Approved 4/12/85
Date

MINUTES OF THE House COMMITTEE ON Judiciary.

The meeting was called to order by Representative Joe Knopp at
Chairperson

3:30 ~~xxx~~a.m./p.m. on March 27, 1985 in room 526-S of the Capitol.

All members were present except:

Representative Duncan was excused.

Committee staff present:
Jerry Donaldson, Legislative Research Department
Mike Heim, Legislative Research Department
Mary Ann Torrence, Revisor of Statutes Office
Mary Hack, Revisor of Statutes Office
Becca Conrad, Secretary
Conferees appearing before the committee:

Ron Smith, Kansas Bar Association
Ralph Skoog, Chairman of the Amendment to Laws Committee of the Topeka Bar Association
Craig Grant, Kansas National Education Association
Kathleen Sebelius, Kansas Trial Lawyers Association
Carol McGuire, Malpractice Victims Coalition of Kansas
Stanley Plesser, Malpractice Victims Coalition
Bobbi Steinbacher, Malpractice Victims Coalition
Lynn Johnson, Kansas Trial Lawyers Association Malpractice Task Force

SB 110 - Concerning medical malpractice liability action; relating to procedures for assessment of exemplary or punitive damages and consideration of collateral sources of indemnification in certain actions.

Ron Smith, Kansas Bar Association, said they felt this bill should go to an interim committee. See Attachment No. 1.

There was discussion on the Collateral Source Rule.

Ralph Skoog, Chairman of the Amendment to Laws Committee of the Topeka Bar Association, said that SB 110 should not be enacted as shown in Attachment No. 2.

The cap on wrongful death and the conditions under which punitive damages could be allowed were discussed.

Craig Grant, Kansas National Education Association, said because their organization represents approximately 20,000 teachers in Kansas, they believe SB 110 could greatly effect their teachers who are consumers of health services in the state. He said two of their KNEA members were appointed to the Citizens Committee which is studying the entire subject of medical malpratice liability. They recommend that action be deferred on SB 110 to a time when that Citizens Committee has had a chance to function and make a report to the Insurance Commissioner and to the state. They asked that SB 110 be reported unfavorably or to at least table the bill until that time when the task force has reported.

Kathleen Sebelius, Kansas Trial Lawyers Association, recommeded that SB 110 be sent to an interim committee for further study. See Attachment No. 3. Her testimony also referred to pages in Attachment No. 4.

Carol McGuire, a member of the Malpractice Victims Coalition of Kansas, spoke against this bill as shown in Attachment No. 5.

Stanley Plesser, a member of the Malpractice Victims Coalition, spoke in opposition to this bill. He had a 16 year old son who died and he said that he did not believe it possible to legislate the limit on the suffering a family endures. He said they lost their son four years ago and it has taken him up until last summer to feel strength again to want to do something valuable. He also lost his business after his son's death. He said the jury system works and should not be tampered with. He also does not believe that this bill would long-range stabilize insurance costs and that passing this bill would give better medical care. He thought energies should be directed towards making sure that the Medical Society police itself properly.

Bobbi Steinbacher, member of Malpractice Victims Coalition, also spoke in opposition to this bill. She has a daughter who is severely disabled as a result of medical malpractice. She said that no one from the insurance industry has told them that if SB 110 is passed that they will reduce the doctors' malpractice insurance. She said the Medical Society needs to "weed out" the repeat offenders. She distributed a list of the Charter Members of the Kansas Victims Malpractice Coalition, Attachment No. 6.

Lynn Johnson, Kansas Trial Lawyers Association Malpractice Task Force, presented proposals as shown in Attachment No. 7. He said they are ready to work with Victims Coalition and the Kansas Medical Society to try to assure good quality medical care in the State of Kansas, good results from that good quality of medical care, and adequate compensation for the victims. He said they will also work with the Board of Healing Arts and with the Kansas Medical Society to offer their services to trial lawyers on a pro bono basis to make sure that the small percent of offenders are not costing the other physicians too much in the way of medical malpractice.

Mr. Johnson also said that if the cost of insurance really is a concern to those in rural areas who are providing services that are necessary in those areas, they are willing to work on a pro bono basis with the Kansas Medical Society to address those issues through any number of ways. He said in one state there are a group of doctors who hired an attorney and they are suing the insurance commissioner to get to the bottom of why the rates are so high. They would also ask the legislature to set up a special committee with power of subpoena and they will act as Kansas Medical Society's attorneys. They will get to the bottom of why insurance premiums are so high.

He said SB 110 does not address any of these isuses and he reviewed the proposals on Attachment No. 7.

Members of the committee and conferees discussed the subjects of punitive damages, the low percentage of actual recoveries from law suits for malpractice and the subjection of doctors who were not negligent, the advertising on television of attorneys for malpractice cases, why screening provisions of the statute on malpractice cases does not work, claims filed against the fund, and the difference in awards granted for automobile accident cases and medical malpractice or products liability cases.

The Chairman announced that three judges would testify on SB 110 and final action would be taken tomorrow.

He also announced that the committee is scheduled to meet tomorrow noon to take action on previously heard bills (not including SB 110).

The meeting adjourned at 5:45 p.m.

RON SMITH
Legislative Counsel

KANSAS BAR ASSOCIATION

Sub. for SB 110
House Judiciary Committee
March 27, 1985

Mr. Chairman. Members of the committee. My name is Ron Smith. I am Legislative Counsel for the Kansas Bar Association.

The Kansas Bar Association represents 4,200 of the state's 5,800 attorneys. Our attorney-members are in every county, practice all types of law, represent both plaintiffs and defendants. Their common bond is they want a good legal system within which to help Kansans with their legal problems.

Our legislative policies are made by our Executive Council. The Council consists of 21 lawyers from across the state. Ten members are elected by geographic districts. Our Executive Council includes members of the Judiciary.

I have some general remarks and specific ones pertaining to the provisions of Sub. for SB 110.

KBA is actively involved in seeking meaningful solutions to medical malpractice premium problems. But solutions, to be fair, must be far-reaching. They will be interrelated. This is why we think the proper course is interim study.

It was a little tense yesterday. The stakes are very high, and very important. This is a tough issue. To say that I can speak with one voice for all the various interests and opinions which fall within the Kansas Bar Association on this issue would be presumptuous. I will try to be as objective as I can about this bill.

What if you were going to play a basketball game where you knew in advance the rules had been changed to benefit only one team? Or one player on that team? Many people confronted with that fact would refuse to play the game.

I think this is true in the practice of law -- and our tort law system -- regardless of whether you are a plaintiff's or a defense lawyer, regardless whether you are a plaintiff or defendant. The rules are very important because we aren't involved in a game! The overall way those rules are made determines whether our court system is fair to individuals who come to those courts

Attachment No. 1
House Judiciary
March 27, 1985

for justice.

I know, Mr. Chairman, that you want conferees to discuss provisions of this bill. Other conferees will discuss individual sections in detail. With your permission, the philosophy going into this bill is just as important as the component parts and I'd like to discuss those philosophies.

SB 110 speaks to rule changes. Plain and simple. The legislature has been appointed as rules chairman. And you're going to decide. The most that special interest groups -- Insurance companies, the Kansas Medical Society, KTLA and the Kansas Bar Association--should receive from you is fairness.

I don't think your constituents want legislators to act unless your actions improve the legal system. You don't get extra pay for each bill you pass up here.

I think you should ignore the advances in word processing that accounts for most of the letters you have about this issue.

Your constituents want you to act in their best interests <u>based on facts</u>. They don't have the facts, and in most instances no way to get the facts. You do. You are their representatives. I think they trust you to represent their best interests.

It is difficult to do what is right. There are a lot of competing pressures. Each of you wants to satisfy as many constituents back home as you can. You want to be able to go home and tell your doctor and lawyer constituents that you did something for each of them.

I believe you should do NOTHING FOR EITHER Doctors or lawyers.

This bill should speak to what is best for the legal system, and those constituents who will go before that legal system to have their disputes resolved.

You get to choose the best and most fair medical-legal system available to consumers of legal and medical services. I don't think you should have to worry about choosing sides in a dispute which has been nicely labeled a fight between doctors and lawyers.

I think all of us -- doctors, hospitals, lawyers, patients, judges, insurance companies, the public -- all of us are part of the problem, but we are also part of the solution, too. I don't think you should allow any one group to play off against another.

I'd like to briefly discuss two fundamental concepts that we've not had a chance to discuss because this is the first committee hearings on these issues.

These concepts are the foundation of our court system. They are (1) the tort law system, and (2) the adversary relationship within that system.

There is nothing magic about a court system. Every country has one. They exist to resolve disputes. Nothing more. Nothing less. They do it in widely different ways. The Soviet Union has a civil litigation system. They resolve disputes. I don't think you'd like it.

Oliver Wendell Holmes, in his thesis "The Common Law" said that tort law has two purposes: deterrence and compensation. What advocates of tort reform really ask you is to diminish the dual role of tort law from deterrence and compensation to the singular role of compensation alone. Tort law was not devised to do that--and that is not a weakness of the system.

In the law, the fundamental concept is that each person is responsible for his own actions and each person has a right to his day in court.

Tort law has developed literally over hundreds of years. The principles of law and medicine which we see today are the survivors of many other principles that have fallen by the wayside. Both are trial and error systems. Barney Clark died with the world's first artificial heart; William Schroeder lives on. Trial and error. Separate but Equal schools for black and white children was the law of the land from the Civil War until 1954. We changed that law because society changes.

If you look back in time, we used to resolve legal disputes and cure the sick using crude methods. We used to boil people's arms in oil, and if they healed without infection they were telling the truth and therefore not guilty. Doctors used to treat infections by bleeding people with leeches.

Kansas Medical Society would have you believe that the legal system still boils arms while modern medicine uses microsurgery and cat-scanners, and therefore the legal system is at fault with everything that is wrong with the medical-legal dispute resolution system.

I suggest that the tort law and medicine have both progressed together, and have come a long way the last 200 years. Trial and error.

Tort law and the adversarial system must allow the weak the same standing and importance as the powerful.

Tort law and the adversarial system is not a mechanism for liability insurors to transfer part of their potential liability onto medical insurance. Professor Concannon told you the abolition of the collateral source rule does that unless structured properly.

Tort law and the adversarial system is not a mechanism for plaintiffs to chase deep pockets on the theory that if you chase someone long enough you'll catch them.

Tort law and the adversarial system should not be available only for those people and corporations seeking special protection or privileges if the privileges they seek is not available to the public at large.

Tort law and the adversarial system provide remedies for wrongs. Nothing more. Nothing less.

KBA sincerely believes that the development of American tort law and the related adversary system is the best dispute resolution system ever devised. This does not mean the system is perfect or that it can't be improved. But if you look at other systems, ours is superior. That is why the Kansas Bar Association has a deep concern for what you are doing here with this bill, and the manner in which you are acting.

Let me speak to some specifics of yesterday's testimony and this legislation.

I.

I hope no one believes this law will positively affect malpractice premiums. That is not the purpose of this bill.

II.

Sub. for SB 110 regulates only the medical malpractice verdict. It does not apply to settlements or spurious lawsuits. You are regulating the verdict in cases where the jury finds negligence.

You heard yesterday that some malpractice actions are filed with punitive damage counts solely for the purpose of scaring a doctor into a forced settlement. Assume that is correct. Where in this bill do we solve that problem?

Jerry's remarks indicate better than my own why all these

problems should go to a summer interim study. Interim study is not for purposes of delay. Interim study is designed to help legislators discover all the facts before you legislate complex matters.

III.

Two days ago Professor Concannon described the collateral source rule. He also described potential problems that you must speak to. In order to be fair, you must make a jury an expert on liens and subrogation as well as medical malpractice. Most doctors believe juries are incapable of handling complex issues of medicial treatment.

We believe to the extent you allow our system to confuse a jury, no party gets justice. I think it is more appropriate for you to consider whether the judge ought to apply the same principles of review on a post-trial motion that this bill currently assigns to a jury.

IV.

Limiting the collateral source rule has a peculiar effect when used to offset medical malpractice awards. The physician whose negligent treatment causes the injury may have his bill for that negligent treatment paid by the patient's Blue Cross. Then when the physician is sued, the doctor also gets to deduct the amounts paid Blue Cross -- from his damages.

We create a Hobson's Choice: The more a physician charges a patient for negligent medical treatment, the more their own damages for that negligence are relieved.

Under section 2(b) of this act, the jury will not be informed about this double dip.

V.

You'll recall yesterday, Jerry Slaughter passed out suggested amendments regarding punitive damages. Note the definition. What they've done is codify the Patterned Instructions for Kansas in 3 of the 4 instructions judges use to help juries define conduct that might result in punitive damages: gross negligence, fraud or malice. What they leave out is "wanton conduct." The "wanton conduct" definition states:

> "Wanton conduct" means an act performed with a realization of the imminence of danger to another, and a reckless disregard or complete indifference to the

probable consequences of the act.

If we're going to codify PIK, let's codify all of it.

VI.

The Kansas Medical Society quoted some statistics from the Rand Corporation that collateral source rules and caps on awards will bring 20 to 50% reductions in severity and numbers of lawsuits. From this study, they are convinced SB 110 it will stabilize premiums.

That publication is called "The Frequency and Severity of Medical Malpractice Claims," by Patricia M. Danzon of Duke University. It was written in 1982. Let me quote from the executive summary:

> "Of the post-1975 tort reforms, caps on awards and mandatory offset of collateral compensation appear to have had the greatest effects (on limiting malpractice awards). States enacting a cap are ESTIMATED to have had 19 percent lower average severity within two years. Mandatory collateral source offset in effect for two years is estimated to result in a fifty percent reduction in severity."

That sounded like what Jerry said. Now let's quote the very next sentence that was not mentioned yesterday:

> "However, these ESTIMATES, based on claims closed in calendar years 1975-78, cannot measure the full, long-run effects on claim costs on a policy-year basis and may be influenced by other factors occurring at that time, which could not be included in the analysis."

From another paragraph, same page:

> "Diversity and growth in claim frequency are partly the result of changes in medical services and would therefore not be fully eliminated even if legal environments were uniform. An increase of 100 doctors per 100,000 population is associated with an increase of 3.6 claims per 100,000 population. The density of lawyers per capita does NOT signficantly affect claim frequency, after we control for physician density per capita and urbanization."

I'll not comment further on these magnificent Rand Corporation statistics.

VII.

Rep. Solbach briefly touched yesterday on the history of SB 507, enacted last year. That bill was requested and supported by the medical community. It doubled the basic medical malpractice coverage from $100,000 to $200,000. I think you can assume that doubling the coverage would cause virtually double the base premium.

507 increased the surcharge the commissioner levied to make the Health Care Stabilization Fund solvent. Insurance Commissioner Bell promised the Ways & Means committees last year that he was going to make that fund actuarily sound. That was a promise for higher surcharges.

In their testimony last year, the Medical Society said SB 507 would make big strides towards eliminating the problems that were producing high medical malpractice insurance premiums.

SB 507 was effective July 1, 1984. Less than two months after the effective date of this act, the Medical Society begins thumping the tub for the concepts you see in front of you right now. They called for tort reform BEFORE the $15 million case was handed down in Johnson County in October.

How much of your doctor's anguish comes from SB 507's provisions? I don't know. What if it is 90% of the increase? Are you going to limit the awards of the most severely injured plaintiffs in medical actions because of the increase that doctors brought on themselves? Without knowing the answer to that question?

VIII.

Tomorrow you'll hear from judges who've presided over several large malpractice cases. Ask them to describe the powers that a district judge has to lower or increase awards after the jury verdict. If they didn't use those powers, ask them if they thought the verdict was justified. I think you will learn a lot from their answers.

IX.

This brings us to Indiana. The Medical Society indicated physician-owned companies in Indiana were indicating no increase in premiums. I'll not dispute that fact. I do want to bring to your attention some other facts and let you

draw your own conclusion.

Indiana's malpractice laws were passed in 1976 and have withstood court challenges. They have a $15 million fund similar to the Kansas Health Care Stabilization Fund--with surcharges on premiums. They have a $500,000 total limit on awards, and require a $100,000 base commercial policy. The amount of the yearly surcharge on premiums is set by the Indiana legislature, not their insurance commissioner. They regulate attorneys fees, too.

The 1984 Indiana Health Care Fund, which had $15 million in it, paid out $17 million in claims in 1984 -- even with all these those elaborate laws. That fund is broke!

The Kansas Medical Society's figures indicate the <u>average</u> premium for physicians in high-risk specialities in Indiana is $8,000 while in Kansas the same physicians pay an average of $20,000. You must put that on an apples to apples comparison, however. I assume both figures include average surcharges.

The Indiana insurance commissioner's counsel told me several weeks ago that in Indiana, $8,000 purchases only $500,000 in coverage. That is a cost of $16 per thousand dollars of coverage. In Kansas, $20,000 buys the same type of physician $3.2 million in coverage. That is a cost of $6.67 per thousand.

What is the significance of those cost per thousand figures? I don't know. But I cannot reconcile why a state with strict controls on medical malpractice awards require insurance costs more per thousand to cover the same type of doctors than does Kansas. Kansas has no statutory limits.

All you can draw from the Indiana experience is that it raises serious doubts that artificial cost controls work.

X.

Jerry said yesterday that "The Board of Healing Arts now has the tools to get negligent physicians out of business." We agree. Then we don't need this bill. Let me give you some hard statistics to back up Jerry's remarks. From a 1981 Rand Corporation Note by John Rolph, he reports on a study on 8,000 Los Angeles area doctors, of all specialities. They covered a four-year closed claims study and found that 46 of the 8,000 doctors had four or more claims against them. Less than 1/2 of 1 percent of the physicians accounted for 10% of the lawsuits and 30% of the claims paid.

Obviously, if those 46 weren't practicing, perhaps 30% of the L.A. premium could be affected.

I suspect the same is true in Kansas, that a small group of physicians cause a disproportionate number of repeat incidences of negligence.

XI.

Jerry Slaughter mentioned that the legislature must get medical negligence injury compensation out of the adversarial tort law system and into a better system of compensation.

You have to listen for the catch words. "Too much money is going to plaintiff attorneys and not enough going to the injuried patient."

I cannot disagree more!

If I am a rural physician paying very high medical malpractice premiums and I've never been sued, and I don't commit malpractice, then I don't want any of my liability insurance premiums going to plaintiffs. I want that insurance company and that defense lawyer in there fighting for me! I don't want 27 cents going to the plaintiff. I want all of that premium to go to successfully defend physicians from malpractice claims.

The medical malpractice insurance system is not -- I repeat, <u>not</u> -- designed to deliver benefits. We're not talking about a system like Blue Cross where they take in premiums, deduct small administrative charges and shell out benefits. We're talking about a legal liability protection system, where the insurance company has considerable administrative costs and duties. They have an absolute obligation to investigate claims, determine which are meritorious, and evaluate those where there is an obligation to defend clients.

The goal of the Medical Society should be zero going to the plaintiff, not 100%. When payouts to plaintiffs reaches zero, that will mean less evidence of malpractice exist.

<u>That</u> will lower the malpractice premiums. Don't let your constituents get confused on that point.

XII.

Mr. Chairman, I'll cover the cap on pain and suffering quickly. Artificial caps on awards constitute artificial justice. Artificial justice is not, never has been, and never should be the goal of American courts. We have an individualized system of justice where everyone has a right to their day in court. We should not treat people like cattle.

Section 3 says to the jury, "The legislature doesn't trust you to make decisions. Legislators are going to decide the value of human misery. Even though the jury hears all the evidence, we have all the answers."

Conclusion

I'll close with our famous notation with which lay persons love to strike out at lawyers. The quote is from Shakespeare's Dick the Butcher who says, "First thing we do, is kill all the lawyers."

This bill is the tender beginnings of the fond hopes of many who want to get out of the adversarial tort law system. It is the Dick the Butcher approach to justice.

If you read that play, however, you'll find that Dick the Butcher was a member of a group of terrorists bent on overthrowing the government. In order to do that they had to kill all those who could read or write. They accused the King of corrupting the youth by organizing grammar schools. Literacy, knowledge and people armed with facts were the enemy.

People don't like the facts getting in the way of their pre-conceived notions.

I don't think those of us in the legal profession realistically believe that we're going to be popular with people like Dick the Butcher. Lawyers have a habit of coming down on both sides of the issue all the time. Unlike those who practice medicine, there are few miracles in the practice of law. Unlike Medicine, where most people win, some litigants lose cases.

But KBA sees a tort-law, adversarial system which works and is worth preserving. We have to preserve that system unless better ideas come along.

If change is to come lawyer's don't fear it so long as change is rational and justified. Such justification comes only after considerable discussion. Most of all, tort law change must come only if it is shown to be in the public

interest.

In our opinion, SB 110 has yet to meet those standards.

Testimony on behalf of The Topeka Bar Association
Before Kansas House Judiciary Committee
Regarding Sub. S.B. 110

3:30 P.M. Wednesday, March 27, 1985

Mr. Chairman, Members of the Committee, I am Ralph Skoog, Chairman of the Amendment to Laws Committee of The Topeka Bar Association and as such, have been specifically requested by the unanimous vote of the Topeka Bar Association to appear before this Committee in support of the position of the Kansas Bar Association and in opposition to the fundamental thrust and provisions of Substitute Senate Bill 110.

The Topeka Bar Association is a professional association of lawyers admitted to practice law in Kansas living or practicing in Topeka, Shawnee County, Kansas. The Association has in excess of 500 regular members.

