occurrence rates where most of the recent years losses are unknown is next to impossible.

On August 13, 1975 I sent William Wolff displays that are not attached. I'll be glad to answer any questions on those displays or the attached Exhibits.

Kansas Insurance Department

Medical Malpractice

Final Report - Outline of

Subcommittee Recommendations

The Commissioner originally announced the formulation of eleven (11) subcommittees charged with intensively reviewing eleven relevant areas of the medical malpractice situation of July 2, 1975. Specifically, these subcommittees were charged with the responsibility of reviewing and analyzing the areas of: Re-evaluation, Re-licensure and Re-certification of Health Care Providers; Peer Review; Grievance Procedures; Prevention of Medical Injuries; Patient/Health Care Providers Relationships; Arbitrations; Claims Review; Ad Damnum; Contingency Fees; Informed Consent; and Statutes of Limitations.

These eleven (11) categories are not intended to represent the only matters which must be researched for possible alleviation of the medical malpractice problem, but they do represent what was believed to be a general consensus of opinion between the health care providers, legal profession and insurance companies.

The study committees were comprised of individuals who are not only reputable citizens of this state, but also prominent members of the medical profession, the legal profession, other professional groups, the insurance industry and the general public.

The chairmen of the various subcommittees made available to the Commissioner a tentative outline of the findings of their respective committees in a meeting held in the State Office Building on July 17, 1975. The committee was expected to have a finalized report available by August 1, 1975, which would be suitable for presentation to the Kansas Legislature's Special Committee on Medical Malpractice.

Subcommittes reporting to date:

1. Re-certification, Re-licensure and Re-evaluation
2. Peer Review
3. Prevention of Medical Injuries
4. Grievance Procedures
5. Patient/Health-Care Provider Relationships
6. Arbitration
7. Claims Review

8. Statutes of Limitations

9. Contingency Fees

10. Informed Consent

Subcommittees not reporting to date (final reports expected by no later than September 1, 1975):

1. Ad Damnum

The attached information represents, in outline form, the recommendations of all reporting subcommittees. A final report is not available at this date from the Ad Damnum subcommittee. Note: See subcommittees' final reports for discussion, suggested implementation, anticipated results, etc.

Senator Wesley Sowers, chairman of the Kansas Legislature's Special Committee on Medical Malpractice, will be furnished a complete set of copies of the subcommittees' final reports. Members of the Special Committee or other interested individuals may obtain copies of the subcommittees' final reports from the Insurance Department upon request.

Final Report

Re-certification, Re-licensure and Re-evaluation

Summary Outline

M. Martin Halley, M.D., Chairman

In this subcommittee's final report dated August 1, 1975, the following recommendations were presented:

1. Re-certification of health-care providers

   The subcommittee believes that certification and re-certification especially is desirable and should be encouraged. Re-certification, however, is felt to be outside the feasible scope of committee review since initial certification is not a prerequisite for practice and is an internal mechanism of various health-care groups.

2. Institutional providers (hospitals and similar institutions)

   Injury prevention programs are essential. Injury prevention programs should include detailed evaluation, remedial recommendations, appropriate action and claims analysis in the following areas:

   a. Review of deaths and medical complications on a continuing basis.

   b. Review of all other hospital incidents causing injury to patients on a continuing basis.

   c. Institutional patient grievance identification mechanisms as well as consideration of patient advocacy programs.

3. Non-institutional providers (physicians, dentists, doctors of chiropractic, osteopaths)

   Continuing education requirements for periodic license renewal or re-registration should be mandatory.

4. Consideration should be given to legislative immunity from suit for committee activities concerned with provider review and also for the members of the Board of Healing Arts relative to their activities in controlling licensure.

5. House Bill 2008, Session of 1975, was approved in its concepts dealing with limitation of licensure in specified instances, rehabilitation of practitioners, and continuing education. The bill was considered inadequate in regard to its provision for evaluation of foreign medical graduates by the Kansas Board of Healing Arts. The subcommittee felt that qualifications for physicians/practitioners in Kansas through endorcement or examination should not be lessened.

Final Report

Peer Review

Summary Outline

Mr. Robert D. Loughbom, Attorney
Chairman

This subcommittee's final report, presented to Commissioner Bell on August 1, 1975, contained the following recommendations:

1. The Peer Review Subcommittee considered the existing Kansas healing arts and various peer review procedures now existing.

2. The subcommittee found that existing peer review systems serve a useful and worthwhile purpose in the health-care field and that peer review is more appropriately a function to be utilized within the various professional societies as presently constituted. The subcommittee found that improvements can and probably should be made but done so primarily within the existing structure. Peer review is what the words imply, namely, review committees as opposed to disiplinary committees. Information which should be referred to the Healing Arts Board should, if at all possible, provide immunity to those furnishing and relaying the information. There was a finding that no new and separate creature of the Legislature is necessary to improve the peer review system. Any peer review follow-up should be primarily through the Healing Arts Board or other applicable existing boards, such as the State Board of Nursing.

3. The subcommittee recommends no new or independent peer review legislation but rather that present procedures established within the laws governing licensing and regulations that health-care providers be strengthened by appropriate statutory amendments or enactments with primary consideration being given to the Healing Arts Board and making available to it peer review findings primarily received with immunity to those furnishing the information and report. An additional provision within the Healing Arts to take affirmative action if the peer review reports so indicate in such areas as limitation of practice of the licensee, for example. Adequate funding is a necessity if proper investigation and enforcement of professional competency is to be supervised and enforced.

4. Implementation of the recommendations can best be achieved by statutory amendments or enactments to existing legislation, and once this is accomplished, the respective peer review organizations now functioning may well be in a position to strengthen their respective peer review procedures.

Final Report

Prevention of Medical Injuries

Summary Outline

Mr. Donald J. Jones, Chairman
The St. Paul Insurance Company

Following this subcommittee's final meeting, the following recommendations were submitted to Commissioner Bell in a letter dated July 30, 1975:

1. That the state of Kansas establish the position of a medical ombudsman to be appointed by the Governor from candidates to be submitted by the Governor's Advisory Committee on Health.

2. That hospital insurers be required by the Insurance Commissioner to provide safety engineering inspection and professional loss prevention services on a regularly scheduled basis, and that the information gathered by insurers on medical injuries be utilized to prevent further injuries.

3. That minimum equipment requirements be established by the State Board of Health in all hospitals in relation to the surgical procedures to be performed in those hospitals, and that these restrictions be stringently enforced.

4. That the Insurance Commissioner's office study the feasibility of allowing insurance companies to exclude coverage for certain medical treatments or surgical procedures by doctors who have experienced an unusual number of bad results in the past while providing these treatments or surgical procedures.

5. That a physician or surgeon must be in attendance for all major surgical procedures to assist the surgeon in charge.

Final Report

Grievance Procedures

Summary Outline

Mr. Joseph B. Mackey
Executive Vice President
(Hutchinson Hospital Corporation)
Chairman

This subcommittee's final recommendations were submitted to Commissioner Bell following the subcommittee's final meeting on July 23, 1975. This subcommittee's recommendations are:

1. The subcommittee recommends the establishment of a statewide public office to receive and investigate complaints regarding the delivery of health care.

2. Such office would serve as an informal mediation and negotiation mechanism to aid in the resolution of complaints at the earliest possible date.

3. In order to carry out its function, this office would have to compile a list of currently available mechanisms for consumer complaints and refer grievances to them where appropriate.

4. If no mechanisms are available or sufficient, then this office can conduct its own investigation to try to resolve the dispute.

5. Said office should maintain records of health-care complaints and periodically issue public reports.

6. This office must make the public aware, not only of its existence, but also of other legal assistance mechanisms.

7. The efforts of this office at effecting a settlement of a dispute should not be used as evidence in any subsequent adversary proceedings involving the same or similar issues.

Kansas Claims Experience

Based on the period 1/1/65 to 12/31/74

		CUMULATIVE
Reported during policy year	7.1%	7.1
Reported during second year	31.6	38.7
Reported during third year	37.0	75.7
Reported during fourth year	15.0	90.7
Reported during fifth year	4.0	94.7
Reported during sixth year	1.4	96.
Reported during seventh year	0.8	96.
Reported after seven years	3.1	100.

TRENDING THIS DEVELOPMENT, AAY from 1974 ~~TO~~ AS ~~THAT~~ THE OCCURRENCE YEAR, WE WOULD NOT KNOW OF 5% OF THE 3,000 ACTIONS WHICH WERE FILED IN 1974, until 1979 OR after 1979 THERE WOULD BE 150 ACTIONS YET TO BE REPORTED.

In 1958 M.P. thought we made an underwriting profit of $5,000. 16 years later we paid a claim which was reported in 1973. The amount paid — $175,000.

YOUR Independent Insurance AGENT SERVES YOU FIRST

Independent Insurance Agents of Kansas

EXECUTIVE OFFICE

August 28, 1975

TO: Special Committee on Malpractice Insurance

We appreciate the opportunity to appear before the committee and present our views on the medical malpractice problem. It is my pleasure to introduce Mr. Paul Tompkins who will represent the Independent Insurance Agents of Kansas.

Mr. Tompkins is President of the Sargent Insurance Agency of Topeka and is Past-President of our Association. He is the independent insurance agent for malpractice and property and casualty insurance for several physicians and professional associations of physicians. Mr. Tompkins is also a prominent independent agent for liability insurance of other professionals in the Topeka area.

I am enclosing copies of Mr. Tompkins' remarks for your review.

