MINUTES

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

August 15-16, 1985
Room 514-S, Statehouse

Members Present

Representative Joe Knopp, Chairman
Senator Jack Walker, Vice-Chairman
Senator Roy M. Ehrlich
Senator Paul Feleciano
Senator Frank D. Gaines
Senator Jeanne Hoferer
Senator Nancy Parrish
Senator Jack Steineger
Senator Robert Talkington
Senator Wint Winter, Jr.
Senator Eric Yost
Representative Marvin Barkis
Representative William Brady
Representative J. Frank Buehler
Representative Rex Hoy
Representative Ruth Luzzati
Representative Michael O'Neal
Representative Vincent Snowbarger
Representative John Solbach
Representative Dale Sprague
Representative Thomas Walker

Staff Present

Mike Heim, Kansas Legislative Research Department
Melinda Hanson, Kansas Legislative Research Department
Mary Ann Torrence, Revisor of Statutes Office
Mary Hack, Revisor of Statutes Office
Bob Coldsnow, Legislative Counsel
Mary Jane Holt, Secretary

Others Present

Judge Marion Chipman, Olathe
Judge Donald Allegrucci, Pittsburg
Judge Michael Corrigan, Wichita
Dr. D. Kay Clawson, Executive Vice-Chancellor, University of Kansas Medical Center
Richard Von Ende, Executive Secretary, University of Kansas
Dr. Jane Corboy, Senior Resident in Family Practice, University of Kansas Medical Center
Marlin Rein, Associate Hospital Administrator and Associate University Director of Business Affairs, University of Kansas
William Kauffman, General Counsel, State Board of Regents
Steven Ruddick, Associate General Counsel for the University of Kansas
Judge Patrick Kelly, Wichita
Ron Green, Legislative Division of Post Audit
Donald G. Strole, General Counsel of the Board of Healing Arts
Judge Charles E. Worden, Norton
Lynn Johnson, Attorney
Wayne Stratton, Attorney
Ron Smith, Legislative Counsel, Kansas Bar Association
Jerry Slaughter, Kansas Medical Society
Kathern Forest, American Association of Retired Persons, Wichita
Patricia Henshall, Office of Judicial Administrator

Others Present (continued)

Ted Fay, Kansas Insurance Department
L. M. Cornish, Kansas Association of Property and Casualty Companies
Charles Belt, Wichita Chamber of Commerce
Lee Wright, Farmers Insurance Group, Mission
Ralph Gundelfinger, Providers Insurance Company, Kansas City
Kathy Riscoe, Woodsman Companies, Kansas City
Jim McBride, United Way
Beth Sheffel, League of Women Voters
Irv Sheffel, Menninger Foundation
Marsha Hutchison, Kansas Medical Society
Dave Toplikar, Lawrence Journal-World
Steve Robrahn, Associated Press
Mark Bennett, American Insurance Association
Mike Mullen, Medical Protective Company, Ft. Wayne, Indiana
Sherman A. Parks, Jr., Kansas Chiropractic Association
Harold Riehm, Kansas Association of Osteopathic Medicine
Tom Bell, Kansas Hospital Association
Pat Davis, Governor's Office
Lori Class, United Way/League of Women Voters
Richard A. Uhlig, Secretary, Board of Healing Arts
Michele Hinds, Kansas State Nurses Association
Pat Schafer, Division of Budget
Meredith Williams, Legislative Division of Post Audit
Richard B. Greene, Wamego City Hospital
Derenda Mitchell, Kansas Insurance Department

August 15, 1985
Morning Session

The meeting was called to order by the Chairman, Representative Joe Knopp at 10:00 a.m.

Judge Marion Chipman, District Judge of Johnson County, testified before the Committee in response to a letter from Mike Heim. He stated screening panels had been used three times in the last five years in Johnson County and none of the cases were settled by the screening panel. In regard to panels of judges, Judge Chipman stated the court was not responsible for delaying the trial or the disposition of medical malpractice cases. The delays are caused by the huge volume of discovery involved. He agreed that a judge that had experience in hearing medical malpractice cases would be more effective in settling disputes.

Judge Chipman explained he prefers to use settlement conferences. After the pretrial conference, the judge asks the parties involved to go to a settlement conference heard by a judge different than the judge that will hear the case. All parties are asked to be present that have unlimited authority to authorize settlements. He stated it would be fair, in his opinion, that the party be assessed court costs and attorney fees who refused to accept a settlement and subsequently lost at trial or if the award was smaller than the settlement offer in the case of the plaintiff or greater in the case of the defendant. He said there was no reason why prejudgement interest should not be permitted in medical malpractice cases. He said frequently insurers do well by delaying a case and investing the money.

Judge Chipman said he did not think appointing special masters would resolve any problems in medical malpractice cases. He questioned whether in Kansas you can constitutionally require mandatory arbitration. He further stated he has never used remittur or additur. He said the jury should decide the size of the awards. He said there has never been a substitute for a jury and that people who serve on his juries often have college educations and know how to handle money. In regard to motions for summary judgement and directed verdicts, he stated first there has to be no question of fact before either motion could be granted and in medical malpractice cases there are almost always disputed facts. He suggested the Legislature should determine why there are so many medical malpractice cases in Kansas, rather than how the courts should handle the cases.

Judge Donald Allegrucci, District Judge of Crawford, Cherokee, and Labette counties said he had a problem with 1985 S.B. 110. He stated there is malpractice and people are being injured by it. He noted he has tried two malpractice cases with jury awards of $1 million and $5 million. He said there was no question the plaintiffs were injured and could never work again.

Judge Allegrucci stated in his court no one had requested screening panels. He cited expense and time as reasons screening panels are not used. He also stated panels of judges, or judges that would hear all medical malpractice cases, would require more judges and more court rooms. In regard to settlement conferences, he stated they should be required for all tort actions, not just medical malpractice cases. He said Iowa has a separate docket for settlement conferences. He said there would be constitutional problems with arbitration, and the size of jury awards should be left to the jury to decide, not the judge. He said remittur has been upheld in Kansas but

not additur to date. He also stated he has never had a motion for summary judgement filed in his court because there is almost always a question of fact in such cases.

Judge Michael Corrigan, District Judge of Sedgwick County said that in Wichita screening panels are not used very much due to the fact they are not effective and do not accomplish anything. In regard to settlement conferences, he said, there has been no statistical evidence that there has been any savings of time, costs, or of cases. He noted that higher malpractice premiums were affecting lawyers and other professionals also and cited one attorney's malpractice insurance premium that went from $1,200 to $12,000 in a two-year period.

Judge Corrigan further stated there would be constitutional problems with masters and arbitration. He also stated motions for summary judgement and directed verdicts are rarely used in civil malpractice cases. He also stated juries should determine the size of awards and determine the amounts for pain and suffering. He said that many areas of the law are complicated not just malpractice and there is not a need for special panels of judges to hear these cases.

In answer to Committee questions, all three judges stated they have never had an evidenciary hearing on attorney fees in medical malpractice cases. They stated there has never been a complaint filed by a litigant on the unreasonableness of the fee. Judge Corrigan stated a $500,000 or $1,000,000 cap on awards would not be good.

Judge Allegrucci stated the Health Care Stabilization Fund, in some cases, had refused to work with the defendants in settling cases, and did not become involved in some cases before the case went to trial. Judge Chipman said in the Humana case no one showed up at a settlement conference representing the Fund and at another meeting a very young and inexperienced attorney was there to represent the Fund. Judge Corrigan stated 60 to 70 percent of the medical malpractice cases in Sedgwick County were decided for the defendant.

All three judges stated the awards, in the cases they had tried, were not excessive. They also said the awards were comparable to other types of injury cases. They stated some of the cases go to trial due to the lack of a realistic effort to make a settlement. Judge Chipman recommended requiring a settlement conference and assess penalties to the party who refuses to accept the recommendation of the conferees.

A Committee member asked the judges what they would recommend concerning the Health Care Stabilization Fund. Judge Allegrucci recommended getting the Fund represented early in the case and the person representing the Fund should have some control over the defense. Judge Chipman suggested the Fund could be made a party so they could participate in discovery and the settlement conferences. Judge Chipman said within the last two months he was contacted by an experienced competent attorney on behalf of the Fund regarding a case. This has lead him to believe the defense of the Fund is improving.

The Committee questioned the judges about requiring the medical experts be from the state of Kansas. The judges stated doctors will not testify against their colleagues and the experts that are used in Kansas are very well qualified. They suggested counsel for both sides carefully examine the expert witnesses and the standards of care are carefully examined. The judges stated they also give instructions to the jury concerning the standards of care.

When asked if itemized verdicts would be acceptable in malpractice cases, all judges said there would be no problem with requiring juries to itemize their awards. When asked if screening panel reports ought to be admissible, Judge Chipman said it offended his idea of the rules of evidence and he felt the same thing could be accomplished with a settlement conference.

The Committee recessed for lunch.

Afternoon Session

Mike Heim distributed copies of the testimony of Judge Wayne H. Phillips, District Judge, Division 7, Wyandotte County who could not be present, to the Committee (Attachment I). He also informed the Committee copies of 1985 S.B. 362 (Attachment II), which permits the University of Kansas Medical Center to be a self-insurer under the Health Care Providers Insurance Availability Act, for persons who are residents at the Medical Center, and the Attorney General's Opinion No. 85-73 (Attachment III), dated July 1, 1985, were placed in their Committee notebooks. The Attorney General's opinion concerns the liability of the Medical Center as self-insurer for residents who work elsewhere as physicians during the hours they are not employed at their postgraduate training program.

The Chairman introduced Richard L. Von Ende, Executive Secretary, University of Kansas. Mr. Von Ende explained that residents are under the supervision of Medical Center physicians who are liable for their actions. He said under the provisions of S.B. 362, the resident is not exempted and therefore, the Medical Center and hence the state of Kansas, is responsible for the actions of residents whether performing services at the Medical Center or elsewhere. He also stated the Commissioner of Insurance has stated residents cannot buy limited policies to cover themselves while working at emergency centers or other employment away from the Medical Center.

Derenda Mitchell, Kansas Insurance Department stated coverage is available to a resident on a limited short term basis. The difficulty is with the claims made policy that is required in Kansas. She said the coverage in Kansas permits gaps in that if a resident works for 30 days and is covered by a claims made policy, the actual claim has to be filed within this period for the policy to cover the claim. She noted Missouri permits occurrence policies and that if a short term occurrence policy were available in Kansas this would resolve the Medical Center concerns.

Dr. D. Kay Clawson, Executive Vice-Chancellor, University of Kansas Medical Center testified the self-insured malpractice insurance premium is $1,437,101 for their clinical faculty. The faculty has to pay not only for malpractice insurance, their secretaries and nurses for clinics, but also retain only 62 percent of their salaries. In 1983 the aggregate premium for resident coverage was $289,000, of which the state paid $236,000 and the foundation for physicians made up the difference. In 1984 the premium was $489,000, of which the state paid $404,000, and the foundation paid the difference. The 1985 premium for residents was $1,048,998, of which the state paid $814,000. It has been projected the 1986 premium will be in excess of $1,500,000. S.B. 362, in the Attorney General's opinion, makes the University responsible for residents 24 hours day, seven days week, which covers their moonlighting activities. The University defines moonlighting to mean any extra pay made by a resident over and above what the University pays the resident. An appropriate type of moonlighting is locum tenens, which means when a resident fills in for a doctor who is away from his practice on vacation as an example. Missouri hospitals have purchased limited liability occurrence policy insurance coverage so the Medical Center residents can moonlight in their hospitals. Dr. Clawson noted that Dr. Steve Owen, Chief Resident in Medicine, stated the residents should have the opportunity to purchase insurance without having to pay the premium required for $200,000 per occurrence and $600,000 annual aggregate for 365 days of the year when residents moonlight about two nights a month.

Dr. Jane Corboy, Senior Resident in Family Practice, testified the educational value of moonlighting is very important. It teaches the residents to make decisions about patient management and care quickly and more efficiently. Moonlighting also affords the resident the opportunity to use resources in the community and to make contact with patients different from those at the Medical Center. She stated the residents feel they should be responsible for their actions outside the University and would like to be responsible for purchasing their own insurance for their moonlighting.

In answer to Committee questions, Dr. Corboy replied if the residents could purchase short-term coverage they could afford, the residents would be glad to purchase their own insurance for moonlighting.

Mike Mullen, Medical Protective Company, said his company offers occurrence policies for residents at a rate of 50 percent of the class 1 rate. Dr. Corboy said she would be willing to pay for the coverage at that rate. During Committee discussion, Dr. Clawson stated the University is working on the resident moonlighting insurance problem regarding legislation, and on a policy clarifying approved and unapproved moonlighting. It was noted a supplemental opinion from the Attorney General had been requested on the issue of whether the University is able to control the type of moonlighting a resident may do.

Judge Patrick F. Kelly, United States District Court, Wichita, testified regarding the settlement conference program undertaken in his court approximately a year ago. Materials and procedures were distributed to the Committee (Attachment IV). Also distributed were copies of the Crowe and Playtex opinions (Attachment V). He stated a trial court should have the right to mandate a confrontation between litigants and counsel, presided over by someone they all respect. He said he had a problem with some contingency fee agreements where the lawyer is actually becoming a partner in the case. He said a 50 percent contingency fee arrangement was unconscionable. He said he did not have a problem with a contingent fee of one-third. He noted in reviewing attorneys' fees as required by statute he does not raise issues he is not asked to raise. He did not recommend only certain judges being assigned to hear only medical malpractice cases. He stated his settlement conferences have been held on a trial basis for about one year and that he expects approval for another year's trial program with possibly some changes. He stated there is some opposition to the mediation panel. Judge Kelly said he does not favor binding arbitration. He recommended the Committee study the settlement conference program being used in Detroit, Michigan. In Oklahoma City he noted courts mandatorily interchange cases with judges for settlement conference purposes. They have a full-time magistrate whose sole duty is to handle settlements in that city. Judge Kelly noted he has a part-time magistrate for his court handling settlement work two days a week.

Judge Kelly stated in his court the trial date is set early. He contacts the attorneys within 30 days and discusses the nature of the case. A pretrial conference, a settlement conference, and a trial setting are made at that meeting for an early trial. Since the first of the year, 13 out of 22 cases were settled that were heard by the magistrate and 5 out of 10 cases were settled that were heard by a mediator. Each of the five medical malpractice cases filed since the first of the year were also settled. One of the cases was settled for more than $1 million.

Judge Kelly suggested the Committee should hear from members of his mediation panel to get their impressions of how it works first hand.

In answer to Committee questions, Judge Kelly responded he was not in favor of using information from screening panels at a trial. He said the setting of punitive damages should be done by a jury, not be set by a judge. He would rather have the authority to turn the physician over to the State Board of Healing Arts for sanction if the jury found the physician recklessly indifferent. He also does not believe there should be a cap on pain and suffering. He stated the settlement conference should work in state courts. In regard to the collateral source rule and informing the jury what the attorney fees are, Judge Kelly said they were not applicable and would just clutter up the trial. He stated punitive damages should be a sanction rather than a monetary award in some cases.

Judge Kelly recommended the settlement conferences not be made mandatory by statute rather settlement conferences should be left to the discretion of the particular court. He said that a party which refuses to settle should not always be penalized if they are testing the law or are just convinced that they have a good case. He noted the U.S. Supreme Court in a civil rights case recently assessed the plaintiff's attorney costs after the plaintiff refused to settle in a civil rights case and the jury awarded less than the settlement offer.

He said the Health Care Stabilization Fund was receiving good quality representation now. In regard to the new collateral source rule enacted by S.B. 110, Judge Kelly said he had a problem with this only applying to the health care profession. He noted he upheld the new law recently but had serious reservations about it.

The Committee recessed until 9:00 a.m. Friday, August 16, 1985.

August 16, 1985
Morning Session

Ron Green, Legislative Division of Post Audit, reported on the Performance Audit of the State Board of Healing Arts. The Audit addressed the following questions:

1. Do current procedures for reporting cases of incompetent health care practitioners to the Board appear to be adequate?

2. How effective is the Board in protecting the public against unprofessional, improper, unauthorized, and unqualified practice of the healing arts?

3. What is the trend in the balance of the Health Care Stabilization Fund?

The audit found that current procedures do not appear to be adequate to ensure that all possible violations of the Healing Arts Act are reported to the Board. The reporting requirements of the Healing Arts Act are less stringent than those recommended by the Federation of State Medical Boards. Under the Healing Arts Act, possible or suspected violations of the Act do not have to be reported, and health care organizations cannot be penalized for failing to report.

The audit concluded the Board in many cases has achieved the primary goal of protecting the public against unprofessional, improper, or unauthorized practice of the healing arts, while at the same time giving due process to the licensees under investigation. In some cases, the Board did not go far enough however, in its efforts to protect the public interest, such as: (1) the Board's recordkeeping system does not allow adequate tracking of disciplinary cases; (2) complaints most commonly relate to patient care problems, but more disciplinary actions relate to overprescription of drugs or impaired physicians; (3) malpractice petitions are not being used as intended to generate investigations of allegedly negligent doctors; and (4) current procedures do not ensure that all doctors practicing in Kansas have the required malpractice liability insurance.