The proposed Bill is seriously flawed in both concept and specific provisions.

In the first place there has been no showing that there should be any justification in the Legislature specifically determining that citizens of Kansas injured by reason of negligence of physicians or other health care providers should not be fully compensated for the injuries which they suffer. Our whole fundamental system of freedom and justice is founded in the concept that citizens should be responsible for the consequences of their acts. While there are some exceptions, there has been no showing that this Bill is in any way appropriate legislative response to the claimed problem of injury by way of medical negligence.

The provisions of Section 1. regarding punitive damages have not been shown to be either necessary or justified in relation to any case or cases which have been determined by the Courts of this State.

In regard to Section 2., the proposals with regard to the collateral source rule are obviously much broader than the Legislature intends. The Legislature can't intend that life insurance proceeds paid to a widow or children should benefit a wrongdoer by reducing his obligation for the injury which she suffered. Likewise, with reference to Social Security Disability, which may or may not be authorized or be granted or continued. The suggestion of the Bill that liens or subrogation rights should be submitted for a jury to try to ferret out in determining what the value of the damages sustained to the injured party is, is completely without any justification. The concept of having whatever benefits and provisions that an injured person has paid for on their own inurred to the benefit of a wrong-

Attachment No. 2
House Judiciary
March 27, 1985

doer, is clearly not a subject that this Committee or this Legislature is sufficiently acquainted with to determine as a matter of public policy at this time.

Section 3., is an affront to the entire justice system. The provision suggesting that no person, no matter how long they live in what sort of maimed condition, cannot have been reasonably damaged in an amount in excess of $250,000.00 defies both reason and logic.

Section 4., provides for the issue of the tax laws being an additional matter which would be for the jury to decide. If it is to be instructed upon, then it necessarily is a subject upon which evidence should be provided and the idea that each jury trial would include a tax expert's evidence as to the many ways in which the tax codes, as they change, do or might in the future apply, is completely unwarranted.

For the above reasons and the many others provided by testimony to this Committee, The Topeka Bar Association respectfully submits that Substitute Senate Bill 110 should not be enacted.

Respectfully submitted,

Ralph E. Skoog, Chairman
Amendment to Laws Committee
The Topeka Bar Association

TESTIMONY
IN OPPOSITION TO

SUBSTITUTE S.B. 110

ON
MEDICAL MALPRACTICE

Kathleen Gilligan Sebelius
Executive Director
Kansas Trial Lawyers Association
March 27, 1985

Attachment No. 3
House Judiciary
March 27, 1985

Substitute for S.B. 110, introduced by the Senate Judiciary Committee, at the request of the Kansas Medical Society, represents a dramatic departure from the current system of tort litigation. The Kansas Legislature is being asked to intervene in the legal system, to change the rules which have governed the trial of law suits and to impose arbitrary limits and restrictions on the rights of the victims of malpractice. Before agreeing to act on parts of this radical legislation, it is crucial to examine the current situation, to determine whether or not a problem exists and then to design a solution specific to the problem. It is essential to ask at every step, who will be hurt by a change in the current status and who stands to benefit.

Malpractice is not a term invented by attorneys or judges, but it identifies negligence on the part of health care providers. There are men, women and children across this state and country who, through no fault of their own, will suffer permanent damage as a result of medical negligence.

While there are numerous instances in which a doctor used good judgment and was unsuccessful, or a birth defect resulted from a genetic accident or act of God, there are too many examples of serious injury caused to healthy people by careless and negligent performance.

The contingency fee system, while frequently criticized, provides an economic disincentive to pursue questionable

cases. Current data shows that only approximately 25% of malpractice claims result in any payment to the plaintiff, so lawyers do not collect any fees in 75% of all malpractice cases. Lawyers decline 4 of every 5 cases due to questionable liability, no finding of negligence or limited damages.

There are relatively few attorneys who concentrate on representing victims in cases. Malpractice law is extraordinarily costly and difficult, and requires intense study. A lawyer must prove that a doctor departed from the ordinary standard of care in a like or similar community. And that proof is only provided by another doctor who is willing to say that a peer did not meet the recognized standard of care.

During the mid-70's, the last wave of medical malpractice crisis, insurance companies declared that they would no longer write malpractice legislation. Doctors throughout the country were in a panic. In some states there were strikes and walk-outs. Legislatures in some areas responded with massive restrictions of victims' rights, similar to provisions in S.B. 110. Other states, like Kansas, developed legislation to solve the "crisis of availability".

The Health Care Stabilization Fund was created as a special state-operated company to write insurance for Kansas health care providers and to insulate Kansans from the national experience.

Before delving further into the insurance situation, it should be recognized that one decade later the crisis is different. No one testified yesterday that liability insurance was not available. It is available in Kansas. The crisis you are being asked to address is affordability. Is the cost of liability insurance too expensive? What are those costs paying for? Are there ways of lowering those costs?

The most amazing feature of the testimony heard yesterday was what was missing. There was no data about gross income of doctors in Kansas compared to malpractice premiums. There was no evidence introduced about what doctors are paying in Kansas, or how many doctors in each specialty area pay what fee.

While the Kansas Medical Society may say that this data is irrelevant, we would disagree. The liability insurance field has gone haywire and every group which carries coverage has been charged enormous increases. My husband is an attorney with one of the largest firms in Topeka. Their malpractice insurance will be raised 450% next year. Similar erratic increases have been charged to CPA's, architects, engineers and others; and yet, the doctors are asking for special legislation to address their situation. Is it justified?

At the outset the question must be asked: "Does malpractice exist in the medical community?" And the answer is a resounding and unfortunate yes.

Every national study, including the Rand Corporation Study, major closed claims studies in Florida and California, and even studies by the American Medical Association indicate that even though malpractice claims are rising, only a small fraction of the incidents result in a claim.

While there were 435,000 hospital admissions and 39,400 live births in 1983, only 156 malpractice claims were filed. Malpractice suits represent a small percentage of civil case filings: 156 of 84,756 in FY83 or .18%.

But, the alarming data that has been revealed when examining the statistics is that Kansas doctors have not done a good job at peer review. Kansas Medical Soceity testimony in the Senate showed that 64% of the doctors in Kansas have never been sued and another 24% have been sued only once. Those figures comprise 88% of the doctors in the state.

In reviewing 693 case petitions from the Insurance Commissioner, we found that 31 doctors were responsible for 16% of the malpractice claims. It is estimated that this same group may be responsible for 40-50% of the total awards paid to victims in Kansas. Consequently, less than 1% of Kansas doctors are responsible for a bulk of the claims and rising costs.

Last year the Legislature passed a section in Senate Bill 507 which sealed medical peer review records, one of the few candid records of medical evaluation. This was at the insistance of the Medical Societv. The sealed records combined with

the confidentiality of some large settlements and awards by the Insurance Commissioner's office, further retard efforts to identify and discipline negligent doctors.

The medical malpractice system is designed to perform two functions: the deterrence of medical negligence and the compensation of victims. The liability rule transfers from the patient to the physician the expected costs of injury which the patient would be willing to pay to prevent.

Patricia Danzon, an economist formerly with the Rand Corporation, now with Duke University, has done most extensive work in the country studying this issue. In recent testimony to Congress she stated:

> "The most extreme criticisms of the malpractice system are unfounded. Far from being excessive, the number of claims falls short of the number of incidents of malpractice. This disposition process is far from random. Court awards are strongly influenced by the economic loss of the plaintiff."

Then if indeed malpractice exists, and if the victims have a right to be compensated, are the costs too high?

In Kansas and nationally, malpractice premiums comprise less than 1% of the total health care dollar. (See Insurance Data handout). According to the American Medical Association this 1% ratio has been in place since 1968. This means that even if this entire area of law was abolished and no health care provider ever had to purchase insurance, and returned every dollar to the citizens of Kansas, their health care bill would be reduced by less than 1%.

The term "defensive medicine" has now replaced the discussion about rising health care costs due to malpractice. We would heartily concur with the conclusions of the medical profession on this topic.

The American Medical Association 1984 "Study of Professional Liability Problems" said the following about defensive medicine:

> "If in fact 30% of health care costs are attributable to 'defensive medicine', the Committee on Professional Liability would point out that it would be a gross exaggeration to conclude that all of these costs are wasteful. The best defensive medicine, of course, is simply good medical practice and medical care which is defensible! If 'defensive medicine' means that good medicine is being practiced so that the physician can defend himself successfully if a bad result occurs, then the public would be in favor of 'defensive medicine'. Claims experience would show, however, that all of the diagnostic tests in the world are insufficient to provide a successful defense for an unskilled or unthinking physician. Also, the vast majority of diagnostic testing that might be classified as 'defensive medicine' by hindsight proves to be clinically appropriate in the patient's interests and in the defense of claims."

Are individual doctors paying too much for insurance? According to data which we have compiled, Kansas doctors will pay approximately 4% of their "after expenses, before taxes income" in malpractice insurance in 1985. In 1979, Kansas doctors paid approximately 4% of income for liability insurance. Is this a major crisis?

The aggregate figures tend to hide some of the specific dilemmas referred to in yesterday's testimony: the plight of

the rural doctor in Kansas, the high premiums paid by high risk specialist, particularly those doctors who deliver babies.

What have these premium dollars been used for? Why have the costs risen so dramatically?

In the October 1984 Report on the Health Care Stabilization Fund, prepared by Insurance Commissioner Fletcher Bell, the Legislature was given some cumulative data. From July 1, 1976 through December 31, 1983, the Fund collected $14.5 million from health care providers in Kansas. Of that amount $11 million or 76% was paid to claimants and $2.8 million went to defense and administration expenses.

Victims used their awards and settlements to pay bills. Some money went to the lawyers who helped to fight for the compensation dollars; other money was returned to the health community to pay medical bills. The vast majority of claims in Kansas are small; since 1976, 77% were settled for less than $10,000. There have been only 8 awards or settlements over $1,000,000 since the inception of the Fund.

If there are relatively few claims, and, according to Kansas Medical Society statistics, the vast majority of Kansas doctors have never been sued or sued only once, and most claims are relatively small, why have the insurance premiums risen so dramatically? We must look to the insurance industry and ask for some accountability. While the testimony from the Kansas Medical Society and one insurance representative alleged that

the trial lawyers will discuss insurance as a delay or smoke-screen, it is difficult to know how in good conscience you can address the problem of rising malpractice insurance premiums without looking at data from the insurance industry.

Again, it is striking that no one who is involved in malpractice insurance in Kansas appreared before the House Judiciary Committee or appeared in the Senate. There was no representative from St. Paul or Medical Protective, the two major primary carriers in Kansas and the country. Also, you heard no testimony from any representative of the Health Care Stabilization Fund, a special state-operated insurance company for doctors.

We need a brief review of the Kansas medical liability insurance situation. The Legislature created the Health Care Stabilization Fund in 1976, to provide excess coverage over $100,000 to health care providers in Kansas. Doctors were required to purchase $100,000 in primary coverage on the open market. A "surcharge", a percentage of the primary coverage, was set each year and paid into the Fund for excess coverage.

Although malpractice claims were increasing during the early 80's, and major sums of money were being paid to victims, health care providers in Kansas paid no surcharge for 3 years (FY 81, FY 82, FY 83). Indeed the surcharge in 1980 was only 15%. It is not difficult to see that the Fund would be in serious financial difficulty.

It is interesting that none of the proponents of S.B. 110 reminded you that last year the entire medical community and the Insurance Commissioner's Office came to the Legislature to urge the passage of S.B. 507, which was designed to make the Fund actuarially sound, to pay off past debts and to stabilize the medical liability insurance situation. The Kansas Medical Society said in testimony supporting S.B. 507 that "Kansas doctors know that the bill (S.B. 507) would raise premiums 50% to 100%" and while they were not thrilled with the situation, they wholeheartedly endorsed the bill.

S.B. 507 did the following things:

- raised primary coverage for providers from $100,000 to $200,000;
- capped the liability of the Fund at $3,000,000.
- allowed an 80% surcharge on providers.

The actuarial studies indicated that S.B. 507 was essential for the Fund, and predicted that the rates could be lowered as soon as the past debt was paid.

You are being urged to pass major restrictions of victims' rights in S.B. 110 and in a large part the impetus comes not from the legal community, but from the legislation which was written by the insurance and medical industries last year.

Included in your packet is some national insurance data. The source is Bests "Casualty Loss Reserve Development Report", 1975-1983. The front sheet summarizes data from the top 75 companies writing malpractice insurance. As you can see,

investment income is $300 million more than losses paid for those years.

Since less than half the claims are settled with indemnity, or any payment to the plaintiff, it is clear that the incurred losses column, while dramatic, is not very accurate. "Losses paid" is money actually used to settle claims. So nationally, malpractice underwriters have earned $7.3 billion in premiums and $1.7 billion in investment income, and paid out only $1.5 billion in claims.

The next two sheets show the data for Medical Protective and St. Paul, the two major malpractice carriers in Kansas. Again, losses paid are a fraction of the earned premiums. Then why are doctors paying such high rates for insurance?

In reality, malpractice insurance in Kansas has a cap, a specific ceiling. It has since the creation of the Fund. Primary coverage insurers know that their company has a maximum liability of $200,000 per claim. (It was $100,000 until July 1, 1984). Why with such predictable and certain laibility limits are rates continuing to rise?

Yesterday, Homer Cowan told you that society is to blame; that predictability is shot. Since rates are based on past track records, the companies are at a loss for the future, according to Mr. Cowen. While that testimony may be applicable to New Jersey or Texas, it makes no sense in Kansas. The companies writing primary coverage in Kansas (the first $200,000)

have no uncertainty about the liability. It doesn't matter if the case is worth $20 million or $250,000; these companies will only pay $200,000.

The Fund is a separate insurance company with its own unique problem, but Kansas doctors' malpractice rates and surcharge are based on primary coverage.

What has been collected from Kansas doctors in premiums since 1976? What has been paid in claims? This data might give you some insight as to the severity of the problem. Again, no evidence has been given to the Legislature to support the massive rate increases.

It seems totally unfair for Dr. Linda Warren, who you heard yesterday, to pay rates similar to an urban OB/GYN and to have huge increases even though she has never been sued. Nothing in Substitute S.B. 110 addresses her plight.

While the Rand study showed that a mandatory offset of collateral payments will reduce awards, the bill before you does not have those features. In addition, although there is evidence that if you legislate a cap, or deduct other sources of funds, total awards to victims will be lowered, there is no evidence that any cost savings will be passed on to the doctor, much less to the general public. In every state, including those that passed provisions similar to S.B. 110, malpractice premiums have risen every year and health care costs have skyrocketed.

You will hear some testimony from victims, those Kansans who have suffered at the hands of doctors. How many of them will you limit by passing this legislation? Who will you help?

Currently, there are at least 3 other bills dealing with malpractice in the legislature including total immunity for residents of KU Medical Center, removing the Fund from Fletcher Bell's office and placing it under the jurisdiction of the Attorney General, and strengthening the discovery power of the Board of Healing Arts.

These issues and many others need to be carefully and systematically reviewed, because they are interrelated. There will be a major interim study on malpractice and there is an ongoing intensive review being conducted by a 20-member Citizen's Committee called together by Insurance Commissioner Bell.

The four elements of the bill have been mentioned before. At the very least, the collateral soruce rule involves numerous complicated decisions including what money sources to consider, is subrogation more fair than evidence introduction, what effect will the comparative fault statute have? We request that this issue be considered in an interim study. The taxability issue is tied to collateral source.

The arbitrary cap on pain and suffering damages is antithetical to the entire jury system. It presumes that men and women on a jury are incapable of reasonable and careful decisions. Enclosed in your packet is an opinion in McGuire v.

Sifers. On page 373, the court quotes from the Kirk case to say:

> "...Pain and suffering have no known dimensions, mathematical or financial. There is no exact relationship between money and physical or mental injury or suffering, the various factors involved are not capable of proof in dollars and cents. For this very practical reason the only standard for evaluation is such amount as reasonable persons estimate to be fair compensation for the injuries suffered, and the law has entrusted the administration of this criterion to the impartial conscience and judgment of jurors, who may be expected to act reasonably, intelligently and in harmony with the evidence..." (p. 141).
>
> "The times in which we live are highly inflationary, with constantly climbing prices and a continually shrinking dollar. It is against this sort of a background that we must consider the dictates of conscience."

We endorse this concept.

We urge the Legislature to resist hasty or fragmented action and offer our services to work and study this complex area. In addition, we would urge that if any legislation is considered for 1985, it be confined to punitive damages, which is an element of great concern to the medical community. Changes in the collateral source rule and a cap on damages need to be thoughtfully and systematically considered, weighing all of the benefits and the liabilities.

The plea yesterday was to solve the insurance crisis for doctors in Kansas. We urge you to be cautious in restricting the rights of injured citizens unless compelling evidence is introduced to link the provisions of S.B. 110 to the public good. Please allow the Citizens Committee and interim committee to gather facts, to determine whether there is a crisis, and to suggest specific legislation to solve that crisis.

THE AMERICAN MEDICAL ASSOCIATION IS WRONG - THERE IS NO MEDICAL MALPRACTICE INSURANCE CRISIS

Thomas G. Goddard

Public Affairs Department
Association of Trial Lawyers of America

Attachment No. 4
House Judiciary
March 27, 1985

THE AMERICAN MEDICAL ASSOCIATION IS WRONG - THERE IS NO MEDICAL MALPRACTICE INSURANCE CRISIS

Thomas G. Goddard

Public Affairs Department
Association of Trial Lawyers of America

The medical industry is once again raising a hue and cry about a "medical malpractice crisis," just as it did a decade ago. Once again, health care providers are asking state legislatures across the land to enact special interest legislation to protect them from the consequences of their own negligence. Once again, some of the most powerful economic and political forces in America are knocking at the door of opportunity, and, once again, health care consumers undoubtedly will be out-spent in the political battle over their legal rights. And finally, once again, the primary protection citizens have against this medical-insurance-political juggernaut is truth.

Ten years ago, when the medical malpractice insurance industry first cried "wolf," citizens who opposed the proposed radical legal changes had little evidence with which to work. Insurers were not required to report medical malpractice as a separate line of insurance until 1975, far too late to prevent special interest legislation from being passed in every state in the Union during the mid-1970's.

The story is different now. Now we have nearly a decade of experience and information upon which we can base our policy decisions. What is vital is that we, the public, public officials, and the media, take advantage of this experience and take a hard look at the facts. The stakes are too high for us to be fooled again.

THERE IS NO MEDICAL MALPRACTICE INSURANCE CRISIS

What is a "crisis in insurance"? "Crisis" is a very strong word. It cannot mean simply that things are more expensive than they were yesterday. It cannot mean that a corporation is not expanding as fast as it might. It cannot

mean that an individual's income, though very, very high already, could be higher. Yet, proponents of the medical industry's special interest legislation would argue that "crisis" can be defined as all of these, and more.

Unlike the mid-1970's, there is no claim this time of lack of availability of medical malpractice insurance. The AMA's roundtable on medical malpractice makes that clear: "availability doesn't seem to be a problem" (1), "[i]t's not comparable to the mid-'70's crisis in availability. . ." (2).

The claim, then, is that there is a "crisis" because malpractice insurance costs too much, is getting more expensive all the time, and is driving up the cost of health care. Furthermore, the argument goes, fear of malpractice claims is forcing doctors to practice "defensive medicine," defined as health care undertaken primarily in response to fear of litigation. Let's look at the facts.

1. Medical Malpractice Insurance Premiums Are Less Than One-Half Of One Percent Of Health Care Costs

Since 1976, the cost of malpractice insurance has actually been steadily declining as a percentage of total health care costs, until it now, at $1.5 billion in 1983 (3), is less than one-half of one percent of total health care costs ($355.4 billion) (4). Put another way, medical malpractice premiums have actually declined by 45% as a percentage of health care costs. Even the insurance industry's estimates of incurred loss and loss expense payments have remained quite constant at the one-half percent mark ($1.69 billion) (5).

The cost of malpractice insurance is not only low when compared to the cost of health care, it is low in absolute terms: in 1983, the average American spent nearly $1,500 on health care (6); of that, only $6.08, or eleven cents a

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(1) Tim Morse, senior marketing officer, medical services division, The St. Paul Fire & Marine Insurance Companies, from Professional Liability in the '80s, Report 2, American Medical Association Special Task Force on Professional Liability and Insurance (November 1984), p.4.
(2) Douglass M. Phillips, executive vice president, Medical Mutual Insurance Company of North Carolina, id.
(3) A.M.Best's Casualty Loss Reserve Development, 1984.
(4) Gibson, Robert M., et al, "National Health Expenditures, 1983," 6 Health Care Financing Review 1 (Winter 1984).
(5) A.M.Best's, supra, fn (3).
(6) Gibson, supra, fn (4).

week, went to malpractice insurance premiums (7).