Kindest personal regards,

James D Wallace

James D. Wallace, cae
Executive Manager

JDW:eeo

encl.

James D. Wallace cpcu clu, Executive Manager

917 Topeka Avenue, Topeka, Kansas 66612 Tel. 913 232-0561

Testimony of Paul D. Tompkins
Representing
Independent Insurance Agents of Kansas
August 28, 1975

We appreciate the opportunity to present the views of Independent Insurance Agents regarding to the medical malpractice problem. I am going to limit my remarks to explaining the role of the independent insurance agent and commenting on only the medical malpractice problem as distinguished from similar problems being faced by most other professional groups. In a very real sense the problems of medical professionals are not unique. Independent Insurance Agents, for example, are experiencing a rapid rise in the number of professional liability lawsuits against them and in the size of court awards. In addition, independent insurance agents are being held to an ever increasing degree of professional responsibility for their business activities.

The same case could be made for engineers, attorneys, accountants, and many other groups.

Independent agents are involved with the insurance of almost all Kansas medical professionals. The role of the independent insurance agent can be defined as follows:

1. *Determining the insurance needs of the medical professional.*
2. *Finding the best available insurance markets.*
3. *Coordinating and negotiating insurance rates and coverages.*
4. *Notifying, processing and finalizing claims, underwriting reports and various communications between insurance company and insured.*
5. *Periodic review and update of existing insurance programs.*

1. *Determining Insurance Needs* - While all professionals need and desire malpractice coverage this is only a small portion of the problem. It makes a difference whether the professional operates as an individual or through group practice. The firm may be incorporated or unincorporated which will affect the insurance needs. Some individuals require much higher limits of liability in order to protect their existing assets and future earnings. Some have greater liquidity and net worth thereby allowing a higher retention on malpractice and other forms of coverage. The impact of the retention limit must be measured against the individual's risk bearing capability.

Malpractice insurance must be coordinated with other exposures to loss that are encountered within the medical field. This can include general premises liability, workmen's compensation, liability coverage for owned and nonowned automobiles and other common exposures. It is normal, in fact, for physcians to require a package of coverage insuring personal investments and activities that must be coordinated with the professional coverage. Poor planing will either result in overlapping policy provisions that cause double payment of premium or, conversly, gaps in coverage between the policy provisions that make up the portfolio of insurance finally developed. Usually a survey form is completed which attempts to display a financial picture of the insurance needs of the individual at any one point in time. Of course this picture is constantly changing.

2. *Finding the Best Available Insurance Markets* - This is a time consuming inexact science that normally requires much correspondence, telephone conversations and personal visitations to financial and insurance centers such as Kansas City, Chicago and New York. The best

available markets are constantly changing so that the independent agent is well advised to keep his channels of communication open with not only insurance carriers but fellow independent insurance agents. In the field of malpractice insurance it is frequently necessary to contact both admitted and nonadmitted markets. The admitted market consists of those companies that are permitted to write insurance in the state of Kansas after having met the requirements of the Insurance Departnent. Non-admitted markets are those companies which do not operate under the regulation of the Insurance Department and are therefore permitted to write policies only when the admitted market cannot fulfill the need. It is important to recognize that many of the largest international insurors, including noteably Lloyds of London, have permanently elected not to operate as an admitted insuror due to what they feel are restrictive laws and regulations by state insurance departments. In malpractice insurance and liability lines generally it has become increasingly necessary to research nonadmitted markets to obtain the best possible coverage and rates. There is no directory or computor that provides this information. It's one of the major challenges to the professional ability of an independent insurance agent to be aware of the constantly changing markets in the admitted and nonadmitted areas. The agent must know not only the availibity of the coverage but the ability and willingness of the carrier to perform in the event of loss. This includes financial stability, quality of service and claims paying reputation.

3. *Negotiation and Cordination of Insurance Rates and Coverages* - Malpractice insurance is normally negotiated in two or three layers of coverage. The first layer is known as primary coverage and contains a limit per claim which is commonly $100,000 to $500,000 and an aggregrate

limit per year of from $300,000 to $1,000,000. Normally a retention by the individual or firm will be required on the primary coverage of from $1,000 to $10,000. The rate varies with the per claim limit, aggregrate limit, retention amount and coverage. An additional set of limits in another policy with frequently a different insurance carrier is normally required to provide coverage over the primary limit. This policy is referred to as either an excess policy or an umbrella policy. Technically the difference between an excess policy and an umbrella is that the excess provides coverage similar to the primary malpractice policy except in higher limits and pays after the primary policy limits have been exhausted. The umbrella policy provides this function but also adds broadened coverage for exposures not provided in the basic malpractice coverage. Examples would be false arrest, invasion of privacy, undue familarity and other exposures to loss of the medical professionals that are not protected by a malpractice policy covering bodily injury only (as contrasted with personal injury).

Between the excess or umbrella policy and the primary policy it is frequently necessary to negotiate a third layer of coverage where the primary policy is not available in amounts high enough to match the primary amount exclusion of the excess or umbrella coverage. I would like to restate this with an example because this situation frequently occurs in Kansas. The Medical Protection Insurance Company is a large writer of physicians for primary coverage and until recently was willing to write limits of from $100,000 to $500,000 on a per claim basis and $300,000 to $1,000,000 on an aggregrate. The company has now reduced its commitment to $200,000 per claim and $600,000 aggregrate and will not write at limits higher than this. The excess and umbrella carriers

on the other hand are demanding higher limits before their policies will pick up the exposures to loss. It is therefore frequently necessary to search the nonadmitted market for a carrier that will pick up the exposure between the $200/600,000 limit and the bottom limit that the excess or umbrella carrier is willing to provide. The independent agent's job, obviously, is to negotiate all of this into a package of coverage that will satisfy the medical professionals' needs.

I should mention that independent agents must appply for and pay for a special license from the state of Kansas to approach the non-admitted market. They are also required to pay a 2% premium tax on these coverages and submit periodic reports of policies issued. I have discussed problems with negotiating malpractice insurance but there are many more problems in coordinating the malpractice with the other forms of insurance needed by the doctor and/or hospital. These are frequently more complex than the malpractice lines but all the policies together ideally should fulfill the function of protecting the professionals' assets and future earnings from liability judgments and fortuitous losses.

4. *Notifying, Processing and Communicating* - After the policies have finally been issued and premiums paid the independent insurance agent's responsibilities continue. When a claim occurs or the possibility of a policy claim the agent serves as a notification point and a communicator on the medical professional's behalf in seeing that carriers are properly notified. The professional reputation of the physician or surgeon is a most valued possession and it is necessary that claim reporting and claim handling be accomplished in a manner that will safeguard this reputation. Insurance carriers require frequent

underwriting reports and other communicative forms and documents. If these are not properly completed it can result in misunderstanding and even withdrawal of market by the insurance company. The independent agent must maintain the trust of both the carrier and the insured in completing and forwarding these underwriting reports on a regular basis. It is rare that all the information is readily available that is needed to construct surveys or reports for any individual doctor or professional firm. The agency handles also the more mundane services of financing policy premiums, issuing endorsements and processing billings between insured and carrier.

5. *Reviewing and Updating Existing Coverage* - Unfortunately the medical malpractice market in recent years has been extremely volatile. It is therefore necessary to renegotiate and update policies on a much more frequent basis than is common with other lines of coverage. A perfect example is the recent change in coverage filing by the St. Paul Insurance Company in Kansas to a "claims made" policy. Whereas before the malpractice policy would provide coverage for any claim brought forward under the policy no matter when the event occurred, the new policy coverage is limited to those events which occur during the current policy period. Without going into all of the intracacies of a claims made policy (which I am sure the St. Paul representatives will be glad to explain) this filing change effects all of the doctors' coverages presently and requires him to maintain a special policy upon his retirement from practice. The independent insurance agent must understand the affect of this change and be alert to seeing that the additional coverages required are provided.

Policy limits that are adequate one year will be inadequate the next. Retention amounts must be changed based upon the firm's liquid

cash position. As insurance markets contract or expand it frequently becomes possible to afford a reduction in premium and is sometimes advisable to switch carriers, particularly in the nonadmitted field, if service or financial solvency issues arise.

This has been a short overview of the independent agent's role in providing malpractice insurance. As a final comment I might add that the independent insurance agent's exposure to liability suits by the doctor against the agent are considerably greater in this area than in other safer lines of insurance that are more easily written. It is not unusual for the independent agent's professional liability carrier to insist upon higher limits of retention, higher premiums or restricted coverage if the agent is writing a great deal of professional liability clients.

Payment to the independent agent for his services is accomplished in the form of a percentage of the premium paid. This commission percentage fluctuates considerably and the agent's position is comparable to the attorney in that the amount of compensation he receives (based upon a number of factors such as premium volume, type of insurance company, line loss ratio and other factors) is only a rough measure of the amount of effort required to properly service the business. For this reason it is not uncommon for some independent agents to specialize in this line of business and for others to not solicit malpractice clients because they prefer to spend their time and expertise in other areas. It is obvious that any solution to the malpractice problem must take into the account the independent insurance agent who performs such a vital role in servicing this type of insurance. I would like to repeat my initial observation that the increase in exposure to liability suits

both as to quantity and amount of judgments is not unique to medical professionals but in fact is a general trend occuring in all areas of professional responsibility. Possibly the committee should consider whether or not it's research should include professional liability and even products liability on a general basis rather than being restricted to medical professionals. A comparison of the insurance premiums paid by professional engineers with general medical practioneers will graphically illustrate this point.