In regard to the Health Care Stabilization Fund, the audit report stated the balance in the Health Care Stabilization Fund, after declining for three years, has increased significantly in fiscal year 1985. The annual number of claims filed against the Fund has increased each year since fiscal year 1979. The number of claim awards paid by the Fund has increased each year since fiscal year 1980, and the average amount per award has also risen sharply. The reimposition of the premium surcharge has stopped the decline in the Fund balance. The surcharge, which is 110 percent for the current fiscal year, is expected to produce more than $24,000,000 for the Fund in fiscal year 1986. Actuarial estimates are for the surcharge to remain at about 100 percent for the next two years. These high surcharges, in conjunction with higher rates for basic coverage, have generated great concern in the medical and insurance industries. Although there is no easy solution to the problem of medical malpractice injuries and costs, close scrutiny of impaired and incompetent doctors by the Board of Healing Arts should help to minimize the number of malpractice actions in the long run.

Recommendations by the Division of Post Audit are listed in the Audit Report (see Attachment VI). Responses from the Board of Healing Arts and the Insurance Commission are also included in the attached report.

Donald G. Strole, General Counsel of the Board of Healing Arts introduced Richard A. Uhlig, Secretary of the Board of Healing Arts. Mr. Strole distributed copies of testimony from the Humana case to the Committee as an example of why sometimes the Board is unable to take action quickly. Doctors do not always report violations and go through a peer review process, he noted (see Attachment VII). Mr. Strole stated the Board of Healing Arts agrees with the recommendations of the Audit Division with the exceptions as listed in the responses in Attachment VI.

In answer to questioning by the Committee, Mr. Strole stated there is nothing specific in the statutes or the rules and regulations requiring reporting by a peer review committee. S.B. 374 in the Senate Public Health and Welfare Committee requires a report be made to the Board of Healing Arts and allows the Board to defer back to the hospital to take action. The Committee Vice-Chairman explained peer review is conducted on a random sampling of case records that are selected by the medical records department.

Mr. Strole further replied they need support staff such as law clerks and medical assistants to look at petitions, complaints, and depositions. They could use ten law clerks and three or four medical assistants. They have been allowed to budget $2,500 for a law clerk. He testified they need a large sum of money budgeted for hearing officers. The Board raised the fees last year and they have money, but they need approval to spend the money.

Mr. Strole responded to a question by a Committee member that the Department of Health and Environment regulates hospitals and the Board of Healing Arts has licensing authority over the physical members of the medical staff of hospitals.

Mr. Strole stated the revocation or suspension of a physician's license involves four or five years for a hearing and the court appeal process, during which time the doctor is able to practice. The Board prefers to use a cease and desist order, consent order, or a stipulation, thereby protecting the public as quickly as possible. He said the Board was in the process of working with the University of Kansas Medical Center in establishing remedial education programs for doctors found by the Board to be deficient in an area.

A Committee member asked if there were any states that have umbrella boards or organizations that handle all matters concerning health care. Mike Heim stated he had distributed to the Committee excerpts from The New England Journal of Medicine concerning the disciplinary board in Florida (see Attachment VIII).

Mr. Strole recommended the law be changed to require hospitals to report to the State Board of Healing Arts about resignations of doctors from hospitals.

Jerry Slaughter explained to the Committee there is a national standardized peer review process and every hospital must meet these standards or lose their certification by the Joint Commission on the Accreditation of Hospitals. He also said hospitals in Kansas were not lowering their peer review standards to attract doctors.

Judge Charles E. Worden, Norton, testified the Legislature should not put limits on the liability or responsibility that doctors have to their patients. The people of the state of Kansas should have the right of redress themselves to solve their own disputes. In regard to screening panels, he related from his experience it took six months to get the screening panels in place and four months to a year and a half to obtain the opinions. There is no legal way to force an opinion from a screening panel. Screening panels are very difficult to utilize in western Kansas due to the lack of doctors and the fact that most of the doctors in western Kansas are economically associated.

In answer to Committee questions, Judge Worden stated the Legislature should not restrict the right of an indivdual to have his case heard before a jury. Judges are now beginning to assess costs against attorneys who file frivolous suits and also against those that have a frivolous defense. He said doctors have done very well in the rural areas and he doubted the medical malpractice insurance premiums would amount to 10 percent of their net income. He noted many doctors in rural areas are millionaires and some own thousands of acres of land.

In response to a question on settlement conferences, Judge Worden stated he and Judge Steven P. Flood of Hays have agreed to run each other's settlement conferences. They are going to make their settlement conferences somewhat binding and with penalty provisions for those that do not attempt to settle reasonably. He noted he normally has one or two medical malpractice cases pending.

He further replied to Committee questions that jury awards have not been larger in medical malpractice cases in his court than in personal injury cases. Awards tend to be small in the rural areas and the juries tend to protect their doctors. Judge Worden stated that each side has experts and they more or less cancel each other's effectiveness.

The Committee recessed for lunch.

Afternoon Session

The Chairman passed out a list of topics the Committee might consider during Committee discussion later in the afternoon (see Attachment IX).

Lynn Johnson described the role of a plaintiff's attorney in medical malpractice cases. He testified his clients are usually referred to him by other lawyers or other people who have had medical malpractice cases. The usual complaint involves poor communication by the physician. His firm takes one out of every 25 cases they are contacted about. He listed as reasons for not taking a case as the statute of limitations has expired, the damages are limited to the point it would not be economically feasible, or it is obvious there is no case. If a decision is made to pursue the case, they obtain all of the medical records and paralegals make an analysis of the records. If after examining the medical records, they decide there is a case, they obtain medical experts opinions, with the client's permission. If the experts agree there was a deviation of care, they then agree to represent the client. Up to this point, if they do not accept a case, the client is charged only for expenses incurred. The client is not charged for the time spent by the law firm. Finding qualified experts is time consuming and expensive. He also stated juries are not influenced by a badly injured plaintiff in terms of sympathy awards or finding negligence if there has been none.

In answer to Committee questions, Mr. Johnson said there are just as many bodily injury nuisance cases filed as there are medical malpractice nuisance cases. The smallest amount of expenses incurred on behalf of a client on a case they have tried was $24,000. Five hundred to 2,000 hours are involved in preparing a case. He said screening panels, if they worked right, would be good. Screening panels are costly and time consuming and could encourage smaller suits, he said. Doctors and nurses that are expert witnesses charge $100 to $300 an hour or $1,000 to $3,000 by the day. He stated a requirement that there be certification that an expert witness or opinion has been obtained, would be in order to attach to a malpractice petition. Ninety percent of all cases are settled and most cases are not settled for what they are worth until after discovery and after the defense attorney has taken a deposition of the plaintiff's expert and the plaintiff's attorney has taken depositions from the defendant's expert and the defendant, he said. He said something was needed to get attorneys for both sides moving quicker on cases.

Wayne Stratton described the role of a defendant's attorney and testified that usually the first notice the physician has of a medical malpractice lawsuit is when he is served with a summons. Often no complaint had been made by the patient to the doctor. Cases are tried on the characterization of what occurred and it becomes a confrontation of expert witnesses. Defense has to find out what the expert for the plaintiff is going to say so they can counter with an expert that would be just as persuasive.

In answer to Committee questions, Mr. Stratton stated the information the screening panel has is the original medical records and x-rays. The parties are entitled to file additional suggestions and reports of experts. For screening panels to be effective, there should be a cap on awards, he said. A Rand Corporation study found that the average medical malpractice claim is four times higher than claims in automobile cases, he noted. Mr. Stratton stated claims pending before the Health Care Stabilization Fund represents a potential liability of $90 million. He also said there should be a cap on pain and suffering. He thought the collateral source rule would prove to be of assistance. He further stated there are not many economic restraints in medical malpractice cases. He said he was not indicting the jury system but questioned whether our society could afford this method of compensating injured parties.

Ron Smith, Legislative Counsel for the Kansas Bar Association, cautioned the Committee against making changes in the tort law system and listed past legislative changes that have already been made. He further stated the Kansas Bar Association would support legislation repealing the 15 percent post-judgement interest rate and proposed the interest rate be tied to the current T-bill rate. He discussed the weaknesses and biases of screening panels, the present value of future damages, the inadvisability of mandating structured settlements and payment of judgements, the opposition to regulation of contingent fees, and the standard of care (see Attachment X).

The Chairman suggested at the September meeting the Committee should meet the first day in the old Supreme Court room and hold a public meeting. Staff stated risk management was scheduled for the September meeting. The Committee discussed topics for future meetings. The suggestion was made that some of the members should meet and select topics for the Committee to study further. It was suggested staff could use the list of suggested topics, add to it, and summarize the different positions the Committee had heard on the various issues, and make recommendations on the various topics. Staff could also receive input from the interest groups and present all of this at the next Committee meeting.

A Committee member recommended the Committee needs a full day or more for Committee discussion.

Representative Sprague, Representative Snowbarger, Senator Feleciano, and Representative Knopp offered to monitor the Insurance Commissioner's subcommittee investigating the effect of various caps on the Health Care Stabilization Fund and make a report at the September meeting. The subcommittee is scheduled to meet on September 10 and 11. A Committee member expressed an interest in having someone from the Insurance Commissioner's subcommittee make a report to the Committee.

After Committee discussion the Chairman suggested at the Committee meeting September 12 the Committee hold a public hearing, hear a report from the Insurance Department's actuary, and hear testimony on risk management. September 13 would be devoted to Committee discussion, and that these meetings take place in the old Supreme Court room. It was decided to begin the September 12th meeting at 9:00 a.m.

Staff was directed to draft legislation incorporating the suggestions of the Legislative Post Audit report, permitting occurrence policies for Medical Center residents and legislation requiring itemized jury awards.

The Committee adjourned.

Prepared by Mike Heim

Approved by Committee on:

September 13, 1985
(date)

DISTRICT COURT OF KANSAS

CHAMBERS OF
WAYNE H. PHILLIPS
JUDGE

COURT HOUSE
KANSAS CITY, KANSAS
66101

WYANDOTTE COUNTY

August 9, 1985

The Legislative Research Department
Room 545-N, Statehouse
Topeka, Kansas 66612

Attention: Mike Heim
Principal Analyst

Dear Mr. Heim:

As mentioned when you called, I have scheduled civil jury cases August 12th through 16th and as of this time, two are still going.

Enclosed find my thoughts on the questions submitted. Please relay such to the special committee.

Cordially,

Wayne H Phillips

WAYNE H. PHILLIPS
Judge, Division 7
WHP:maf
Enc.

8/15-16/85
Attachment I

DISTRICT COURT OF KANSAS

CHAMBERS OF
WAYNE H. PHILLIPS
JUDGE

COURT HOUSE
KANSAS CITY, KANSAS
66101

WYANDOTTE COUNTY

I write this August 9th as my calendar of civil jury cases scheduled August 12-16 appears not to be settling and I expect to be in trial August 15th. I was appointed to the Bench in 1975 following 16 years as a single practioner in Wyandotte County. I handled most facets of law in one form or another before becoming a Judge.

In answer to the questions submitted to me for addressing before the special committee on medical malpractice, my thoughts are as follows:

1. Screening panels are seldom used in our county. The statute seems to provide a good tool for reviewing alleged malpractice. When it has been used potential suits are often settled. I feel the reluctance to use such panels goes back to the old trial tradition of "ambush" and not wanting the opposition to see your hand before the game is played. In my estimation mandatory screening panels would be of benefit to both attorneys and the medical community. Insight could be garnered from other states that have made it mandatory, as in Colorado.

2. Panel of Judges. If the problem is expediting cases, I find no benefit in creating a special judicial panel. Of the six district Judges who hear civil and criminal jury cases in Wyandotte

County, early trial setting is not a problem. The primary delay arises over certain defense counsel for the small number of medical malpractice insurance carriers being overburdened. Trial settings are often continued several times because these certain few lawyers are deposing witnesses and experts throughout the country, or world, or have conflicts between jurisdictions. Lastly, I don't know any Judge that would like a continuous dose of malpractice cases, just as in domestic matters.

3. Settlement conferences, and 4. Masters.

These two are lumped together because my reaction is the same. 95% or more of all civil cases settle through compromise. Settlement conferences or trial to Masters require that someone determine the worth to the injured party from a particular set of facts and circumstances. Why should an injured plaintiff submit their claim to a person instead of a jury -- they can try the case to a Judge if they want. Again, this goes back to "expediting" and I don't find this to be a problem.

5. Arbitration of minor medical malpractice claims could benefit docket congestion. Such congestion is not so much a court problem as an attorney problem. Who would decide what dollar amount is minor? If a threshold of $100,000 is set, every case would be filed seeking $125,000 or more.

6. Size of jury awards. In my experience on the Bench, except for one med-mal case, the medical awards are comparable to awards in products, Federal Employers' Liability Act, and auto negligence cases. I had a corporate trespass case with a verdict of $375,000. Several

FELA cases have exceeded $500,000. Only once have I given remittur and that was in a wrongful arrest suit where racial overtones came into play. The verdict of twelve, eleven, or ten civil jurors generally goes undisturbed.

7. Summary judgment and directed verdicts. Pre-supposing all allegations of plaintiff are true and regarded in the light most favorable to them, most Judges are reluctant to grant summary judgments. I have, and Mr. Johnson is presently appealing a motion to dismiss I sustained. The record on appeal is that most such decisions -- unless the plaintiff has no case at all -- are reversed and remanded for trial. All med-mal cases are rooted in alleged negligence of the care provider. The plaintiff has an expert to so testify or the case wouldn't be filed. Under these circumstances it becomes a question of fact for jury determination. Summary judgment doesn't lie.

Our Kansas Pattern Instructions require professional negligence be determined through expert testimony. If plaintiff does not or cannot produce such expert, I have directed verdicts for the defendant.

With the passage of Substitute Senate Bill 110 this past legislative session, which allows the revealing of medical indemnification to the jury and bifurcating the trial for punitive damages, I personally feel the legislature has intruded far enough. I would not be upset about revealing to the jury that any award is not taxable to the recipient. This instruction has been given in FELA cases for years.

I grew up in a Missouri town of 500. No one would ever think of suing our only M.D. When he retired at 90, nearly 1500 people came. My first 5-6 years on the Bench I tried 8 med-mal cases before a plaintiff won judgment. The "onslaught" or "explosion" you are concerned with arises from several factors:

1. more doctors;
2. medical advances;
3. development of new tools and techniques;
4. experimental drugs and procedures;
5. longer longevity of population;
6. lack of involvement of doctors in community -- association with associates;
7. failure to become intimate with patient -- numbers;
8. media coverage given large judgments;
9. disportionate income of medical profession;
10. availability of medical experts;
11. expertise of attorneys.

Part of the answer lies in the medical profession and health care providers exerting more control and taking corrective measures over their lax or incompetent brothern. The eleven points I listed above probably will not change. Since the Hiroshima bomb explosion the legal profession has considered many catastrophic events. A few recents ones are the Federal civil rights actions under USC 1983; the Union Carbide chemical spill in India; the Hiatt collapse in Kansas City; Proctor & Gamble's problems with Rely; the Dalcon shield; asbestos used in building insulation and the employees' lung problems; the proliferation of class actions under various theories; Ford Pinto's gas tanks.

When I first started law practice I handled a lot of boundary disputes and read many abstracts. These actions are mostly gone. Back in the 60's during the racial unrest many suits were brought under the "mob" law. These are gone. I remember many bitter probate

battles over real and personal property. These have mostly disappeared. With women working, man's bitter curse of alimony is not nearly the burden it used to be.

These are but a few of the changes in the warps and woofs of the legal profession. Time may not heal all things, but all things will pass as will the professional and public outcry over medical negligence.

I thank you for the opportunity to present my views to this committee.