2. Medical Malpractice Insurance Companies Are Profitable, Even If They Won't Admit It

Part of the so-called "crisis" in medical insurance is alleged to be the insurance companies' inability to keep far enough ahead of escalating losses to make a profit. In its first report in the highly publicized series of three, the AMA Task Force demonstrates a lack of understanding of how medical malpractice insurers make money. In that report, the Task Force focuses on the insurance industry's "estimate of incurred loss and loss expense payments" as an indicator of profitability of the industry. What it fails to mention is that a particularly important component of profitability of malpractice insurers is investment income. Malpractice insurers pay claims relatively slowly: for the occurrence years 1978-1983, the industry paid an average of only 3.6% of incurred losses by the end of the first year, 9.6% by the end of the second year, and 19.0% by the end of the third year (8). Meanwhile, the assets encumbered by reserves (measured by the difference between what the insurer has paid and the estimate of incurred loss and loss expense payments) earn investment income at a rate in excess of 10% (9). For the six occurrence years from 1978 through 1983, the medical malpractice insurance industry earned approximately $300 million more in investment income on assets encumbered by reserves than it paid to victims ($1.761 billion in investment income (10) as opposed to $1.465 billion in losses paid (11)). When one considers that those companies also earned $7.344 billion in premiums (12), it becomes evident that malpractice insurers are doing better than they would have the public, or the doctors they insure, believe.

In fact, on several occasions, doctors have successfully sued their insurance companies for over-charging or

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(7) From A.M.Best's, supra, fn (3).
(8) A.M.Best's, supra, fn (3).
(9) Report of Findings, Conclusions and Recommendations, Submitted by Dominick L. Gabrielli, Deputy Superintendent of Insurance, In the Matter of: Medical Malpractice Insurance Association Physicians and Surgeons Professional Liability Rate Filings Made April 12, 1983 and June 13,1984 (December 10, 1984), approved and adopted by Order of James P. Corcoran, Superintendent of Insurance, State of New York, January 11, 1985.
(10) "Investment Income Analysis of Medical Malpractice Insurance," Public Affairs Department, Association of Trial Lawyers of America, February 1985.
(11) A.M. Best's, supra, fn (3).
(12) Id.

anti-competitive business practices. The California Supreme Court ordered a rebate to 5,000 California physicians of $9,200 to each - more than four times the average premium paid during the year of the over-charging (13). These claims of malpractice insurance over-charging have not subsided with the passage of time - on February 26, 1985, a group of New York physicians filed suit against the Commissioner of Insurance, challenging a recent order raising malpractice premiums of one company in that state (14).

3. The Average Doctor Pays A Very Small Percent Of Gross Income For Medical Malpractice Insurance

Clearly, the cost of medical malpractice insurance is not a burden on the average citizen, particularly compared with total health care costs. But is that cost a burden on physicians? The answer is, by and large, no. The average American physician spends only 2.9% of his or her gross income (currently estimated at around $200,000) on medical malpractice insurance (15). This is just slightly more than the 2.3% spent on "professional-car upkeep," but, interestingly enough, well over the 1.2% spent on continuing education (16). In fact, an examination of U.S. Census Bureau statistics relating to the growth in the number of physicians in the United States indicates that the average premium per physician actually declined from 1977 to 1981 by 6.5% (17). Obviously, some physicians spend a greater percentage of their gross income than 2.9% on malpractice premiums, but even neurosurgeons, who pay the highest percentage of gross income of any specialty, are spending only 5.8% (18). The very high premiums that are so highly publicized are very rare - 57% of doctors spend less than $5,000 on malpractice premiums, while only 12% spend over $15,000 (19), with these highest premiums being paid by those well-paid surgical specialists whose work constitutes the greatest risk of harm to health care consumers. In short,

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(13) Southern California Physicians Council v. Travelers Insurance Co. See, also, St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 98 S. Ct. 2923 (1978), on the subject of anti-competitive practices of medical malpractice insurers in Rhode Island.

(14) New York Times, February 26, 1985.

(15) Kirchner, Merian, "Is Your Practice Begging For More Money?," Medical Economics 214, 230 (November 12, 1984).

(16) Id. at 231.

(17) From Statistical Abstract of the United States 1984, Bureau of the Census, U.S. Department of Commerce, p.111, and A.M. Best's Casualty Loss Reserve Development, 1978 through 1984.

(18) Id. at 230.

(19) Id. at 229.

as New York trial lawyer Richard Shandell put it recently, a New York City doctor, who pays the highest premiums in the country, pays a smaller percentage of his gross income on liability insurance than does a New York City cab driver (20).

4. "Defensive Medicine" Is Merely Careful Medicine

Advocates of radical restrictions on the rights of health care consumers argue that it is the cost of defensive medicine which bears the true price tag of the so-called medical malpractice insurance "crisis." The first question that must be answered is, "what is defensive medicine?" There is no consensus on the answer to that question. As it was once put, ". . . what might appear to be defensive medical practice to one clinician may, to another, be quality medical care." (21) One report has concluded that, while increased electronic fetal monitoring and caesarian sections probably were caused by the growing number of suits around fetal injuries, those procedures did increase the survival of newborn babies (22). As it was put recently by a representative of the American Medical Association before a Kansas Citizens' Task Force on Medical Malpractice, defensive medicine is too nebulous a concept to serve as the basis of tort restrictive legislation.

It should also be noted that defensive medicine can not only cost money, but can also save money. It is a common characteristic of first-party health insurance plans to require a second opinion as a prerequisite to full compensation for a surgical procedure. Both the uncertainty of definition and the uncertainty of economic impact of defensive medicine call into question the medical industry's claims.

One of the distressing things about the medical industry's claims that the threat of litigation forces health care providers to provide unnecessary treatment is that it is a violation of the medical profession's own ethical code to "provide or prescribe unnecessary services" (23). Surely physicians cannot expect the public to believe that this decidedly minuscule economic burden of medical malpractice insurance would lead a significant number of physicians to violate such a clear ethical mandate.

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(20) Shandell, Richard, Letter to the Editor of the Wall Street Journal, October 6, 1983.
(21) Tancredi and Barondess, "The Problem of Defensive Medicine, 200 Science 879 (May 1978).
(22) Id. at 882.
(23) Section 2.12, Current Opinion of the Judicial Council of the American Medical Association.

Even if one could define defensive medicine so as to distinguish careful practice from unnecessary surgery, and second, if one were to accept as true the American Medical Association's top estimate of the so-called "cost of defensive medicine," that cost works out to be $1.19 per week for the average American. Where is the crisis?

In short, to the extent "defensive medicine" constitutes improved health care (sponge counts, fetal monitoring), it must not be discouraged. To the extent it constitutes unnecessary treatment, it is unmistakeably unethical, and cannot be excused by claims that the burden of malpractice insurance (remember, that's 0.42% of health costs and 2.9% of physicians' incomes) drive health care providers to practice it.

5. Health Care Costs Are Causing Increased Malpractice Costs, Not The Other Way Around

The irony of the argument that medical malpractice costs are driving up the cost of health care is that the contrary is probably more accurate: because a very large percentage of medical malpractice verdicts are to pay for past and future medical care, it is in fact the rising cost of health care which has prompted juries to award higher verdicts.

THE CAUSE OF MALPRACTICE LITIGATION IS MEDICAL NEGLIGENCE

Every study that has examined the question of what percentage of instances of medical negligence result in the filing of malpractice claims has concluded that there is substantially more medical negligence than there are malpractice suits. A study included in the Report of the Secretary's Commission on Medical Malpractice revealed that only one in every fifteen severe injuries resulting from medical negligence led to malpractice claims (24). Similarly, a Rand Corporation study found that "at most one in ten incidents of malpractice result in a claim, and of these, less than half, or one in 25, receive payment" (25).

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(24) Pocincki, L.S., et al, "The Incidence of Iatrogenic Injuries," Appendix, Report of the Secretary's Commission on Medical Malpractice (DHEW Publication No [OS] 73-89), Washington, D.C., Government Printing Office, 1973, pp. 50-70.

(25) Danzon, P.M., Ph.D., "An Economic Analysis of Medical Malpractice," 1 Behavioral Sciences and the Law 39, 42 (1983).

It should be no surprise that medical negligence is the primary cause of malpractice litigation. Testifying before the U.S. Department of Health, Education and Welfare Commission on Medical Malpractice, Eli Bernzwig, former president of Argonaut Insurance Company and the Commission's Executive Director, concluded that:

> The time has come for all parties seeking solutions to the malpractice problems to recognize that the root cause of the current malpractice problem is the substantial number of injuries and other adverse results sustained by patients during the course of hospital and medical treatment.

That conclusion is no less true today than it was in 1975. Yet the American Medical Association, in the "Action Plan" released on February 14, 1985 by its Special Task Force on Professional Liability and Insurance proposed four general categories of "solutions," IN THIS ORDER: (1) public relations, (2) special interest legislation, (3) improving the medical industry's "defense capability," and lastly, (4) risk control and quality review (26). That the AMA should place quality review last among its proposals should not be surprising: the medical professions historically do not adequately discipline their own members. A couple of examples illustrate this point. For example, in the State of Washington, with over a 30% increase in the number of licensed physicians between 1976 and 1981 and an approximate 400% increase in the number of referrals to the State Medical Disciplinary Board, not one physician's license was revoked in 1981 (27). During the late 1970's, one Florida doctor accounted for 31 paid claims - he is still practicing medicine in that state, never sanctioned (28). These are not isolated instances, according to a report issued by the Oversight and Investigations Subcommittee of the United States House of Representatives Committee on Interstate and Foreign Commerce. One of the findings of that report was that professional standard review organizations entrusted with the responsibility of measuring care at hospitals were not fulfilling their responsibility (29).

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(26) AMA Special Task Force on Professional Liability and Insurance Action Plan, American Medical Association, February 1985.

(27) Medical Disciplinary Board, Washington State Department of Licensing.

(28) Closed Claims Study of Medical Malpractice Insurance, 1975-1982, Office of the Insurance Commissioner, State of Florida (1983).

(29) Surgical Performance, Necessity and Quality," Oversight and Investigations Subcommittee of the United States House of Representatives Committee on Interstate and Foreign Commerce, December, 1978.

In light of the poor record of the medical profession in terms of disciplining those few, repeatedly careless doctors it is that much more important that we preserve the present system. As one study by the Rand Corporation pointed out:

> By finding fault and assessing damages against the negligent provider, the system sends all providers a signal that discourages future carelessness and reduces future damages (30).

In fact, the way medical malpractice insurers have generally set premiums, i.e., by specialty groupings as opposed to by the experience of individual physicians, has decreased the efficiency of the system in terms of encouraging the safe practice of medicine by permitting consistently negligent physicians to spread their risk of error among their more careful fellow doctors (31). These "repeaters" have a substantial impact on losses paid. A closed claims study released in 1983 by Florida Insurance Commissioner Gunter revealed that, from 1975 through 1982, a group of "repeaters" comprising only 0.7% of the total number of Florida physicians were responsible for 24% of the claims in which indemnity payments were made (32). A four-year California study demonstrated that the Florida figures were not a fluke: 0.6% of the 8,000 Los Angeles area physicians studied accounted for 10% of all claims and 30% of all payments (33).

THE PROPOSALS OF THE MEDICAL INDUSTRY ARE SIMPLY SPECIAL INTEREST LEGISLATION

The proposals of the medical industry to restrict the rights of health care consumers are nothing more than special interest legislation. That industry asks that a special niche in American law be carved out for doctors, while the rest of us are held responsible for our carelessness under time-tested rules of law. The "need" for this special

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(30) Schwartz, William B., M.D., and Komesar, Neil K., J.D., Ph.D., "Doctors, Damages and Deterrence," 298 New England Journal of Medicine 1282 (June 8, 1978) (From the Rand Corporation, Santa Monica, California).
(31) Id.
(32) Florida Closed Claim Study, supra, fn (28).
(33) Ferber, S., Sheridan, B., "Six Cherished Malpractice Myths Put To Rest, 52 Medical Economics 150 (1975).

protection from traditional American principles of responsibility does not even relate to the technical or scientific nature of the medical profession: the standard of care required of physicians is established by the medical profession itself. A doctor cannot be held negligent unless his conduct falls below the minimum level of care considered acceptable by other doctors in the same field of practice. Yet this standard is not reasonable enough for the medical industrialists. They propose a wide variety of methods to prevent victims of medical carelessness from obtaining full compensation for their injuries. What follows is an analysis of a few of these proposals to further insulate doctors from the consequences of their carelessness.

1. Limitations On Damages

The AMA would restrict a medical negligence victim's right to recover damages for pain and suffering and a variety of other so-called "non-economic" damages. Other versions of this proposal currently under consideration in some states would limit damages of all kinds to a rigid amount. Any version of this proposal amounts to an effort to shift the costs of medical negligence to the very group of people who need compensation the most: the brain-damaged children, quadriplegics, and other acute victims of medical carelessness. This division of society into classes; seriously injured persons versus less seriously injured persons, victims of medical carelessness versus victims of the carelessness of ordinary citizens, is so antithetical to basic concepts of American justice that such classifications have been held unconstitutional by courts in two-thirds of the states where a court of record has ruled on the issue (34). What is fair compensation for the permanent loss of the use of a child's brain? How do you determine the damages for the permanent loss of sight? How do you compensate for a permanent inability to walk? These are tough questions, but questions which American juries decide every day in this country in cases brought by victims of drunk drivers, defective products, and a limitless variety of other cases involving human carelessness. The burden is clearly upon

(34) Florida Medical Center v. Von Stetina, 436 So.2d 1022 (Fla.App.1983); Jones v. State Board of Medicine, Nos. 55527 and 55586 (D.C. Idaho 1980), on remand from 97 Idaho 859, 555 P.2d 399 (1976); Wright v. Central Du Page Hospital Assoc., 63 Ill.2d 313, 347 N.E.2d 736 (1976); McGuffey v. Hall, 557 S.W.2d 401 (Ky. 1977); Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978); Simon v. St Elizabeth Medical Center, 355 N.E.2d 903, 908 (Ohio Ct. of Common Pleas 1976); Graley v. Satayatham, 74 Ohio Ops. 2d 316, 343 N.E.2d 832 (Ct. of Common Pleas 1976).

the medical industrialists to tell us why their lack of caution should be exempt from this level of scrutiny - a burden they have clearly not carried.

2. Immunity Of Doctors from Punitive Damages For Malicious, Immoral, Wanton, Willful, Or Reckless Acts

For the ordinary citizen, the law recognizes that there are certain acts which are so so outrageous that they merit punishment, but not quite bad enough that they merit criminal prosecution. In those cases, where the victim can show that the defendant acted recklessly, maliciously, wantonly, willfully, or immorally, most courts allow punitive damages to be awarded. The AMA is now asking legislatures to provide special protection for those members of the medical profession who act in such an outrageous manner. The unusual aspect of this request is that punitive damages are extraordinarily rare in medical malpractice cases. For example, in 1984, for the first time in the history of the state, a Kansas jury awarded punitive damages in a medical malpractice case. Again, this proposal is simply another request for special privileges for a group of people who do not need them.

3. Government-Imposed Restrictions On Attorneys' Fees

One of the arguments most frequently raised by proponents of special interest legislation for hospitals and doctors is that trial lawyers are encouraged to bring "frivolous" malpractice suits because they are customarily paid on the on the contingency fee system. In that system, the attorney receives no fee unless and until he obtains an award for his client, and his fee is based on a percentage of that award (usually one-third). To deal with that supposed problem, the medical industry is proposing that government step into the contractual arrangement between victim and lawyer and dictate the terms of that private agreement. In fact, the contingency fee system makes the frivolous suit less likely:

> The lawyer who is paid a contingency fee . . . is not likely to invest time and several thousand dollars in out-of-pocket expenses on a case with little prospect of success. Under the system of contingency fees, lawyers thus have the incentive to filter out capricious suits, which otherwise would overload the courts, harass physicians and produce no social benefits. (35)

Another justification given by the medical industry for this proposed intrusion on a citizen's right to contract is that limiting contingent fees is an effort to increase the

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(35) Schwartz, supra, fn (30).

amount of money actually paid to the medical negligence victim. One need only answer the following question to test the sincerity of that claim: how many of us could afford to hire a lawyer on an hourly basis to pursue a negligence case against the vast resources of an insurance company in a case which might require the expenditure of tens of thousands of dollars just for expenses (costs of expert witnesses, investigation fees, and even photocopying voluminous hospital records), not to mention lawyers' fees ranging from $80 per hour to $300 per hour? Very few of us could even start such a case (especially if we were unable to work as a result of injuries), and, for those who could, maintaining an action against an economic entity with seemingly endless resources would be very difficult at best.

A Rand Corporation study commissioned by the United States Department of Health Education and Welfare which examined all of claims of advocates of limits on contingency fees concluded that any restriction on those fees would be inappropriate (36). No, the proponents of this brand of special interest legislation are not trying to stop frivolous lawsuits, they are not trying to increase payments to victims. They are simply trying to prevent victims of medical negligence from pursuing their legitimate claims. Nothing more, nothing less.

4. Elimination of the Collateral Source Rule

The AMA proposes that states abolish the collateral source rule. This is an important rule of law in most states which prevents a person found to be guilty of negligence from reducing the amount he owes his victim by the amount which the victim has received from other sources, like health insurance or government benefits. Once again, the proponents of this legislation want to shift the costs of carelessness away from the careless and to the innocent victim, who paid for his health insurance, the innocent employer of the victim, who paid for the victim's group insurance, or the innocent taxpayer, who paid for the government benefits. The injustice of this proposal is evident on its face.

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(36) Danzon, Patricia M., "Contingent Fees For Personal Injury Litigation," prepared for the Health Care Financing Administration, U.S. Department of Health, Education, and Welfare (R-2458-HCFA), June 1980.

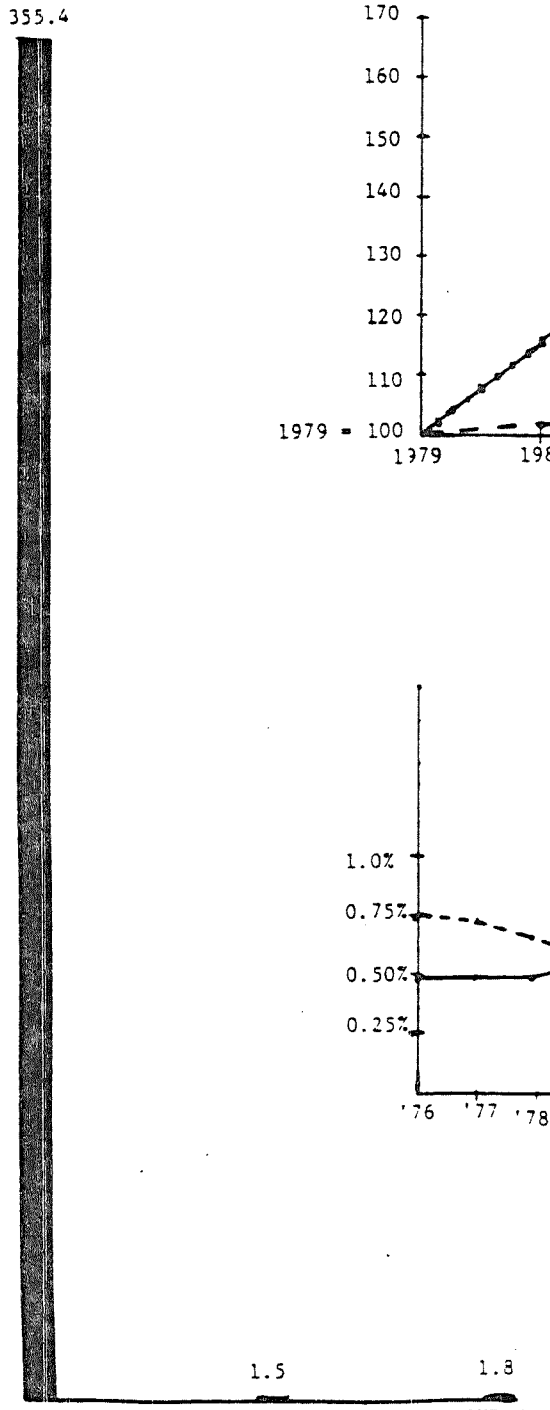
CONCLUSION

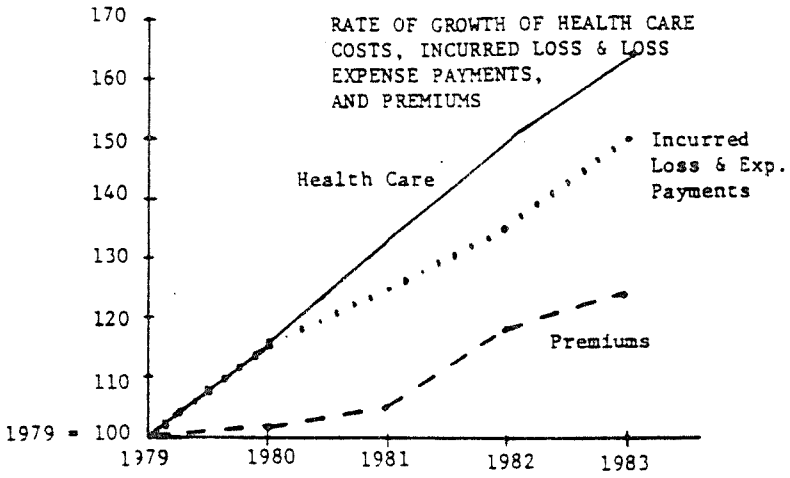
There is a medical malpractice problem. It is too much medical malpractice. As James S. Todd, M.D., Diplomate of the American Board of Surgery and a Trustee of the American Medical Association once said,

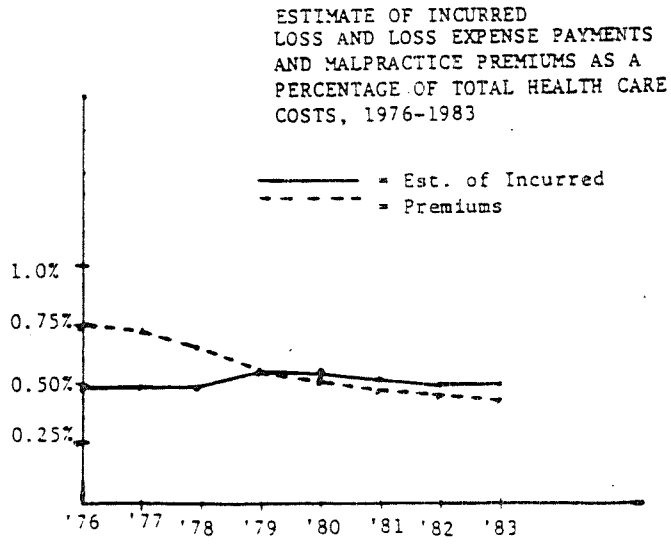
> ". . . Efforts directed toward tort reform and legislative relief must be reasonable and not self-serving. Malpractice is a medical problem, not a legal one, and those injured as a result of negligence are entitled to fair and prompt compensation. . . ."