Independent agents are aware and vitally concerned with the shrinking insurance market for all types of professional liability insurance. This committee is in the process of considering changes in the statute of limitations, establishment of claims review committees, encouragement of arbitration, relicensing requirements for health care providers, and improving the system of gathering and reporting statistical information. We believe these studies will prove to be helpful to the overall insurance climate for malpractice. In addition we wouldlike to recommend that the committee consider establishing a section of the Insurance Department to be a first receiver of complaints and coordination office for malpractice claims. This would not be mandatory. Under the present system it is rare that a patient will know the insurance carrier of a physician in order to register as a claimant. If Kansans could refer to the Insurance Department initially the Department could then determine the malpractice insuror and place the two parties in touch. Many small claims could be handled in this manner and even larger ones would result in quicker, more economical settlement under the watchful eye of the Insurance Department. This one improvement in claims reporting procedures could be very beneficial in reducing overall claims costs in Kansas.

It has been proposed by some groups that joint underwriting associations be established for liability insurance, that state insurance funds be created and that the tort system be drastically amended. We are opposed to these proposals at the present time since we feel it is too early to abandon the existing system of insurance and tort liability. In case these types of proposals are pursued further it would be our hope that independent insurance agents would be allowed to present material regarding the make up of such programs.

It is our belief that the medical profession is not asking for special consideration in the cost of their insurance or in fulfilling their responsibilities to the Kansas public. All businessmen and professionals are required to pay an important portion of their income in the payment of insurance premiums which varies with the amount of risk involved. Medical health care providers are no exception and we believe that with improvements in Kansas statutes, claims handling procedures and health care methods the present system can be made to operate in an efficient and satisfactory manner.

August 28, 1975

KANSAS BLUE CROSS-BLUE SHIELD

Thank you for the opportunity to present a few remarks on behalf of Kansas Blue Cross and Blue Shield concerning problems related to malpractice insurance for doctors and institutions. I am Henry Meiners, Vice President for Professional and Institutional Affairs.

One comment on yesterday's testimony before this Committee. Someone suggested the creation of a quasi-public joint underwriting pool with contributions from medical insurors and others. Medical insurors such as Blue Cross and Blue Shield would need to increase premiums to raise the money to contribute to such a pool. This would result in a selective tax on those Kansas citizens who plan ahead by insuring for their medical expense. The funds raised (the pool) would be for the potential benefit of all Kansas citizens. Would this be the fairest method of obtaining funds for a quasi-public pool of this kind?

In general, Kansas Blue Cross and Blue Shield agrees that some action is needed to resolve the medical malpractice insurance problem that exists today and to take steps to prevent the problem from becoming significantly more serious.

I will not spend any time demonstrating that some hospitals and physicians have been asked to pay malpractice insurance premiums two or three or four times higher than they were paying a year ago or that it is anticipated that these premiums will show additional significant increases in the near future. I am sure that others either have or will provide detailed information on this subject.

The Kansas Blue Cross and Blue Shield concerns, more appropriately, relate to the effect of these problems on the patients or the consumers, if you will. On behalf of its subscribers, Blue Cross and Blue Shield is now purchasing health care for more than 45% of the citizens of Kansas. Additionally, Blue Cross and

lue Shield is responsible for financial arrangements for another eleven or twelve percent of Kansas citizens who are eligible for Medicare. We also serve as fiscal agent for the state in processing the bills for the citizens eligible for Medicaid and we pay bills for health care on behalf of the military establishment for military dependents.

In my testimony today, I would like to emphasize two specific points related to the medical malpractice subject.

First, I can report that we are observing increases in the charges made for health care which are directly related to the increased premium costs. We do not have a precise measurement of this increase, but it is obvious that this effect is only beginning. Unless some action is taken, such increases in cost will certainly accelerate.

Second, the increased threat of legal actions related to malpractice is causing physicians and other providers to practice defensive medicine. During the past year, the number of services received by Blue Cross and Blue Shield subscribers increased at a rate of almost 4%. This is an increase in a trend that has been evident for several years. This means that for some reason the average patient is likely to receive more laboratory tests, x-rays, and other diagnostic procedures than he would have received a few years ago. In studying this phenomena and in discussing it with physicians and other providers, we find that in some cases procedures are carried out which are actually not required for the benefit of the patient. The answer is that the recorded results of the procedure might be useful in defending a legal action which would accuse the physician or the hospital of not doing everything possible for the benefit of the patient.

In our opinion, the two points outlined above are unnecessarily increasing the cost of health care. We believe that unless some steps are taken, cost increases of this kind will continue to add to the health care expenses for Kansas citizens. I will be happy to try to respond to any questions you might have.

SUPPLEMENTARY REPORT

MEDICAL MALPRACTICE

AND

PROFESSIONAL LIABILITY

INSURANCE IN THE STATE

OF

KANSAS

AUGUST 28, 1975

FLETCHER BELL

COMMISSIONER OF INSURANCE

STATE OF KANSAS

INTRODUCTION

This report supplements the previous reports issued by this Department on Medical Malpractice Insurance in the State of Kansas dated March 14, 1975 and June 25, 1975.

The purpose of this document is to provide additional information regarding the present Kansas medical malpractice insurance market. Also provided with this report is a summary of the recommendations of the subcommittees which were appointed by the commissioner on July 2, 1975 and charged with intensively reviewing eleven relevant areas of the present medical malpractice situation in Kansas. (Exhibit 1 provides a list of the subcommittees, membership and a summary of their findings and recommendations as presented to the commissioner). The information provided by these subcommittees was quite helpful, and many of their findings and recommendations were used in whole or in part in developing this Department's position and report.

Section One of this report sets forth the recommendations of the Department dealing specifically with the medical malpractice situation in the state of Kansas. It is felt that the implementation of the recommendations contained herein will substantially alleviate many of the difficulties currently being experienced in the area of professional liability insurance. Section Two contains information supportive of this Department's recommendations. Section Three of this supplementary report presents an overview of the current medical malpractice insurance market. The final section of the report provides this Department's conclusions regarding the Kansas medical malpractice insurance market.

SECTION I

DEPARTMENT RECOMMENDATIONS FOR LEGISLATIVE CHANGES

I. Changes to improve the quality of health care:

1. Centralize licensure, re-certification, regulation and supervision of all medical-care providers and institutions under one state agency.

2. Staff and fund the agency either by fees or general revenue funds to the extent necessary to carry out its responsibilities.

3. Require supervising agency to adopt regulations, pursuant to statutory guidelines, mandating the establishment of peer review mechanisms, grievance procedures, pre-admission screening processes (institutions), pre-surgery review and patient injury prevention committees.

4. Establish a mechanism within the agency to review and assist the public with respect to patient complaints and assist in the implementation of other mechanisms which would improve the physician-patient relationship.

5. Serve as a collection agency of information effecting or potentially effecting the delivery of adequate health-care services and also undertake such other activities as necessary

to maintain and improve the Kansas health-care environment.

II. Alternative mediation procedures for malpractice litigation:

Implement procedures for the arbitration of tort claims alleging damages due the rendering or failure to render professional services, preceded by a claims review panel. The arbitration process should be either voluntary and binding, or, compulsory and non-binding.

III. Changes to the statutory environment of malpractice claims:

1. Eliminate the inclusion of the dollar amounts in the plaintiff's prayer for recovery of alleged damages (sometimes referred to as the ad damnum clause).

2. Reduce the present discovery period as set forth in K.S.A. 60-513 from the present ten years to a maximum of four years and retain the present two-year statute of limitations.

IV. Changes related to the malpractice insurance regulation:

1. Eliminate the "insured's consent to settle" clause from malpractice policies issued in this state by statutory requirement.

2. Provide for a Joint Underwriting Association (J.U.A.), or another pooling mechanism, of insurers to collectively assume malpractice risks that are not assumed individually which would be implemented upon a determination that malpractice insurance is not reasonably available. The J.U.A. would be composed of all insurers authorized to write liability insurance in the state of Kansas.

3. Imposition of statutory restrictions on an insurer's ability to cancel or refuse to renew malpractice insurance policies similar to the private passenger automobile cancellation/non-renewal provisions currently in force.

4. Provide for the issuance of group malpractice insurance policies (similar to life and/or accident and health group insurance policies).

(It is to be emphasized that these recommendations have been developed as a comprehensive approach to remedial legislative activity. The extraction and use of individual components is not contemplated.)

SECTION II

DEPARTMENT RECOMMENDATIONS AND COMMENTS

I. Changes to improve the quality of health care:

1. Centralize licensure, re-certification, regulation and supervision of all medical-care providers and institutions under one state agency.

Comments: Presently the regulatory agencies for the supervision and licensing of health-care providers (as provided for under Chapter 65 of the Kansas Statutes Annotated, or any other statute providing for the licensure or regulation of persons or institutions related to the Kansas health-care delivery system) are decentralized without any apparent interrelated supervision of the various health-care delivery institutions and medical practitioners; for example, hospitals, nursing homes, medical clinics, physicians, surgeons, osteopaths, chiropractors, dentists, nurses, physical therapy, etc. It is apparent that one centralized regulatory agency could more efficiently provide the control of the Kansas health-care delivery system and the licensing of all medical practitioners and health-care institutions to insure minimum standards of professional services and competence.

2. Staff and fund the agency either by fees or general revenue

funds to the extent necessary to carry out its responsibilities.

Comments: If the centralized supervisory agency is to be effective in improving the quality of all health-care providers, adequate resources must be provided.