Wayne H. Phillips
WAYNE H. PHILLIPS

SENATE BILL No. 362

AN ACT concerning health care providers; relating to the definition thereof; relating to persons engaged in a postgraduate training program approved by the state board of healing arts and operated by the university of Kansas medical center; amending K.S.A. 1984 Supp. 40-3401, 40-3402, 40-3404 and 40-3414 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1984 Supp. 40-3401 is hereby amended to read as follows: 40-3401. As used in this act the following terms shall have the meanings respectively ascribed to them herein:

(a) "Applicant" means any health care provider;

(b) "Basic coverage" means a policy of professional liability insurance required to be maintained by each health care provider pursuant to the provisions of subsection (a) or (b) of K.S.A. 40-3402 and amendments thereto;

(c) "Commissioner" means the commissioner of insurance;

(d) "Fiscal year" means the year commencing on the effective date of this act and each year, commencing on the first day of that month, thereafter;

(e) "Fund" means the health care stabilization fund established pursuant to subsection (a) of K.S.A. 40-3403 and amendments thereto;

(f) "Health care provider" means a person licensed to practice any branch of the healing arts by the state board of healing arts, a person who holds a temporary permit to practice any branch of the healing arts issued by the state board of healing arts, a person engaged in a postgraduate training program approved by the state board of healing arts, a medical care facility licensed by the department of health and environment, a health maintenance organization issued a certificate of authority by the commissioner of insurance, an optometrist licensed by the board of examiners in optometry, a podiatrist registered by the state board of healing arts, a pharmacist registered by the state board of pharmacy, a licensed professional nurse who is licensed by the board of nursing and certified as a nurse anesthetist by the American association of nurse anesthetists, 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, a Kansas not-for-profit corporation organized for the purpose of rendering professional services by persons who are health care providers as defined by this subsection (f), a dentist certified by the state board of healing arts to administer anesthetics under K.S.A. 65-2899 and amendments thereto, a physical therapist registered by the state board of healing arts, or a mental health center or mental health clinic licensed by the secretary of social and rehabilitation services, except that health care provider does not include *(1)* any state institution for the mentally retarded *or (2) any state psychiatric hospital*;

(g) "Inactive health care provider" means a person or other entity who purchased basic coverage or qualified as a self-insurer on or subsequent to the effective date of this act but who, at the time a claim is made for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, does not have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider;

(h) "Insurer" means any corporation, association, reciprocal exchange, inter-insurer and any other legal entity authorized to write bodily injury or property damage liability insurance in this state, including workmen's compensation and automobile liability insurance, pursuant to the provisions of the acts contained in article 9, 11, 12 or 16 of chapter 40 of Kansas Statutes Annotated;

(i) "Plan" means the operating and administrative rules and procedures developed by insurers and rating organizations or the commissioner to make professional liability insurance available to health care providers;

(j) "Professional liability insurance" means insurance providing coverage for legal liability arising out of the performance of professional services rendered or which should have been rendered by a health care provider;

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(k) "Rating organization" means a corporation, an unincorporated association, a partnership or an individual licensed pursuant to K.S.A. 40-930 or 40-1114, or both sections, and amendments to those sections to make rates for professional liability insurance;

(l) "Self-insurer" means a health care provider who has qualified as a self-insurer pursuant to K.S.A. 40-3414 and amendments thereto *or the university of Kansas medical center for persons who are engaged, under the supervision of the clinical faculty member of the university of Kansas school of medicine, in a postgraduate training program approved by the state board of healing arts and operated by the university of Kansas medical center*;

(m) "Medical care facility" means the same when used in the health care provider insurance availability act as the meaning ascribed to that term in K.S.A. 65-425 and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a medical care facility;

(n) "Mental health center" means a mental health center licensed by the secretary of social and rehabilitation services under K.S.A. 75-3307b and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a mental health center;

(o) "Mental health clinic" means a mental health clinic licensed by the secretary of social and rehabilitation services under K.S.A. 75-3307b and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a mental health clinic;

(p) "State institution for the mentally retarded" means Norton state hospital, Winfield state hospital and training center, Parsons state hospital and training center and the Kansas neurological institute.;

(q) "State psychiatric hospital" means Larned state hospital, Osawatomie state hospital, Rainbow mental health facility and Topeka state hospital.

Sec. 2. K.S.A. 1984 Supp. 40-3402 is hereby amended to read as follows: 40-3402. (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 $200,000 per occurrence, subject to not less than a $600,000 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 *or is a person who is engaged under the supervision of the clinical faculty member of the university of Kansas school of medicine, in a postgraduate training program approved by the state board of healing arts and operated by the university of Kansas medical center and is insured pursuant to K.S.A. 40-3414, and amendments thereto*. Such policy shall provide as a minimum coverage for claims made during the term of the policy which were incurred during the term of such policy or during the prior term of a similar policy.

(1) Each insurer providing basic coverage shall within 30 days after the premium for the basic coverage is received by the insurer or within 30 days from the effective date of this act, whichever is later, notify the commissioner that such coverage is or will be in effect. Such notification shall be on a form approved by the commissioner and shall include information identifying the professional liability policy issued or to be issued, the name and address of all health care providers covered by the policy, the amount of the annual premium, the inception and expiration

dates of the coverage and such other information as the commissioner shall require. A copy of the notice required by this subsection shall be furnished the named insured.

(2) In the event of termination of basic coverage by cancellation, nonrenewal, expiration or otherwise by either the insurer or named insured, notice of such termination shall be furnished by the insurer to the commissioner, the state agency which licenses, registers or certifies the named insured and the named insured. Such notice shall be provided no less than 30 days prior to the effective date of any termination initiated by the insurer or within 10 days after the date coverage is terminated at the request of the named insured and shall include the name and address of the health care provider or providers for whom basic coverage is terminated and the date basic coverage will cease to be in effect. No basic coverage shall be terminated by cancellation or failure to renew by the insurer unless such insurer provides a notice of termination as required by this subsection.

(3) Any professional liability insurance policy issued, delivered or in effect in this state on and after the effective date of this act shall contain or be endorsed to provide basic coverage as required by subsection (a) of this section. Notwithstanding any omitted or inconsistent language, any contract of professional liability insurance shall be construed to obligate the insurer to meet all the mandatory requirements and obligations of this act. The liability of an insurer for claims made prior to July 1, 1984, shall not exceed those limits of insurance provided by such policy prior to July 1, 1984.

(b) Unless a nonresident health care provider is a self-insurer, such provider shall not render professional service as a health care provider in this state unless such provider maintains coverage in effect as prescribed by subsection (a) of this section, except such coverage may be provided by a nonadmitted insurer who has filed the form required in paragraph (1) of subsection (b) of this section.

(1) Every insurance company authorized to transact business in this state, that is authorized to issue professional liability insurance in any jurisdiction, shall file with the commissioner, as a condition of its continued transaction of business within this state, a form prescribed by the commissioner declaring that its professional liability insurance policies, wherever issued, shall be deemed to provide at least the insurance required by this subsection when the insured is rendering professional services as a nonresident health care provider in this state. Any nonadmitted insurer may file such a form.

(2) Every nonresident health care provider who is required to maintain basic coverage pursuant to this subsection shall pay the surcharge levied by the commissioner pursuant to subsection (a) of K.S.A. 40-3404 and amendments thereto directly to the commissioner and shall furnish to the commissioner the information required in paragraph (1) of subsection (a) of this section.

(c) Every health care provider that is a self-insurer *or the university of Kansas medical center for persons who are engaged under the supervision of the clinical faculty member of the university of Kansas school of medicine in a postgraduate training center approved by the state board of healing arts and operated by the university of Kansas medical center* shall pay the surcharge levied by the commissioner pursuant to subsection (a) of K.S.A. 40-3404 and amendments thereto directly to the commissioner and shall furnish to the commissioner the information required in paragraph (1) of subsection (a) of this section.

Sec. 3. K.S.A. 1984 Supp. 40-3404 is hereby amended to read as follows: 40-3404. (a) Except for any health care provider whose participation in the fund has been terminated pursuant to subsection (g) of K.S.A. 40-3403 and amendments thereto, the commissioner shall levy an annual premium surcharge on each health care provider who has obtained basic coverage and upon each self-insurer for each fiscal year. Such premium surcharge shall be an amount equal to a percentage of the annual premium paid by the health care provider for the basic coverage required

to be maintained as a condition to coverage by the fund by subsection (a) of K.S.A. 40-3402 and amendments thereto. The annual premium surcharge upon each self-insurer, *except for the university of Kansas medical center*, shall be an amount equal to a percentage of the amount such self-insurer would pay for basic coverage as calculated in accordance with rating procedures approved by the commissioner pursuant to K.S.A. 40-3413 and amendments thereto. *The annual premium surcharge upon the university of Kansas medical center for persons who are engaged, under the supervision of the clinical faculty member of the university of Kansas school of medicine, in a postgraduate training program approved by the state board of healing arts and operated by the university of Kansas medical center shall be an amount equal to a percentage of an assumed aggregate premium of $600,000.*

(b) In the case of a resident health care provider who is not a self-insurer, the premium surcharge shall be collected in addition to the annual premium for the basic coverage by the insurer and shall not be subject to the provisions of K.S.A. 40-252, 40-1113 and 40-2801 *et seq.*, and amendments to these sections. The amount of the premium surcharge shall be shown separately on the policy or an endorsement thereto and shall be specifically identified as such. Such premium surcharge shall be due and payable by the insurer to the commissioner within 30 days after the annual premium for the basic coverage is received by the insurer, but in the event basic coverage is in effect at the time this act becomes effective, such surcharge shall be based upon the unearned premium until policy expiration and annually thereafter. Within 15 days immediately following the effective date of this act, the commissioner shall send to each insurer information necessary for their compliance with this subsection. The certificate of authority of any insurer who fails to comply with the provisions of this subsection shall be suspended pursuant to K.S.A. 40-222 and amendments thereto until such insurer shall pay the annual premium surcharge due and payable to the commissioner. In the case of a nonresident health care provider or a self-insurer, the premium surcharge shall be collected in the manner prescribed in K.S.A. 40-3402 and amendments thereto.

(c) The premium surcharge shall be an amount deemed sufficient by the commissioner to fund anticipated claims based upon reasonably prudent actuarial principles. In setting the amount of such surcharge, the commissioner: (1) May require any health care provider who has paid a surcharge for less than 24 months to pay a higher surcharge than other health care providers; and (2) shall amortize any anticipated deficiencies in the fund over a reasonable period of time.

Sec. 4. K.S.A. 1984 Supp. 40-3414 is hereby amended to read as follows: 40-3414. (a) Any health care provider whose annual insurance premium is or would be $100,000 or more for basic coverage calculated in accordance with rating procedures approved by the commissioner pursuant to K.S.A. 40-3413 and amendments thereto, may qualify as a self-insurer by obtaining a certificate of self-insurance from the commissioner. Upon application of any such health care provider, on a form prescribed by the commissioner, the commissioner may issue a certificate of self-insurance if the commissioner is satisfied that the applicant is possessed and will continue to be possessed of ability to pay any judgment for which liability exists equal to the amount of basic coverage required of a health care provider obtained against such applicant arising from the applicant's rendering of professional services as a health care provider. In making such determination the commissioner shall consider (1) the financial condition of the applicant, (2) the procedures adopted and followed by the applicant to process and handle claims and potential claims, (3) the amount and liquidity of assets reserved for the settlement of claims or potential claims and (4) any other relevant factors. The certificate of self-insurance may contain reasonable conditions prescribed by the commissioner. Upon not less than five days' notice and a hearing pursuant to such notice,

the commissioner may cancel a certificate of self-insurance upon reasonable grounds therefor. Failure to pay any judgment for which the self-insurer is liable arising from the self-insurer's rendering of professional services as a health care provider, the failure to comply with any provision of this act or the failure to comply with any conditions contained in the certificate of self-insurance shall be reasonable grounds for the cancellation of such certificate of self-insurance. The provisions of this subsection shall not apply to the Kansas soldiers' home *or to the University of Kansas medical center for persons who are engaged, under the supervision of a clinical faculty member of the university of Kansas school of medicine, in a postgraduate training program approved by the state board of healing arts and operated by the university of Kansas medical center.*

(b) Any health care provider who holds a certificate of self-insurance shall pay the applicable surcharge set forth in subsection (c) of K.S.A. 40-3402 and amendments thereto.

The Kansas soldiers' home shall be a self-insurer and shall pay the applicable surcharge set forth in subsection (c) of K.S.A. 40-3402 and amendments thereto.

The university of Kansas medical center for persons who are engaged, under the supervision of a clinical faculty member of the university of Kansas school of medicine, in a postgraduate training program approved by the state board of healing arts and operated by the university of Kansas medical center shall be a self-insurer and the university of Kansas medical center shall pay the applicable surcharge set forth in subsection (c) of K.S.A. 40-3402 and amendments thereto.

Sec. 5. K.S.A. 1984 Supp. 40-3401, 40-3402, 40-3404 and 40-3414 are hereby repealed.

Sec. 6. This act shall take effect and be in force from and after its publication in the statute book.

I hereby certify that the above BILL originated in the SENATE, and passed that body

____

SENATE concurred in
HOUSE amendments ______________________

____
President of the Senate.

____
Secretary of the Senate.

Passed the HOUSE
as amended ______________________

____
Speaker of the House.

____
Chief Clerk of the House.

APPROVED ______________________

____
Governor.

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612

ROBERT T. STEPHAN
ATTORNEY GENERAL

MAIN PHONE: (913) 296-2215
CONSUMER PROTECTION: 296-3751

July 1, 1985

ATTORNEY GENERAL OPINION NO. 85- 73

The Honorable Fletcher Bell
Commissioner of Insurance
420 SW 9th Street
Topeka, Kansas 66612

Re: Insurance -- Health Care Provider Insurance -- Professional Liability Insurance; Self-Insurance of Residents by University of Kansas Medical Center

Synopsis: 1985 Senate Bill No. 362 permits the University of Kansas Medical Center to be a self-insurer under the Health Care Provider Insurance Availability Act, K.S.A. 1984 Supp. 40-3401 et seq., for persons who are residents at the Medical Center. Coverage provided by the Medical Center for its residents is professional liability insurance of the same type as is offered by a private insurer, and accordingly extends to activities of the residents whenever they act as health care providers, either at the Medical Center itself or elsewhere. Cited herein: K.S.A. 1984 Supp. 40-3401, 40-3402, both as amended by 1985 Senate Bill No. 362; K.S.A. 1984 Supp. 40-3403; K.S.A. 1984 Supp. 40-3404, as amended by 1985 Senate Bill No. 362; K.S.A. 1984 Supp. 40-3408; 40-3409; K.S.A. 1984 Supp. 40-3414, as amended by 1985 Senate Bill No. 362; K.S.A. 1984 Supp. 65-2811.

* * *

Dear Commissioner Bell:

As Insurance Commissioner for the State of Kansas, you request our opinion on behalf of the Health Care Stabilization Fund, which is created pursuant to K.S.A. 1984 Supp. 40-3403 and

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which acts as a secondary insurer for health care providers in this state. Specifically, you inquire concerning the status of residents at the University of Kansas Medical Center, which under the provisions of 1985 Senate Bill No. 362 is now a self-insurer for such persons. Questions have arisen as to the extent to which the Medical Center is liable as self-insurer for the actions of its residents, i.e. is the school liable only for residents' actions while on the premises or under the direct supervision of a faculty member elsewhere, or is the coverage 24-hour in scope, wherever and whenever the resident undertakes to act as a health care provider?

1985 Senate Bill No. 362 amended various provisions of the Health Care Provider Insurance Availability Act, K.S.A. 1984 Supp. 40-3401 et seq. The act requires each health care provider to maintain a policy of professional liability insurance which contain basic provisions set out at K.S.A. 1984 Supp. 40-3402(a), as amended by section 2 of the bill. Any judgment which rendered in excess of the basic coverage amounts brings into play the Health Care Stabilization Fund (K.S.A. 1984 Supp. 40-3403) which is administered by your office and financed by a surcharge on each health care provider and self-insurer. K.S.A. 1984 40-3404, as amended by 1985 Senate Bill No. 362. Under the definition of "health care provider" found in the bill [K.S.A. 1984 Supp. 40-3401(f), as amended by section 1), both the Medical Center ("a medical care facility licensed by the department of health and environment") and each resident ("a person engaged in a postgraduate training program approved by the state board of healing arts") are included, and so must either have professional liability insurance or be self-insured in order to render professional services in this state.

By virtue of section 4 of the bill, which amends K.S.A. 1984 Supp. 40-3414, the Medical Center is made a self-insurer as to "persons who are engaged, under the supervision of a clinical faculty member of the university of Kansas school of medicine, in a postgraduate training program approved by the state board of healing arts and operated by the university of Kansas medical center." Such persons, who are commonly referred to as residents, have completed their course of instruction at the Medical Center or another medical school and have obtained a temporary permit to practice from the State Board of Healing Arts. Pursuant to K.S.A. 1984 Supp. 65-2811(b), a resident may engage in the practice of his or her branch of the healing arts while engaged in a postgraduate training program, although private practice is prohibited. We are informed that a number of residents at the Medical center also are employed by other health care providers (i.e. hospital emergency rooms) while in the training program at the university.

As a self-insurer, the Medical Center is liable for the surcharge assessed for the Health Care Stabilization Fund (which for 1985 will be 110% of $600,000). In working with the Medical Center, the Health Care Stabilization Fund, in its role as excess carrier, may require the Medical Center to provide the information required of private insurers by K.S.A. 1984 Supp. 40-3402(a)(1), as amended by section 2. Such action is consistent with the responsibility of the primary insurer (i.e. the Medical Center) to conduct itself in good faith so as not to expose its insureds and any excess carrier to losses beyond the primary policy limits. In addition, the limits on the Medical Center's liability as self-insurer for each of the residents are the same as those for a private insurer (i.e. minimum of $200,000 per occurrence, minimum of $600,000 annual aggregate for all claims). K.S.A. 1984 Supp. 40-3408. The Medical Center, as self-insurer, is also responsible for defending actions brought by plaintiffs against one or more residents. K.S.A. 1984 Supp. 40-3409(b).

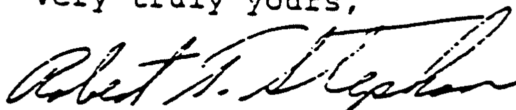
A question has been presented as to the liability of the Medical Center for residents who work elsewhere during the hours they are not employed at their postgraduate training program. A suggestion has been made that the provisions of the bill allow the Medical Center to limit its self-insurance of the residents to only activities which occur in the center itself or under the supervision of faculty at facilities elsewhere. In reading the bill, however, we find that the only limitation of coverage appears in the definition of "professional liability insurance" in K.S.A. 1984 Supp. 40-3401, as amended, which defines the term [at subsection (j)] as "insurance providing coverage for legal liability arising out of the performance of professional services rendered or which should have been rendered by a health care provider." Residents, therefore, who are "moonlighting" would appear to be covered by the Medical Center for the period of time the residents work outside the Medical Center, provided the residents are undertaking the performance of professional services. In other words, the designation of the Medical Center as a self-insurer for the residents appears to refer to the type of health care providers who are covered and not what activities are covered. Questions concerning supervision would appear to be more appropriately raised during the course of a lawsuit to determine the percentages of responsibility attributable to the various parties, rather than making coverage initially dependent upon the question of supervision.