It is time for all the parties in this very important issue to stop the baseless cries for legislative relief, and to sit down and get serious about protecting the most important consumer - the health care consumer. After all, we are all potential victims. We all have a stake in the outcome.

MEDICAL MALPRACTICE INSURANCE: THE REAL STORY







Sources: U.S. Census Bureau
A.M. Best's Casualty Loss Reserve Dvlpmt.

INSURANCE DATA

A. Premium Information.

Years	Total Malpractice Premiums Paid by Health Care Providers[1]	Total Personal Health Care Costs in Kansas[2]	% of Premiums to Health Care Costs
1985	$ 32 million	$ 3,299,000,000	.96%
1984	$ 24 million	$ 3,066,000,000	.78%
1983	$ 12.5 million	$ 2,833,000,000	.44%
1982	$ 9.5 million	$ 2,600,000,000	.36%
1981	$ - ? -	$ 2,400,000,000	- ? -[3]
1980	$ 12.8 million	$ 2,100,000,000	.61%
1979	$ 16.9 million	$ 1,900,000,000	.89%

The above statistics show that malpractice premiums in Kansas represent less than 1% of the total health care costs in Kansas. For three years (1981, 1982, 1983), doctors in Kansas paid no surcharge for Fund insurance.

1. Kansas Office of Insurance Commissioner.
2. Kansas Department of Health and Environment.
3. The Insurance Office has no accurate data for 1981.

B. Per Capita Expenditures.

Years	Per Capita Health Care Expenditures in Kansas	Per Capital Share of Malpractice Premiums
1985	$ 1,375	$ 13.33
1984	$ 1,277	$ 10.00
1983	$ 1,180	$ 5.20
1982	$ 1,083	$ 4.00
1981	$ 1,000	$ ---
1980	$ 875	$ 5.00
1979	$ 792	$ 7.00

This chart shows the amount, per person, spent on health care in Kansas. Then the total amount of the health care premiums are divided among the citizens in Kansas. If malpractice were abolished and every dollar was returned to the citizens of Kansas, in 1985 citizens would get a total of $13.33, in exchange for losing their legal rights.

C. Doctors Income.

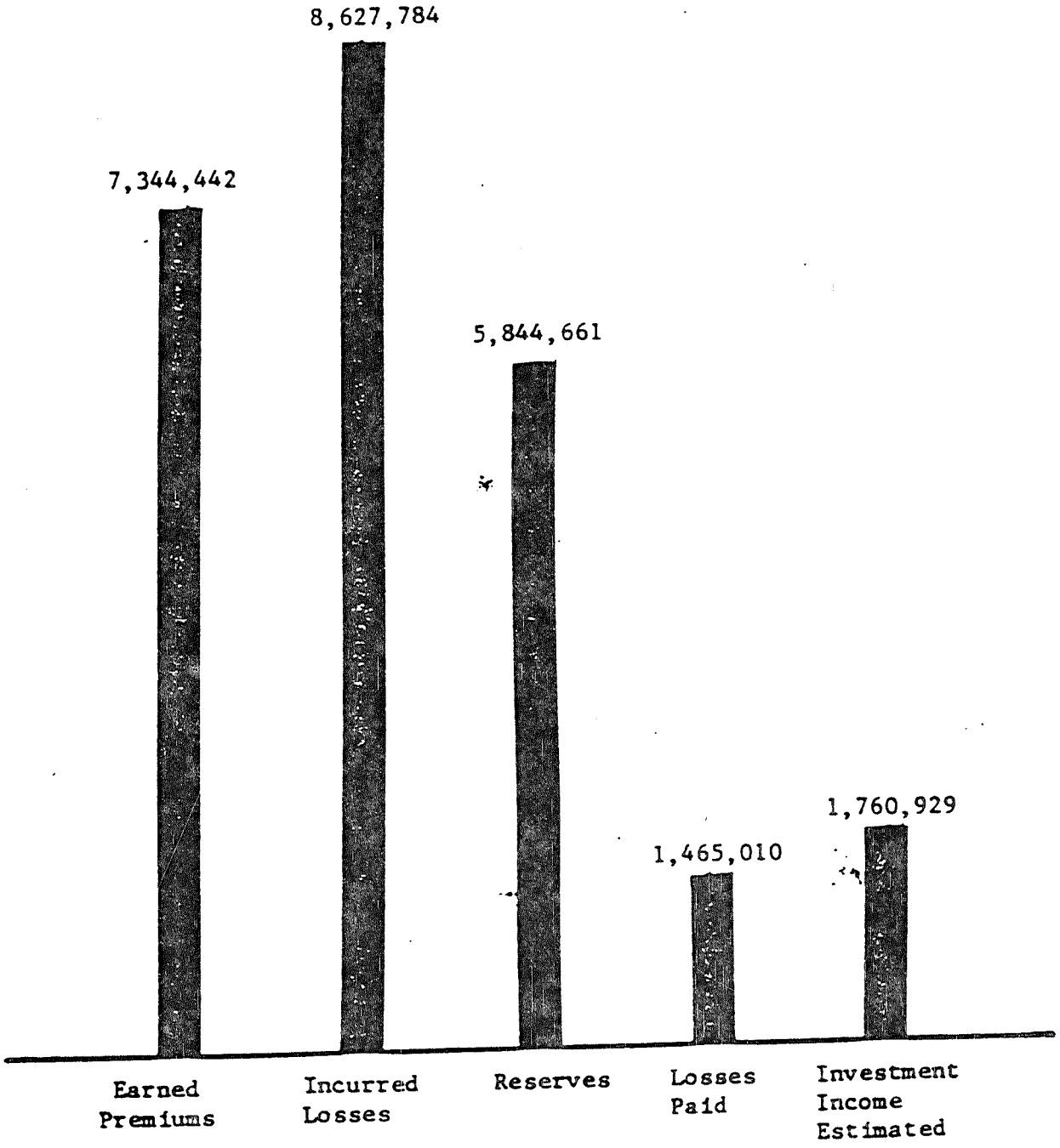
Year	Doctor's Income in Kansas[1]	Doctor's Share of Malpractice Premiums[2]	% of Income Paid in Malpractice Premiums
1985	$ 524 million	$ 21 million	4%
1984	$ 486 million	$ 16 million	3.2%
1983	$ 447 million	$ 8 million	2%
1982	$ 408 million	$ 6 million	1.5%
1981	$ 394 million	$ ----	----
1980	$ 323 million	$ 8 million	2.4%
1979	$ 294 million	$ 11 million	4%

The figures of doctors' incomes in Kansas[1] comes from the American Medical Association survey of the West North Central Region. This is salary, before taxes, but after expenses. The Kansas Department of Health and Environment uses the same data.

The share of malpractice premiums[2] is taken from the September 1, 1984 "Report on the Health Care Provider Insurance Availability Act", prepared by Commissioner Fletcher Bell. According to their data, doctors paid 65% of the total premiums in 1983 (other health care providers pay the rest). While that precentage may be too high for prior years, it gives the doctors the maximum credit for malpractice payments.

In 1985, doctors in Kansas will pay approximately 4% of their "after expenses salary" in malpractice premiums. In 1979, they paid approximately 4% of their salary in premiums.

MEDICAL MALPRACTICE
SELECTED 75 COMPANIES
1978-1983



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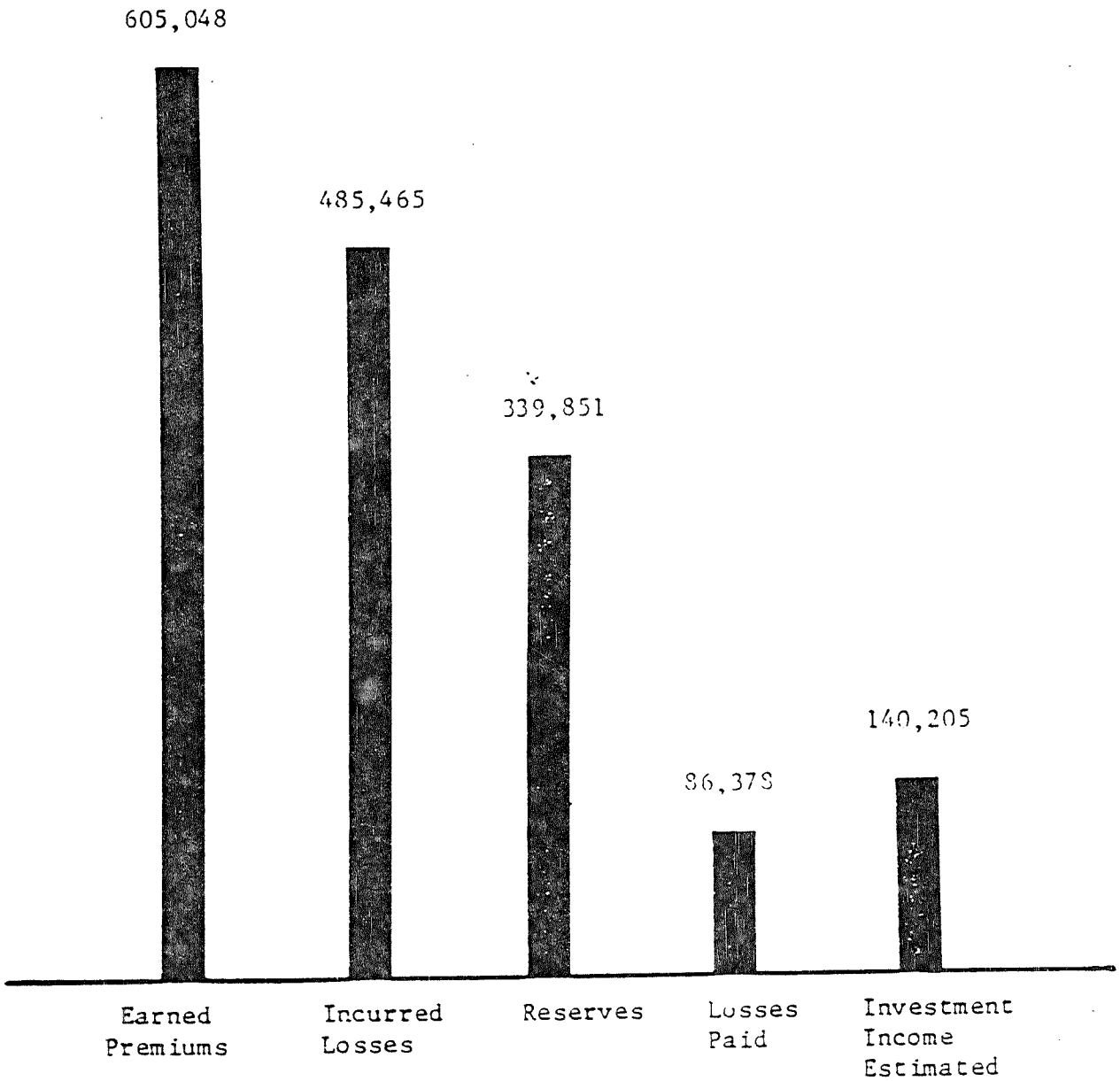
MEDICAL MALPRATICE
THE MEDICAL PROTECTIVE COMPANY
1976-1983



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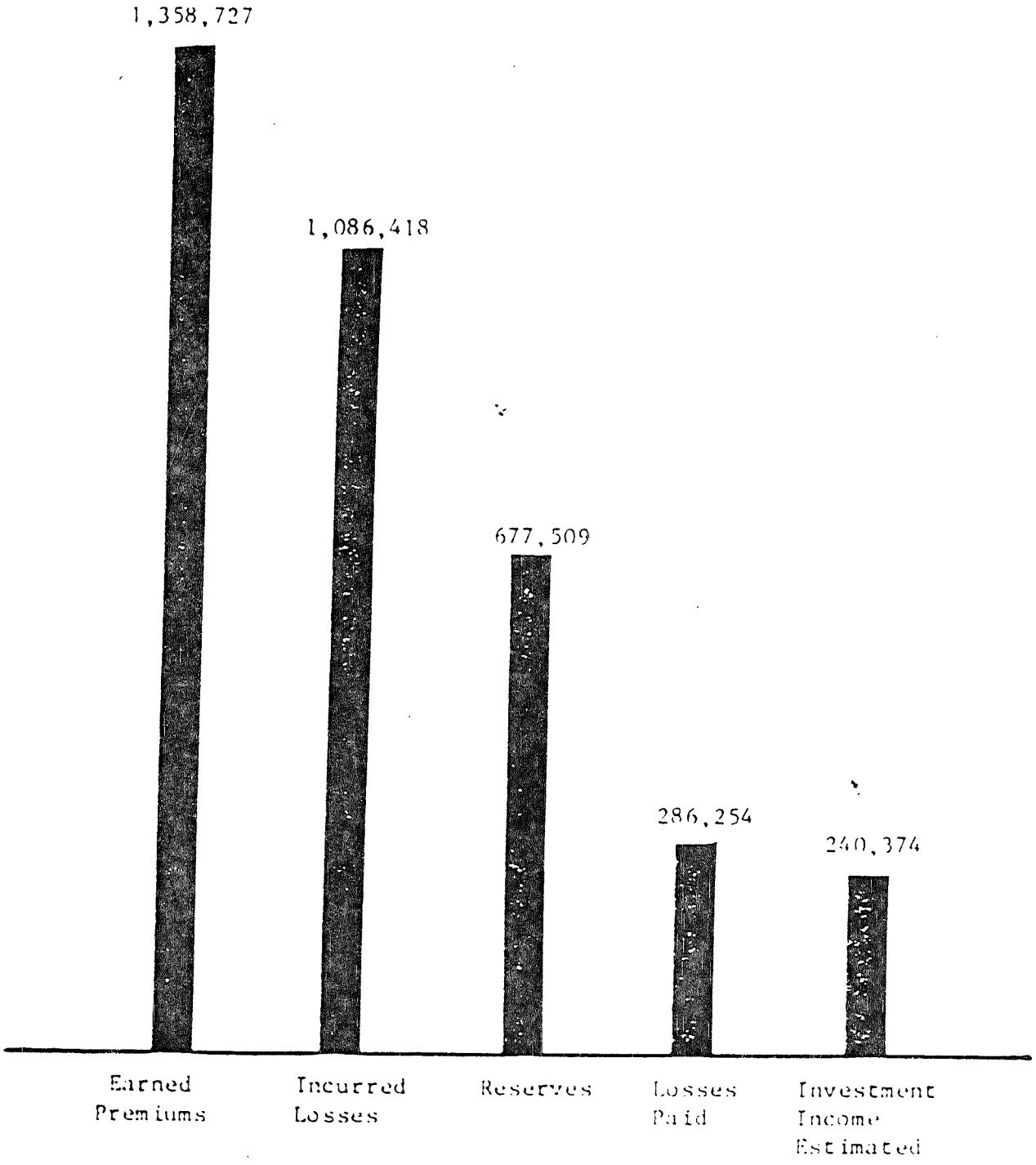
MEDICAL MALPRACTICE
ST. PAUL GROUP
1975-1983



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III. Review of the Specific Changes Within Each "Reform" Area.

A. Collateral Source Rule.

1. 33 states have no changes in the collateral source rule.

2. 17 states have modified or abolished the collateral source rule.

a. 3 states have abolished collateral source rule.

(1) Iowa - constitutionally upheld.
(2) Idaho - declared unconstitutional.
(3) North Dakota - declared unconstitutional.

b. 14 states have made various modifications in the collateral source rule.

(1) After award deductions for collateral sources.

Held Constitutional (a) Alaska.
Held Constitutional (b) Florida (subrogation possible).
(c) Nebraska.
(d) New York.
(e) Pennsylvania (no subrogation).
Declared Unconstitutional (f) New Hampshire (jury reduces award by collateral source, but expenses for the collateral source reduces the amount reduced).

(2) Collateral source evidence admissible.

Held Constitutional (a) Arizona (no subrogation).
Held Constitutional (b) California (no subrogation).
(c) Rhode Island.

(3) Public collateral sources admissible, private collateral sources inadmissible.

(a) Washington.
(b) Tennessee.
(c) South Dakota (subrogation possible).
(d) Delaware.

(4) Modified.

Declared Unconstitutional (a) Ohio.

3. General Summary.

a. 4 state Supreme Courts have declared modifications or abolishments of the collateral source rule UNCONSTITUTIONAL.

b. 5 state Supreme Courts have held modifications or abolishments of the collateral source rule CONSTITUTIONAL.

C. Limits on Awards.

1. 33 states place no limits or caps on awards.

2. 18 states have some type of limitation on awards.

a. General limits on awards.

Declared Unconstitutional (1) Illinois - $500,000 limit on recoveries. (effective 1976).

(2) South Dakota - $500,000 limit on general damages, special damages uneffected. (1975).

(3) Virginia - $1,000,000 limit overall. (1976).

Declared Unconstitutional (4) North Dakota - $300,000 limit for awards arising out of one occurence. (1977).

Declared Unconstitutional (5) Ohio - $200,000 limit on general damages in non-death cases. (effective 1975).

b. Limitations on non-economic loss.

Held Constitutional (1) California - $250,000 limit on non-economic damages. (1975).

(2) New Hampshire - $250,000 limit on non-economic loss. (1977).

Declared Unconstitutional (3) Texas - $500,000 limit on non-medical expenses. (1977).

(4) New Mexico - $100,000 per provider/$500,000 per incident. Fund pays between $100,000 and $500,000 but jury may award amount in excess of $500,000, if the excess is equal to the cost of medical care or benefits present in case. (1976).

c. Provider/occurrence limits and overall limits.

Declared Unconstitutional (1) Florida - $200,000 per claim/$500,000 per occurence.

Declared Unconstitutional (2) Idaho - $150,000 per patient/$300,000 aggregate for doctor. $150,000 per patient/$300,000 aggregate for hospital or 10 times number of beds. Actions limited to common law negligence. (1975).

Held Constitutional (3) Indiana - $100,000 per practitioner per incident/$300,000 aggregate annually. Fund available up to $500,000. (1975).

Held Constitutional (4) Louisiana - $100,000 per health care provider/$500,000 overall limitation on liability. Fund pays between $100,000 and $500,000. Limited liability for state services. (1975).

Held Constitutional (5) Nebraska - $1,000,000 limit for health care provider/$6,000,000 limit. Fund pays betwen $1,000,000 and $6,000,000. (1976).

(6) Wyoming - $50,000 mandatory insurance/$1,000,000 limit. Fund pays between $50,000 and $1,000,000. (1977).

d. Provider/occurrence limits with no limits on total award.

(1) Oregon - $100,000 per claim/$300,000 per occurrence. Excess paid by Insurance Commissioner. (1975).

(2) South Carolina - $100,000 per claim/$300,000 per year. Fund pays excess. (1976).

(3) Wisconsin - $200,000 per practitioner per incident/$600,000 aggregate annually or limit of policy which ever is higher. Fund pays excess. (1975).

3. General Summary.

a. 3 of the 5 general limitations on award have been declared unconstitutional, while none of them have been held constitutional.

b. 1 limit on non-economic loss has been declared unconstituional and 1 has been held constitutional. No recorded decision on the other 2 states with this type of limit.

c. 2 of the 6 states with limitation on the provider/occurrent and overall limits have been declared unconstitutional. 3 other states with these type of limitations have upheld the constitutionality.

d. No decisions on the states with limitations on provider/occurrence and no overall limits.

May 1984

ADVANCE SHEETS

OF

The Kansas Supreme Court

Vol. 235 No. 2

Pages 260 to 533, inclusive Opinions filed in April 1984

AND OF

The Kansas Court of Appeals

2d Series

Vol. 9 No. 6

Pages 363 to 403, inclusive Opinions filed in March-April 1984

Cases Argued and Determined in

THE APPELLATE COURTS, STATE OF KANSAS

NOTICE

To facilitate speedy publication these sheets are not in final form. Attorneys are requested to call prompt attention to stenographical or other formal errors for correction in the bound volume.

Reporter:
RICHARD D. ROSS

Second-class postage paid at Topeka, Kansas

No. 55,469

CAROL M. McGUIRE, *Appellee/Cross-Appellant*, v. EARL C. SIFERS, M.D., *et al.*, *Appellants/Cross-Appellees*, v. FLETCHER BELL, Commissioner of Insurance, As Administrator of the Health Care Stabilization Fund, *Intervenor*.