If it can be assumed that the budgets of the existing supervisory and licensing boards and/or agencies are sufficient to effectively perform their responsibilities, this recommendation should not require the expenditure of additional funds. On the other hand, if the existing budgets are inadequate, the present fees should be increased or general revenue funds appropriated to the extent necessary to support this essential activity.

3. Require supervising agency to adopt regulations, pursuant to statutory guidelines, mandating the establishment of peer review mechanisms, grievance procedures, pre-admission screening processes (institutions), pre-surgery review and patient injury prevention committees.

Comments: Centralization of the licensure, re-certification, regulation and supervision of all health-care providers and institutions would provide an opportunity for the implementation of a strong state peer review mechanism with appropriate statutory authority and guidelines for phases of the health-care delivery system.

The peer review mechanism should be established separate from any federal requirement to establish the Professional Standards Review Organization (PSRO) and should be capable of providing peer review of any health-care provider licensed under Chapter 65 of the Kansas Statutes Annotated. Grievance procedures, pre-admission screening processes (institutions), pre-surgery review and patient injury prevention committees should be required and implemented at the primary health-care delivery levels (that is, the hospital, institution, clinic or individual health-care provider).

The above recommendations for licensing, re-certification, peer review, grievance procedures, pre-admission screening (institutions), pre-surgery review and patient injury prevention committees are required to provide an improved health-care delivery system and reduce the necessity for utilization of the malpractice claim as a quality control mechanism.

4. Establish a mechanism within the agency to review and assist the public with respect to patient complaints and assist in the implementation of other mechanisms which would improve the physician-patient relationship.

Comments: Presently the decentralization of the health-care regulation and supervision presents the general public with a confusing and sometimes unresponsive system for the communication of grievances or complaints regarding the health care received in this state. A centralized agency responsible for the regulation and supervision of all health-care delivery systems in this state could provide assistance to allegedly injured patients in resolving their complaints and grievances.

5. Serve as a collection agency of information effecting or potentially effecting the delivery of adequate health-care services and also undertake such other activities as necessary to maintain and improve the Kansas health-care environment.

Comments: Centralization of the licensure and supervision of all health-care providers would provide a natural point of the collection and maintenance of related information concerning the level, problems or experience of the health-care services provided in the state of Kansas.

II. Alternative mediation procedures for malpractice litigation:

Implement procedures for the arbitration of tort claims alleging damages due the rendering or failure to render professional services, preceded by a claims review panel. The arbitration process should be either voluntary and binding,

or, compulsory and non-binding.

It is recommended that this Department's subcommittee's recommendations on arbitration be considered by the Kansas Legislature for possible implementation in the state of Kansas. The following is a summary outline of the subcommittee's final recommendations as submitted to this Department on July 30, 1975:

A. The subcommittee recommends arbitration be a means of resolving malpractice suits in the state of Kansas.

B. The subcommittee recommends that an arbitration mechanism be constructed and that this be preceded by a mandatory medical review panel composed of the defendent's peers. The medical review panel needs to decide deviations from standard practice and approximate cause to injury, and these findings need to be admissible in future legal proceedings.

C. The subcommittee recommends that the words "other than a claim in tort" be deleted from the Kansas Uniform Arbitration Act (K.S.A. 5-401, Line 8).

D. The subcommittee recommends that arbitration be either

a. Voluntary and binding; or

b. Compulsory and non-binding

E. The subcommittee recommends that members of the arbitration committee should be composed of three voting members and one non-voting chairman. The voting members should be chosen as follows:

a. One chosen by plaintiff;

b. One chosen by defendent;

c. One chosen by these two; and

d. An attorney - chairman appointed from a roster of attorneys by the district judge.

Comments: This recommendation is supported by the following advantages of arbitration:

"(a) it permits speedier handling of claims; (b) it saves the time of the parties, the witnesses, and their legal counsel; (c) it permits the use of a sophisticated decision-maker or makers who may actually be an expert or experts in the field of controversy; (d) proceedings are informal and the technical rules of evidence may be relaxed; and (e) the decision is final, with a very limited

potential of appeal. Finally, and perhaps most important in the field of professional liability, is the fact that the arbitration process is a fact-finding procedure conducted without the emotional overtones and adversary atmosphere of the courtroom."(1)

III. Changes to the statutory environment of malpractice claims:

1. Eliminate the inclusion of the dollar amounts in the plaintiff's prayer for recovery of alleged damages (sometimes referred to as the ad damnum clause).

Comments: "Astronomical amount of damages set forth in the malpractice complaints by attorneys are an unnecessary source of friction between the legal and medical professions. These large demands attract sensational newspaper coverage, impose needless anxiety and often unfounded notoriety upon defendent physicians, create a feeling of unfair persecution in the medical world and are of no special benefit to the plaintiff-patients."(2)

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(1) Page 94, Report of the Secretary's Commission on Medical Malpractice, DHEW Publication No. (OS) 73-88, dated January 16, 1973.

(2) Page 38, Report of the Secretary's Commission on Medical Malpractice, DHEW Publication No. (OS) 73-88, dated January 16, 1973.

2. Reduce the present discovery period as set forth in K.S.A. 60-513 from the present ten years to a maximum of four years and retain the present two-year statute of limitations.

Comments: All existing information indicates that approximately 95 percent of all medical malpractice claims are made within the first six years after the occurrence of the alleged injury (see page 9 of this Department's report dated March 14, 1975). Therefore, it would appear that a four-year discovery period may not adversely affect the general public of this state to any significant degree. The four-year discovery period would produce an improved claims climate for the Kansas health-care providers and the respective insurers of such health-care providers.

IV. Changes related to the malpractice insurance regulation:

1. Eliminate the "insured's consent to settle" clause from malpractice policies issued in this state by statutory requirement.

Comments: Currently some malpractice policies require the insurance company to obtain the insured's consent (written consent in some instances) to settle a malpractice claim which in the past has prevented the insurance companies from settling some claims in a more expedient manner. This provision has and is being withdrawn from the malpractice policies currently in

effect in Kansas, and it is this Department's opinion that such consent provisions are not in the best interest of the general public in resolving allegations of malpractice. Furthermore, the malpractice liability insurance programs are the only programs which have incorporated the unique insured's consent to settlement provisions, and the continuation of such policy provisions in malpractice policies is no more justifiable than the inclusion of similar provisions in automobile, homeowners or other liability insurance policies.

2. Require a Joint Underwriting Association (J.U.A.), or another pooling mechanism, of insurers to collectively assume malpractice risks that are not assumed individually. The J.U.A. would be composed of all insurers authorized to write liability insurance in the state of Kansas.

Comments: With the adoption of the other recommendations, it is anticipated that insurance coverage in the normal market will be available to most health-care providers. However, implementation of this proposal will offer at least minimal coverage to those health-care providers who cannot obtain coverage in the normal market. This concept has already been implemented by the legislature for automobile liability and workmen's compensation insurance. Implementation of a pooling mechanism would include a recommended $500,000/$1,500,000 limitation of coverage available for each medical practitioner through the pooling mechanism.

Insurance coverage beyond these limits would have to be obtained through the normal insurance markets.

3. Implementation of a malpractice cancellation/non-renewal regulation similar to automobile cancellation/non-renewal provisions currently in force.

Comments: It is proposed that the legislature enact provisions to reasonably restrict the cancellation and non-renewal of malpractice policies in order to prevent the unexpected discontinuance of malpractice insurance coverages without adequate justification. This requirement would incorporate provisions which would prohibit the insurance carrier from terminating or cancelling existing coverage without adequate justification and/or notice.

4. Provide for the issuance of group malpractice insurance policies (similar to life or accident and health insurance group insurance policies).

Comments: In recognition of the problems encountered in the establishment of a strong insured/insurer relationship, development of malpractice claims experience and other matters which are apparently lacking in the insurance company/health-care provider relationships the legislature should modify existing insurance laws and regulations to provide for the issuance of group malpractice policies in this state. The

group policy concept does offer certain advantages for both the insured and the insurance company. Although specific details of such a proposal have not been formulated, this Department will provide the input and justification for such revisions as the need develops.

In summary of the above recommendations of this Department, changes within the health-care delivery system itself and resulting social attitudes which no longer hold the medical practitioner in esteem, have contributed significantly to the problems being encountered currently.

The general public's attitude cannot be changed with legislative proposals which restrict and diminish their legal rights. One of the significant reasons this Department has placed the emphasis on improving the Kansas health-care delivery system, rather than concentrating in the areas of limiting financial responsibility of medical-care providers, patient's compensation fund, guarantee of insurance, burden of proof, informed consent, punitive damages, breach of contract, good Samaritan principal for emergency care in hospitals and other matters which would benefit only the health-care delivery system at the expense of the public, is that if patient injuries do exist, primary responsibility for those injuries should be the burden of the Kansas health-care delivery system. Patient injuries should not be the burden of the general public of the state of Kansas.

SECTION III

CURRENT MEDICAL MALPRACTICE INSURANCE MARKET

1. Malpractice Insurance Costs: Since the date of this Department's last report, medical malpractice insurance rates have not increased to any measurable degree for companies admitted to write physicians' and surgeons' professional liability insurance in the state of Kansas. Some individual medical practitioners have advised this Department of higher renewal premiums during the recent weeks; however, these increases are apparently isolated to premium revisions effected by the non-admitted excess lines insurance facilities which are not regulated by this Department. This Department recognizes that some of the recent premium quotations from the non-admitted excess lines insurance facilities do, in fact, appear to be unreasonable in view of the coverage being afforded.