Further, we are informed that professional liability insurance offering coverage for less than twenty-four hours per day for health care providers is not available in Kansas. As a matter of

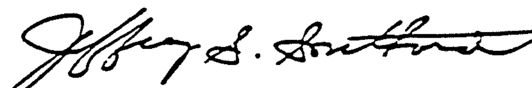
law, an insurer would be unable to obtain approval on a policy form covering less than twenty-four (24) hours because the insurer would then violate the basic coverage requirements of the Health Care Provider Insurance Availability Act, as noted above. Consequently, a resident would be unable to obtain a policy which covered only the period of time he moonlighted. Residents would therefore be faced with the choices of going without coverage in violation of the law, incurring double coverage at their own expense through the private purchase of insurance, or eliminating outside work, thus potentially restricting the availability of health care services in Kansas. In that legislation should not be construed in ways which lead to uncertainty, injustice or confusion if it is possible to do otherwise [State v. Dubish, 234 Kan. 708 (1984)], we do not believe that 1985 Senate Bill No. 362 should be read to as to limit the coverage provided by the Medical Center as self-insurer for its residents.

In conclusion, 1985 Senate Bill No. 362 permits the University of Kansas Medical Center to be a self-insurer under the Health Care Provider Insurance Availability Act, K.S.A. 1984 Supp. 40-3401 et seq., for persons who are residents at the Medical Center. Coverage provided by the Medical Center for its residents is professional liability insurance of the same type as is offered by a private insurer, and accordingly extends to activities of the residents whenever they act as health care providers, either at the Medical Center itself or elsewhere.

Very truly yours,



ROBERT T. STEPHAN
ATTORNEY GENERAL OF KANSAS



Jeffrey S. Southard
Deputy Attorney General

RTS:JSS:crw

United States District Court
District of Kansas

Patrick F. Kelly
Judge

United States Courthouse
Wichita, Kansas 67202

August 2, 1985

Mr. Mike Heim
Kansas Legislative Research
Department
545 State Office Building
Topeka, Kansas 66612

Dear Mike:

This confirms our telephone conference in which you invited me to participate in an informal hearing with legislative members. It is my understanding that your interest is with regard to the settlement conference program undertaken by me approximately one year ago. I will be pleased to participate and be in attendance on August 15, 1985, at 3:00 P.M. During the interim, I trust you will provide me with a copy of the program, the names of others in attendance, and the place where the hearing will be held.

The legislative members should understand that I will appear only for the purpose of reviewing the concept of the program itself and to tender comments as to its success. It certainly is not my purpose to recommend or encourage adoption of this or any other program; in other words, that is for the Legislature, not for me.

You have requested some advance material, and I am enclosing certain portions of my file which are geared to the mechanics of the program. These first include the local rule authorized by our court about a year ago, which is presently operating on at least a trial basis, my colleagues having permitted me to experiment with it.

Here, this Court is in communication with the attorneys involved in any litigation within approximately 30 days' time from the date of answer. We review discovery requisites, encourage settlement, set pretrial conference and settlement conference dates, and schedule the trial. All of us thereafter work toward the trial date and, of course, this very process serves as a catalyst for settlement discussions. I enclose a copy of that scheduling order to show you the format and attach to it a personal letter which goes to the attorneys, the thrust of which discusses my philosophy on the subject of settlement and provides the attorneys with the names of available mediators appointed by me, from whom they are at liberty to make a selection. Here in Wichita we have the benefit of a part-time magistrate, Judge Tom Reid, a former state trial judge, who serves the court two days a week and is principally involved with settlement conferences. He has been handling at least two conferences each Friday and is now taking some cases referred by Judge Crow. The mediators have

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been selected in concert with recommendations from a select committee drawn from the American College of Trial Lawyers. Last November I hosted a conference in my courtroom with all of these persons in attendance, at which time we orientated them as to their expected role. These lawyers are compensated at the rate of $100 per hour, the compensation being shared equally by the litigants. In my view, a settlement conference is no more than an occasion for confrontation between adversaries, i.e., lawyers and litigants. I require the presence of a principal who has authority to say "yes" or "no". Of paramount importance is the necessity that discussion be taken up in a private setting, privileged from me, where the parties can fully explore the opportunities for an amicable disposition. The mediator or magistrate must be someone whose judgment the parties respect.

Next, I enclose a copy of the order appointing the magistrate or a mediator, which order sets in place our rules of procedure. Attached to the order is a second letter from me which I believe you will find of interest. It says it all insofar as I am concerned as to the litigants' preparation for this meeting.

If the legislative members have at hand copies of this material, they will be in a better position to review with me the mechanics of the process, and hopefully they can come to appreciate my pride in the success of the program. I will try to pull together some numerical statistics on the program.

Regards,

Patrick F. Kelly

PFK:br
Enclosures

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF KANSAS

⊠

Plaintiff(s),)
)
vs.) No. ⊠
)
⊠
Defendant(s).)
)

SCHEDULING ORDER

The above matter is now at issue, and after conference with ⊠, the Court sets the following guidelines:

1. Discovery will commence on ⊠. The defense counsel shall initiate a meeting to explore discovery requisites and settlement prospects* as set forth in Rule 16(a) (F.R.Civ.P.). Said meeting is to be confirmed by letter from plaintiff counsel, copy of same to the Court. Counsel will appear in chambers for a status conference on ⊠, at ⊠. (may be waived if mutually agreed to by all parties, or may be done by conference call; in either event, notice to be given in advance to the Court). Cutoff for discovery will expire ⊠.

2. A pretrial conference is scheduled in chambers on ⊠, at ⊠. In this, counsel are requested to meet in advance for the purpose of drafting an agreed-upon order or their own proposals, but in every event an order will issue.

3. A settlement conference* is scheduled ⊠. Further details on this will be provided counsel at the time of the pretrial conference.

4. The case is scheduled for ⊠ trial, ⊠ alternate, on ⊠. ⊠.

5. ⊠.

6. Continuances will only be granted on a showing of good cause.

IT IS SO ORDERED this ⊠.

PATRICK F. KELLY, JUDGE

* See attachments

United States District Court
District of Kansas

Patrick F. Kelly
Judge

United States Courthouse
Wichita, Kansas 67202

Dear Counsel:

As you know, we are under way here with engagement of Local Rule 45, i.e., settlement conferences.

I will require such a conference prior to trial of this case. You should also know that this will require the presence of your client and/or principal, i.e., a person with authority to say "yes" or "no".

Magistrate Tom Reid is available to serve as a settlement judge for this Court. In addition, however, we are under way with a mediation panel from which you may select a mediator for this purpose. A copy of the panel is enclosed for your immediate review.

You are now requested to meet with your adversary to explore discovery requisites and settlement prospects. Perhaps this session can be the time to at least open discussions for the purpose of resolving the whole matter. I needn't remind you that a prompt resolution saves the expense of discovery and valuable time, and provides a degree of certainty which full trial never will. Simply said, it is surely no sign of weakness to at least explore the likelihood of settlement - now.

Perhaps at the time of your first meeting you will want to discuss the use of a mediator and select such a person. If you desire to commence the settlement process in advance of the scheduled settlement conference, by all means feel welcome to communicate with Marlin and he will coordinate the arrangements.

Patrick F. Kelly

Enclosures

SETTLEMENT JUDGE:

Hon. John Thomas Reid
Part-Time U.S. Magistrate

MEMBERS OF MEDIATION PANEL:

Robert R. Arnold
Daniel C. Bachmann
M. Ralph Baehr
Eldon L. Boisseau
Don W. Bostwick
B. Mack Bryant
David P. Calvert
John T. Conlee
H. W. "Bud" Fanning
William C. Farmer*
A. J. "Jack" Focht
John Foulston
Dennis L. Gillen
Brian G. Grace
Charles W. Harris
William A. Hensley
James Z. Hernandez
Kenneth Hiebsch
Richard C. Hite**
H. E. Jones*
Darrell D. Kellogg
Joseph W. Kennedy
E. Lee Kinch
Gerald D. Lasswell
Calvin L. McMillan
Robert Martin*
Phillip Mellor
Gerald L. Michaud*
Donald R. Newkirk*
Payne H. Ratner, Jr.*
Chris Redmond
Harry E. Robbins
Robert J. Roth
James W. Sargent
Robert M. Siefkin*
Roger M. Sherwood
William R. Smith
Richard I. Stephenson
Charles H. Stewart (Kingman, Kan.)
Mikel L. Stout
Paul L. Thomas
William Tinker, Sr.
Darrell L. Warta
John P. Woolf
Gerrit H. Wormhoudt

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* Member, Executive Committee

** Chairman, Executive Committee

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF KANSAS

⊠ Plaintiff(s), vs. ⊠ Defendant(s).	))))))))	No. ⊠

MEMORANDUM ORDER

Consistent with Rule 16 of the Federal Rules of Civil Procedure, exploration of settlement prospects of the referred matter is encouraged. Consistent with Rule 45 of this Court, a settlement conference is required. In this, and with agreement of counsel, the matter is assigned unto ⊠, a ⊠, for the purpose of undertaking a settlement conference with litigants, their principals, and counsel. The conference is scheduled on ⊠, in ⊠, at ⊠M. The ⊠ is at liberty to reschedule the conference at a more convenient time or place. Counsel are reminded that the matter is also scheduled for ⊠ trial on ⊠. Briefs, summaries of key witness testimony, and requested ⊠ are to be filed no later than ⊠.

The purpose of the settlement conference is to permit an informal discussion between the attorneys, parties, and the ⊠ of every aspect of the lawsuit bearing on its settlement value, thus permitting the ⊠ to privately express his views concerning

the actual dollar settlement value or other reasonable basis for disposition of the case.

While the Court has attached additional guidelines for counsels' review, the format is essentially as follows:

Prior to the settlement conference, the attorneys should discuss settlement with their respective clients or principals. Additionally, the opposing attorneys should informally explore settlement prospects, at least in the interest of ascertaining the parameters, if any.

In advance of the hearing, counsel are encouraged to submit a settlement conference statement, detailing the factual or legal issues and relief requested. The statement may include such documentation as expert witness reports, etc. The statement may be shared with opposing counsel, but it is not to be filed as a part of the record in this case. Use of exhibits and demonstrative evidence at the conference is also authorized.

The attorney responsible for the trial of the case will be present at the conference with a person having actual settlement authority. If, for good reason, such persons cannot be present, advance approval should be secured from the Court for a procedure where such persons are telephonically available, and opposing counsel should be advised of this development.

The parties, their representatives, and attorneys are expected to be completely candid with the ⊠ so that he may properly guide settlement discussions.

⊠ is at liberty to converse with the lawyers and their clients outside the hearing of the adverse parties.

Neither the settlement conference statements nor communications during the settlement conference with the ⊠ can be used by either party in the trial of the case. ⊠ will not communicate to the trial judge the confidences of the conference except to advise as to whether or not the case has been settled.

Costs, including reasonable fees where applicable, shall be mutually assessed to the litigants.

IT IS SO ORDERED this ⊠.

PATRICK F. KELLY, JUDGE

SETTLEMENT CONFERENCE FORMAT AND GUIDELINES

The obvious purpose of this program is to enhance settlement prospects by means of an actual, but informal, confrontation with your adversary. You should understand from the outset, however, that it is not my intention to impose a settlement on anyone. Indeed, having given this process your best, and it fails, the courtroom is yours!

Some Perspectives

The first requisite is that you now communicate with your client or principals with regard to settlement prospects or parameters, and assure their presence at the hearing. The success of this program is geared to having the litigants directly involved and perhaps, for the first time, come to grips with all that is involved.

Permit me to suggest, however, that even before you communicate with your client, you take time for some personal reflections and think through your case. Discovery is completed and you have at hand the pretrial order. You ought to know your case now as well as you ever will, save, of course, for that time when the combat gets under way! Ask yourself, is a trial of this case really necessary? What really is at stake? Surely your own ego isn't standing in the way! Are you that certain that you will win? What are the risks? Where are you vulnerable? Have you seriously considered your adversary's position? Have you considered the skill, experience and record of success of your adversary's counsel? What about you? What is your experience, your record?

What does your client really want? Hopefully, his expectations have not been unduly inflated, i.e., can't lose - can't win! Is he somehow seeking full, unrelenting vindication - massive damages - even punitive damages? Isn't there some way to compromise and keep your client's pride? If substantive damages are your quest, are your own views reasonable and provable? Do you have a plan? Have you considered the ramifications even if you win, i.e., coverage, ability to pay? If your demands are substantive <u>but realistic</u>, have you considered a structured settlement and other options? In some settings, have you considered an expression of regret, reinstatement or reassignment; perhaps a sealed settlement, i.e., agreement not to divulge the terms of settlement? If your client is asked to fall back, have you considered reduction of <u>your</u> fees? What are the costs, i.e., expenses of litigation? Jury trials get expensive and time is measured in days. Appeals speak for more delay and more expense. While you may relish the combat and believe you have a bell-ringer, jury trials aren't always that pleasant for your client. Often the clients suffer a terrible emotional toll when the win

isn't worth the effort. While you know best, I trust you have at least given thought to some of these ramifications.

The one thing about jury trials is that they are final! Indeed, as you probably know, however meritorious the cause may appear, however well tried the case may be, it can also be lost! There are, of course, other considerations applicable to both sides -- these are only a few.

Now when you communicate with your client or principals, have your own plan and perspective in mind and stand ready to counsel your client candidly and objectively. When you then initiate an informal conference with your adversary, and the plaintiff's counsel is expected to undertake this, stand ready to explore settlement within reasonable parameters if possible. The process of making demands and awaiting counteroffers may have its place, but responsible, experienced attorneys ought to be in a position to discuss disposition within the framework of known parameters.

Surely a willingness to at least explore the areas is no sign of weakness, and it is encouraged.

The Conference

When you and your client come to the conference, the settlement judge or mediator will allow each lawyer to make an initial statement concerning his client's position. It should be used as a concise and persuasive summary of why your client will prevail in the litigation. Best preparation is from a carefully prepared outline and utilization of exhibits or demonstrative aids to illustrate key issues of fact. Do not discuss making concessions during this initial statement -- the judge or mediator will probably convince you to make concessions soon enough.

Following this process, the judge or mediator will want to visit with both sides, privately, and in the interest of narrowing the issues subject to negotiations. What do you really want or what will you take, or what will you really pay, if anything? By all means, be willing to concede points of weakness. He may well touch upon many of the areas discussed above. If he urges compromise or concessions in certain areas, and you agree, say so. He will also visit with your adversaries in the same manner and may return to each again and again until some reasonable plan or basis is formulated. He will, of course, seek your client's commitment or concessions. Notwithstanding whatever the parties have agreed to, or not, he will also give both sides his best advice as to the basis for settlement. In this, he may well tell the plaintiff that his case is considered baseless or probably can't be won or won't reach the plaintiff's expectations. He may well tell the defendant that his views are unrealistic. Even if the session leaves disposition unresolved, he will have done his best to find some basis for accord. With your contribution, if there is a way, it probably can be found.

Simply said, you may be a most experienced, well-prepared, and successful "litigator"; you may love to try cases, and, of course, you get paid to try cases. For the moment, however, your skill is that of a negotiator. You are asked to think through your case in its entirety and think "compromise" when it is in the best interest of your client to do so.

Indeed, you proceed here with my very best wishes.

Respectfully,

Patrick F. Kelly

United States District Court
District of Kansas

Patrick F. Kelly
Judge

August 2, 1985

United States Courthouse
Wichita, Kansas 67202

Mr. Mike Heim
Kansas Legislative Research
Department
545 State Office Building
Topeka, Kansas 66612

Dear Mike:

This confirms my telephone conference with you regarding two rather provocative opinions recently entered by this Court. Copies of the Crowe and Playtex opinions are enclosed.

Regards,

Patrick F. Kelly

PFK:br
Enclosures

8/15-16/85

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF KANSAS

FILED
MAY 24 1985
ARTHUR G. JOHNSON, Clerk

KELLY M. O'GILVIE, Individually and as Administrator of the Estate of Betty L. O'Gilvie, Deceased; and STEPHANIE L. O'GILVIE, a Minor, and KEVIN M. O'GILVIE, a Minor, By and Through Kelly M. O'Gilvie, Their Father and Natural Guardian,

Plaintiffs,

vs.

INTERNATIONAL PLAYTEX, INC., a Corporation,

Defendant.

No. 83-1846-K

REMITTITUR OF PUNITIVE DAMAGES

On February 25, 1985, the jury unanimously responded to certain questions propounded by the Court as follows:

1. Was decedent Betty O'Gilvie, in late March 1983 and during the course of her menstrual cycle, using defendant's product?

Yes __X__ No _____

2. In March 1983, did use of Playtex super deodorant tampons cause or contribute to the cause of toxic shock syndrome?

Yes __X__ No _____

3. As compared to all other tampons, including competitors, is there an increased risk of contracting toxic shock syndrome when using these super deodorant tampons?

Yes __X__ No _____

4. Did the label and instructions inside and outside the Playtex box at the time the product was being used by Betty O'Gilvie adequately and fairly

inform and warn Betty O'Gilvie of the risk of TSS which may be fatal from using Playtex tampons?