SYLLABUS BY THE COURT

1. APPEAL AND ERROR—*Invited Error by Appealing Party.* Where a party procures a court to proceed in a particular way thereby inviting a particular ruling, that party is precluded from assailing such proceeding and ruling on appellate review.
2. TORTS—*Sufficiency of Verdict for Damages.* An examination of the numerous cases challenging the sufficiency, or insufficiency, of a verdict for damages reveals no simple, symmetrical pattern or design, as each case seems to stand on its own facts.
3. APPEAL AND ERROR—*Appellate Review of Jury Verdict for Damages—Allegation of Excessive Verdict Reviewed.* An appellate court should be cautious when requested to substitute its judgment for that of the trier of fact that heard the case. We cannot say under the facts of this case the verdict is so excessive as to shock the conscience or indicate passion and prejudice on the party of the jury.
4. INSURANCE—*Health Care Providers—Professional Liability Insurance Required.* Professional liability insurance is required to be maintained by all health care providers as a condition to rendering services in the state.
5. CORPORATIONS—*Professional Corporation—Statutory Authority.* A professional corporation is subject to the general laws of Kansas relating to corporations except that any provision of the professional corporation law shall take precedence over any provision of the general corporation law where they conflict.
6. SAME—*Professional Corporation—Incorporation of Health Care Providers.* A professional corporation is subject to certain responsibilities when it is formed. Health care providers who incorporate may do so to gain certain advantages. They must also accept certain liabilities, such as the application of the doctrine of respondeat superior.
7. SAME—*Professional Corporation—Application of Doctrine of Respondeat Superior to Professional Corporation.* If the legislature had intended to abrogate the doctrine of respondeat superior as to professional corporations it could have and would have done so through the enactment of specific and definitive legislation.
8. JUDGMENTS—*Effective Date of Judgment.* No judgment is effective unless and until a journal entry or judgment form is signed by the trial judge and filed with the clerk of the court.
9. DAMAGES—*Interest on Verdict for Unliquidated Damages—Time That Interest begins to Accrue.* It is error to allow interest on a verdict for unliquidated damages for the time between its finding and rendition of the judgment thereon.

10. JUDGMENTS—*Interest—Tender of Judgment Required to Avoid Accrual of Interest on Appeal.* If the judgment debtor wishes to avoid the accrual of interest on appeal, he must tender the amount of the judgment or pay the amount into court.
11. SAME—*Interest—Payment of Judgment into Court by Judgment Debtor—Interest Not Recoverable on Deposited Money.* Once a judgment debtor pays the full amount of money payable on a judgment into court, interest is not recoverable on the monies deposited in court.
12. HUSBAND AND WIFE—*Loss of Consortium—Vesting of Cause of Action—Reduction of Award by Percentage of Injured Spouse's Fault.* The cause of action to recover for loss of consortium vests in the spouse who files an action for personal injuries, not in the spouse who actually suffers the loss of consortium. Our statutes require the award for loss of consortium be reduced by the percentage of the injured spouse's fault.

Appeal from Johnson district court, J. STEWART McWILLIAMS, judge. Opinion filed April 27, 1984. Affirmed in part and reversed in part.

M. Warren McCamish, of Williamson & Cubbison, of Kansas City, argued the cause, and *John L. Peterson* and *Timothy P. McCarthy*, of the same firm, were with him on the brief for the appellants/cross-appellees.

Jay Thomas, of Barnett & Ross, Chartered, of Kansas City, argued the cause, and *James M. Barnett*, of the same firm, was with him on the brief for the appellee/cross-appellant.

Michael J. Dutton, special assistant attorney general, argued the cause and was on the brief for intervenor Fletcher Bell, as Administrator of the Health Care Stabilization Fund.

The opinion of the court was delivered by

LOCKETT, J.: This is a direct appeal of a medical malpractice action instituted by Carol M. McGuire against Earl C. Sifers, M.D. and Sifers, Taylor and Hitchcock, M.D.'s, Chartered, a professional corporation. Count I claims damages suffered by McGuire (plaintiff). Count II claims damages for loss of consortium pursuant to K.S.A. 23-205. The case was tried before a jury in November, 1982. The jury returned a verdict for $600,000.00 in Count I and $82,000.00 in Count II. The trial judge reduced both Count I and Count II by the 35% fault attributed to the plaintiff by the jury. The final judgment totaled $443,300.00. The defendants appeal. Plaintiff cross-appeals. Insurance Commissioner Fletcher Bell, as Administrator of the Kansas Health Care Stabilization Fund (Fund), was permitted to intervene.

In January, 1976, McGuire was referred by her family physician to Dr. Sifers, a surgeon, for monitoring and observation of several lumps in her breast. McGuire's condition was diagnosed

as fibrocystic disease, a forming of cysts in the breast tissue. Biopsies were taken to aid in determining whether the cysts were harmless, premalignant or cancerous. To treat the fibrocystic disease, Dr. Sifers performed subcutaneous mastectomy surgery upon the plaintiff in May, 1979. Dr. Sifers' primary objective in performing the surgery was to prevent the possibility of the plaintiff developing breast cancer later. During the plaintiff's operation, Dr. Sifers removed breast tissue from between the muscle and skin, and silicone gel implants were inserted to reconstruct the breast. Approximately 20% of the breast tissue was not removed by Dr. Sifers to permit possible further breast reconstruction at a future time.

Complications arose after the plaintiff's surgery. The nipple areas grew dark and hardened; the skin died and pulled away from the breast. Surgery was performed by Dr. Sifers in August, 1979, to remove those areas of dead skin and to close the wound. Dr. Sifers removed the stitches several weeks later. The day Dr. Sifers removed McGuire's stitches, the incision opened and required restitching at an emergency room. From August to November, 1979, the plaintiff's stitches in the breast area reopened requiring restitching three or four times. When the incisions broke open, implants were visible. Where the stitches failed, openings were sometimes two or three inches wide.

In an effort to solve the problem Dr. Sifers removed the breast implants in November, 1979, and placed smaller implants in the breasts. For a three to four month period the plaintiff began to feel better and all incisions remained closed. Since her first operation the plaintiff had been confined to bed; she was now allowed to get up and take over household chores.

Troubles began anew in March, 1980, when the incision on the right breast opened. Dr. Sifers repeatedly performed corrective surgery. The incisions continually broke open between March and May, 1980. In May, 1980, Dr. Sifers again replaced one of the implants with a smaller implant. In the new implant area the incision opened frequently between May and August, 1980. Both breast implants were removed in August, 1980, by Dr. Sifers. The plaintiff, still in pain, consulted another doctor in August, 1980. In December, 1980, after office treatment and surgery performed by the second doctor, the plaintiff recovered. McGuire has not yet determined whether complete breast reconstruction surgery should be attempted.

At trial the plaintiff introduced expert witness testimony to prove Dr. Sifers treated the plaintiff in a medically negligent manner before, during and after surgery. The jury found for the plaintiff on November 24, 1982. The jury apportioned 65% of the fault to Dr. Sifers and 35% to the plaintiff. The trial judge reduced the judgment in both Count 1 and Count 2 by 35%. the judgment totaled $443,300.00. The defendants appeal. Plaintiff cross-appeals. The Insurance Commissioner, representing the Fund, was allowed to intervene in the appeal.

The first issue involves the admission into evidence of a portion of Dr. Sifers' testimony. During the presentation of plaintiff's evidence, Dr. Sifers was called as a witness.

The defendants contend reports of the Hospital Quality Assurance Committee introduced through Dr. Sifers' testimony was irrelevant and erroneously admitted since these events occurred after the plaintiff's surgery. From the transcript of Dr. Sifers' testimony, it is not clear which events occurred before or after the plaintiff's surgery. Dr. Sifers, in his answers to questions propounded by plaintiff's counsel, interjected into evidence the matters which his counsel now claims as error. Just prior to that testimony, Dr. Sifers asked his attorney if he should answer the question. Defendants' counsel urged him to answer. The defendants' counsel did then object to the relevancy of a portion of the doctor's testimony concerning matters subsequent to the plaintiff's surgery.

Relevant evidence is evidence having any tendency in reason to prove any material fact and the determination of relevancy is a matter of logic and experience, not a matter of law. *State v. Norman*, 232 Kan. 102, Syl. ¶ 4, 652 P.2d 683 (1982). Subject to certain exclusionary rules, the admission of evidence lies within the sound discretion of the trial court. *State v. Norman*, 232 Kan. at 108. Some of the matters contained within Dr. Sifers' testimony were events that occurred prior to plaintiff's surgery. At the time of trial, defendants failed to object that specific events occurred after the surgery. Without specific objections, the admission of evidence is generally not reversible error. See *State v. Garcia*, 233 Kan. 589, Syl. ¶ 7, 664 P.2d 1343 (1983).

The defendants did object to the admission of Bethany Medical Center documents promulgated in June of 1981, subsequent

to plaintiff's operation, which set restrictions on the performance of subcutaneous mastectomy surgery. It was Dr. Sifers who, while testifying at the trial, produced the documents from his briefcase; he then stated he had been using similar standards contained within the papers since 1971. Dr. Sifers' own testimony established the relevancy of these documents after he had voluntarily produced the documents.

The plaintiff claims if error was committed by admission of the evidence, it was harmless in the face of expert testimony. In addition defendants fail to show how the testimony prejudiced them. K.S.A. 60-261 provides:

"No error in either the admission or the exclusion of evidence and no error or defect in any ruling or order or in anything done or omitted by the court or by any of the parties is ground for granting a new trial or for setting aside a verdict or for vacating, modifying or otherwise disturbing a judgment or order, unless refusal to take such action appears to the court inconsistent with substantial justice. The court at every stage of the proceeding must disregard any error or defect in the proceeding which does not affect the substantial rights of the parties."

Here it was Dr. Sifers who actually inserted into evidence the statement defense counsel claims as error. His client endeavored at trial to justify his past actions by implying his course of conduct in 1979 has been adopted as the proper standard for procedures in 1982. Despite defendants' attorney's objections urging the judge to require his client to stop testifying, the doctor continued to defend his prior actions. Defendants now claim that evidence was not relevant and it was error to admit the evidence. It was the defendant himself who proceeded in a manner which required the trial judge to admit the evidence. Where a party procures a court to proceed in a particular way thereby inviting a particular ruling, that party is precluded from assailing such proceeding and ruling on appellate review. *Grimm v. Pallesen*, 215 Kan. 660, 527 P.2d 978 (1974). The trial court did not err in admitting the evidence.

Defendants contend the evidence did not support the amount of the verdict. They contend the $600,000.00 the jury awarded to the plaintiff, before reduction for plaintiff's comparative fault, should shock the conscience of this court. The defendants cite the case of *Kirk v. Beachner Constuction Co., Inc.*, 214 Kan. 733, Syl. ¶ 1, 522 P.2d 176 (1974), where this court stated:

"Where the charge of excessive verdict is based on the passion or prejudice of the jury and depends for support solely on the size of the verdict, the trial court will not be reversed for refusing a new trial, nor will a remittitur be ordered, unless the amount of the verdict in the light of the evidence shocks the conscience of the appellate court."

Defendants claim a large portion of the plaintiff's damages were compensation for past and future pain, suffering, disabilities, disfigurement and mental anguish. The plaintiff agrees with this assessment.

The court in *Kirk* also said at 214 Kan. 736-37:

"An examination of the numerous cases challenging the sufficiency, or insufficiency, of a verdict reveals no simple, symmetrical pattern or design. Each case seems to stand on its own facts. We deem it fruitless to attempt a reconciliation of the various amounts which have or have not been held excessive, and we shall undertake no such effort. Perhaps no better explanation can be given for the lack of dollars and cents uniformity in our decisions than is expressed in *Domann v. Pence*, 183 Kan. 135, 325 P.2d 321:

"'. . . Pain and suffering have no known dimensions, mathematical or financial. There is no exact relationship between money and physical or mental injury or suffering, and the various factors involved are not capable of proof in dollars and cents. For this very practical reason the only standard for evaluation is such amount as reasonable persons estimate to be fair compensation for the injuries suffered, and the law has entrusted the administration of this criterion to the impartial conscience and judgment of jurors, who may be expected to act reasonably, intelligently and in harmony with the evidence. . . .' (p. 141.)

. . . .

"The times in which we live are highly inflationary, with constantly climbing prices and a continually shrinking dollar. It is against this sort of a background that we must consider the dictates of conscience."

An appellate court should be cautious when requested to substitute its judgment for that of the trier of fact that heard the case. We cannot say, under these facts, the verdict is so excessive as to shock the conscience or indicate passion and prejudice on the part of the jury.

The defendant, Sifers, Taylor and Hitchcock, M.D.'s, Chartered, a professional corporation (Corporation), appeals from the denial of its motion for a directed verdict at the close of all the evidence. The Corporation contends it was not liable for Dr. Sifers' negligence under the doctrine of respondeat superior. The Corporation bases its argument upon the Kansas Health Care Provider Insurance Availability Act (Act). K.S.A. 40-3401 *et seq.* The Insurance Commissioner opposes the Corporation on this issue. The Act was examined by the court in *State ex rel. Schneider v. Liggett*, 223 Kan. 610, 611, 576 P.2d 221 (1978):

"The Kansas Health Care Provider Insurance Availability Act was passed by the 1976 legislature as a partial response to increasing pressure brought upon Kansas health care providers because of the national medical malpractice crisis. The primary feature of the act is the requirement that all health care providers operating within the state must obtain professional malpractice liability insurance (40-3402) and pay a surcharge to the health care stablilization fund (40-3404). The law requires the provider to carry a basic policy of $100,000 per occurrence and an annual aggregate of $300,000 for all claims made during the period. The stabilization fund provides for the payment of claims in excess of policy limits. Included in the act is a provision requiring every health care insurer to participate in an apportionment plan whereby any health care provider may obtain liability insurance from the plan if insurance from a conventional source (40-3413) is not available.

"The problem of obtaining and maintaining affordable malpractice insurance came before the legislature in 1971, 1973 and 1975. As a result, the legislature enacted a law in 1975 requiring all health care insurers to report their claims experience to the commissioner of insurance (K.S.A. 1975 Supp. 40-1126, *et seq.*). In 1976, however, the problem had grown to such proportions it received full legislative attention. A legislative interim committee was told in detail how insurance costs had skyrocketed on present policies, policies were unavailable for new doctors, insurers were beginning to withdraw from the medical malpractice field, and the availability of medical service in some Kansas communities was threatened. In response, the committee proposed twelve bills, including the act in the present controversy.

"The original bill did not require mandatory insurance coverage, nor did it require payment of the surcharge. These provisions were added by the legislature at the behest of Insurance Commissioner Fletcher Bell. The mandatory coverage provision, it was alleged, would provide for the financial stability of the insurance availability program and would assure all Kansans they would have a source of recovery for damages resulting from malpractice."

For an in-depth analysis see Reports of Special Committees to the 1976 Kansas Legislature re: Proposal No. 42—Medical Malpractice.

As noted in *State ex rel. Schneider v. Liggett*, the Fund is required to pay "[a]ny amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any such injury or death arising out of the rendering of or the failure to render professional services within or without this state." K.S.A. 1983 Supp. 40-3403(*b*). (No change since statute passed in 1976.) Health care providers covered by the Act include "a person licensed to practice any branch of the healing arts by the state board of healing arts," and "a professional corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by such law to form such a

corporation and who are health care providers as defined by this subsection." K.S.A. 1983 Supp. 40-3401(*f*). (No change in these portions of the statute since statute passed in 1976.)

The Act classifies both the doctor and the professional corporation as health care providers. The Corporation argues the legislature did not intend for both a doctor and his or her professional corporation be liable to a patient for the same occurrence. The Corporation claims if both the doctor and the professional corporation are liable for the same occurrence, premium costs of medical malpractice insurance will be increased, thereby defeating the purpose of the Act.

Physicians who are shareholders or employed by a professional corporation are required by the Act to obtain basic liability coverage the same as other physicians who are not shareholders or employees of a professional corporation. The Corporation claims professional corporations classified as health care providers are required to have malpractice insurance to protect patients where nurses or medical technicians employed by that professional corporation are negligent.

The laws of this state contain broad general provisions authorizing the organization of corporations for any lawful business purpose. K.S.A. 17-6001(*b*). Other statutes permit persons engaged in certain professions, when licensed to practice that profession, to form corporations for the practice of their profession. K.S.A. 17-2707.

A professional corporation is subject to the general laws of Kansas relating to corporations except that any provision of the professional corporation law shall take precedence over any provision of the general corporation law where they conflict. K.S.A. 17-2708. There is no conflict between general laws governing corporations and professional corporation laws in this case; therefore, the general corporation law controls.

Professional liability insurance is required to be maintained by all health care providers as a condition to rendering services in the state. K.S.A. 40-3402 provides in part:

"(*a*) A policy of professional liability insurance approved by the commissioner and issued by an insurer duly authorized to transact business in this state in which the limit of the insurer's liability is not less than one hundred thousand dollars ($100,000) per occurrence, subject to not less than a three hundred thousand dollar ($300,000) annual aggregate for all claims made during the policy period, shall be maintained in effect by each resident health care provider as a

condition to rendering professional service as a health care provider in this state, unless such health care provider is a self-insurer."

K.S.A. 1983 Supp. 40-3401(*f*) defines both Dr. Sifers, a person licensed to practice a branch of the healing arts, and the Corporation as a "health care provider." Each health care provider is required by statute to maintain professional liability insurance.

K.S.A. 1983 Supp. 40-3403 provides for the establishment of a fund to pay any amount due from a judgment or settlement in excess of the basic coverage of all liable health care providers. It states in part:

"(*a*) For the purpose of paying damages for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider, self-insurer or inactive health care provider subsequent to the time that such health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in a segregated fund in the state treasury. The commissioner shall administer the fund or contract for the administration of the fund with an insurance company authorized to do business in this state.

"(*b*) Subject to subsection (*e*), the fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in *excess of the basic coverage liability of all liable resident health care providers* or resident self-insurers for any such injury or death arising out of the rendering of or the failure to render professional services within or without this state . . . ." Emphasis supplied.

The Fund must pay any amount of a judgment or settlement in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers.

The basic coverage required for a health care provider is set forth in K.S.A. 40-3408 which states in part:

"The insurer of a health care provider covered by the fund or self-insurer shall be liable only for the first one hundred thousand dollars ($100,000) of a claim for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, subject to an annual aggregate of three hundred thousand dollars ($300,000) for all such claims against the health care provider. However, if any liability insurance in excess of such amounts is applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act."

The Corporation claims even though there are two health care providers, Dr. Sifers and the Corporation, each required to maintain professional liability insurance, only Dr. Sifers' insurer is liable for the first $100,000.00 of the plaintiff's claim.

The Corporation makes two arguments why corporations are not liable for negligent acts of doctors who are shareholders or employees. Both arguments are based on legislative intent, and cite no authority or legislative history to support them.

Defendants first argue because professional corporations were not included in the original definition of health care provider, the legislature must have intended that doctors and their professional corporations were to be treated independently, thus vitiating the vicarious liability between them. This line of reasoning is without merit and cannot be supported by examining the legislative history of Senate Bill No. 646 (L. 1976, ch. 231). Senate Bill No. 646 was changed four times during its legislative course. When examining those changes one finds that the groups included in the definition of health care provider changed with each draft. Some groups were added to the definition while others were deleted. The reason for changes was not that the legislature was considering the doctrine of respondeat superior or issues of liability between parties. It was for the reason the respective groups asked to be included or excluded from the Act. This is recognized by this court in *Liggett*, 223 Kan. at 612, where we noted that nurses and dentists were exempted from the Act because they asked to be exempted, while pharmacists were included in the Act because they asked to be included.

The legislature included professional corporations in the bill for the same reason it included pharmacists, that is because it was asked to include professional corporations in the Act. Professional corporations were added to Senate Bill No. 646 in conference committees after the bill had already been through two Senate committees and one House committee. Since the relevant language was added to the bill in conference committee, it is difficult to establish with any degree of certainty why it was added. The reason the legislature was concerned was that it knew professional corporations could be liable for their doctor stockholders' and doctor employees' negligent acts through respondeat superior and it wanted corporations to have the limited protection provided by the Act. This is the only logical explanation of why corporations were included. There is no question that the doctrine of respondeat superior was applicable to doctors and their corporations in Kansas at the time of enactment. See *Jacobson v. Parrill*, 186 Kan. 467, 472, 351 P.2d 194 (1960).

So, instead of abrogating the doctrine of respondeat superior as

appellant contends, the professional corporations were added as health care providers to protect the professional corporations from unlimited exposure. If this was not the underlying intent of the legislature, it most certainly has had that effect because all professional corporations of doctors in Kansas now have professional liability policies and these policies cover their employee doctors.

In their second argument, appellants contend because doctors and corporations are both defined as health care providers and are required to carry the basic coverage limits, the doctrine of respondeat superior is inapplicable. There must be a showing of independent fault on the parts of the doctor and the professional corporation before the professional corporation is liable. Or, in other words, appellants contend that the legislature changed the tort law of vicarious liability in Kansas by requiring both the doctors and professional corporations to have the coverage.

This court reviewed the doctrine of respondeat superior or vicarious liability as applied to corporations in *Kline v. Multi-Media Cablevision, Inc.*, 233 Kan. 988, 989, 666 P.2d 711 (1983):

"[A] corporation is liable for the torts of its agent when committed within the scope of the agent's authority and course of employment even though it did not authorize or ratify the tortious acts. [Citation omitted.] A related rule of law states a principal is responsible for the torts of its agent where the tortious acts are incidental to and in furtherance of the principal's business, even though outside the scope of the agent's authority."