2. Availability of Adequate Coverage for New Physicians and Surgeons Establishing Practices in Kansas: For all classes of new physicians and surgeons, except anesthesiologists, entering the Kansas health-care market, adequate insurance appears to be available through the normal insurance agency system. Certain individual medical practitioners have experienced difficulty in obtaining insurance coverage due to unique circumstances in their training and/or experience (such as a psychiatrist desiring coverage for part-time emergency

room physician exposure and foreign-trained medical personnel establishing temporary practice in Kansas).

3. Market Availability and Stability for Existing Medical Practitioners: With the exception of anesthesiologists, the majority of Kansas physicians and surgeons continue to be insured through the admitted insurance market which appears to remain relatively stable.

An existing problem involving anesthesiologists created by the revision of the limits of liability offered to the insured medical practitioners appears to have created an intermediate coverage problem which has not been resolved to date. This intermediate coverage problem entails the lack of coverage between the primary insurance policy (providing first dollar coverage up to the limits of $200,000/$600,000) and the excess insurance policy (which is designed to cover losses over $500,000/$1,000,000). The existing intermediate coverage or "gap" of $300,000/$400,000 was created when The Medical Protective Company reduced the previously available coverage of $1,000,000 to $200,000/$600,000 on June 1, 1975, and excess insurance companies retained their requirement of a minimum underlying malpractice insurance policy affording $500,000/$1,000,000. To this date these revisions could provoke a potentially volatile situation which may confront other Kansas anesthesiologists and surgeons.

The impact of the Lloyd's of London facility withdrawal from the Kansas and country-wide medical malpractice market mentioned in this Department's last report dated June 25, 1975, has been a factor in the continuity of coverage at reasonable costs for many Kansas medical practitioners insured by the non-admitted excess lines insurance markets. The Lloyd's withdrawal has also been an apparent, but undocumented, factor in the problems encountered by the anesthesiologists in locating the desired excess insurance programs and the required "gap" coverage between primary and excess insurance contracts.

4. Physicians and Surgeons without Professional Liability Insurance Coverage: As indicated in this Department's June 25, 1975 report, one individual medical practitioner had not been able to locate any potential insurance market willing to provide insurance for his professional risk. To the best of this Department's knowledge, there are, at this time, two additional practitioners who have not been able to obtain an offer of permanent coverage. (An additional 62-year-old surgeon who can obtain only physicians' professional liability insurance and a foreign-trained surgeon desiring to practice in Kansas for only one year). However, both of these additional surgeons have obtained temporary or limited professional liability insurance. All three situations will continue to receive the assistance of this Department in obtaining adequate insurance.

5. Summary of Current Medical Malpractice Market: Widespread availability and cost problems related to professional liability insurance for Kansas physicians, surgeons and hospitals were first encountered in the fall of 1974 when several of the major professional liability insurers requested significant rate increases. Although the percentage of the requested rate increases did not vary significantly from prior rate proposals (the average annual rate increase for the calendar years 1968 through 1973 is approximately 50 percent per year), the companies proposing these latest increases indicated that approval of the new rates would permit their companies to renew only existing policies; that is, even if the higher rates were approved, no new policies would be written by these companies in the state of Kansas. In order to prevent a major crisis from developing, this Department sought and received informal commitments from the major insurance companies, which have traditionally provided a majority of the Kansas physicians', surgeons' and hospitals' professional liability insurance market, to renew all existing policies whenever possible and also provide additional coverage for any new physician or surgeon establishing or joining an existing medical practice in the state of Kansas. Furthermore, the assistance and cooperation of other admitted insurance companies were solicited, and informal agreements were made to the effect that all insurance companies would attempt to remain in the Kansas physicians', surgeons' and hospitals' professional liability insurance market.

Until late June of 1975, these informal commitments appeared to be providing a somewhat stabilized market for the health-care pro-

viders insured by the admitted (regulated) insurance market. At this time, the first information of an impending withdrawal of the Lloyd's of London Underwriters (a non-admitted or unregulated insurance facility) from the United States medical malpractice insurance market became available, and by July 1, 1975, the Lloyd's had formally withdrawn from this essential market. As pointed out earlier in this report, this Department is not able to provide a detailed evaluation of the impact of Lloyd's withdrawal. Other situations occurring in June, such as the reduction of policy limits by one major insurance company, adversely affected the Kansas medical malpractice insurance market; and just recently, two insurance companies have notified this Department regarding the elimination of new and renewal primary and/or excess coverages for anesthesiologists.

Although recent insurance market availability problems and fluctuations have been encountered for groups or entire classes of Kansas health-care providers (which differ significantly from the individual problems initially encountered), this Department will continue to attempt to provide reasonable stability and availability of medical professional liability insurance coverages from the admitted (regulated) insurance companies. This Department's continued success, however, will depend largely on the possibility of reducing the health-care provider's exposure to claims and the severity of loss when claims are incurred.

In essence, this Department has attempted during the last eight

months to stabilize the Kansas medical professional liability insurance market and provide to the various parties related to the apparent problem areas along with the Kansas Legislative Special Committee on Medical Malpractice with sufficient time to study and make the necessary revisions to correct the problems which might exist. The continued success of this Department's efforts to prevent a collapse or other severe crisis in the Kansas medical professional liability insurance market depends on the responsible and equitable actions of the other parties involved.

SECTION IV

CONCLUSION

The problems which are now being faced in the state of Kansas regarding the continued availability of medical professional liability insurance are most serious, and they must be dealt with and resolved as quickly as possible. Therefore, this Department, after careful consultation, has completed an in-depth analysis of the situation, and the recommendations contained herein are the result of this Department's efforts to isolate and set forth the specific areas which have apparently created, or contributed to, medical malpractice claims and loss problems, for the physicians, surgeons, hospitals and other health-care providers in the state of Kansas.

If for any reason delays are encountered in the implementation of measures or procedures which would improve the level of the quality of health care, or improve the system for mediation of medical malpractice claims in this state, the availability and cost problems encountered with medical professional liability insurance will become more serious than ever before. The contributing factors of social attitude cannot be improved with legislation which infringes upon the general public's right to be fairly and equitably compensated when acts of medical malpractice do occur. In the opinion of this Department, the general area of reducing the incident of patient injuries and providing alternative mediation mechanisms for settling allegations of medical injuries must be implemented before legislative revisions, which impose restrictions upon the general public of this state, are considered or implemented; however, if attempts to reduce

patient injuries and/or the cost of malpractice mediation and settlement costs do not provide satisfactory results, it may then be necessary to consider imposing limitations on the injured patient's rights to legal recourse. It is imperative, however, that the general public's rights should not be reduced or diminished until no other possible or conceivable alternative exists.

MEDICAL MALPRACTICE

SUBCOMMITTEES

July 2, 1975

Fletcher Bell
Commissioner of Insurance

INDEX

MEDICAL MALPRACTICE COMMITTEES

Chairmen

Re-evaluation, Re-licensure and Re-certification of Health-Care Providers

Chairperson:

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314 Medical Arts Building
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(Continued on Next Page)

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WIBW Television - AM/FM
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Topeka, Kansas 66606 (272-3456)

Charges for the Subcommittee

on Re-evaluation, Re-licensure and

Re-certification of Health-Care Providers

The subcommittee to study the current licensure and certification requirements of Kansas health-care providers is charged with the responsibility of determining whether formalized procedures requiring re-evaluation, re-licensure and re-certification of all Kansas health-care providers and health-care institutions should be implemented by the Kansas Board of Healing Arts or other responsible agencies. The subcommittee should determine and itemize as findings the advantages and disadvantages of the existing and contemplated licensure and certification procedures and make specific recommendations for any revisions deemed necessary. The purpose will be to determine what change, if any, will best serve the public interest.

The findings of the subcommittee will be summarized in a report which will also contain the suggested recommendations of the subcommittee, including the proposed dates or dates of implementation.

The report must contain:

1. A brief summary of the present procedures for licensure and certification utilized in this state to include information regarding the past and on-going activities of the Kansas Board of Healing Arts;
2. The Kansas evidentiary material considered;
3. The findings at which the subcommittee arrived;
4. The recommendations based upon the findings;
5. The suggested or required means of implementation of the recommendations;
6. Anticipated results of such recommendation.

Subcommittee on

Peer Review

Chairperson:

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Charges for the Subcommittee to Study Peer Review

The subcommittee to study peer review is charged with the responsibility of determining whether a system of peer review should be established to investigate incidents involving medical injuries. The purpose will be to determine what change, if any, will best serve the public interest.

In fulfilling this responsibility, the subcommittee will consider and itemize as findings the advantages and disadvantages of establishing a peer review panel. If such a panel is found to be necessary, the subcommittee should then consider the advantages and disadvantages of granting immunity to panel members while acting in their official capacity, methods of forwarding matters to the panel, procedures to be employed by the panel and possible sanction to be recommended by the panel to the Board of Healing Arts or other responsible organization, possibly including censure, suspension or expulsion from practice.

The findings of the subcommittee will be summarized in a report which will also contain the suggested recommendations of the subcommittee.

The report must contain:

1. The Kansas evidentiary material considered;
2. The findings at which the subcommittee arrived;
3. The recommendations based upon the findings;
4. The suggested or required means of implementation of the recommendations;
5. Anticipated results of such recommendation.