Yes _____ No __X__

5. Do you find International Playtex and/or Dr. Thomas Hays to be at fault in this case?

Yes __X__ No _____

6. If you answer No. 5 "yes", then, considering all of the fault at 100%, what percentage of fault is attributable to each of the following:

International Playtex	(0 to 100%)	80%
Dr. Hays (and his agents or employees)	(0 to 100%)	20%
	Total	100%

7. Without considering the percentage of fault found in No. 6, what total amount of damages do you find should be awarded:

Conscious pain and suffering of Betty O'Gilvie	$250,000.00
Nonpecuniary loss (not to exceed $25,000.00) to Kelly O'Gilvie and children	25,000.00
Pecuniary loss to Kelly O'Gilvie and children	1,250,000.00

8. Did International Playtex know, or should it have known, of the increased risk of developing toxic shock syndrome when using Playtex super deodorant tampons at the time of the death of Betty O'Gilvie?

Yes __X__ No _____

9. Was the failure of International Playtex to adequately warn about the increased risk of toxic shock syndrome with the usage of Playtex super deodorant tampons a reckless disregard by International Playtex of the consequences of its acts?

Yes __X__ No _____

10. If your answer to No. 9 is "yes", you may assess punitive damages as you feel are warranted from the evidence.

Punitive damages $10 million

On March 21, 1985, the Court took up defendant's motions, all of which were overruled. Specifically, the jury's assessment of punitive damages, while substantial, was found to be not excessive, nor did it shock the Court's conscience. In the Court's view, in light of the evidence and the jury's findings, the jurors expressed their "outrage" the only way they could - with money damages. Conversely, the jurors were actually saying, "Take that damnable product off the market!"

Following the Court's findings and rulings, the Court tendered a provocative proposition to the defendant. Speaking indirectly to the President of Beatrice Company, the parent company of defendant International Playtex, the Court commented in substance as follows:

> That this person should know, that in the Court's view, there was ample evidence to support each finding of the jury; that punitive damages are essentially intended to deter wrongdoing; that in the event there are no changes contemplated by the defendant International Playtex, such damages as manifested by this jury are probably "only the beginning. There surely will be others!"

Further, the Court ventured that the President of Beatrice was probably an entirely decent person, and if he concurred with these findings, he would surely order a change.

The Court then represented to defendant's counsel that in the event this person, or his authorized representative, elected to appear in this Court on April 29, 1985, to acknowledge the

jury's findings as factually established and announce the removal of the polyacrylate tampon from the marketplace, the Court in turn would consider a substantial reduction, if not elimination, of the punitive damages award.

The Court's tender of a reduction of any portion of the jury verdict on the basis of the conditions set forth was probably without precedent. This proposition was an innovative remedy geared to what the Court reasoned as "that which ought to be." In this, the Court has drawn from similar experiences in dealing with those persons who have appeared here for the purposes of punishment. In many instances the ordeal itself is punishment enough. In others, deterrence is paramount. When wrongdoing is acknowledged, where changed is agreed to, indeed, where change has occurred, the Court is usually impressed and persuaded principally as to what further punishment, if any, is then in order. In the Court's view, such remedial events are appropriate elements of mitigation which, in the Court's discretion, should be noted and considered.

Within two weeks of that hearing, the Court noted the defendant's public announcement to the effect that its Playtex Slender, Super and Super Plus Tampons - those containing polyacrylate fibers - will no longer be made. Shortly thereafter, defendant's counsel communicated with the Court in the interest of further conference and for a continuance of the pending hearing. With the concurrence of plaintiffs' counsel, the Court conferred with counsel for International Playtex; the hearing was set over to May 24, 1985.

At the outset, the defendant's counsel were apprised that it has never been the Court's intention to negotiate or otherwise dictate the course of defendant's decisions. Indeed, whatever decisions were made by the defendant company, were its alone to make.

In the course of the first session, the defendant's counsel specifically represented that the defendant had indeed removed polyacrylate fibers from all tampons, and all tampons with polyacrylate fibers are being removed from the market. The Court discussed the present state of the warning on defendant's product which acknowledges an "association" between the use of the tampon and toxic shock syndrome (TSS). The jury found that this warning was inadequate and the Court concurs. Additionally, the Court took up the necessity of a broad-spread communication by the industry to the consuming public and the medical community with regard to early signs and symptoms of TSS.

As to the need for a public education program, the defendant's counsel have outlined a meaningful program which, given time and exposure, should serve to inform and alert the public and medical community about the toxic shock process.

With regard to the warning, defendant's counsel have represented to the Court that as of now the defendant's alert statement or any warnings with regard to the sale of any tampon will be modified to include the following:

> There are scientific studies which have concluded that tampons contribute to the cause of TSS.

While some may argue as to the adequacy of this statement, all should agree that it represents a sizeable "first step."

Indeed, the Court is the first to note the sense of sincerity exercised by defendant's counsel. The Court is ever sensitive to certain pragmatics of this action. Given misperception, it could surely be abused by some, either in the course of pending litigation here or elsewhere -- and in future days! However unfortunate, it may well invite additional litigation. From the Court's perspective, however, the defendant's action represents a commendable exercise of fortitude and decency.

Of paramount importance, the Court finds that such action is a significant postjudgment remedial and mitigatory response to the jury's findings. Indeed, the jury's intent has been substantially sufficed. In view of the defendant's actions, the Court finds that the punitive damages award is now, in part, excessive and unnecessary. The jury's finding of ten million dollars ($10,000,000.00) is reduced to the amount of one million three hundred fifty thousand dollars ($1,350,000.00), effective from February 26, 1985. This remaining sum is intended to represent the jury's assessment regarding the element of punishment and is clearly the proprietary right of the plaintiffs. In the Court's view, such an amount is fair, reasonable and deserving. In light of defendant's action, the Court here asserts that International Playtex should not be called upon to respond in any punitive damage claims, at least with those matters pending here. It has faced its situation, it has acted most responsibly, and it has acted decently. It can be no further deterred; it has been punished enough!

Some comment is in order for the benefit of the plaintiff, Mr. Kelly O'Gilvie, for himself and on behalf of his children. Following the jury's verdict, they enjoyed the expectancy of a substantial recovery. Yet, they did not bring this action for personal enrichment. They sought punitive damages solely to punish and deter the defendant from future wrongdoing. In the face of defendant's announcements and representations, the plaintiffs have truly won!

Additionally, perhaps some solace is owing to plaintiffs' counsel. These lawyers, doubtless, have proceeded here with an attorney fee arrangement contingent upon the amount of recovery. This procedure is entirely acceptable and understood. They have surely advanced substantial expenses necessary for the successful trial of this case. To reduce the recovery reduces their expectancy. Fortunately, trial of this case involves the kinds of lawyers with whom the Court can find comfort in open discussions.

The Court is first to note that it is only through these attorneys' considerable efforts, their commitment of much time in study and preparation, and their skills in the trial of this case, that plaintiffs have prevailed. Not every lawyer would share this experience. In the Court's view, however, they are also the kinds of lawyers who quietly share a certain professional satisfaction and sense of pride in seeing our adversary system work. Their efforts here have literally changed an industry! In the minds of good lawyers such as these, no amount of recompense quite touches that accomplishment. To them, the

Court suggests that there will be other cases and other conquests. Indeed, attorneys such as these are always welcome here.

IT IS THEREFORE ORDERED this 24 day of May, 1985, that the jury's assessment of ten million dollars ($10,000,000.00) punitive damages is reduced to the sum of one million three hundred fifty thousand dollars ($1,350,000.00), effective from the date of first entry of judgment.

PATRICK F. KELLY, JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF KANSAS

KATHERINE CROWE, an Incapacitated Minor, By and Through Her Parents, Natural Guardians and Next Friends, SALLY A. CROWE and FREDERICK J. CROWE,

Plaintiff,

vs.

ANNE WIGGLESWORTH, M.D., MAURA WELCH, M.D., Individually and as Co-Partners, d/b/a KAW VALLEY WOMEN'S HEALTH CENTER,

Defendants.

No. 84-1792-K

FILED
AUG - 2 1985
ARTHUR G. JOHNSON, Clerk
By ______________ Deputy

MEMORANDUM AND ORDER

This is a medical malpractice action brought under the Court's diversity jurisdiction. Plaintiff Crowe is an incapacitated minor residing in Oregon, suing through her parents as natural guardians and next friends. Defendants Wigglesworth and Welch are Kansas physicians, partners holding themselves out to the public as the Kaw Valley Women's Health Center. Dr. Wigglesworth provided prenatal care to Sally Crowe, plaintiff's mother, and attended plaintiff's birth in August, 1983. Plaintiff now claims Dr. Wigglesworth was negligent during the labor and delivery, causing plaintiff numerous and severe permanent injuries. Her complaint was filed November 9, 1984, and trial was recently scheduled to begin August 6, 1985.

At the time plaintiff filed her complaint, the modified collateral source rule contained in K.S.A. 60-471 governed the

AO 72A
(Rev. 8/82)

admissibility of evidence of reimbursement or indemnification received by a party injured by the negligence of a health care provider. In late April 1985, the Kansas Legislature repealed K.S.A. 60-471 and, in the substitute for Senate Bill No. 110, enacted a new rule governing the admissibility of this evidence in medical malpractice liability actions. 1985 Kan. Sess. Laws, Ch. 197, Sec. 3. The parties to this case filed briefs addressing the applicability and constitutionality of this rule. For the reasons which follow, the Court concludes Section 3 of the new act applies to this case and that, notwithstanding the Court's serious misgivings about this legislation, within the limited confines of that section, the infringement on plaintiff's rights resulting from abolition of the collateral source rule does not rise to the level of an equal protection violation.

The new act contains three sections. The first is a definitional section. Section 2 establishes a bifurcated procedure for assessing punitive damages in medical malpractice liability actions. It places a ceiling on the total that can be assessed, limits a plaintiff's recovery to 50% of the amount awarded in a given case, and requires the remaining 50% be paid to the state health care stabilization fund. Plaintiff Crowe does not seek punitive damages in the present case. Accordingly, issues concerning the applicability and constitutionality of Section 2 are not before the Court.

Section 3 of the new act, however, directly affects this case. That section abandons, for medical malpractice liability actions, the common law collateral source rule and provides in-

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stead defendants are entitled to the benefit of evidence of all reimbursement or indemnification "paid or to be paid to or for the benefit" of a party injured by the negligence of a health care provider. There is no question the section applies to this diversity action. Further, it is clear that even though the Legislature generally intended the entire act to take effect July 1, 1985, it specifically intended Section 3 to apply "to any action pending or brought on or after July 1, 1985, regardless of when the cause of action accrued." (Emphasis added.) 1985 Kan. Sess. Laws, Ch. 197, Sections 3(d), 6. Far more difficult is plaintiff's assertion Section 3 of the act violates her rights, under the federal and state constitutions, to equal protection of the law. Analysis of this issue requires a short historical review.

The common law collateral source rule excluded evidence showing damages claimed by a party were actually paid by someone else, or that services had been provided gratuitously. Doran v. Priddy, 534 F.Supp. 30, 35 (D. Kan. 1981). In Grayson v. Williams, 256 F.2d 61, 65 (10th Cir. 1958), the Court of Appeals addressed the public policy underlying this rule:

> Where part of a wrongdoer's liability is discharged by payment from collateral source . . . the question arises who shall benefit therefrom, the wrongdoer or the injured person. No reason in law, equity or good conscience can be advanced why a wrongdoer should benefit from part payment from a collateral source of damages caused by his wrongful act. If there must be a windfall certainly it is more just that the injured person shall profit therefrom, rather than the wrongdoer shall be relieved of his full responsibility for his wrongdoing. We think we may judicially note that notwithstanding that the law contemplates full compensation, incidental losses and handicaps are suf-

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fered in a great number of personal injury cases which are not, and cannot be, fully compensated.

See also Restatement (Second) of Torts §920A(2), Comment b (1979).

Responding to the so-called medical malpractice crisis in 1976, the Kansas Legislature enacted K.S.A. 60-471, which modified the common law collateral source rule. The new evidentiary rule contained in subsection (a) of the statute read:

> In any action for damages for personal injuries or death arising out of the rendering of or the failure to render professional services by any health care provider, evidence of any reimbursement or indemnification received by a party for damages sustained from such injury or death, excluding payments from insurance paid for in whole or in part by such party or his or her employer, and services provided by a health maintenance organization to treat any such injury, excluding services paid for in whole or in part by such party or his or her employer, shall be admissible for consideration by the trier of fact subject to the provisions of subsection (b). Such evidence shall be accorded such weight as the trier of fact shall choose to ascribe to that evidence in determining the amount of damages to be awarded to such party.

The federal courts of Kansas were the first to address the constitutionality of K.S.A. 60-471. Judge Rogers upheld the statute against equal protection challenges in Marlatt v. Hutton, No. 76-46-C5 (D. Kan. Apr. 3, 1979), and again in Holman v. The Menninger Foundation, No. 79-4090 (D. Kan. July 13, 1982) (order denying motion in limine). However, in Doran v. Priddy, 534 F.Supp. 30 (D. Kan. 1981), Judge Theis ruled K.S.A. 60-471 violated the equal protection clauses of both the United States and Kansas Constitutions. He reached that conclusion largely because of the following hypothetical situation showing the inequitable

treatment of two patients suffering similar injuries at the hands of the same health care provider:

> One is wealthy, and has insurance, while the other has no resources to pay for medical care and is uninsured. The first is able to retain private nursing care, which is paid for by the insurance, while the second, needing the same continual care, is cared for by his wife, who was forced to quit her job to stay home and care for him. It is said the modified collateral source rule would exclude evidence that the private nursing care for the first patient was in fact paid for by the insurance company, while the jury would be apprised of the fact that the second patient's care was provided free by his wife, and perhaps she had been earning only the minimum wage at the job she left.

534 F.Supp. at 36.

The Kansas Supreme Court was faced with a constitutional challenge to K.S.A. 60-471 only recently, and it agreed with Judge Theis' analysis and conclusion. Wentling v. Medical Anesthesia Services, P.A., No. 56,984, slip op. at 24 (Kan. June 21, 1985). That Court noted yet another situation highlighting the discriminatory effects of K.S.A. 60-471:

> If the statute is to be applied according to its plain language, an even more invidious hypothetical example comes to mind. Assume a married couple is injured in the same catastrophe. They are both treated by the same health care provider with disastrous results. The husband is employed and his employer provides health insurance. The wife is not gainfully employed. In separate actions for similar treatment provided by the same health care provider as a result of the same catastrophe, the fact that the wife's medical expenses were paid by insurance is proper evidence to submit to the jury but the same evidence as it applies to the husband is not. Such a distinction makes no sense whatsoever.

Wentling, slip op. at 23.

Effective July 1, 1985, the Legislature repealed K.S.A. 60-471 and enacted the following rule governing the admissibility of evidence of collateral source benefits:

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(a) In any medical malpractice liability action, evidence of the amount of reimbursement or indemnification paid or to be paid to or for the benefit of a claimant under the following shall be admissible: (1) medical, disability or other insurance coverage except life insurance coverage; or (2) workers' compensation, military service benefit plan, employment wage continuation plan, social welfare benefit program or other benefit plan or program provided by law.

(b) When evidence of reimbursement or indemnification of a claimant is admitted pursuant to subsection (a), the claimant may present evidence of any amounts paid to secure the right to such reimbursement or indemnification and the extent to which the right to recovery is subject to a lien or subrogation right.

(c) In determining damages in a medical malpractice action, the trier of fact shall consider: (1) The extent to which damages awarded will duplicate reimbursement or indemnification specified in subsection (a); and (2) the extent to which such reimbursement or indemnification is offset by amounts or rights specified in subsection (b).

1985 Kan. Sess. Laws, Ch. 197, Sec. 3.

Plaintiff Crowe argues Section 3 contains infirmities similar to those of the old statute and is therefore unconstitutional. Defendants respond the new enactment has eliminated the artificial distinctions drawn by K.S.A. 60-471 and works no violation of plaintiff's equal protection rights.

Whether a state statute or regulation violates the equal protection clause depends on the facts and circumstances behind the law, the interests which the state claims to be protecting, and the interest of those who are disadvantaged by the classification. Williams v. Rhodes, 393 U.S. 23, 30, 21 L.Ed.2d 24, 89 S.Ct. 5 (1968). In legislation of the type here at issue, out of the similarly situated group of persons injured by the tortious acts of others, the state has isolated for different treatment those persons injured by the negligent acts or omissions of health care providers.

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The first issue concerns the standard of review used to test the constitutionality of Section 3. Constitutional equal protection analysis involves one of three levels of scrutiny, which have been often stated and need only quick review.

The most stringent standard of review is "strict scrutiny," under which a statute or regulation is stripped of its presumption of constitutionality and the state must demonstrate a compelling governmental interest justifying the classification. The strict scrutiny test applies only to legislation regulating the exercise of a fundamental right or isolating for special treatment a suspect class of persons, i.e., on the basis of race, religion, national origin, etc. San Antonio Independent School District v. Rodriguez, 411 U.S. 1, 16-17, 36 L.Ed.2d 16, 93 S.Ct. 1278 (1973). The class of persons injured by medical malpractice has never been recognized as "suspect" under constitutional analysis. There is conflicting authority on the question whether a plaintiff's right to sue and recover for the tortious acts of another is "fundamental" under the Constitution. See Duke Power Co. v. Carolina Env. Study Group, 438 U.S. 59, 93-94, 57 L.Ed.2d 595, 98 S.Ct. 2620 (1978); Kenyon v. Hammer, 142 Ariz. 69, 688 P.2d 961 (1984); White v. State of Montana, 661 P.2d 1272 (Mont. 1983). However, that particular question need not be resolved here because the Court is faced only with a procedural rule governing the admissibility of evidence. Whatever the nature of plaintiff's right to maintain the action, her right to withhold from the trier of fact particular items of evidence is certainly not "fundamental."