The rationale for the doctrine of respondeat superior was stated in 53 Am. Jur. 2d, Master and Servant § 417 at p. 432:

"The doctrine of respondeat superior, under which liability is imposed upon the master for the acts of his servants committed in the course or within the scope of their employment, has its foundation or origin in consideration of public policy, convenience, and justice. It is elemental that every person in the management of his affairs shall so conduct them as not to cause an injury to another, and if he undertakes to manage his affairs through others, he remains bound so to manage them that third persons are not injured by any breach of legal duty on the part of such others while they are engaged upon his business and within the scope of their authority. 'The maxim of respondeat superior,' said Lord Chief Justice Best in Hall v. Smith, 'is bottomed on this principal: that he who expects to derive advantage from an act which is done by another for him must answer for any injury which a third person may sustain from it.' "

A professional corporation is subject to certain responsibilities when it is formed. Health care providers who incorporate may do so to gain certain advantages. They must also accept certain

liabilities, such as the application of the doctrine of respondeat superior. Such liability may result in greater care being taken by professional corporations when employing physicians.

There is no indication in the Act or in legislative committee reports or minutes indicating the legislature intended to abrogate the application of respondeat superior to professional corporations who are health care providers. K.S.A. 40-3402 requires each health care provider to maintain minimum malpractice insurance of $100,000.00 per occurrence and an annual aggregate of $300,000.00 for all claims made during the period. The Fund will pay the amount in excess of the basic coverage liability. K.S.A. 1983 Supp. 40-3403(*b*). The Act does not limit liability to $100,000.00 for all health care providers in any occurrence. It only limits each health care provider's liability to $100,000.00 for each occurrence. Several health care providers can be held liable in the same malpractice action. The Act's goal of limiting the cost of malpractice insurance may be still reached, although a professional corporate health care provider is subject to malpractice liability, for the reason its potential liability is restricted by the Act.

The legislature made these decisions based upon other considerations, not because it wanted to address vicarious liability of doctors and their corporations. If the legislature had intended to abrogate the doctrine of respondeat superior as to professional corporations, it could have and would have done so through the enactment of specific and definitive legislation. But, it did not do this. The reason why is that it did not consider abrogating this long-standing rule of law as to doctors and their professional corporations. Since the rule of respondeat superior was not changed as to doctors and professional corporations by the legislature in the Act, the rule is still applicable to Dr. Sifers and the Corporation. Therefore, the Corporation is responsible for the negligent act of its employee. As such, the trial court's ruling is correct and must be upheld.

Subsequent to the jury verdict of November 24, 1982, the trial court scheduled a hearing for December 8, 1982, to determine whether the separate award to the plaintiff on behalf of her husband should be reduced by the percentage of fault attributed to the plaintiff. After the hearing the issue was taken under advisement by the court. By Memorandum Decision dated and

filed January 4, 1983, the trial court ruled that any recovery for Terry McGuire pursuant to K.S.A. 23-205 should be reduced by the percentage of fault attributed to the plaintiff. The plaintiff cross-appealed from this decision. A Journal Entry of Judgment in the amount of $443,300.00 was signed by all parties and filed with the Clerk of the District Court of Johnson County, Kansas on January 5, 1983.

A Motion for New Trial or, in the Alternative, the Request for Remittitur was filed by defendants on January 17, 1983. On February 3, 1983, the trial court overruled both motions.

On February 4, 1983, the Fund mailed $243,300.00 to the Clerk of the District Court as full payment of its share of the judgment.

March 2, 1983, defendants filed a Notice of Appeal. Dr. Sifers filed a separate motion requesting the trial court issue an order to allow payment of $100,000.00 into court, to toll the interest on that portion of the judgment against Dr. Sifers. That motion was granted the same day. As a result, the Medical Protective Company, on behalf of Dr. Sifers, paid the amount of $100,000.00 into the Clerk of the District Court.

The Insurance Commissioner's motion to intervene, on behalf of the Fund, was granted April 6, 1983.

A motion was filed by plaintiff asking the court to fix a date from which interest should run on the judgment amount, and a hearing was duly held on March 11, 1983. The trial court ruled that since less than the total amount had been tendered to the Clerk of the District Court, the statutory interest rate of 15% should run on the total amount of the judgment of $443,330.00, even though $343,300.00 had previously been paid into court. The trial court further ruled that the statutory interest rate of 15% should attach to the judgment as of the date of the jury verdict of November 24, 1982, as opposed to the date the journal entry of judgment was filed, January 5, 1983.

The defendants and the Insurance Commissioner raise two questions concerning postjudgment interest.

First, the defendants and the Insurance Commissioner contend postjudgment interest should run from January 5, 1983, the day the journal entry was filed, not from the November 4, 1982, date the verdict was returned by the jury. The parties complain the trial court erred when it ordered postjudgment interest to run from the date of the verdict.

Plaintiff cites *Reel v. Kress & Co.*, 192 Kan. 525, 389 P.2d 831 (1964); *Degnan v. Young Bros. Cattle Co.*, 152 Kan. 250, 103 P.2d 918 (1940); *Koontz v. Weide*, 111 Kan. 709, 208 Pac. 651 (1922). All cases cited by the plaintiff predate the 1976 amendment of K.S.A. 60-258.

K.S.A. 1983 Supp. 16-204(*c*) provides:

"Any judgment rendered by a court of this state on or after July 1, 1982, shall bear interest on and after the day on which the judgment is rendered, at the rate of 15% per annum."

In *State v. Dubish*, 234 Kan. 708, 714, 675 P.2d 877 (1984), the court stated:

"K.S.A. 60-258 was amended in 1976, and now provides:

" 'Entry of judgments [shall] be subject to the provisions of section 60-254(*b*). No judgment shall be effective unless and until a journal entry or judgment form is signed by the trial judge and filed with the clerk of the court. . . .

" 'When judgment is entered by judgment form the clerk shall serve a copy of the judgment form on all attorneys of record within three days. Service may be made personally or by mail. Failure of service of a copy of the judgment form shall not affect the validity of the judgment.'

"The new statute's language is clear. No judgment is effective unless and until a journal entry or judgment form is signed by the trial judge and filed with the clerk of the court. *In re Estate of Burns*, 227 Kan. 573, 575, 608 P.2d 942 (1980)."

Under the present statute, there is no judgment rendered for interest to commence until a journal entry or judgment form is signed by the trial judge and filed with the clerk of the court. See 1 Gard's Kansas C. Civ. Proc. 2d Annot. § 60-258 (1979).

Where there is more than one claim for relief or multiple parties K.S.A. 60-258 states entry of judgment shall be subject to the provisions of K.S.A. 60-254(*b*), which provides:

"When more than one claim for relief is presented in an action, whether as a claim, counterclaim, cross-claim, or third-party claim, or when multiple parties are involved, the court may direct the entry of a final judgment as to one or more but fewer than all of the claims or parties only upon an express determination that there is no just reason for delay and upon an express direction for the entry of judgment. In the absence of such determination and direction, any order or other form of decision, however designated, which adjudicates fewer than all the claims or the rights and liabilities of fewer than all the parties shall not terminate the action as to any of the claims or parties, and the order or other form of decision is subject to revision at any time before the entry of judgment adjudicating all the claims and the rights and liabilities of all the parties."

Plaintiff argues all issues were resolved on Count I, the claim for

her own injuries, when the verdict was returned by the jury; unresolved issues remained only on Count II, the claim for loss of consortium, and therefore, postjudgment interest should run on Count I from the date the verdict was returned. This is incorrect. A final judgment of one or more of the claims in a lawsuit pursuant to K.S.A. 60-254(*b*), to be effective, must follow the filing requirements of K.S.A. 60-258. Without a journal entry or judgment form as prescribed by K.S.A. 60-258, there was no judgment on any issue. It is error to allow interest on a verdict for unliquidated damages for the time between its finding and rendition of the judgment thereon. *Milling Co. v. Buoy,* 71 Kan. 293, Syl. ¶ 3, 80 Pac. 591 (1905).

The plaintiff claims losing parties by delaying the entry of judgment are capable of denying the prevailing party interest it is entitled to receive. In most cases a journal entry can be filed, finalizing judgment, shortly after trial. Trial courts should prevent intentional delay of the entry of judgment by filing a judgment form or requiring that a journal entry be signed and filed with the clerk of the court as soon as possible.

Second, the defendants' and the Insurance Commissioner's claim is that the trial court erred in ruling postjudgment interest should run on the $443,300.00 judgment although $343,300.00 was paid to the clerk of the district court. The Insurance Commissioner on behalf of the Health Care Stabilization Fund paid $243,300.00 into court and Dr. Sifers' insurer paid $100,000.00 into court.

In *Schaefer & Associates v. Schirmer,* 3 Kan. App. 2d 114, 119-20, 590 P.2d 1087 (1979), Judge Spencer wrote:

"If the judgment debtor wishes to avoid the accrual of interest on appeal, he must *tender* the amount of the judgment or pay the amount into court. [Citations omitted.]

"The trial court offered plaintiff the opportunity to avoid the accrual of interest on appeal by making payment into court, with appropriate orders directing that such would not constitute an acquiescence. Plaintiff did not avail itself of that opportunity. Under our statute, interest on the judgment must therefore continue to accrue until it is paid." Emphasis supplied.

In *Bartlett v. Heersche,* 209 Kan. 369, Syl. ¶ 2, 496 P.2d 1314 (1972), this court stated:

"Once a judgment debtor pays the full amount of money payable on a judgment into court, interest is not recoverable on the monies deposited in court."

Neither *Bartlett* nor *Schaefer* addresses the question of whether partial payment of a judgment tolls postjudgment interest on the portion paid into court, but the language used in the opinions suggests a judgment debtor must pay the full amount of the judgment into court to toll postjudgment interest. In *Schaefer* the word "tender" is utilized. This court stated in *Carpenter v. Riley,* 234 Kan. 758, Syl. ¶ 1, 675 P.2d 900 (1984):

"Tender is an unconditional offer to perform a condition or obligation. The party making tender must have the ability for immediate performance. The tender must be absolute and unconditional to be effectual."

47 C.J.S., Interest & Usury § 62, pp.148-50 states:

"To suspend the accrual of interest on a debt, a tender must be in the full amount owed by the debtor, as adjudicated by the trial court, or on appeal, regardless of whether the tender is made before or after the bringing of a suit. Accordingly, this rule is applicable to tenders made before bringing suit, or during litigation, or after judgment, and pending appeal.

"The accrual of interest on a debt is not generally suspended by the tender in an amount less than the amount due, and the fact that there is a bona fide dispute as to the amount of the indebtedness is no bar to granting of interest if the amount offered falls short of the amount found to be due. Thus, a tender of the principal amount of an indebtedness may not stop the accrual of interest thereon where it does not include accrued interest, costs, or attorney fees. . . .

"A partial payment of a judgment into court, however, may stop the accrual of interest on that part of the judgment that has been satisfied, if it is a legally sufficient tender and can be treated as a partial payment, and if the clerk of the court is directed to apply the partial payment to the reduction of the amount of the judgment."

Dr. Sifers' insurer and the intervenor Insurance Commissioner did not intend their payment into court to be a partial payment of their portion of the judgment. Their intent was to fully pay the portion of the judgment for which they were responsible to the plaintiff, thereby tolling the statutory rate of interest pending appeal.

The defendants and the intervenor argue the plaintiff is receiving an unfair windfall because she is receiving statutory postjudgment interest at a 15% interest rate and close to 9% interest on the funds already paid into court. To hold that the accrual of interest was not tolled will unjustly enrich the plaintiff who is receiving interest on the money already paid plus, under the trial court's order, statutory interest of 15% on the entire judgment until paid.

47 C.J.S., Interest & Usury § 23, p. 69, contains this statement:

"The allowance of interest on a judgment, under the statutes, is not a measure of damages, but a compensation fixed by law for the purpose of indemnifying the judgment creditor for the nonpayment of the liquidated claim and the loss of the use of his money, although the interest has been held to be a legal incident of the judgment, and a distinct substantive part of the debt."

We have determined the professional corporation's insurer was responsible for its employee's, Dr. Sifers, negligent acts while treating the plaintiff. The Corporation's insurer, as a health care provider, was subject to liability not to exceed $100,000.00 for its employee's negligent act notwithstanding that the employee, Dr. Sifers, also a health care provider, was required to pay $100,000.00. Therefore, Dr. Sifers' insurer and the Fund have paid into court the full amount of the judgments against them. The remaining unpaid portion of the judgment ($100,000.00) was the responsibility of the professional corporation's insurer. Payment by Dr. Sifers' insurer and the Insurance Commissioner for the Fund was an unconditional tender of the full amount they owed. There was no partial payment of the judgment against Dr. Sifers' insurer and the Fund. The professional corporation, having failed to pay its proper portion of the judgment, owes the remaining $100,000.00, at the legal rate of interest allowed by law from the date the journal entry was filed with the clerk of the court.

The plaintiff cross-appeals from the trial court's ruling that the award for the plaintiff's loss of consortium claim be reduced by the comparative fault attributed to the plaintiff. The question is one of first impression.

Loss of consortium actions are brought pursuant to K.S.A. 23-205, which provides:

"Where, through the wrong of another, a married person shall sustain personal injuries causing the loss or impairment of his or her ability to perform services, *the right of action to recover damages for such loss or impairment shall vest solely in such person*, and any recovery therefor, so far as it is based upon the loss or impairment of his or her ability to perform services in the household and in the discharge of his or her domestic duties, shall be for the benefit of such person's spouse so far as he or she shall be entitled thereto. Nothing herein shall in any way affect the right of the spouse to recover damages for the wrongful death of his or her spouse." Emphasis supplied.

K.S.A. 60-258a(*a*), a portion of the comparative negligence statute, states:

"(*a*) The contributory negligence of any party in a civil action shall not bar such party or said party's legal representative from recovering damages for negligence resulting in death, personal injury or property damage, if such party's negligence was less than the causal negligence of the party or parties against whom claim for recovery is made, *but the award of damages to any party in such action shall be diminished in proportion to the amount of negligence attributed to such party.* If any such party is claiming damages for a decedent's wrongful death, the negligence of the decedent, if any, shall be imputed to such party." Emphasis supplied.

The right to recover for loss of consortium vests in the spouse who files an action for personal injuries, not in the spouse who actually suffers the loss of consortium. K.S.A. 23-205. See *Cornett v. City of Neodesha*, 187 Kan. 60, 62, 353 P.2d 975 (1960). The award of damages for loss of consortium is to the plaintiff for the benefit of the spouse. K.S.A. 60-258a(*a*) requires the award for damages to any party shall be reduced by the amount of negligence attributed to such party. The language of our statutes requires the award for loss of consortium be reduced by the percentage of the injured spouse's fault. See also *Miles v. West*, 224 Kan. 284, 580 P.2d 876 (1978). The trial court was correct.

Affirmed in part and reversed in part.

Slightly more than an inch of rain had swollen Indian Creek and other waterways in the Kansas City area late Friday and early Saturday. But there was little substantial property

the Kansas City area, leaving clouds and temperatures in the mid-40s.

About the same time Mrs. Lucas left

See Search, pg. 22A, col. 1

Critics say Kansas too easy on incompetent doctors

By Jenny Deam and Eric Palmer
staff writers

The Kansas Board of Healing Arts was created a generation ago for doctors to protect the public against incompetence by policing their own ranks.

But the handling of some recent cases has raised questions about just who is being protected.

Critics contend that the 13-member board takes months, sometimes years, to review public complaints, leaving the public vulnerable against potentially bad doctors.

And even when action is taken, the outcome of disciplinary proceedings has shown an inability or unwillingness by board members to take a firm stand against their peers, say other doctors, patients and their lawyers.

Last year, four doctors out of the 4,188 practicing medical doctors, doctors of osteopathy and chiropractors in Kansas lost licenses, according to board officials.

During the two years before that, only one doctor per year lost his license.

In one 1982 case, the board decided not to discipline a well-known Wichita physician who had been sued five times for performing allegedly unnecessary rectal surgery on small children.

An expert witness from California who came to Kansas to testify at the proceedings found the outcome unsettling.

"The final verdict came down skewed in favor of protecting the doctor," Dr. David Fleisher, a pediatrician from Los Angeles, said in a recent interview.

Board members and staff deny that

See Doctors, pg. 12A, col. 1

Doctors continued from pg. 1A

they cannot take a firm stand against doctors when it is appropriate.

"We are not headhunters," said Betty Jo McNett, the board's president and only lay person member. "We investigate any complaint that comes before us but we don't try to find doctors that need discipline.

"All the doctors (on the board) are open-minded and fair and we do protect the public."

Board members and staff say they have taken steps, including the addition of two full-time lawyers in the last two years, to promote a more aggressive stance in disciplining bad doctors.

They concede the board has been slow in handling some cases, but say it does the best it can within the framework allowed by state lawmakers.

The discipline process is slow and "cumbersome" but is necessary to ensure due process rights for accused doctors, board officials say.

"Until we prove the case we can't say someone can't practice medicine," said Donald Strole, the board's general counsel since 1983.

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In 1957 Kansas lawmakers created the medical regulatory board, which is composed almost entirely of doctors and is financed by doctors' license fees.

Currently it is made up of five medical doctors, three doctors of osteopathy, three chiropractors, one podiatrist and one lay person. Each member is appointed by the governor and paid $35 for each of their bimonthly meetings, plus expenses.

During the last year an estimated 150 complaints were lodged against doctors across the state. But board officials say the vast majority of those did not warrant board action.

In the four cases in which licenses were lost, one was surrendered by a doctor already in prison after being convicted of trading drugs for homosexual acts. Another was from a doctor with a drinking problem who gave up his license on the condition his name not be made public. His license has since been reinstated.

A doctor accused of incompetence in obstetrics surrendered his license and now practices in California. The fourth case involved a resident doctor at the University of Kansas Medical Center who submitted false medical school credentials.

By comparison, in Missouri, which has more than twice as many doctors as Kansas, there were seven times as many licenses revoked or surrendered during 1983—28 out of the 8,745 practicing in the state.

And Missouri's Board of Registration for the Healing Arts currently is seeking to restrict the license of the president of the Missouri State Medical Association, who is accused of gross negligence and misconduct.

Gary Clark, executive secretary of the Missouri board, said the process takes more time than he would like but that the most serious cases are always dealt with first to provide the most protection for the public.

"We have a good system in Missouri," he said. "There is no question about it. The public is protected."

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In Kansas, it is not the licenses revoked that have brought the most public comment. It is those that have not been.

For example:

● Dr. Earl Sifers, a general surgeon with offices in Merriam and Kansas City, Kan., has been sued 18 times in the last four years for malpractice. Some of those patients allege he performed unnecessary mastectomies—the surgical removal of a breast—and all claim he botched treatment after the surgery.

He has been barred from performing breast surgery at Bethany Medical Center and his surgery has been restricted at Shawnee Mission Medical Center.

Dr. Sifers has maintained in sworn testimony that he has one of the best surgical records in Kansas City.

Recently he filed a multimillion-dollar suit against Shawnee Mission Medical Center in an attempt to get his privileges there reinstated. He contends the action against him by the hospital was arbitrary and damaged his reputation.

Mr. Strole said the board began reviewing the Sifers case two years ago when it learned malpractice suits had been filed. He said it will still be several months before a decision is rendered on whether there is "probable cause" to call a license revocation hearing.

The board already has required Dr. Sifers to get a psychological and neurological evaluation. The Mayo Clinic in Minnesota gave him a clean bill of health, Mr. Strole said.

The board also has sent pathology reports on some of Dr. Sifers' patients to other doctors for review.

But Mr. Strole said that because Dr. Sifers is no longer doing mastectomies, the case may be dropped.

Ms. McNett said, however, she questions whether the case has moved quickly enough.

"I don't feel the public is being adequately protected in this instance," she said.

Dr. Gordon Maxwell, a Salina obstetrician and gynecologist who has been on the board since 1979, disagrees.

"I'm certain from the public's viewpoint it looks like we're sitting on it, but in real terms, in legal terms, we're doing everything we can," he said.

● Dr. Richard Brownrigg, a Dodge City urologist and former mayor, was convicted last fall of shooting his ex-wife's boyfriend five times. Although Dr. Brownrigg contended he acted in self-defense, he was sentenced to three to 10 years in prison on an aggravated battery charge.

Dr. Brownrigg was summoned to Topeka last December for a license revocation hearing, but the board voted unanimously to allow him to continue his practice. Mr. Strole said the doctor "made a very favorable impression" on the board.

He defended the board's action, saying the shooting did not directly affect Dr. Brownrigg's medical practice and no patients have complained.

But Dan Love, Ford County attorney, said he questions the board's lack of action against a convicted felon. He said that during the trial he pointed to the apparent conflict between shooting a man and a doctor's sworn oath of protecting human life.

Mr. Strole said the board did not see it that way.

"There was no evidence this is anything but an isolated incident," he said.

Dr. Brownrigg is now appealing his conviction. Should he be imprisoned, Mr. Strole said he would urge that the doctor be allowed to continue his practice behind bars.

● Dr. Clifford Jones, a Wichita general practitioner, had his license suspended because of drinking, but it was reinstated with a signed agreement by the doctor not to drink, board members said.

He was called back before the board in March 1981 on new complaints of a drinking problem.