Subcommittee on

Prevention of Medical Injuries

Chairperson:

Mr. Don Jones, Resident Secretary
St. Paul Insurance Companies
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210 West Tenth Street
Kansas City, Missouri 64105

Members:

Insurance Representatives:

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General Public Representative:

Mr. E. Maurice Nuss
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Topeka, Kansas 66604
(913) 233-4474

Charges for the Subcommittee to Study Prevention of Medical Injuries

The subcommittee to study prevention of medical injuries is charged with the responsibility of determining what methods may be initiated to reduce injuries and the techniques most likely to achieve that objective and reduce the incidence of medical injuries to patients. The purpose will be to determine what change, if any, will best serve the public interest.

In fulfilling this responsibility, the subcommittee will consider and itemize as findings, proposals for implementation by insurance companies, government agencies and/or organizations which could improve loss prevention efforts in the area of medical injury and recommend any revisions in existing practices which might be necessary. The findings of the subcommittee will be summarized in a report which will also contain the suggested recommendations of the subcommittee.

The report must contain:

1. The Kansas evidentiary material considered;
2. The findings at which the subcommittee arrived;
3. The recommendations based upon the findings;
4. The suggested or required means of implementation of the recommendations;
5. Anticipated results of such recommendation.

Subcommittee on

Grievance Procedures

Chairperson:

Mr. Joseph B. Mackey
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Ottawa, Kansas 66067
(913) 242-2157

General Public Representative:

Mr. John G. Montgomery
Daily Union
Post Office Box 129
Junction City, Kansas 66441

Charges for the Subcommittee to Study Grievance Procedures

The subcommittee to study grievance procedures is charged with the responsibility of determining whether or not a system providing for investigation and consideration of patient grievances should be established by health-care providers who would be capable of dealing with health-care problems. The purpose will be to determine what change or what procedures could be instituted, if any, to best serve the public interest.

In fulfilling this responsibility, the subcommittee will consider and itemize as findings the advantages and disadvantages of voluntary or mandatory institutional or non-institutional grievance procedures. The subcommittee will also consider the possible development of a model grievance procedure(s) or mechanism(s) including operating guidelines to deal with problems involving patient care applicable to all health-care providers. The findings of the subcommittee will be summarized in a report which will also contain the suggested recommendations of such subcommittee.

The report must contain:

1. The Kansas evidentiary material considered;
2. The findings at which the subcommittee arrived;
3. The recommendations based upon the findings;
4. The suggested or required means of implementation of the recommendations;
5. Anticipated results of such recommendation.

Subcommittee on

Patient/Health-Care Provider Relationships

Chairperson:

Mr. Henry Meiners
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Professional and Institutional Affairs
Blue Cross/Blue Shield
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Mr. Ralph McGee
Executive Secretary-Treasurer
Kansas State Federation of Labor
525 Topeka Avenue
Topeka, Kansas 66603

Charges for the Subcommittee to Study Patient/Health-Care Provider Relationships

The subcommittee to study patient/health-care provider relationships is charged with the responsibility of determining whether the patient/health-care provider relationship can be improved and thereby lower the incidence of alleged malpractice suits. The purpose will be to determine what change or procedures, if any, will best serve the public interest.

In fulfilling this responsibility, the subcommittee will consider whether the information provided to patients as to what they can reasonably expect from medical treatment and/or the education of health-care providers in regard to establishing communications and rapport with patients can be improved to reduce the tensions which apparently arise or exist in some situations. The subcommittee shall also consider whether educational courses should place more emphasis on the human element in their training programs. The findings of the subcommittee will be summarized in a report which will also contain the suggested recommendations of the subcommittee.

The report must contain:

1. The Kansas evidentiary material considered;
2. The findings at which the subcommittee arrived;
3. The recommendations based upon the findings;
4. The suggested or required means of implementation of the recommendations;
5. Anticipated results of such recommendation.

Subcommittee on Arbitration

Chairperson:

Dan Roberts, M.D.
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Steven P. Flood
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Hays, Kansas 67601

General Public Representatives:

Mr. Clyde Reed, Publisher
The Parsons Sun
Box 836
Parsons, Kansas 67357

Charges for the Subcommittee to Study Arbitration

The subcommittee to study arbitration is charged with the responsibility of determining whether a system of arbitration, or other mediation procedure, should be established to consider cases involving allegations of medical malpractice and whether such a system would be beneficial in Kansas. The purpose will be to determine what change, if any, will best serve the public interest.

In fulfilling this responsibility, the subcommittee will consider and itemize as findings the advantages and disadvantages of arbitration plans which might be used in Kansas. The subcommittee will also consider the advantages of amending the current Kansas Uniform Arbitration Act (K.S.A. 5-201) to include tort claims involving health-care providers. If arbitration or mediation is found to be necessary, the subcommittee should also consider different types of arbitration or mediation including mandatory, voluntary, binding and non-binding systems including a study of the scope of judicial review of the various types. The findings of the subcommittee will be summarized in a report which will also contain the suggested recommendations of the subcommittee.

The report must contain:

1. A brief summary of the present arbitration procedures available under current Kansas Uniform Arbitration Act.
2. The Kansas evidentiary material considered;
3. The findings at which the subcommittee arrived;
4. The recommendations based upon the findings;
5. The suggested or required means of implementation of the recommendations;
6. Anticipated results of such recommendation.

Subcommittee on Claims Review

Chairperson:

Mr. M. D. Crown, Vice President
The Western Insurance Companies
Fourteen East First Street
Fort Scott, Kansas 66701

Members:

Insurance Representative:

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Mr. Roy C. House, President
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Kansas City, Kansas 66101

General Public Representative:

Mr. Harold Krogh, Professor of B.A.
University of Kansas
307 Summerfield Hall
Lawrence, Kansas 66045

Charges for the Subcommittee to Study Claims Review

The subcommittee to study claims review is charged with the responsibility of determining whether a system of reviewing proposed or prospective claims prior to the filing of a formal legal action (due to the rendering or failure to render medical health-care treatment) should be established. Furthermore, the subcommittee must also consider: the composition and selection of the claims review panel or committee; whether the results of the claims review procedure may or may not be admissable in any subsequent judicial process; whether immunity from suit resulting from claims review decisions should be granted to the members of the committee or panel; and other organizational and operational procedures. The purpose will be to determine what change, if any, will best serve the public interest.

In fulfilling this responsibility, the subcommittee will consider and itemize as findings the advantages and disadvantages of programs of claims review (or other claims review/screening procedures) which might be used in Kansas. The findings of the subcommittee will be summarized in a report which will also contain the suggested recommendations of such subcommittee.

The report must contain:

1. The Kansas evidentiary material considered;
2. The findings at which the subcommittee arrived;
3. The recommendations based upon the findings;
4. The suggested or required means of implementation of the recommendations;
5. Anticipated results of such recommendation.

Subcommittee on Ad Damnum

Chairperson:

John Wilkinson
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(232-0564)

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Insurance Representatives

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111 E. Rutledge
Yates Center, Kansas 66873

General Public Representatives

Travis Glass
P. O. Box 490
Lawrence, Kansas 66044

Charges for the Subcommittee to Study the Ad Damnum Clause

The subcommittee to study the prayer for specified amounts (Ad Damnum) of malpractice suits is charged with the responsibility of determining whether specified amounts of damages being sought in a claimant's petition should be maintained in its present state, limited or modified to a certain extent or eliminated entirely from the claimant's petition in allegations involving medical malpractice. The purpose will be to determine what change, if any, will best serve the public interest.

In fulfilling this responsibility, the subcommittee will consider and itemize as findings the advantages and disadvantages of the present application of the specified amounts claimed as damages in Kansas and recommend any revisions which might be necessary.

The findings of the subcommittee shall be summarized in a report which will also contain the suggested recommendations of the subcommittee.

The report must contain:

1. The Kansas evidentiary material considered;
2. The findings at which the subcommittee arrived;
3. The recommendations based upon the findings;
4. The suggested or required means of implementation of the recommendations;
5. Anticipated results of such recommendation.

Charges for the Subcommittee to Study Contingency Fees

The subcommittee to study contingency fees will be charged with the responsibility of determining whether the attorneys' contingency fees should be limited in cases involving allegations of medical malpractice. The purpose will be to determine what change, if any, will best serve the public interest.

In fulfilling this responsibility, the subcommittee will consider and itemize as findings, advantages and disadvantages of the present system, alternative systems (such as a sliding scale, percentage ceiling, etc.), and suggest necessary revisions, if any, to the present system. The findings of the subcommittee will be summarized in a report which will also contain the suggested recommendations of the subcommittee.

The report must contain:

1. The Kansas evidentiary material considered;
2. The findings at which the subcommittee arrived;
3. The recommendations based upon the findings;
4. The suggested or required means of implementation of the recommendations;
5. Anticipated results of such recommendation.

Subcommittee on

Contingency Fees

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Chairperson:

Mr. Howard C. Kline
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Mr. R. J. Anderson
Publisher
Kansas City Kansan
Kansas City, Kansas 66101

Subcommittee on

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General Public Representative:

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700 Kansas Avenue
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Charges for the Subcommittee to Study Informed Consent

The subcommittee to study informed consent is charged with the responsibility of determining whether or not the doctrine of informed consent as applied in Kansas, should be revised in cases involving allegations of medical malpractice and whether or not the doctrine is subject to abuse. The purpose will be to determine what change, if any, will best serve the public interest.

In fulfilling this responsibility, the subcommittee will consider and itemize as findings the advantages and disadvantages of the present application of the doctrine in Kansas and recommend any revisions which might be necessary. The findings of the subcommittee will be summarized in a report which will also contain the suggested recommendations of the subcommittee.