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The second, middle-level analytical approach is variously referred to as the "substantial relationship" or "means-scrutiny" test, under which the statutory "classification must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relationship to the object of the legislation, so that all persons similarly circumstanced shall be treated alike." Reed v. Reed, 404 U.S. 71, 76, 30 L.Ed.2d 225, 92 S.Ct. 251 (1971). However, the Supreme Court has applied this intermediate level of inquiry only to gender-based classifications, see Craig v. Boren, 429 U.S. 190, 50 L.Ed.2d 397, 97 S.Ct. 451 (1976), and Reed v. Reed, supra; and to classifications based on legitimacy, see Trimble v. Gordon, 430 U.S. 762, 52 L.Ed.2d 31, 97 S.Ct. 1459 (1977). Although Judge Theis relied on the substantial relationship test to strike down K.S.A. 60-471 in Doran v. Priddy, 534 F.Supp. 30, with all respect to its learned colleague, this Court does not agree an injured plaintiff's right to exclude particular items of evidence in a medical malpractice liability action stands on the same constitutional footing as the right to freedom from discrimination based on one's sex or legitimacy.

The third and most permissive standard is the "rational basis" or "reasonable relationship" test set forth in McGowan v. Maryland, 366 U.S. 420, 425-26, 6 L.Ed.2d 393, 81 S.Ct. 1101 (1961). Under this standard, a statute is presumed constitutional and the challenger bears the burden of proving the classification "rests on grounds wholly irrelevant to achievement of the state's objective." If there exists a rational reason for

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the disparate treatment, that is, if the classification is rationally related to furthering a legitimate state interest, there is no denial of equal protection. Vance v. Bradley, 440 U.S. 93, 97, 59 L.Ed.2d 171, 99 S.Ct. 939 (1979).

Defendants direct this Court's attention to a host of decisions from other jurisdictions holding all manner of medical malpractice crisis relief statutes, including remedies such as that contained in Section 3, subject only to the rational basis test to determine their constitutionality under the equal protection clause. But blind adherence to this most permissive constitutional standard and the consequent over-indulgence of state legislatures in these matters have been properly criticized as an abdication of judicial responsibility. Jones v. State Board of Medicine, 97 Idaho 859, 555 P.2d 399, 411 (1976). The Supreme Court of Arizona correctly recognized that the various legislative remedies granted to the insurance industry and the medical profession will differently affect a variety of rights held by an injured plaintiff, and that the level of scrutiny employed to test the constitutional sufficiency of a statute depends not on the fact it was enacted in response to the purported crisis but on the nature of the injured party's right which is affected by the particular legislation at issue. See Kenyon v. Hammer, 142 Ariz. 69, 688 P.2d 961, 975 (1984) (holding the rational basis test applies only to those portions of a statute not affecting plaintiff's fundamental right to bring the action).

This Court agrees with the Kenyon v. Hammer analysis and emphatically rejects defendants' suggestion it is bound to apply

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the most permissive constitutional standard to any and all legislative responses to the alleged crisis. However, at issue in this case is merely a procedural enactment, a rule of evidence, and the Court is satisfied the rational basis test is the appropriate level of inquiry. The question of what level of scrutiny properly applies to other statutes or enactments more directly affecting the right to maintain an action to recover for medical malpractice is reserved for future cases.

Does the new evidentiary rule contained in Section 3 perpetuate the same distinctions for which K.S.A. 60-471 was declared unconstitutional? The fundamental problem with 60-471 was that it excluded all evidence of reimbursement or indemnification received by an injured party whenever that party, or any employer acting on the party's behalf, had made payments in any amount for the insurance. That exception gave rise to the different treatment between wealthy and indigent plaintiffs (Doran v. Priddy, supra) and between employed persons who pay for their insurance and homemakers who do not (Wentling v. Medical Anesthesia Services, P.A., supra). Section 3 does not operate in the same manner as did 60-471. It begins with the principle that evidence of any and all reimbursement or indemnification received by an injured plaintiff is admissible in a medical malpractice liability action, regardless of whether the plaintiff or her employer paid for the insurance or whether it was provided free of cost. If a plaintiff has contributed toward the insurance, evidence of amounts paid to receive the protection may then be

admitted to show the net benefit received, as may be evidence of a lien or subrogation right held by the insuror.

Applying Section 3 to the hypothetical fact situation which concerned Judge Theis in Doran leads this Court to believe both wealthy and indigent plaintiffs will now receive substantially similar treatment. Evidence that insurance paid for private nursing care received by a wealthy plaintiff would be admissible, as would evidence that the indigent's care was provided "free" by his wife. The wealthy plaintiff would in turn be entitled to show amounts paid as premiums to receive the insurance, and the indigent plaintiff would be entitled to show wages lost by his wife because of the necessity of caring for him. Nor does Section 3 result in different treatment between persons employed outside of the home and those who are not, the distinction which disturbed the Kansas Supreme Court in Wentling. In the hypothetical situation of that case involving the injured married couple, Section 3 would now require admission of evidence of all insurance benefits received by both husband and wife. If the husband's employer provided his insurance, the husband would be entitled to no offset, but if the husband paid for the family policy covering his wife, she would be entitled to admit evidence showing those amounts paid. The absurd distinctions drawn by K.S.A. 60-471 are no longer apparent in the new rule.

Does Section 3 draw new or different distinctions violating plaintiff's equal protection rights? The inquiry required under the rational basis test is whether any state of facts reasonably may be conceived to justify the statutory discrimination.

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McGowan v. Maryland, 366 U.S. 420, 426 (1961). Three courts faced with this question and applying the rational basis test have concluded abolition of the collateral source rule in medical malpractice liability actions does not violate the equal protection clause. In Eastin v. Broomfield, 116 Ariz. 576, 570 P.2d 744 (1977), the Arizona Supreme Court stated the purpose and constitutionality of a similar legislative enactment in the following terms:

> The purpose of this rule is to inform the fact finder of the true extent of the plaintiff's economic loss in order to avoid the inequity of windfall recoveries. The resulting judgments will no doubt reflect a setoff for the benefits the plaintiff has already received and these lower judgments would be reflected in lower malpractice insurance premiums, one of the objectives of the legislation. It should be noted that admission into evidence of plaintiffs' collateral benefits in no way guarantees any reduction in the damages awarded by the trier of fact. The jury may still choose to ignore the collateral benefits in making its decision as to the damages sustained by the plaintiffs.
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> * * *
>
> . . . Abolition of the collateral source rule does not deprive the medical malpractice claimant of any property interest accorded protection by the due process clause of the United States Constitution. Nor is the application of the rule only to malpractice actions so arbitrary and unreasonable as to deny to medical malpractice claimants equal protection of the laws. The rule was intended by the legislature to give the jury the true extent of damages sustained by the plaintiff thereby. By scaling down the size of jury verdicts by the amount of collateral benefits the plaintiff may have received, the legislature could reasonably assume that a reduction in premiums would follow. This was one of the reasons for the Act. The legislature is entitled to proceed "one step at a time, addressing itself to the phase of the problem which seems most acute to the legislative mind." Williamson v. Lee Optical Co., 348 U.S. 483, 489, 75 S.Ct. 461, 465, 99 L.Ed. 563, 573 (1955).

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570 P.2d at 753. See also Barme v. Wood, 122 Cal.App.3d 395, 176 Cal.Rptr. 42 (1981); and Pinillos v. Cedars of Lebanon Hospital Corp., 403 So.2d 365 (Fla. 1981).

Legislative attempts to abolish or modify the collateral source rule in medical malpractice liability actions have not been successful in all states, however. The Supreme Court of North Dakota struck down that state's Medical Malpractice Act on constitutional grounds in part because it "nearly abolished" the collateral source doctrine. Arneson v. Olson, 270 N.W.2d 125, 137 (N.D. 1978). In Ohio, a legislative provision closely resembling K.S.A. 60-471 was declared a violation of equal protection because there was found to be no compelling governmental interest in conferring benefits on medical malpractice defendants unavailable to other defendants in tort cases. Graley v. Satayatham, 74 Ohio Ops. 2d 316, 343 N.E.2d 832, 836 (1976). Notably, the courts in both cases applied tests other than the rational basis test this Court deems appropriate.

After reviewing these cases and the legislation here at issue, this Court is satisfied the discriminatory treatment required by Section 3 is rationally related to the purported legislative goals. The Legislature could reasonably conclude that insofar as the size of medical malpractice verdicts allegedly affects the so-called crisis, an effort to more closely relate those verdicts to the actual loss suffered by plaintiffs would offer the malpractice insurance companies some relief. To this extent it was deemed reasonable to isolate and require special treatment for medical malpractice plaintiffs. Furthermore,

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Section 3 does not perpetuate the patent discrimination among various medical malpractice plaintiffs that existed previously under K.S.A. 60-471. All such persons are now subject to a possible reduction of their verdicts for benefits received from collateral sources, after credit for payments made and existing liens or subrogation rights.

This, however, is not to say that the legislation at issue isn't riddled with problems of a very prejudicial nature. Regarding the application of Section 3, the Legislature wholly failed to account for its impact in cases where a plaintiff seeks recovery for injuries in addition to medical malpractice. Judge Theis recognized the same problem with K.S.A. 60-471:

> Another possible scenario involves the plaintiff injured in some kind of accident. His or her injuries are then allegedly aggravated by the negligence of a health care provider. Said provider is joined as a third party defendant, or as a co-defendant in the original action. Particularly because of the comparative negligence law of Kansas, with its abolition of joint and several liability, and its requirement of joinder of claims, plaintiff would of necessity have to assert his or her claims against the health care provider once joined, if at all. Health care provider would be entitled to offer and benefit from evidence of collateral sources, while the original tortfeasor would not. Similar difficulties arise if a defective product, such as an intrauterine birth control device is alleged to be involved, since the manufacturer would not be entitled to benefit from the collateral source evidence.

Doran v. Priddy, 534 F.Supp. at 36.

The recent case of Wooderson v. Ortho Pharmaceutical Corp., 235 Kan. 387, 681 P.2d 1038 (1984), best exemplifies Judge Theis' concerns. In 1972, plaintiff Wooderson's physician prescribed for her an oral contraceptive, Ortho-Novum 1/80, manufactured by Ortho Pharmaceutical Corporation (Ortho). Plaintiff ingested the

contraceptive for a number of years and ultimately suffered acute renal failure with a variety of complications. The defendants originally named in the suit were Ortho and plaintiff's gynecologists. After pretrial conference, plaintiff settled her claims against the physicians, and the case went to trial solely on the product liability claims against Ortho. Wooderson, 235 Kan. at 412-413. Had the medical malpractice claims not been settled, however, under Section 3 the physicians would have been entitled to present evidence at trial of all reimbursement or indemnification paid to or on behalf of plaintiff, while the same evidence would have been inadmissible for the benefit of co-defendant Ortho. In addition to the patent unfairness of isolating the physicians for preferential treatment as against the manufacturer, the situation would clearly create an atmosphere of confusion and consequent prejudice in which any instruction on the narrow purposes for which the jury could consider such evidence would be ineffectual.

Obviously those are not the facts of the present case, and the Court reserves judgment on the question of whether these serious problems in the application of Section 3 will, in a case such as Wooderson, rise to the level of a constitutional violation.

On a more fundamental level, this Court is not at all persuaded this discriminatory legislation is needed or that it will achieve its stated goals. Regarding need, defendants cavalierly refer to the "obvious" medical malpractice crisis justifying this legislation. What is apparently so clear to the medical profes-

sion, the insurance industry, their respective lobbyists, and the Legislature is a matter of deep and growing concern to this Court as well as a number of commentators and other courts across the country. In the Legislature's haste to remedy the situation, it has overlooked or, more likely, ignored the fundamental cause of the so-called crisis: it is the unmistakable result not of excessive verdicts, but of excessive malpractice by health care providers.

Further, some courts have found that the highly touted malpractice insurance crisis of 1975-76 was limited to that time period, is no longer an "obvious" crisis, and may not now continue to be used to justify imposing separate and unequal treatment on medical malpractice litigants. Boucher v. Sayeed, 459 A.2d 87, 93 (R.I. 1983). Others have rightfully questioned the complicity of the insurance industry in this situation. Citizens of Idaho were treated to the spectacle of medical malpractice insurers insisting on legislative relief in part because of "'abnormally low earnings from investments.'" (Emphasis added.) Jones v. State Board of Medicine, 97 Idaho 859, 555 P.2d 399, 413 (1976). The absurdity of that situation is akin to a products manufacturer requesting and receiving a limitation on liability because of low sales in a previous year. In 1976, the Travelers Insurance Companies faced billion dollar litigation instituted by a physicians' council after Travelers demanded a 486% rate increase; the company ultimately returned 50 million dollars in excess premiums. Carlova, How Doctors Forced a

Malpractice Carrier to Refund $50 Million, Medical Economics, July 20, 1981, at 171, 172.

Admittedly, plaintiff has submitted no evidence of similar abuses in the State of Kansas, but neither have defendants put forth any proof whatsoever of a current "crisis" justifying the legislation at issue. Other courts have refused to uphold the constitutionality of a particular enactment until such supporting evidence is produced. See Jones v. State Board of Medicine, supra, 555 P.2d at 416. Nevertheless, because the statute presently at issue is simply a procedural rule of evidence, the Court is willing to accept at face value the Legislature's insistence the situation is such as to require this relief, with the caveat that in future cases concerning more fundamental denials of a plaintiff's rights strict proof thereof may be demanded.

Assuming there exists a bona fide malpractice crisis, as this Court now assumes for the purposes of this issue, other courts have questioned whether it even justifies this type of legislative response. Although the constitutional analysis of Graley v. Satayatham, 74 Ohio Ops. 2d 316, 343 N.E.2d 832 (1976), has been rejected in the present case, that court's observations on the justification of similar legislation merits careful consideration:

> There is no satisfactory reason for this separate and unequal treatment. There obviously is "no compelling governmental interest" unless it be argued that any segment of the public in financial distress be at least partly relieved of financial accountability for its negligence. To articulate the requirement is to demonstrate its absurdity, for at one time or another every type of profession or business undergoes difficult times, and it is not the business of government to manipulate the law so as to provide succor to one

class, the medical, by depriving another, the malpracticed patients, of the equal protection mandated by the constitution. Even remaining within the area of the professions, it is notable that the special consideration given to the medical profession by these statutes is not given to lawyers or denists or others who are subject to malpractice suits.

Additionally, assuming a valid legislative purpose to enact laws relating to protection of the public's health, this legislation may be counter-productive. The extending of special litigation benefits to the medical profession certainly cannot be considered as relating to protection of the public health. On the contrary, the quality of health care may actually decline. To the extent that in tort actions of the malpractice type if the medical profession is less accountable than formerly, relaxation of medical standards may occur with the public the victim.

343 N.E.2d at 837-38 (emphasis added).

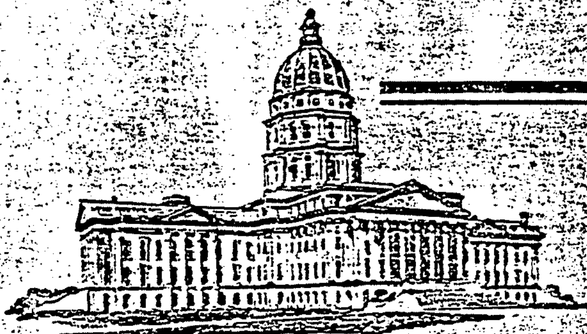
Even courts which have upheld such legislation under the rational basis test have expressed doubt about whether the challenged legislation will accomplish the aims of lowering the cost of and assuring the availability of medical care for citizens of the state. See Seoane v. Ortho Pharmaceuticals, Inc., 472 F.Supp. 468, 472 (D. La. 1979).

These concerns noted, the Court is of course aware that normally questions regarding the wisdom or likely success of a legislative enactment are not grounds for concluding it violates the Constitution. It is nevertheless possible that in an appropriate case concerning other such legislation the Court could conclude any conceivable "benefits" are sufficiently remote that the statutory discrimination is indeed wholly irrelevant to achievement of the state's ostensible objective.

IT IS THEREFORE ORDERED this 24 day of August, 1985, that 1985 Kan. Sess. Laws, Ch. 197, Sec. 3, shall apply to the trial

of this action and the parties are entitled to the admission of all evidence thereby permitted. Counsel for all parties shall appear before this Court on August 5, 1985, at 4:00 P.M., for a status conference in anticipation of trial.

PATRICK F. KELLY, JUDGE



PERFORMANCE AUDIT REPORT

Board of Healing Arts

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas

August 1985

8/15-16/85
Attach[illegible] VI

Legislative Post Audit Committee

Legislative Division of Post Audit

THE LEGISLATIVE POST Audit Committee and its audit agency, the Legislative Division of Post Audit, are the audit arm of Kansas government. The programs and activities of State government now cost about $3 billion a year. As legislators and administrators try increasingly to allocate tax dollars effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by Legislative Post Audit helps provide that information.

As a guide to all their work, the auditors use the audit standards set forth by the U.S. General Accounting Office and endorsed by the American Institute of Certified Public Accountants. These standards were also adopted by the Legislative Post Audit Committee.

The Legislative Post Audit Committee is a bipartisan committee comprising five senators and five representatives. Of the Senate members, three are appointed by the President of the Senate and two are appointed by the Senate Minority Leader. Of the Representatives, three are appointed by the Speaker of the House and two are appointed by the Minority Leader.