At that hearing, some board members said they believed Dr. Jones' speech was slurred and he appeared intoxicated. It was decided, however, that no action would be taken that day, according to board members.

On his way home from the Topeka hearing, Dr. Jones was killed in a one-car accident on the Kansas Turnpike. Kansas Highway Patrol reports show his blood alcohol level was 0.31 percent—more than three times the legal limit of intoxication.

Dr. Maxwell defended the board's lack of action. "We don't have the power to arrest people," he said.

● Dr. Medo Mirza, a Wichita pediatric surgeon, was called before the board in 1982 after five malpractice suits claiming unnecessary surgery on children were settled out of court.

It took six days of hearings over two months to hear what some call the most emotional case ever to come before the board.

On one side were parents and doctors who alleged that Dr. Mirza had performed rectal surgery after misdiagnosing a rare intestinal condition.

Jan Vyff Payne of Wichita said in an interview that her 2-month-old daughter was taken to the doctor for constipation. Shannon Vyff was diagnosed as having Hirschsprung's disease, or a lack of nerve endings in the lower portion of her large intestine and rectal area. Other doctors testified that she did not have the disease.

Eventually Shannon underwent 23 surgeries by the time she was in the first grade to correct the damage done by the original surgery by Dr. Mirza, her mother said.

On the other side were parents who said the surgeon had saved their children's lives. They believed he was being persecuted.

In the end, the board concluded there was not enough evidence to revoke the doctor's license.

But now, three years later, there has been some rethinking. Ms. McNett concedes all of the evidence may not have been presented because the board's part-time attorney was not fully prepared.

Gerald Michaud, a Wichita lawyer who specializes in malpractice cases, called the proceeding a "whitewash."

Mr. Michaud was the plaintiffs' attorney in the suits against the surgeon and said he was told by the board's appointed attorney that he could assist in its case against the doctor. He contends he had years' worth of evidence about the case that could have been presented.

But the lawyer said he was barred by the board from assisting.

Instead, the case was handled solely by Topeka lawyer Wallace Buck, the board's appointed attorney.

Mr. Buck said in a recent interview he could not recall why Mr. Michaud was not allowed to assist in the case. He said he believed the reason may have been that the presence of Mr. Michaud may have been too inflammatory.

"We weren't in there necessarily to take a doctor's license," he said. "It was to present all the evidence."

He said he believed all of the evidence was indeed presented and the outcome of the case was correct.

Mr. Strole said, however, that the board may have erred in not allowing Mr. Michaud to participate. "Michaud would be in there if I had anything to say about it," he said.

Dr. Fleisher, a clinical professor of pediatrics at the University of California at Los Angeles and pediatrician at Cedars-Sinai Medical Center, testified at the hearing about three of the five children allegedly misdiagnosed by Dr. Mirza. Following their initial surgery by Dr. Mirza, Dr. Fleisher became the children's doctor.

He said he was surprised by the board's decision not to discipline Dr. Mirza. He contended in a recent interview that the board was "working at protecting the rights of the doctor with, perhaps, not enough consideration for the vulnerability of the patients."

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Seeing a problem in disciplining the state's doctors, legislators last year approved a bill designed to bolster the board's effectiveness.

Born out of the Senate's Ways and Means Committee, Senate Bill 507 both added a full-time prosecutor to the board's staff and created independent review panels to decide the merit of complaints against doctors.

But those close to the board see the new law as a mixed blessing.

On one hand they applaud the addition of a prosecutor, a position they say has been needed to aggressively handle cases. But on the other hand, the board sees the review panels as another layer in an already burdensome process.

Prior to last year, the board relied on appointed attorneys to act as prosecutor at discipline hearings. Mr. Strole said that often those attorneys were unfamiliar with the cases they were expected to handle.

In September, Topeka lawyer Larry Buening assumed duties as the board's prosecutor, becoming the board's second full-time staff attorney.

But even with that change, some say the board's problems of inaction are so deeply ingrained that the addition of one lawyer will not solve them.

Staff and board members alike criticize the addition of review panels to the discipline process.

Mr. Strole said the added step will "allow the doctor another vehicle to escape liability."

Currently, when a complaint against a doctor is lodged, it goes first to Mr. Buening and the state's lone investigator for review. By comparison, Missouri has a staff of seven investigators.

If merit is found by Mr. Buening, the complaint is forwarded to the review panel—an independent committee composed of three doctors within the same medical field. If the panel decides there should be further action, the case is sent to the board for a hearing.

"I don't feel the review committees are necessary," said Ms. McNett.

Mr. Strole said the board has recently taken steps to deal with potentially dangerous situations more quickly.

As in the Sifers case, he said the board has begun seeking agreements from doctors to limit their practice or voluntarily cease the part of their practice that is causing complaints. That way, Mr. Strole said, the public is protected but the doctor can keep his license.

Both Mr. Buening and Mr. Strole complain of a lack of cooperation from state agencies as they gather information to launch an investigation.

Mr. Strole said the state Department of Insurance repeatedly has failed to provide information about doctors who are the subject of repeated malpractice cases. He claims the insurance department, which administers the state's malpractice fund, has evidence that would be useful in investigations.

A measure was introduced this year by the state Senate's Judiciary Committee to force the insurance department to turn over documents to the board.

Officials with the insurance department say the only records denied are those about malpractice cases that court has ordered closed.

STAR FORUM

Real Estate/Pages 5D

Sunday, March 17, 1985 Page 1D

Malpractice debate

Doctors seek limit on awards, fees

By Thomas L. Taylor, M.D.

Professional liability in general is a complex problem, as patients, doctors, lawyers, lawmakers, jurors, insurance professionals, economists, engineers, architects and journalists all acknowledge. Medical malpractice in particular was described as a "complex problem" 12 years ago in an HEW Commission report. Unfortunately, it is 12 years more complex now than it was then.

The protection I am required to purchase to maintain a license to practice general surgery in Kansas will be 12 times greater this year than it was when that HEW report was published. Doctors in Kansas purchase basic coverage limits of $200,000 and pay a surcharge to a fund administered by the state insurance commissioner's office.

But instead of stabilizing the problem as it was envisioned by our lawmakers, our Health Care Stabilization Fund has been used by some trial lawyers in much the same way that a wily fox uses the farmer who tries to remedy the fox problem by putting more chickens in the coop. Our coop is empty in spite of the 80 to 120 percent surcharge that physicians pay in addition to their basic premium cost.

The burden of the medical malpractice problem includes, but goes far beyond, the financial burden shouldered by the doctor. There will be increasing numbers of doctors who simply will not be able to sustain that cost in managing their practice. Ultimately, the dollar cost, and more importantly intangible attrition costs, will be borne by the public at large.

The Hyatt skywalk collapse was a bell ringer. People in general, and jurors in particular, began to think in terms of multimillion-dollar awards for the tragic personal injuries that resulted from the July 17, 1981, disaster.

Since then there have been many multimillion-dollar awards in and out of court for medical malpractice. Most recently, the punitive damages award against a Johnson County hospital and a group of obstetricians (two of whom had no personal involvement with the case) has received some publicity.

The prospects that all of us now share regarding the specter of alleged punitive

See Pro, pg. 4D, col. 1

Dr. Thomas L. Taylor is a general surgeon in private practice in Johnson County. He is president of the Johnson County Medical Society.

Bill in Legislature

These articles on medical malpractice litigation are prompted by a measure being considered by the Kansas Legislature. The Senate has approved a bill that incorporates certain provisions among those discussed here. All of the issues are expected to be raised as debate unfolds in the House.

Pro *continued from pg. 1D*

damages is frightening because our malpractice insurance does not protect us from punitive damages. A doctor does not willfully cause a bad result, but bad results do happen. Punitive damage implies willful harm, and should be dealt with on a different level from the trial for medical malpractice.

Some states have already enacted statutes which prevent punitive damages in the course of a medical malpractice trial. We are seeking that provision in our bill.

There is no question that people at times are injured in the course of health care delivery. Health care delivery is hazardous, just as the lack of health care delivery can be hazardous. The hazards are compounded as we avail ourselves of high technology, potent pharmacologic agents and multiple complex treatment modalities.

The variable response to these treatment modalities will at times be less than satisfactory but the maloccurrence variables which will inevitably occur in our imperfect science should not be mistaken for malpractice. Nor should the imperfect results of our attempts to improve the imperfect health of our patients be construed as negligence. The present system is not working as effectively as it could to compensate the injured patient, and is not working as fairly as it should for our health care providers. The bill which the Kansas Medical Society has introduced is designed to improve tha system.

In addition to the punitive damages provision, our bill proposes a change in the "collateral source rule." Under the current law, evidence that a plantiff has had medical bills and other damages paid from another source (such as private insurance, state welfare, Medicare or workmen's compensation funds) is not admissable in a malpractice trial. As a result, juries often award money for damages or costs which have already been paid. That is double dipping, and adds to the cost the system must absorb. We suggest that this rule of law be changed so juries can know if damages, costs or lost wages have been compensated from those other (collateral) sources.

We are also proposing a limit on awards. An independently conducted statewide survey and a survey recently published by a Johnson County newspaper indicated that the vast majority of Kansas citizens and Johnson County citizens favor a limit on awards. A reasonable limit on awards, which we have proposed, would help to stabilize the cost of our premiums.

One of the most controversial provisions of our bill recommends a limit on a portion of the plantiff's attorney contingent fee. We are not suggesting a limit on the contingent fee for the first $200,000 of a medical malpractice award. We believe it is appropriate for that to be contractually arranged between the attorney and his or her client. We are proposing a 15 percent limit on the contingent fee for any part of the award that exceeds $200,000. That is the part of the award that comes from the state-administered health care stablization fund. That limit would help to stabilize our fund, and would provide more premium dollars for the injured patient.

Detractors of our bill claim there is no crisis, that doctors are overreacting and taking things too personally. Kansas doctors are responding to a problem that threatens the health and welfare and fiscal stability of all citizens of this state. And yes, we do take it very personally.

Historically, medicine has been an intensely personal profession, based on a relationship between two people, the doctor and the patient. Just as our intelligence, knowledge and skills are reflected in the scientific aspect of our practice, care, concern and compassion are personal attributes which mark the art of our practice.

So as human beings whose lives and personalities and expectations and standards of excellence are mirrored by and so intimately associated with our ability to take care of sick people, of course we take it personally when our professional integrity is assaulted. The present system encourages that. Since it is happening with increasing frequency, doctors are becoming increasingly frightened and wary. They are learning a new art in their practice, the art of defensive medicine. The cost of defensive medicine is difficult to quantitate; estimates range from $15 billion to $40 billion per year nationally. That money could be better spent. But until premiums and awards are stabilized, the incentive for us to practice defensive medicine will continue.

There is a pervasive sense of frustration among the members of our profession and many would like to get out. Sadly, many of our brightest, most competent and most recently trained physicians will not survive this current litigious climate. Who—then—will be the real victims of the malpractice crisis?

None of our proposals will make it more difficult to file or win a legitimate malpractice suit. Our proposals will, however, bring some reasonable reform to a legal system which was designed by attorneys, has been controlled by lawyers, is being protected from change by lawyers and which so heavily rewards lawyers. Patient care will be compromised unless something is done to change the legal system which threatens the future of the best health care delivery system in the world.

STAR FORUM

Real Estate/Pages 5D

Sunday, March 17, 1985 Page 1D

Malpractice debate

Bill threatens legal rights of victims

By Lynn Johnson

Senate Bill 110, created by the Kansas Medical Society and currently being considered by the Kansas Legislature, poses a tremendous threat to the legal rights of all Kansans.

The bill severely limits the ability of medical malpractice victims to seek fair compensation for their losses. It places tight restrictions on the amount of money a victim could receive for necessary, ongoing medical care. In general, it seeks to remake our system of justice so that only a few citizens benefit and the majority of the people of Kansas are placed at a disadvantage.

Con

The sponsor of the bill, the Kansas Medical Society, and its supporters say the bill is necessary because there is a medical malpractice "crisis." They say the bill will reduce the number and size of malpractice awards and malpractice premiums paid by physicians. They argue that with these reductions the overall cost of health care will be contained.

Are these arguments valid? Let's look at them and then see how this legislation would restrict the rights of Kansans.

Is there a medical malpractice "crisis"? There is a malpractice crisis but it is not the one generally cited by the medical society. The fundamental crisis concerns the appalling number of incidents of malpractice that occur. The California Medical Association and California Hospital Association conducted a joint study and found that one in 20 hospital admissions results in a disability caused by the way the patients' cases were managed by doctors and support staff. The report concluded: "Problems

See Con, pg. 4D, col. 1

Lynn Johnson, a lawyer with offices in Johnson and Wyandotte counties, is chairman of the Medical Malpractice Task Force of the Kansas Trial Lawyers Association.

Con

continued from pg. 1D

of performance, rather than purely judgmental issues, were the overwhelming mechanism."

Is the cost of malpractice premiums significantly driving up the cost of health care? In Kansas and nationally, malpractice premiums comprise less than 1 percent of the total health care dollar. According to the American Medical Association, this 1 percent ratio has been in place since 1968. This means that even if this entire area of law was abolished, no health care provider ever had to purchase insurance and every dollar was returned to the citizens of Kansas, the health care bill would be reduced by less than 1 percent.

Are health care dollars being wasted by physicians practicing "defensive medicine" and performing unnecessary tests? There are no studies that support this assertion. Even the AMA has expressed its doubts. A 1984 AMA "Study of Professional Liability Problems" said "... it would be a gross exaggeration to conclude that all of these costs (defensive medicine) are wasteful. Also, the vast majority of diagnostic testing that might be classified as 'defensive medicine' by hindsight proves to be clinically appropriate in the patient's interests and in defense of claims."

If by practicing "defensive medicine" doctors are providing more appropriate care to their patients, then it appears the AMA thinks the consumer is receiving better care and is less likely to be a victim of malpractice.

Is the cost of malpractice premiums paid by physicians too high? Kansas doctors will pay approximately 4 percent of their "after expenses, before taxes income" in malpractice insurance in 1985. In 1979, Kansas doctors paid approximately the same 4 percent of their income for liability insurance. Is this a major crisis? Clearly, it is not.

How will Senate Bill 110 restrict the rights of malpractice victims who seek fair compensation for their injuries? First, regardless of the degree of gross negligence, the law would forbid any punitive damages from being awarded. Second, the compensation for pain and suffering would be limited to $100,000. Third, the total compensation would be limited to $500,000. Funds for ongoing medical care are available only through a complicated and potentially costly process. Finally, the bill severely restricts the contingency fee system.

This bill will hurt all Kansans, but it is particularly harsh on those who are victims of severe malpractice. Forbidding a judgment for punitive damages means that no effort could be made by the court to punish or deter reckless or shocking behavior by doctors and hospitals. If a physician's negligence results in an otherwise healthy newborn baby being brain-damaged for life, no punitive damages could be assessed by the court.

Limiting the compensation for pain and suffering to $100,000 puts an appallingly low value on the dramatic changes that can occur in the quality of life of the victim. If an athletic young man loses the use of his legs as a result of malpractice he would be compensated only $100,000 for having to spend the rest of his life in a wheelchair.

The limitation of $500,000 for the total judgment means that if a victim received $100,000 for pain and suffering, he could then only receive $400,000 more as compensation for lost income and other economic damages. Even using the simplest math, it's clear the victim loses. If a 35-year-old father who earns $40,000 could no longer work, the law would only allow him to be compensated for $400,000 or 10 years of salary. Had he continued working with no raises or cost-of-living increases to age 65, he would have earned $1.2 million.

An absolute limit on future medical care is proposed in Senate Bill 110. For victims who suffer catastrophic injuries, such as brain damage, ongoing health care costs can be exorbitant. The jury would be prevented from making a judgment based on the specific facts in a case.

Moreover, the bill states that any "non-essential specialty items or devices of convenience" would not be covered. Determining what is "non-essential" or a "device of convenience" is a subjective judgment. Conceivably, a wheelchair is a device of convenience as is a van that is equipped to carry someone permanently confined to a wheelchair.

The bill also changes the way medical benefits would be paid to victims. The bill says medical benefits would be paid monthly to victims, and that at any time the court can review that monthly amount. The doctor convicted of malpractice has open access to the victim's medical records, can require the victim to undergo a yearly physical exam and can petition the court at any time to reduce the payments. This provision only ensures that the malpractice suit is never completed and that the victim can be continually harassed.

The contingency fee system is also under attack. The contingency fee system is the consumer's key to the courthouse. It allows victims of malpractice, regardless of their incomes, to seek justice and compensation for their injuries.

The amount of the contingency fee is a decision made by the client and his lawyer. Most victims have the choice of paying their lawyers an hourly fee, regardless of the outcome of the case, or using the contingency fee system. With the contingency fee system the lawyer only gets paid if the court grants an award to the victim. Because of this, the contingency fee system acts as an effective check against frivolous lawsuits.

The bill before the Legislature would set an arbitrary limit on the contingency fee. This would make it more difficult for most victims of malpractice to hire good lawyers and would place a severe financial burden on those who are injured. Preparation of a major malpractice case often takes several years. Under the current system, victims do not have to pay lawyers for the time spent preparing the case or during the trial. The lawyer only gets paid, even after years of work, if an award is made to the victim. Limiting the contingency fee would discourage lawyers from taking malpractice cases that involve extensive preparation. Once again, the rights of those most severely injured would be restricted.

Senate Bill 110 is designed to protect negligent physicians, not the victims of malpractice. The underlying motivations for this bill are twofold: The bill allows physicians to limit their financial liability, regardless of demonstrated negligence, and it frees them from any substantial responsibility for their actions.

Senate Bill 110 chooses as its primary target those victims who have suffered the most at the hands of negligent doctors: those Kansans who have sustained the most catastrophic injuries.

This issue is not just an academic debate. At stake are the very real rights of Kansans. This legislation would create laws that would severely restrict these rights and protect a special-interest group. This cannot be allowed to happen.

Error leaves patient near death

MIAMI (AP) — Doctors accidentally injected a toxic preservative into the spine of a 64-year-old retiree, leaving him comatose with little hope of recovery in what the head surgeon called "a tragic series of human errors."

The substance, glutaraldehyde, was mistaken for spinal fluid that had been removed earlier from the patient during an operation to remove a facial cancer, according to the surgeon, Dr. James Ryan Chandler.

The patient, Bob East, underwent the operation last Friday and was found to be brain dead on Monday. East, a photographer who retired earlier this year after more than 30 years with the Miami Herald, was listed in very guarded condition at Jackson Memorial Hospital.

Hospital officials said that if another scan indicated no brain activity, the family and doctors would decide whether to turn off life supports.

"I know nobody did this on purpose," said East's wife, Tina. "It just fills me with such terrible rage. I think that people who take other people's lives into their hands should be more careful."

The mixup was not discovered until an ophthalmologist, who had dropped off the toxic chemical in an unmarked bottle, returned to the operating room to retrieve it after about an hour. The substance was to be used to preserve the cancerous eye tissue that East was donating to research, Chandler explained.

The substance "was misidentified and then mislabeled and then was injected into the spinal column of Mr. East, thinking of course that the labeled material was spinal fluid," Chandler said.

The surgeon said spinal fluid is removed from patients in such operations and then reinjected after the procedure to check for leaks in protective brain covering, which is exposed during surgery.

What if these citizens were in Kansas?

Pregant woman paralyzed by drug injection

The Associated Press

ALBANY, N.Y. — A pregnant woman was irreversibly paralyzed from the neck down when a physician mistakenly injected a cancer drug into her spinal column instead of a vein, hospital officials said Friday.

The 21-year-old woman, who is 6 months pregnant, was undergoing chemotherapy treatment for a malignant tumor in her sinuses Feb. 27 when a staff resident at Albany Medical Center Hospital misread the label on a syringe, said Dr. Gregory Harper, the woman's attending physician.

The drug, called vincristine, is intended for intravenous use only, but the resident injected it along with other medications into the woman's spinal column, said Dr. Harper. Another resident was observing the procedure, and Dr. Harper was not in the hospital at the time.

The mistake was discovered about an hour later when nurses came in to inject the vincristine and could not find the syringe, said Dr. Harper. Doctors then attempted to flush out the woman's spinal column with a saline solution and used intravenous drugs to try to stop the effects of the vincristine, he said.

The Albany-area woman, who hospital officials said would not be identified, must use a respirator to breathe. Because the vincristine bound itself to her nervous system tissues, the paralysis is irreversible, Dr. Harper said.

The woman is not comatose, and she was told of her condition. The unborn child was not affected and is maintaining a stable heart rate, doctors said.

Dr. Harper said that of 20 to 30 cases he knows of worldwide in which vincristine was injected in the spinal column, only one patient, a 10-year-old boy in Helsinki, Finland, survived. The drug has been used for 15 years to treat a wide variety of cancers.

The state Health Department is investigating the incident, and the residents, who were not identified, were reassigned within the hospital, Dr. Vanko said.

In a similar case, Bob East, a retired photographer for *The Miami Herald*, was pronounced brain dead on Tuesday, four days after doctors at Jackson Memorial Medical Center in Miami accidentally injected him with a chemical preservative during surgery for facial cancer.

payrolls of up to $600 million, and a chance to tie into the future of the auto industry.

"This is the cutting edge," says Joseph Ferran, official with the Texas Economic Development Commission. "We want to be in on it."

State officials like Mr. Ferran are tripping over each other to sell GM on their states. On state and city economic development boards, where a new factory offering only a few score jobs can

plant is being called the prize of the century.