The report must contain:

1. The Kansas evidentiary material considered;
2. The findings at which the subcommittee arrived;
3. The recommendations based upon the findings;
4. The suggested or required means of implementation of the recommendations;
5. Anticipated results of such recommendation.

Subcommittee on

Statutes of Limitations

Chairperson:

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Insurance Representatives:

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Vice President
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Charges for the Subcommittee to Study the Kansas Statutes of Limitations

The subcommittee to study the existing Kansas statutes of limitations (K.S.A. 60-513 and K.S.A. 60-515) will be charged with the responsibility of determining whether such statutes should be revised to provide for a modified discovery provision in cases involving allegations of medical malpractice. The purpose will be to determine what change, if any, will best serve the public interest.

In fulfilling the responsibility, the subcommittee will consider and itemize as findings the equities or inequities of the existing statutes of limitations and discovery provisions contained in such statutes, alternative recommendations and suggested necessary revisions, if any, to the present statutes. The findings of the subcommittee will be summarized in a report which will also contain the suggested recommendations of the subcommittee.

The report must contain:

1. The Kansas evidentiary material considered;
2. The findings at which the subcommittee arrived;
3. The recommendations based upon the findings;
4. The suggested or required means of implementation of the recommendations;
5. Anticipated results of such recommendation.

Final Report

Claims Review

Summary Outline

Mr. M. D. (Dale) Crown
The Western Insurance Companies
Chairman

This subcommittee's final report, dated August 1, 1975, contained the following recommendations:

1. A claims review panel should be established.

2. The decision of the claims review panel should be admissible.

3. The members of the claims review panel should have complete immunity.

4. The members of the claims review panel should be composed of professional personnel of the same class.

5. The selection of the claims review panel and the action taken by such panel should follow the basic format of the Indiana plan with appropriate changes.

Other recommendations:

1. The decisions of the claims review panel should be governed by the locality rule.

2. The instructions of the court should include the locality rule.

3. A subcommittee should be formed to study the merit of a maximum limit of liability.

4. The decision of the claims review panel, including evidentiary material, should be referred to the arbitration board, if established, and the peer review committee, if established.

The above recommendations are discussed in depth in the context of this subcommittee's final report.

Final Report

Statutes of Limitations

Summary Outline

Mr. Gerald Michaud, Attorney
Chairman

It was indicated in a letter submitted to Commissioner Bell on July 28, 1975, that three views of appropriate action surfaced during the course of this subcommittee's deliberation. The subcommittee voted on its three proposals in the following manner:

1. No change in the existing Kansas law with respect to limitations of actions relating to medical malpractice claims. - One vote.

2. Six years statute of limitations for all medical malpractice cases, with no special provision for discovery or for persons under disability. - One vote.

3. Retain the basic two-year limitation; reduce the extended period under the "discovery" provision so that the total period shall not be more than four years beyond the time of the act; provide for persons under legal disability only to the extent that no cause of action shall be barred prior to the claimant's ninth birthday. - Six votes.

Proposal 3., therefore, is the recommendation of this subcommittee. Also submitted with this subcommittee's final report were letters from the various subcommittee members stating either their agreement or disagreement with the results as depicted above.

Final Report

Informed Consent

Summary Outline

John L. Reese, M.D., Chairman

The following information and recommendations have been presented by this subcommittee:

1. Specifically, this subcommittee addressed themselves to the questions of:

   a. Full disclosure versus reasonable disclosure.

   b. Printed (commercial) informed consent sheet signed by the patient and witnessed.

   c. The "community" standard rule and the recent "reasonable man" standard rule.

2. During the course of this subcommittee's discussions, these findings were evident:

   a. Recent social attitudes and civil rights consciousness carried to its extreme and reinforced by a few state supreme court decisions (namely, California and Rhode Island) have created a situation wherein medical malpractice cases without merit more easily find their way into the courts.

   b. As discussed by the HEW Commission on Malpractice, there is evidence that some courts are beginning to apply the doctrine of informed consent unevenly in order to hold a physician liable when the plaintiff's injury is severe but he lacks sufficient evidence to prove the physician's negligence. It has been further observed that this unevenness has been encouraged where expert medical testimony by the plaintiff has not been required. The subcommittee discussed the influence a good lawyer may have on a jury as opposed to his influence on an expert witness. It was concluded that a proper "checks and balance" system would be best served by requiring expert medical testimony by the plaintiff.

   c. Several examples of printed full disclosure forms were reviewed. The advantages and disadvantages of full disclosure and these printed forms witnessed and signed by the patient were discussed. Assuming full disclosure was possible, it was felt such time loss would not benefit the general public as they already are dissatisfied with long waits for doctors' appointments and the non-availability of doctors.

d. The Insurance Commissioner's figures on malpractice claims in Kansas were reviewed, and it was noted there were 423 claims reported by 75 percent of the insurance carriers in Kansas from 1969 to 1973. From the Legal Research Department of the AMA (Medical Liability Commission), six claims appeared in the Kansas courts having to do with informed consent in approximately this same period. This is an incident of less than 5 percent. The subcommittee noted that 44 states presently have a community standard rule doctrine whereby a physician's duty to inform the patient of the possibility of a specific adverse result for a proposed treatment depends upon the circumstances of the particular case and upon the general practice followed by the medical profession in the locality and the custom of the medical profession to inform must be established by medical expert testimony. The subcommittee noted that in the states where a community rule did not apply, malpractice claims were much more prevalent, and many proved to be without merit.

The Subcommittee on Informed Consent made the following recommendations:

1. The present Kansas doctrine of informed consent as stated below become law. Further revision is not advisable.

   a. A physician has an obligation to make reasonable explanation and disclosure to his patient.

   b. Expert medical testimony is required to establish one or more of the elements necessary to support the claim. Because a full disclosure may have a very detrimental effect on patients, physicians may tailor the extent of their disclosure to paitents.

   c. A physician must disclose that which a reasonable medical practitioner would have disclosed under like or similar circumstances.

   d. The subcommittee felt that true justice would be better served if judges required the jury to supply evidence to support their verdict.

Final Report

Contingency Fees

Summary Outline

Judge Robert T. Stephan

The committee considered a 1970 legislative study for the State of Kansas, a study in 1973 by the Department of Health, Education and Welfare, various articles and editorials and legislation from two other states in regard to contingency fees. In addition, invitations were sent to the Kansas Trial Lawyers Association, the Kansas Defense Lawyers Association and the Kansas Medical Association requesting input insofar as contingency fees are concerned. No invitation was extended to the Kansas Hospital Association because of the fact that one of our members informed us that the Hospital Association had nothing specific in regard to contingency fees.

The consensus of the committee was that there was no hard evidentiary material which would show that the contingency fee system as it exists in Kansas had any effect on the availability of insurance or the cost of insurance. By reason of the fact that there was no direct evidence linking contingency fees in Kansas to any insurance problem, it was the consensus of the committee that no recommendation be made to suggest any change in the contingency fee system.

Final Report

Patient/Health-Care Provider Relationships

Summary Outline

Mr. Henry Meiners, Chairman
Kansas Blue Cross and Blue Shield

In this subcommittee's final report to Commissioner Bell, factors which apparently create problems in patient/health-care provider relationships were discussed. The following list was developed:

1. The high degree of specialization and the number of specialists make it difficult for doctors to establish a healthy doctor-patient relationship.

2. Because hospitals are becoming larger and employing ever-increasing numbers of employees, it is becoming more difficult for hospital employees to treat the patient as an individual personality.

3. In many cases, hospital employees may say things to patients which damage the patient/hospital relationship.

4. Greater sophistication in medical procedures and medical treatments create greater risks for patients.

5. In many cases, the expectations of the patient and the patient's family for complete cure are not realistic when related to the patient's problem.

6. Third party payor involvement in the health-care system sometimes hampers relationships between the patient and the health-care provider.

7. Increasingly larger numbers of people are developing an attitude whereby they demand and expect compensation for inconvenience or for alleged damages where there is no real justification for such claims.

8. In many cases, people seek health-care services in the hospital emergency room or at the doctor's office for minor complaints which do not require professional treatment.

Following are this subcommittee's finalized recommendations:

1. It is recommended that health-care providers and health-care provider organizations develop a patient advocate or patient representative system.

2. It is recommended that the Insurance Commissioner take steps to encourage public education concerning the health-care delivery system directed to the problem of unrealistic expectations on the part of the patient and the patient's family.

3. Health-care providers and health-care associations should develop and organize a system of patient education.

4. Encourage the Kansas University School of Medicine to continue and expand courses to medical students concerning the legal implications of the practice of medicine and the need for patient rapport.

5. Encourage all hospitals to include in their in-service education programs courses concerning the legal implications of health-care delivery and the need for patient rapport.

6. Encourage the Legislature, the University of Kansas School of Medicine and others to develop a program to try to keep more of the KU trained physicians in the state of Kansas to practice medicine.

7. Encourage all third party payors of health care to take steps to improve the knowledge of their policyholders on the above subject. Also encourage third party payors to review their procedures and programs to be sure that they do not take any steps which would damage the patient/health-care provider relationship.

POLICY POSITION OF THE HUMAN RESOURCES TASK FORCE ON MEDICAL MALPRACTICE

Adopted by the

Intergovernmental Relations Committee
National Conference of State Legislatures
Meeting, Washington, D. C.