Audits are performed at the direction of the Legislative Post Audit Committee. Legislators or committees should make their requests for performance audits through the Chairman or any other member of the Committee.

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LEGISLATIVE DIVISION OF POST AUDIT

Suite 301, Mills Building
Topeka, Kansas 66612-1285
(913) 296-3792

PERFORMANCE AUDIT REPORT

The Board of Healing Arts and the Health Care Stabilization Fund

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OBTAINING AUDIT INFORMATION

This audit was conducted by Ron Green, Senior Auditor, and Tom Vittitow and Curt Winegarner, Auditors, of the Division's staff. If you need any additional information about the audit's findings, please contact Mr. Green at the Division's offices.

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THE BOARD OF HEALING ARTS AND THE HEALTH CARE STABILIZATION FUND

Summary of Legislative Post Audit's Findings

This audit was conducted to address several questions about the performance of the Board of Healing Arts and about the solvency of the Health Care Stabilization Fund.

Do current procedures for reporting cases of incompetent health care practitioners to the Board appear to be adequate? Although recent legislation has helped to increase the Board's sources of information regarding unsafe health care practitioners, Board officials do not believe that doctors and hospitals are reporting in all cases required by law. Kansas' reporting requirements are less stringent than those recommended by the Federation of State Medical Boards. For example, Kansas law appears to require reporting to the Board of Healing Arts only for clearcut violations rather than suspected or possible violations.

The auditors' recommendations in this area are designed to ensure that the Board receives information about all possible violations of the Healing Arts Act, that all licensees and organizations are fully aware of their legal obligation to report to the Board, and that all malpractice petitions filed with the Insurance Department are received by the Board.

How effective is the Board in protecting the public against unprofessional, improper, or unqualified practice of the healing arts? While the Board has performed well in some areas, a number of its procedures have not served to protect the public. In reviewing disciplinary case files, the auditors noted these significant problems:

--the Board's recordkeeping system does not allow adequate tracking of disciplinary cases
--complaints most commonly relate to patient care problems, but most disciplinary actions relate to overprescription of drugs or impaired physicians
--malpractice petitions are not being used as intended to generate investigations of allegedly incompetent doctors
--current procedures do not ensure that all doctors practicing in Kansas have the required malpractice liability insurance.

Several recommendations are made to address these problems, to clarify the responsibility for supervising disciplinary activities, and to ensure adequate representation of the public interest.

What is the trend in the balancc of the Health Care Stabilization Fund? After declining for three years, the balance in the Fund increased significantly in fiscal year 1985. The number of claim awards paid by the Fund has increased each year since fiscal year 1980, and the average amount per award has also risen sharply. These escalating awards have been offset by reimposition of the premium surcharge paid by health care providers. In fiscal year 1985, an 80 percent surcharge enabled the Fund to grow by about $1.8 million. The surcharge was raised to 110 percent for fiscal year 1986, and is projected to remain at about 100 percent for the next two years.

THE BOARD OF HEALING ARTS AND THE HEALTH CARE STABILIZATION FUND

The State Board of Healing Arts was established by the Legislature in 1957. The Board is responsible for licensing and regulating medical doctors, osteopathic doctors, chiropractors, and podiatrists. Board records show that these licensees total nearly 7,500, about 4,000 of whom are actively practicing in Kansas. In addition, the Board registers physical therapists and physicians' assistants. As part of its responsibilities, the Board is empowered to revoke, suspend, or limit a license after an investigation and hearing.

In the last several years, concerns have been raised regarding the effectiveness of the Board's reporting and disciplinary procedures. In fiscal years 1984 and 1985, the Legislature attempted to address these concerns by increasing the Board's budget and staff, and by establishing mandatory reporting requirements for health care providers and licensees of the Board. Concerns have also been raised over the solvency of the Health Care Stabilization Fund, which pays for successful claims against doctors in malpractice suits when the amount awarded exceeds the minimum amount of liability insurance the State requires each doctor to carry.

On May 15, 1985, the Legislative Post Audit Committee directed the Legislative Division of Post Audit to conduct a performance audit to address the following questions:

1. Do current procedures for reporting cases of incompetent health care practitioners to the Board appear to be adequate?

2. How effective is the Board in protecting the public against unprofessional, improper, unauthorized, and unqualified practice of the healing arts?

3. What is the trend in the balance of the Health Care Stabilization Fund?

To answer these questions, the auditors interviewed staff of the Board, surveyed Board members, and reviewed numerous disciplinary case files. They also interviewed and obtained data from the staff of the Insurance Department, which is responsible for managing the Health Care Stabilization Fund. In general, the auditors found that reporting requirements are not entirely adequate, that the Board's actions are not always effective in protecting the public, and that the Health Care Stabilization Fund balance has risen after declining for the past three years. These findings are discussed in the following sections, preceded by a brief description of the Board of Healing Arts and its major responsibilities and activities.

A Brief Description of the Board of Healing Arts

The Board of Healing Arts is comprised of 13 members appointed by the Governor. Five members are medical doctors, three are osteopaths, three are chiropractors, one is a podiatrist, and one member is from the general public. Each member is appointed to a four-year term, and no member can serve for more than three terms. The Board members annually select a president, vice president, and secretary. The Board secretary is the only salaried Board member. The members of the Board of Healing Arts are listed in Appendix A.

The work of the Board is done under the direction of the secretary and is supervised by the executive secretary. The Board staff includes a general counsel, a disciplinary counsel, an investigator, and six clerical positions. The two attorneys and one clerical position have been added since the start of fiscal year 1984.

The Board of Healing Arts has several areas of responsibility for protecting the public. Each year, the Board conducts two examinations for licensure within each branch of the healing arts. To ensure that persons applying for licensure have received valid medical training, the Board maintains a list of accredited medical schools. When necessary, the Board conducts investigations to determine whether schools are eligible for accreditation. In addition, the Board annually processes license renewals for each of its licensees. In fiscal year 1984, the Board renewed 7,447 licenses. State law has established continuing education requirements for each of the healing arts which must be completed in order to maintain licensure. As part of its license renewal process, the Board requires licensees to submit proof of their continuing education coursework.

Many of these activities are designed to prevent incompetent and unqualified persons from obtaining licensure to practice the healing arts. To deal with questions of competency involving persons who have obtained licensure, the Board has established procedures to investigate and discipline its licensees. Under the Healing Arts Act, the Board may take disciplinary action against a licensee for a number of different acts, including the following:

- —one instance of gross negligence, or repeated instances of ordinary negligence
- —immoral, unprofessional, or dishonorable conduct
- —addiction to or unlawful distribution of alcohol or drugs
- —inability to practice with reasonable skill and safety due to illness, alcoholism, or excessive use of drugs
- —practice outside the scope of licensure
- —fraud, or false advertising
- —failure to pay annual renewal fees or complete continuing education requirements
- —disciplinary action or restriction of licensure by another state
- —conviction of a felony
- —failure to report information required by law

If the Board finds that a licensee has committed any of these acts, it can order the revocation, suspension, or limitation of that person's license. The

Board also has the option of entering into a stipulation agreement with a licensee. Stipulation agreements specify limitations or conditions which a licensee must follow in order to avoid further disciplinary measures by the Board. All disciplinary actions must be approved by a majority vote of the Board.

Do Current Procedures for Reporting Cases of Incompetent Health Care Practitioners to the Board Appear to be Adequate?

To adequately regulate its licensees, any medical licensing board must have timely information about licensees who may be incompetent or impaired in their practice of the healing arts. To determine whether the Board of Healing Arts is receiving this type of information, the auditors reviewed recent changes in the reporting laws and compared them with the standards set by the Federation of State Medical Boards.

Recent Legislation Has Focused on Increasing the Board's Sources of Information Regarding Unsafe Health Care Practitioners

Before 1983, the Kansas Healing Arts Act (K.S.A. 65-2801 et. seq) contained few provisions for reporting incompetent and impaired health care practitioners to the Board. Under K.S.A. 65-2898, persons who voluntarily reported information to the Board regarding alleged incidents of malpractice or the qualifications of any licensee, registrant, or certificate holder were granted immunity from civil liability. However, licensees were only required to report persons they thought were practicing without a license, and to furnish evidence relating to alleged violations already being investigated by the Board.

With support from the Board of Healing Arts, the 1983 Legislature attempted to strengthen the Healing Arts Act by adding several reporting requirements. Under these requirements, licensees must immediately report to the Board any knowledge that another licensee has committed an act "which is a ground for the revocation, suspension, or limitation of a license." Hospitals and other organizations employing licensees must report to the Board if they make a finding that a licensee has committed such an act. In addition, any organization employing licensees of the Board must immediately report to the Board if its medical staff recommends the termination, suspension, or limitation of a licensee's practice privileges for reasons relating to that person's professional competence. Failure of a licensee to report when required by the Healing Arts Act is a ground for disciplinary action by the Board. These additions to the Act were intended to increase the participation of health care providers, including hospitals, clinics, and physicians, in the Board's monitoring and enforcement efforts.

To provide the Board with more timely information regarding malpractice cases, the 1983 legislation also contained a provision requiring the Commissioner of Insurance to forward to the Board any malpractice petitions received in conjunction with a claim against the Health Care Stabilization Fund. In 1985, a further provision was added requiring the Commissioner and the attorneys of record in malpractice cases to submit to the Board any expert

witness reports made available to the opposing parties, and to provide other relevant documents in their possession upon the Board's request.

Most Complaints Received by the Board of Healing Arts Come from Patients and Private Individuals

To determine the sources of complaints received by the Board, the auditors reviewed and categorized all complaints recorded in the Board's complaint log for fiscal year 1985. The table below shows a breakdown of the sources from which the Board received complaints that year.

Sources of Complaints to the Board of Healing Arts Fiscal Year 1985

Source of Complaint	Number	Percent
Patient or Individual	89	46.9
Licensee	23	12.1
Other Government Agency	17	8.9
Professional Organization	14	7.4
Health Care Employer	11	5.8
Board of Healing Arts	11	5.8
Drug Enforcement Agency Report	7	3.7
Anonymous	5	2.6
Other	13	6.8
Total	190	100.0

As the table shows, nearly 47 percent of the complaints were made by patients or individuals, while 18 percent were made by licensees and health care employers. About four percent of the complaints were generated by Drug Enforcement Agency reports submitted periodically to the Board. These reports contain information about prescription drug purchases and sales, which the Board can use to identify licensees who may be misusing or overprescribing medication.

Although Licensees and Hospitals Are Reporting More Frequently, Board Officials Do Not Believe They Are Reporting in All Cases Required by Law

To determine whether sources of complaints to the Board changed as a result of the reporting requirements adopted in 1983, the auditors reviewed the Board's complaint records for fiscal years 1983 and 1984, and compared the results with the figures given above for fiscal year 1985. A completely reliable comparison between the three years was not possible, because the records for 1983 and 1984 were maintained informally and may not be as complete as the formal complaint log begun in fiscal year 1985. However, the figures indicate that there was an increase in the number of complaints received from licensees and hospitals after the reporting requirements went into effect. The Board

recorded nine complaints from licensees and hospitals in fiscal year 1983 (2.4 percent of the total), 12 (9.2 percent) in fiscal year 1984, and 34 (17.9 percent) in fiscal year 1985.

> **$15 MILLION VERDICT**
> **AGAINST DOCTOR AND HOSPITAL**
>
> A Board attorney told the auditors that the Board of Healing Arts first learned of this case in November 1984 when the press reported a $15 million verdict against a doctor and a hospital. The doctor had ordered an anesthetic for a pregnant woman in 1979, which the woman alleged had caused brain damage to her infant. According to the Board attorney, nearly $12 million of the awarded amount was against the hospital and this amount is still under appeal. The verdict included $6.2 million in actual damages and $8.8 million in punitive damages. As of July 1985, the Board 's investigation is still in an early stage and the doctor continues to practice.
>
> The Board attorney did not know why the Board was not notified of the incident for five years. The attorney stated that trial testimony showed a doctor in the same corporate practice was aware of the problem, but did not report any information to the hospital, the Board, or the child's parents. Under legislation passed in 1983, a doctor's alleged medical negligence must be reported to the Board by any licensee who has knowledge of a violation of the Healing Arts Act. This legislation, along with the requirement for malpractice petitions to go to the Board, should help keep the Board informed of potential malpractice cases on a more timely basis.

Although there seems to have been some improvement in reporting by licensees and hospitals, most members of the Board of Healing Arts do not believe they are receiving full information from these sources. On a questionnaire provided by the auditors, nine of 12 responding Board members said they did not think the Board was receiving reports from licensees and hospitals about "all licensees who may be incompetent or impaired in their practice of the healing arts." In addition, the Board's general counsel has indicated in testimony to the Special Committee on Medical Malpractice that reporting by licensees and hospitals has been "at best low and in some instances nonexistent." The general counsel attributed this partly to fear that the licensee or hospital may be sued after making a report to the Board, although State law clearly grants immunity to persons reporting in good faith.

Malpractice Petitions Have Apparently Been Sent to the Board as Required by Law, but the Board Does Not Have a Complete List

Since July 1, 1983, the Insurance Department has been required by law to furnish to the Board of Healing Arts a copy of each malpractice petition filed with the Insurance Department. These petitions are filed on behalf of plaintiffs who may become eligible for payment from the Health Care Stabilization Fund. Malpractice petitions can be an important source of information to the Board because they deal with potentially serious cases of alleged negligence. In addition, they may alert the Board to violations that otherwise would not be reported. According to records supplied by the Insurance Department, a total of 374 petitions were sent to the Board during fiscal years 1984 and 1985.

When the auditors compared the Insurance Department's records with a list of petitions received by the Board of Healing Arts, they found that 36

petitions were missing from the Board's list. The reason for this discrepancy was not ascertainable, as there was no pattern to explain which petitions were not on the Board's list. Board staff indicated they would obtain copies of the missing petitions from the Insurance Department.

Kansas' Reporting Requirements Are Less Stringent than Those Recommended by the Federation of State Medical Boards

The auditors compared the recommendations in the Federation's 1985 publication, A Guide to the Essentials of a Modern Medical Practice Act, with the Kansas Healing Arts Act. That comparison is shown in the accompanying box. The major difference between the two is that the Federation guide would require the reporting of any information which appears to show that a licensee "is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine." The Healing Arts Act only requires reporting "knowledge" that a licensee "has committed any act...which is a ground for the revocation, suspension, or limitation of a license." Thus, Kansas law appears to require reporting to the Board of Healing Arts only for clearcut violations rather than suspected or possible violations.

Comparison of the Kansas Healing Arts Act to Guidelines of the Federation of State Medical Boards

Healing Arts Act	Federation Guide
1. Requires licensees to report when another licensee has committed an act which is a ground for revoking, suspending, or limiting a license.	1. Requires licensees to report when another licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically impaired.
2. Requires health care employers (such as hospitals) to report when their medical staffs find that a licensee has committed an act which is a ground for revoking, suspending, or limiting a license.	2. Requires health care employers to report when a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically impaired.
3. Requires health care employers to report when a licensee's practice privileges have been terminated, suspended, or restricted.	3. Requires health care institutions to report when a licensee's practice privileges have been terminated, suspended, or restricted, or when any licensee voluntarily surrenders practice privileges while under investigation by the institution.
4. Requires reports only from licensees and health care employers. Other statutes require reports from the Insurance Department and the Board of Pharmacy in certain instances.	4. Requires reports from all health care institutions, licensees, state agencies, law enforcement agencies, and courts, as well as the state medical association.
5. Provides no specific penalties for failure to report, other than disciplinary action by the Board or conviction of a misdemeanor for violating the Act.	5. Recommends specific penalties for failure to report.
6. Grants immunity from civil damages to persons and organizations reporting in good faith.	6. Grants immunity from civil damages to persons and organizations reporting in good faith.

Further limitations in the Kansas Act affect the reporting requirements for organizations (like hospitals) that employ licensees. These organizations are

not required to report unless they make a finding that the Healing Arts Act has been violated. Legislation introduced late in the 1985 session would have required health care organizations to report "information" as well as findings that a licensee has committed a punishable act, but no action was taken on the bill.

Under Kansas law, the Board of Pharmacy is required to report to the Board of Healing Arts if it finds evidence that a licensee of the Board has abused controlled substances. As the boxed comparison on page six shows, the Federation guide extends reporting requirements to all state agencies, courts, law enforcement agencies, and health care institutions, as well as the state medical association and its components. The guide also recommends that health care institutions be required to report licensees who voluntarily resign or accept limitation of their staff privileges while under formal or informal investigation by the institution. The Kansas Healing Arts Act has no such requirement.

PROBLEMS PERSIST FOR FIVE YEARS BEFORE BOARD IS INFORMED

In 1979, a hospital learned that one of its staff members was not responding to calls, had falsified entries on patient charts, and had failed to see patients admitted to special care units on a timely basis. A review committee at the hospital found that:

1. The nursing staff had difficulty locating the doctor
2. The doctor did not respond to calls
3. The doctor did not see patients daily
4. The doctor had falsified records
5. The doctor admitted critically ill patients, but did not see them within a specified period.

Following the review, the hospital instituted a six-month plan to monitor the doctor's actions. In 1983, the hospital records noted similar problems and the hospital again decided to monitor the doctor.

In April 1985, a critically ill patient suffered respiratory arrest, but was revived through emergency treatment. Her chart showed she had not been seen by the doctor for three days, though a later entry indicated that the doctor had seen her the day before the emergency. Another incident reported that same month involved a staff resident taking over a case in which impaired breathing could have been fatal without that intervention.