In Michigan, they're talking about their commitment to the "automobile culture" and vow to beat any offer.

There's tough talk in Missouri, too.

"Missouri is the No. 2 automaker, and we plan to be No. 1," said Randy Sissel, press secretary to Gov. John Ashcroft. "So we have to be very aggressive in our

See Saturn, pg. 10A, col. 1

No. 1

Tiffany Chin, of the San Diego Figure Skating Club, skates to victory in the Seniors Ladies U.S. Figure Skating Championships competition at Kemper Arena Saturday. See story on Page 1 Sports. (staff photo by Jim McTaggart)

tors say most of the companies in the program are not cheating, though they do admit that Jenkins and Stapleton's is among perhaps dozens of firms in Missouri and Kansas with dubious claims t minority and female ownership.

The problem is by no means limited to Kansas and Missouri.

See Firms, pg. 14A, col. 1

Breast removal and implant: Did the doctor know best?

By Eric Palmer and Jenny Deam
staff writers

Dr. Earl Churchill Sifers had a vision. With the zeal of a medical pioneer, he wanted to rid women of the horror of breast cancer.

His theory was unconventional and unproven—remove a woman's breast at the first suspicion of cancer, even without solid proof of the disease. Then, to keep her self-esteem intact, implant an artificial breast.

But the vision would bring its own horror to some.

Of the 222 women on whom he has operated since 1969, 16 have sued the Mission Hills general surgeon in the last four years, claiming malpractice and negligence.

They claimed in their lawsuits to suffer for months—sometimes years—from serious infection that kept wounds from healing and fears from subsiding. Some claimed that second and third surgeries were necessary to repair the damage when silicone implants broke through the skin.

All who filed suit claimed to be permanently scarred, both physically and emotionally.

Of the women who claimed Dr. Sifers failed to heal them, 13 say they are victims of a double tragedy. They have said in their lawsuits, and experts have testified in some cases, that the surgeries were unnecessary because cancer was not detected.

(A Merriam woman describes complications she suffered after having a mastectomy and getting artificial breast implants. Page 12A.)

Dr. Sifers has conceded in testimony that two-thirds of all the women he operated on did not have cancer. He also testified that in 40 of the women he treated, breast implants broke through the skin—a rate considered exceedingly high by other medical experts.

But he has denied in sworn testimony any negligence and stated that his surgery record is one of the best in Kansas City.

Dr. Sifers, 61, would not agree to an interview for this story on the recommendation of his attorneys. His attorneys also declined comment because cases are pending.

His comments in this story were drawn from his court testimony in one lawsuit and his sworn deposition in another.

Six of the 16 lawsuits have been settled for more than $1.5 million before they reached trial. The rest are expected to be resolved this year, lawyers say.

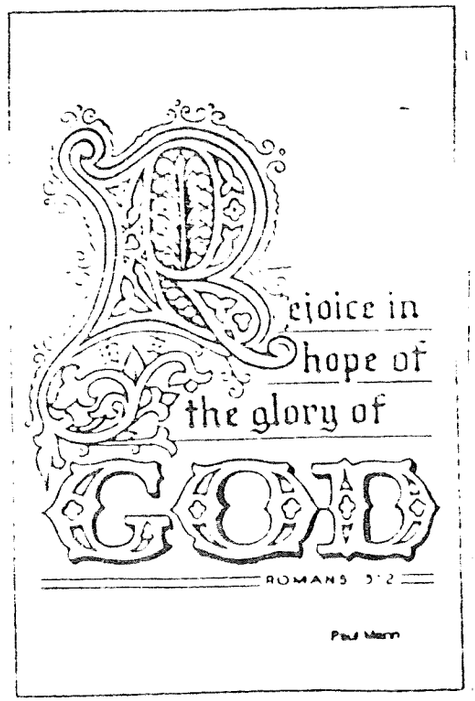
In the one lawsuit that went to trial, a Johnson County jury found Dr. Sifers partly negligent and awarded $143,000 to his patient. That 1982 case, with its explicit and gruesome testimony, is believed by lawyers to have prompted the other women to come forward with similar stories.

With the wave of litigation facing him, Dr. Sifers now has more malpractice suits filed against him than any other physician in Kansas by a margin of more than two to one, according to a comprehensive study by the Kansas Trial Lawyers Association. General surgeons average nationally one claim every four years, according to St. Paul Fire and Marine Insurance, the largest medical malpractice insurer in the country.

On four occasions pathologists—doctors who analyze tissue samples—filed complaints against Dr. Sifers alleging to an overview committee that he had done "inappropriate surgery," according to court testimony.

Meanwhile, Dr. Sifers has been re-

See Doctor, pg. 13A, col. 1



These cases would be limited by the $250,000 cap in SB110.

Doctor *continued from pg. 1A*

stricted by Bethany Medical Center from performing mastectomies—the medical term for removal of breast tissue—and has stopped practicing altogether at Shawnee Mission Medical Center, the hospital where he performed most of the mastectomies.

And the Kansas Board of Healing Arts, concerned about the lawsuits, sent Dr. Sifers for neurological and emotional analysis at the Mayo Clinic in the fall of 1983. He received a clean bill of health.

Some say Dr. Sifers' problems may have been as simple as pride—an inability to ask for help from medical specialists when he needed it.

"He was zealous in his fight against breast cancer," says Dr. John Young, a friend of Dr. Sifers and a surgeon himself. "He is a man who had practiced 30 years and seen many, many women die from breast cancer . . . I think he was sincere and felt this was a way to prevent these women from going through a painful death.

"The problem was not in the way he had done the operations, only in the way he had taken care of the complications . . .It was pride I think that kept him from seeking help."

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Even early in his career, Dr. Sifers sought to realize his vision of ridding women of breast cancer.

Two women in his own family suffered from the disease, he has testified. He knew the odds: One of 11 women is stricken with the disease and about 38,000 die from it every year.

In 1947 he was graduated from the University of Kansas Medical School and did his residency at the Cleveland Clinic, a nationally known hospital in Ohio.

In 1955, Dr. Sifers returned to Kansas—his childhood home—to practice surgery and teach at KU Medical Center. He eventually would have offices both in Merriam and Kansas City, Kan.

He served in top positions of area surgical organizations and was chief of surgery and chief of staff at Bethany Medical Center in Kansas City, Kan.

He also became chairman of the Kansas City Blue Shield board of directors and a member of the national Blue Shield board, where he worked on limiting medical costs.

From his early work at the Cleveland Clinic, he knew that despite the widely different surgical methods of treating breast cancer, none was better at saving lives. At that time options were primarily limited to either modified radical mastectomies, the removal of almost all breast tissue, or to radical mastectomies, removal of all breast tissue and some chest muscle.

The survival rate is about 70 percent—a rate that has not changed in recent history, according to the American Cancer Society.

"Women were dying at the same rate in 1975 as they were 100 years ago," Dr. Sifers has testified. "We should be looking for marks to do earlier surgery . . .to save women from this since it's a primary cause of death in this nation."

From that sprang his vision—a series of mastectomies that he hoped would pioneer a prevention for breast cancer.

Dr. Sifers believed there had to be cell changes in breast tissue that could be identified before a tumor formed. He thought that some forms of breast disease were "premalignant," and that removing the breast early was a woman's best chance of avoiding cancer.

To ease women's fear of being disfigured by the procedure, he believed that artificial implants should replace the breasts.

Dr. Sifers was a general surgeon, not a cosmetic, or plastic, surgeon. He has testified that most of his training for doing implants came from reading.

He undertook his study in earnest.

"I thought I had an original contribution to make," he testified.

"I will present a paper ultimately to the College of Surgeons confirming earlier work indicating that this type of surgery will reduce breast cancer by 95 percent."

In order to prove his theory to the College of Surgeons, he testified, he believed he had to present evidence of at least 50 successful surgeries. He called his plan his "breast series."

By the 1980s, says Dr. Young, Dr. Sifers was probably doing more mastectomies than anyone else in Johnson and Wyandotte counties.

☆ ☆ ☆

For a dozen years he had been performing mastectomies followed by implants without challenge.

Then came a 45-year-old Shawnee housewife named Carol McGuire.

At the 1982 trial of her malpractice suit against Dr. Sifers, gruesome details about post-operative complications came to public attention for the first time.

She testified she had gone to Dr. Sifers with fibrocystic disease, or hardened tissue or lumps in the breasts. Dr. Sifers diagnosed her as "premalignant" and operated.

She said the surgery was followed by a 16 month infection that would not heal. Her silicone implants repeatedly broke through the skin. Eventually her nipples sloughed off.

The question was raised whether Mrs. McGuire even needed surgery. Doctors testified on her behalf that she had no signs of cancer and was never a candidate for surgery.

Dr. Young, the only doctor to testify in Dr. Sifers' behalf, said the operation was valid, however, because of recurring lumps in Mrs. McGuire's breasts.

Dr. Earl Sifers . . . sought to pioneer a prevention for breast cancer

The jury found that Mrs. McGuire was 35 percent negligent in the case because she didn't take as much bed rest as Dr. Sifers had directed.

But the jury still awarded her $443,000 for actual damages—lost wages, medical expenses, pain and suffering, and permanent disfigurement.

Other women contacted attorneys to say that they, too, had been Dr. Sifers' patients and also had suffered.

Jay Thomas, an attorney whose firm is handling 13 of the cases, says the pattern has been fairly consistent: Women with fibrocystic disease went to Dr. Sifers; he told them they had a one-in-three chance of developing cancer; he urged them to undergo a mastectomy; infection set in afterward, forcing additional surgery.

Only after their lawyers gathered evidence about post-operative problems did many of the women learn there were alternatives that might have saved their breasts, he said.

"This is the single hardest moment because we have to be the ones to break the news to them," he said.

Dr. Sifers has testified, however, that he believed the women were "premalignant"—that their fibrocystic disease might someday turn into cancer.

He also testified that he looked for a family history of breast cancer as well as considering patients' requests for surgery because of an overriding fear of cancer. But he testified that sometimes he operated when the only criteria they met was having fibrocystic disease.

Other medical experts say that fibrocystic disease might be an indication for surgery only when the disease is advanced and the patient also has a family history of breast cancer. And then, they say, surgery would not always be necessary.

A study published in *The New England Journal of Medicine* in January showed that 70 percent of the women who have fibrocystic disease are no more likely to get breast cancer than women without it.

Fibrocystic disease has no cure, according to the National Cancer Institute, but it is usually treated with diet and medication for pain. Sometimes lumps can be removed surgically without removing the breast.

The same factors that cause fibrocystic disease probably cause cancer, said

Dr. H. Stephen Gallager, a professor of pathology at the M.D. Anderson Hospital and Tumor Institute in Houston, which is noted for cancer treatment. He said, however, that he doesn't believe anybody knows at what point the disease turns into cancer, so he could never recommend preventive surgery.

☆ ☆ ☆

For some of Dr. Sifers' patients, problems did not begin until months after they left the operating room. For others, they began before Dr. Sifers closed the incision.

The most common complaint was of a post-operative infection that would not heal. Most of the women told in their lawsuits of infections that sometimes lingered for more than a year, turned their skin black and produced open sores.

Other complaints later surfaced in lawsuits:

- Breasts that were too hard, sometimes like softballs.
- Implants that protruded through the skin and had to be surgically replaced.
- The discovery that up to half of the breast tissue was left after the mastectomy even though Dr. Sifers concedes that common medical procedure for mastectomy calls for the removal of at least 90 percent.
- Breast implants that were too large. In one case, according to attorneys, a patient's bra size increassed from a 32A to a 32D after her surgery.

Sometimes one and two subsequent surgeries plus dozens of office visits were needed to correct the problems.

"He would sew me up and it would just come apart again," recalled Aleta Witt, a Merriam woman who for nine months watched holes the size of nickles repeatedly tear through the infected skin of her right breast. "I was just about out of my mind."

Dr. Sifers' testimony shows he was having his own private doubts. In Mrs. Witt's case, he testified that he believed her condition was "horrendous."

Dr. Sifers' experience with implant protrusion—40 out of 222—far exceeds the less than 1 percent rate that usually is expected, said Dr. Carroll L. Zahorsky, a plastic surgeon who did follow-up surgery on four of the women and testified for two of them.

Dr. Sifers said the problem might be the brand of implants he used.

He also claimed the implants were not too large, but he testified that he never made a precise measurement of the excised breast tissue before selecting an implant. At any rate, he said he didn't make his patients' breasts smaller.

"Everybody wants, the patients always want to be maybe a tad larger," he testified.

Once complications appeared, Dr. Sifers testified, he sought help from other doctors. Among those was his son, Dr. Tim Sifers, who was in practice with him.

A notation made by Dr. Tim Sifers on Mrs. McGuire's medical chart read: "Draining again. Someday Daddy is going to learn how to fix this, we hope."

That notation was followed by one from his father saying, "No one else knows how to fix this either."

Dr. Sifers defended his surgery record in a deposition.

"I don't believe there is a surgeon in Kansas who has lost only one set of nipples in 200 operations," he testified. "It's the best record in Kansas City."

Dr. Zahorsky said in an interview that he found Dr. Sifers' procedures to be incomplete.

"A major problem with what Dr. Sifers did was that the surgery was not completed," Dr. Zahorsky said. "We found 30 to 50 percent of the breast tissue had not been removed when we reoperated on them."

He said general surgeons like Dr. Sifers take risks when they work in areas of medicine in which they are not specialists.

Even Dr. Sifers' friend and colleague, Dr. Young, agreed outside help should have been sought.

"We all have complications, but those should be limited to a certain percentage," Dr. Young said. "I think he didn't know how to handle complications from the implant."

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After the Carol McGuire trial surgical committees at Bethany Hospital and Shawnee Mission Medical Center began to review Dr. Sifers' cases. Bethany suspended his privilege to perform the breast procedure. He quit practicing at Shawnee Mission altogether when he and hospital officials could not agree on his standing.

Donald Strole, attorney for the Kansas Board of Healing Arts, said that after learning of the suspensions the board interviewed Dr. Sifers. A pathologist is reviewing some of the cases to see if surgery was justified.

"The big question is whether this kind of preventive surgery should be done at all," Mr. Strole said. "My personal feeling is that he probably did too many surgeries on too many women that were unjustified."

Even if the board decides some of the mastectomies were unnecessary, it probably would take no action other than to get a formal agreement with Dr. Sifers that he would not do the procedure any longer, Mr. Strole said.

Dr. Sifers has, in part, already made that vow.

He testified in one deposition that this phase of his medical career is behind him. His breast series is complete.

"I have done the work and it's finished," Dr. Sifers said.

TESTIMONY IN OPPOSITION TO
SUBSTITUTE S.B. 110
March 27, 1985

I am Carol McGuire, from Shawnee, Kansas, and I am a member of the Malpractice Victims Coalition of Kansas. I am also a medical malpractice victim whose case has already been to trial; so, I don't have anything to gain personally by being here today other than the satisfaction of trying to attain for future/potential malpractice victims the same opportunity I was accorded - to be able to have their malpractice case heard and judged by a jury of their peers.

This is their right as it is yours and mine. I feel it would be a great injustice, to anyone who is a victim of medical malpractice, to put a cap of $250,000 on pain and suffering. Quite obviously, there are cases that would fall below that figure, but there are others that would definitely be worth over $250,000. In my case, the award was approximately $600,000. Almost all of that was for pain and suffering and disfigurement. This bill implies that my award was unjustified.

Each proven malpractice case is always a personal tragedy and extremely traumatic for the person involved. I speak from experience, as I know the physical, emotional and mental turmoil that a person goes through in something like this. It is almost beyond words. This is why I believe the decision on any amount to be recovered should be left up to an impartial panel, who would be able to weigh the merits of any given case, rather than decided, before the fact, by our state legislature or anyone else.

I do not feel that doctors should have any more rights than anyone else in this room today. If Substitute Senate Bill 110 is passed, it will most certainly put the doctors in a privilege position.

So, I am asking that you please vote against this bill for the benefit of all our fellow Kansans. Thank you.

Attachment No. 5
House Judiciary
March 27, 1985

KANSAS VICTIMS MALPRACTICE COALITION

CHARTER MEMBERS

A.P. Artega	Wichita, KS
Amy Artega	Wichita, KS
Dorothy Fox	Wichita, KS
Mildred Lonhart	Wichita, KS
Vickie Payne	Wichita, KS
Walter Payne	Wichita, KS
Michael Wingart	Haysville, KS
Vickie Brooks	Wichita, KS
Brenda Grow	Wichita, KS
LaVonda Sue McAbee	Wichita, KS
Carlis McAbee	Wichita, KS
Robert Hall	Wichita, KS
Esther Elliott	Wichita, KS
Roman Koerner	Wichita, KS
Rocky Wentling	Wichita, KS
Gloria J. Lewis	Wichita, KS
Jim Hilgenfeld	Wichita, KS
Mrs. Rose Rohleder	Wichita, KS
Albert Rohleder	Wichita, KS
Randy Vuff	Wichita, KS
Dow Payne	Wichita, KS
Connie Simmons	Wichita, KS
Raymond Gibson	Wichita, KS
Mary Gibson	Wichita, KS
Jan Payne	Wichita, KS
Leslie Justice	Kansas City, KS
Sherri Rossi	Overland Park, KS
Terri Olsen	Prairie Village, KS
Linda Beecham	Shawnee, KS
Bertha Berghen	Shawnee, KS
John Burghen	Shawnee, KS
Frances Condron	Shawnee, KS
Pat Cooper	Kansas City, KS
Paul Crabtree	Tonganoxie, KS
Phyllis Crabtree	Tonganoxie, KS
John Crane	Shawnee, KS
Pat Crane	Shawnee, KS
Nancy Dorfman	Lenexa, KS
Barbara Gibbons	Kansas City, KS
Tom Gibbons	Kansas City, KS
Janet Gilliland	Louisburg, KS
Mark Gilliland	Louisburg, KS
Delores J. Henderson	Kansas City, KS
Gary R. Henderson	Kansas City, KS
Kathryn Justice	Kansas City, KS
Anna Jane King	Kansas City, MO
Mark Little	Kansas City, KS
Marge Little	Kansas City, KS
Amy Morris	Kansas City, MO
Sue Montana	Prairie Village, KS

Attachment No. 6
House Judiciary
March 27, 1985

Carol McGuire	Shawnee, KS
Bonnie Meyer	Overland Park, KS
Bob Olsen	Prairie Village, KS
Carol Plesser	Prairie Village, KS
Pat Renfro	Prairie Village, KS
Virginia Sharp	Kansas City, KS
Georgia Wallace	Overland Park, KS
Robert Wallace	Overland Park, KS
Fran Werner	Shawnee, KS
Jim Werner	Shawnee, KS
Judy Walker	Shawnee, KS
Larry Ebbs	Pittsburg, KS
Maurice Scales	Girard, KS
Lauren Samon	Overland Park, KS
Carol Samon	Overland Park, KS
Martha Tibbs	Topeka, KS
Kathy Apps	Topeka, KS
Mrs. Theresa Wild	Herrington, KS
Bobbi Steinbacher	Great Bend, KS
Gwen Johnson	Lawrence, KS
Jeannine Davis	Kansas City, MO
Barry Davis	Kansas City, MO
Bertha Humphrey	Shawnee Mission, KS
Sue Shaffer	Independence, KS
Vernon Shaffer	Independence, KS
Bonnie Luth	Bonner Springs, KS
George Long	Kansas City, KS
John Hoadley	Independence, MO
Susan Hoadley	Independence, MO
Tom McCarthy	Leawood, KS
Virginia Morgan	Prairie Village, KS
Patricia Hoffhimes	Lawrence, KS
Gayle Hoffhimes	Lawrence, KS
Terri Laudan	Overland Park, KS
Robert Brousseau	Merriam, KS
Ronald Tewell	Wellington, KS
Gary Studebaker	Topeka, KS
James Studebaker	Holton, KS
Bob Elliot	Topeka, KS
Carol Gillette	Topeka, KS
Vickie Hayland	Topeka, KS
Thelma Kebert	Independence, KS
Karen Miller	Shawnee, KS
Beulah Randall	Topeka, KS
J. Pete Steinbacher	Great Bend, KS
Ida Mae Tingley	Weston, MO
Linda Thompson	Topeka, KS
Gene Cleveland	Anthony, KS
Diane Cleveland	Anthony, KS

KANSAS TRIAL LAWYERS PROPOSALS

I. We propose that doctors who repeatedly commit acts of malpractice pay higher rated premiums.

II. We oppose frivolous lawsuits and support the use of the provisions of K.S.A. 60-2007 and the discovery rules mandated by the Kansas Supreme Court in Nelson v. Miller.

III. We oppose unreasonable and excessive attorney fees and remind the Legislature of the judicial regulation mandated in malpractice cases by K.S.A. 7-121b.

IV. We propose that immediate data be gathered and analyzed to determine the justification for the malpractice rates charged to Kansas doctors and other health care providers. If the rates cannot be justified, the Legislature should award rebates.

V. We propose offering qualified immunity to doctors who are willing to offer testimony at hospital hearings or before the Board of Healing Arts on acts of malpractice.

VI. We propose that the Kansas Board of Healing Arts be given access to pertinent data on acts of malpractice and consider instituting an automatic review of cases resulting in settlements or verdicts over $100,000 and any doctor with more than 2 malpractice claims in a two-year period.

Attachment No. 7
House Judiciary
March 27, 1985