June 5-6, 1975

The cost of purchasing medical professional liability insurance for hospitals, doctors and other health care providers has risen dramatically just in the past couple of years. In some States, malpractice premiums increased 100 percent between 1973-74, making it not uncommon to find doctors practicing in certain high risk categories paying $10,000 to $15,000 per year for malpractice insurance. The consequences of these exorbitant rates naturally contribute to the rise in the cost of health care, since in most cases the cost of the insurance is simply passed on to the physician's patients. Moreover, States are increasingly threatened with the possibility of insurance companies withdrawing their medical liability coverage from the market altogether. Without some intervention, many physicians would be forced to severely restrict or even curtail their practices. The situation has become even more aggravated of late due to the threat of widespread physician strikes and work slowdowns.

While the problems of medical professional liability coverage are reason enough for alarm, the extraordinary increase recently in the number of malpractice suits filed, plus the enormous court awards rendered, have added weight to the conclusion that the present system of coping with the malpractice issue is no longer satisfactory. For those doctors who are able to obtain coverage, many admit that the tremendous rise in malpractice claims has led to the practice of defensive medicine on their part. And there is no doubt that such defensive practices contribute significantly to the Nation's already inflated health care bill.

In addition to the overall negative impact on the health care system, the problem's effect on patients who are injured is of most concern. Data show there are far more medical injuries than there are claims, although this gap is narrowing rapidly. Some estimates of medical injuries caused by negligence are as high as 600,000 a year. Claims take years, not months, to settle and in the end the patient gets far less than half of all premium dollars paid by providers for medical malpractice insurance.

Because the contributory factors surrounding the current malpractice dilemma are complex and multifaceted, it is clear that significant legislative solutions must be, of necessity, far reaching and extremely comprehensive in scope.

The Intergovernmental Relations Committee commends those States which have already addressed the medical malpractice problem. Comprehensive legislation have been passed in a number of state legislatures, such as, Indiana, New York, Florida, California and Michigan, to meet the current emergency

as well as provide long-range solutions to problems arising out of the crisis. A careful monitoring of these enactments should be undertaken so that other States might benefit from these initial experiences.

The Intergovernmental Relations Committee views the impending crisis related to the cost and availability of medical malpractice insurance, and its potential adverse impact upon the Nation's health care system, with grave concern and offers the following recommendations for both state and federal consideration. These recommendations encompass a set of objectives and principles which the Intergovernmental Relations Committee believes must be addressed by any comprehensive legislative attempt at resolving the malpractice crisis.

The Intergovernmental Relations Committee believes that the States have the fundamental responsibility for resolving the medical malpractice problem. We also believe that the only appropriate role of the federal government in the medical malpractice field lies in the operation of a national clearinghouse for the collection, analysis and dissemination of data. It would be beneficial if health-care providers, consumers, attorneys, and the insurance industry form a consortium to collect and report information relating to medical injuries and medical malpractice to a federal or federally-sponsored data gathering service. Therefore, the Intergovernmental Relations Committee further recommends that the Secretary of HEW convene representatives of these groups (1) to determine the kind of data needed, and (2) through existing data facilities in HEW, to work with private industry to develop the information.

In States where the availability of medical professional liability insurance is becoming an extremely serious problem, consideration should be given to the formulation of a joint underwriting association to provide a temporary market during the interim while long range reforms are being formulated. The JUA should consist of all companies writing personal liability injury insurance in the State and should be the exclusive insurer. The JUA should come into operation only upon the determination of the Insurance Commissioner that coverage cannot be obtained through the voluntary, private market. Consideration should also be given to requiring the financial participation of all health care providers in the JUA.

The Intergovernmental Relations Committee finds that inadequacies in the collection and analysis of appropriate data have precluded the development of sound actuarial practices and rates, and that state insurance departments are generally inadequately equipped to monitor effectively the rate-making process employed in establishing malpractice insurance rates. We recommend, therefore, that the National Association of Insurance Commissioners work with the insurance industry to establish a uniform statistical reporting system for medical malpractice insurance and that data be reported to a single data collection agent who will compile it, validate and make it available to state insurance regulators, carriers and other interested users.

The Intergovernmental Relations Committee urges the States to enact legislation requiring insurance companies to provide at least 90 days notice of intention to cancel or not renew a medical professional liability policy.

The Intergovernmental Relations Committee recognizes that all malpractice claims arise out of injuries or adverse results suffered by patients in the course of medical treatment. These injuries or adverse outcomes may or may not be the result of negligence, improper diagnosis or treatment. In fact, the HEW Commission's Report indicated that most of the alleged injuries were not negligently caused. (In 1970, less than 45% of all closed claims terminated in payment either by way of settlement or verdict). Moreover, almost 75 percent (in 1970) of all malpractice claims resulted from medical injuries sustained by individuals while in hospitals. Hence, the Intergovernmental Relations Committee feels that any remedy which aims only at reducing the incidence of negligent conduct on the part of the physicians will be inadequate from the standpoint of protecting the welfare of all health care consumers. Efforts, therefore, must be made to reduce the total number of medical injuries and adverse results of treatment.

The Intergovernmental Relations Committee recommends that Medical Injury Prevention programs be instituted in every hospital. Such programs should investigate and analyze the frequency and causes of both the general categories and specific types of adverse incidents causing injuries to patients; and they should develop appropriate standards and guidelines to minimize risks of injuries and other adverse medical outcomes. Moreover, consideraion should be given to the establishment of a mechanism capable of dealing with patient grievance problems.

The Intergovernmental Relations Committee recommends that courts adopt appropriate rules regarding the awarding of contingent fee rates in malpractice litigation.

The Intergovernmental Relations Committee recommends that legal assistance mechanisms be established, or expanded where they already exist, to assure adequate legal representation to persons with small malpractice claims.

The Intergovernmental Relations Committee recommends that the States enact legislation eliminating inclusion of dollar amounts in "ad damanum"(damages) clauses in malpractice suits.

The Intergovernmental Relations Committee finds that there is a generally recognized right of a patient to be told about the danger inherent in proposed medical treatment. That right is consistent with the nature of the doctor-patient relationship and with fundamental fairness. Evidence, however, points to the possibility that the doctrine has been subject to some abuse by the courts. The Intergovernmental Relations Committee feels that further examination of the doctrine's place in malpractice litigation is required.

The Intergovernmental Relations Committee believes that patients have a right to the information contained in their medical records and recommends that such information be made more easily accessible to patients. The Intergovernmental Relations Committee further recommends that the States enact legislation enabling

patients to obtain access to the information contained in their medical records themselves or through their legal representatives, public or private, without having to file a suit. Special consideration should be given to problems related to psychiatric records.

The Intergovernmental Relations Committee recognizes that the competence of individual providers of health-care affects the overall quality of care. The Intergovernmental Relations Committee also recognizes that most state medical practice acts do not have adequate provisions for disciplining practitioners who have been found incompetent.

The Intergovernmental Relations Committee therefore recommends that all State medical malpractice acts include specific authority to state licensing bodies to suspend or revoke licenses for professional incompetence, negligence or illness. Furthermore, States should revise their licensure laws, as appropriate, to enable their licensing boards to require periodic re-certification and qualification procedures of physicians, dentists, nurses and other health professionals. Additionally, all state health regulatory boards should include lay members and all disciplinary findings of these boards should be available to the public.

The Intergovernmental Relations Committee also urges States to enact legislation to provide, with due process, the appropriate committee of a hospital staff to suspend, revoke, or curtail the privileges of a physician or hospital staff member for good cause shown. Legislation should also provide committee members and the hospital with qualified immunity from suit for their acts and require that notification of disciplinary actions be forwarded to the appropriate state licensing boards.

States should encourage specialty boards to insure that high risk procedures be performed only by trained and qualified persons.

The Intergovernmental Relations Committee urges States to eliminate the "no collateral source" rule so that an injured party's other insurance benefits can be deducted from malpractice compensation awards.

The Intergovernmental Relations Committee urges States to enact statutes of limitation in order to provide that any legal action for professional negligence commence within a reasonable time period from the date the alleged act occurred or was discovered. In statutes of limitations, States should assure that minors receive special protection.

The Intergovernmental Relations Committee recognizes the value of local efforts to mediate medical malpractice disputes, and therefore recommends continuous experimentation with voluntary mediation devices. The Intergovernmental Relations Committee also recommends that persons in addition to attorneys and members of the profession involved in the disputes be included as members of any mediation board or panel.

The Intergovernmental Relations Committee recommends consideration of arbitration as an alternative mode for resolving medical malpractice disputes. The Intergovernmental Relations Committee recommends that all States should adopt legislation to make binding arbitration awards possible.

The Intergovernmental Relations Committee recommends that the States enact legislation to provide qualified immunity to hospitals and members of properly trained hospital rescue teams acting within the scope of their competence while they are attempting to resuscitate any person who is in immediate danger of loss of life, provided good faith is exercised.

The Intergovernmental Relations Committee recommends that the States enact legislation designed to provide qualified immunity to physicians and other health-care personnel who respond to emergencies arising from unexpected complications that arise in the course of medical treatment rendered by other physicians or other health-care personnel.

The Intergovernmental Relations Committee recommends that States require insurers issuing medical malpractice policies to disclose loss prevention and claims settlement practices on request by purchasers in any sales promotional material distributed to prospective purchasers.

Finally, the Intergovernmental Relations Committee calls upon the medical profession to help improve the quality of health care through the elimination of unnecessary medical procedures, such as, unrequired surgery and overprescription of drugs.

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