In May 1985 the doctor's privileges were suspended for 90 days by the hospital's executive committee. In compliance with the reporting laws established in fiscal year 1983, the hospital then notified the Board that this doctor's privileges had been suspended. However, during the previous five years, the Board had received no information about the doctor's shortcomings. The hospital was not required to report to the Board until it had taken formal action to limit the doctor's practice privileges, or found that the doctor had violated the Healing Arts Act. The doctor is currently under review for disciplinary action by the Board.

To ensure compliance with compulsory reporting requirements, the Federation guide recommends adopting specific penalties for demonstrated failure to report. Under the Healing Arts Act, persons who fail to report when required are subject to revocation, suspension, or limitation of their licenses, as well as conviction of a misdemeanor for violating the Act, but there is no

specific penalty for failing to report. In addition, the Healing Arts Act provides no specific penalty for organizations that fail to report.

In keeping with the Federation guide, the State of Florida's Medical Practices Act allows its Board of Medical Examiners to levy fines up to $1,000 against any organization which fails to comply with compulsory reporting requirements. Under the Healing Arts Act, organizations can be penalized only by penalizing individuals on their staffs. For this reason, the Board of Healing Arts may not have the means necessary to enforce compulsory reporting requirements for medical organizations and hospitals.

Conclusion

The number of complaints received by the Board of Healing Arts from licensees and health care employers increased after reporting requirements were added to the Healing Arts Act in 1983. The auditors' findings show that about 18 percent of the complaints received by the Board in fiscal year 1985 came from these sources. However, members and staff of the Board do not believe they are receiving reports from licensees and health care employers in all cases where reporting is required. In addition, the reporting requirements of the Healing Arts Act are less stringent than those recommended by the Federation of State Medical Boards. Under the Healing Arts Act, possible or suspected violations of the Act do not have to be reported, and health care organizations cannot be penalized for failing to report. For these reasons, current procedures do not appear to be adequate to ensure that all possible violations of the Healing Arts Act are reported to the Board.

Recommendations

1. To ensure that the Board of Healing Arts receives information about all possible violations of the Healing Arts Act, the Special Committee on Medical Malpractice should consider the following:

   a. amending K.S.A. 65-28,121 to require hospital medical staffs to report to the Board of Healing Arts whenever they receive information that a licensee may have committed an act which is or may be a ground for disciplinary action by the Board, and to report whenever licensees voluntarily surrender or limit their hospital privileges while under formal or informal investigation by the hospital.

   b. amending K.S.A. 65-28,122 to require licensees of the Board to report whenever they receive information that

another licensee may have committed an act which is or may be a ground for disciplinary action by the Board.

c. amending the Healing Arts Act to provide specific penalties, such as fines, for organizations or licensees that fail to report to the Board when required by law to do so.

d. establishing requirements for other State agencies, law enforcement agencies, and medical associations to report to the Board of Healing Arts concerning licensees who may be incompetent, impaired, or otherwise in violation of the Healing Arts Act.

2. To ensure that all licensees and organizations are fully aware of their legal obligations, the Board of Healing Arts should take steps necessary to publicize any changes in the reporting requirements contained in the Healing Arts Act.

3. To ensure that all malpractice petitions filed with the Insurance Department have been received, the Board of Healing Arts should establish procedures for periodically checking its list of petitions against the records of the Insurance Department.

How Effective is the Board in Protecting the Public Against Unprofessional, Improper, or Unqualified Practice of the Healing Arts?

The main purpose of the Healing Arts Act is to protect the public against unprofessional, improper, unauthorized and unqualified practice of the healing arts and from unprofessional conduct by persons licensed to practice under the Act. As the agency established to administer the Act, the Board of Healing Arts has several areas of responsibility for protecting the public. The Board's primary activities for protecting the public include receiving, investigating, and resolving complaints against doctors, as well as taking disciplinary action against doctors who have violated the Act. Because these activities are central to the Board's efforts in protecting the public, the auditors focused their attention in these areas.

Although the purpose of occupational regulation is to protect the public, studies have shown that regulatory agencies may become sympathetic to--or even dominated by--the industries they regulate. To determine whether the Board of Healing Arts has used its regulatory authority to effectively protect the public interest, the auditors first reviewed the Board's procedures for handling complaints. To obtain first-hand information on how complaints are handled, the auditors reviewed several samples of complaints filed in fiscal years 1984 and 1985. In addition, they examined in detail the disciplinary actions taken by the Board over the past two years, and reviewed other case files of doctors who had a history of serious problems.

In general, the auditors found that while the Board has performed well in some areas, a number of its procedures have not served to protect the public. The Board's handling of complaints can be improved, its recordkeeping system does not allow tracking of disciplinary problems over time, and the disciplinary actions taken do not always go far enough to protect the public interest. These and other findings are discussed in the sections that follow.

The Most Common Type of Complaint Was Improper Patient Care

During fiscal years 1984 and 1985, the Board received and logged 336 complaints. The number of complaints received in fiscal year 1984 is approximate, because the Board did not formally log all complaints until fiscal year 1985.

The Board receives complaints of many different types, including allegations of substandard patient care, improper handling of prescription drugs, and excessive charges. The table below shows the types of complaints received in fiscal years 1984 and 1985.

Types of Complaints Received by the Board of Healing Arts Fiscal Years 1984 and 1985

Type of Complaint	Number	Percent
Patient Care	113	33.6
Handling of Prescription Drugs	48	14.3
Charges and Billing Practices	48	14.3
Professional Conduct or Ethics	39	11.6
Licensure and Scope of Practice	19	5.7
Hospital Privileges	17	5.1
Advertising Practices	16	4.7
Criminal Charge or Conviction	13	3.9
Impaired Physician	7	2.1
Unspecified or Unclear	16	4.7
Total	336	100.0

As the table shows, about 34 percent of all complaints related to patient care provided by doctors. Other common types of complaints related to handling of prescription drugs, charges and billing practices, and professional conduct.

During fiscal years 1984 and 1985, most of the complaints received by the Board concerned medical doctors. This is not surprising, because more than 80 percent of the active doctors in Kansas are M.D.'s. The table on the following page shows the number of active doctors in each major branch of the healing arts, and the number of complaints logged against each group.

	Number of Active Doctors in Kansas, 1984	Percent of Total Active Doctors in Kansas, 1984	Number of Complaints, FY 1984-85	Percent of Total Complaints, FY 1984-85
Medical Doctors	3,212	82.6	211	67.4
Osteopaths	196	5.1	49	15.7
Chiropractors	480	12.3	53	16.9
Total	3,888	100.0	313	100.0

The table shows that complaints received by the Board were in approximately the same percentage as the percentage of active doctors in the State. The percentage of complaints against medical doctors was lower than their percentage of total doctors, while the percentage of complaints against osteopaths and chiropractors was higher than their percentage of all doctors active in Kansas. The Board's procedures for handling these complaints are discussed in the next section.

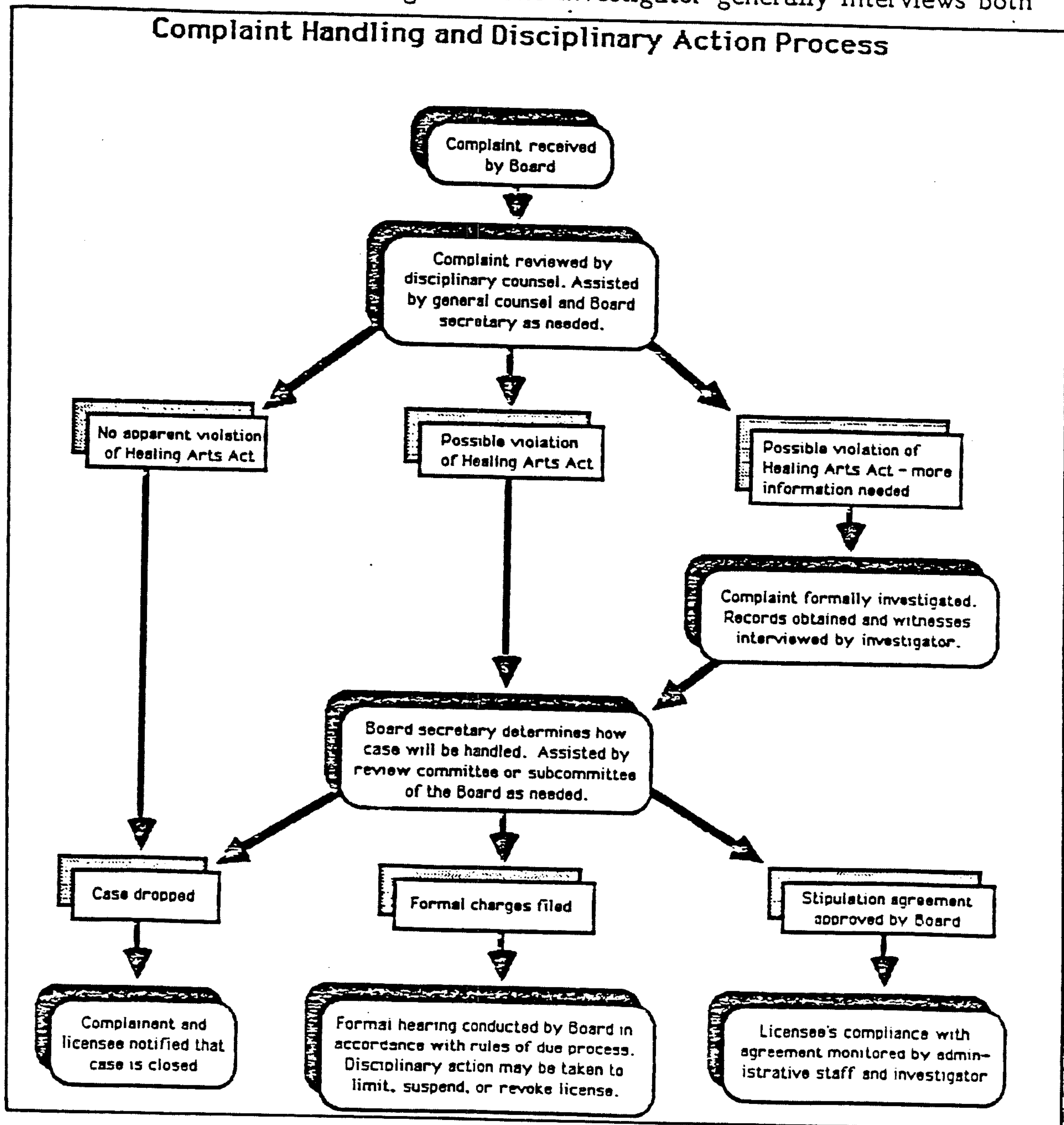
The Board Has Established Procedures for Responding to Complaints About Doctors

The primary responsibility for receiving and responding to complaints lies with the Board's disciplinary counsel. Under K.S.A. 1984 Supp. 65-2840a, the disciplinary counsel has "the duty to investigate or cause to be investigated all matters involving professional incompetency, unprofessional conduct or any other matter which may result in revocation, suspension or limitation of a license."

To screen out frivolous cases, the disciplinary counsel initially responds to all complaints from the general public by mailing a formal complaint form to the complaining party. If this form is completed and returned, the complaint is formally recorded in the Board's complaint log. Complaints received from entities such as hospitals, State agencies and professional organizations are generally recorded in the log without a formal complaint form. In some cases, the disciplinary counsel may record a complaint based upon information received from various outside sources, such as newspaper articles and law enforcement reports.

The complete process for handling complaints is summarized on the following page. Once a complaint has been formally recorded, the disciplinary counsel reviews the information provided to determine whether a possible violation of the Healing Arts Act has taken place. In making this determination, the disciplinary counsel may consult with the Board's general counsel and the secretary of the Board. Complaints that are clearly outside the Board's jurisdiction are closed at this stage, and the complaining party is notified. Sometimes the complaining party is referred to another organization, such as a medical society or consumer protection agency.

If more information is needed to evaluate a complaint, it is assigned to the Board's full-time investigator. The investigator generally interviews both



the complainant and the accused licensee, and obtains copies of all medical records and other documents pertinent to the case. When this information has been compiled, the investigator files a written report with the disciplinary counsel.

At this stage, the secretary of the Board determines whether there is ground for the Board to take formal disciplinary action against the licensee. Although the role of the secretary in conducting disciplinary actions is not formally defined by statute or regulation, the Administrative Procedures Act (which took effect July 1, 1985) allows the Board to designate a chief presiding officer with the power to convene hearings and initiate disciplinary actions

against licensees. The secretary has not been designated as the Board's presiding officer, but the general counsel has indicated that the secretary will probably act in this capacity for the immediate future.

In determining how to resolve a case, the secretary may obtain medical advice regarding the standards of practice within the licensee's branch of the healing arts. For this purpose, the Board maintains a three-person review committee for each of the three main branches of the healing arts--medicine and surgery, osteophatic medicine and surgery, and chiropractic. Depending on the outcome of this review process, the secretary either dismisses the case, files formal charges, or negotiates a stipulation agreement. Stipulation agreements generally allow the licensee to continue practicing within certain restictions that may limit the scope of practice, or require the licensee to take specific coursework, or require an impaired physician to refrain from use of alcohol or drugs.

DOCTOR ADDICTED TO COCAINE

In March 1985 the federal Drug Enforcement Agency reported that since November 1984, a doctor had been purchasing large amounts of cocaine from the pharmacy rated third-highest in the nation for sales of cocaine. An investigation revealed that during the past year this doctor purchased more than 250 30cc bottles of 10 percent cocaine. The pharmacist providing the cocaine said that the doctor had been purchasing it since 1982, and that he was the only physician who purchased cocaine at that pharmacy.

The doctor explained to the Board's investigator and to a review committee that the drug was needed in his practice. However, when confronted by the Board secretary and attorneys in June 1985, he admitted that he was using the cocaine himself. After his admittance to the Menninger Foundation for four days, the doctor was allowed to return to his practice for two weeks to close it down. On July 1, 1985, the Board secretary sent a letter to the doctor requiring him to refrain from the practice of medicine and surgery. Eight days later, when asked by the auditors, the Board's general counsel said that the doctor was still practicing.

The auditors were told that this doctor entered the Menninger Foundation's in-patient drug program on July 15, 1985. Following successful treatment, the Board may enter into a formal agreement with the doctor that he will use no more cocaine or similar drugs, and that he will participate in an outpatient drug program. After consulting with Menninger Foundation officials, the Board's general counsel plans to recommend an agreement to keep the doctor's name confidential as long as the terms are followed. The Board would have an opportunity to vote on this proposal at a public meeting.

If a stipulation agreement is proposed, it must be approved by a majority vote of the full Board. If charges are filed, the Board must conduct a formal hearing at which the licensee may present a defense to the charges. In either case, the Board's action may result in the limitation, suspension, or revocation of the license. Once formal action has been taken by the Board, the complaint is considered closed. However, in cases where stipulations are signed, the Board continues to monitor the licensee's compliance with the agreement, and may take further disciplinary action if necessary.

To determine how effective the Board has been in handling complaints, the auditors reviewed two groups of case files with different characteristics. From the Board's complaint logs for fiscal years 1984 and 1985, the auditors reviewed a random sample of complaints filed against licensees who had fewer than three complaints filed against them. The auditors also reviewed all of the

complaints against licensees who had three or more complaints filed against them during the two fiscal years. The results of these reviews are discussed in the next two sections.

A Random Sample of Complaints Showed That Most Cases are Closed Administratively with Findings That No Violations Occurred

The auditors randomly selected 25 files of complaints submitted to the Board of Healing Arts during fiscal years 1984 and 1985. Fifteen of the cases reviewed had been closed by the Board and 10 cases remained open.

Of the 25 files reviewed, the auditors found that 20 complaints were filed against medical doctors, one complaint was filed against an osteopath, and four were filed against chiropractors. As the following table shows, complaints most often related to improper patient care and drug prescription practices.

Types of Complaints in Random Complaint Sample

Type of Complaint	Number
Patient Care	9
Handling of Prescription Drugs	6
Professional Conduct or Ethics	4
Charges and Billing Practices	3
Hospital Privileges Suspended	2
Other	1
Total Complaints in Sample	25

The auditors' review of the 15 complaint cases closed by the Board showed that these complaints took an average of 3.2 months to resolve. However, the time varied from less than two weeks to more than 16 months. Most of these cases were closed by the Board's administrative staff with findings that no violations of the Healing Arts Act had occurred. Two of the cases were resolved between the licensee and the complainant outside of any Board initiated action. Three cases resulted in disciplinary action; two licensees signed stipulations that specified practices would be changed and a third licensee agreed to alter his practice.

Complaint Resolution	Number of Complaints
Closed administratively by the Board	10
Resolved without Board action	2
Disciplinary action taken by the Board	3
Total	15

In reviewing the three cases which resulted in some form of disciplinary action, the auditors questioned whether the Board's actions appeared to be in the best interest of the general public. The actions taken in these cases can be summarized as follows:

Cases 1 and 2. The Board's review committee found no probable cause to revoke, suspend, or limit the practitioner's license in one case where a chiropractor used and sold "harmonic crystals" to treat persons affected by agent orange or dioxin poisoning, and in another case where a chiropractor used herbal poultices to treat breast cancer. In both cases, the Board reached an agreement stating the licensee would cease the use of these practices until the treatments were proven to be effective.

Case 3. The Board entered into a stipulation agreement with a medical doctor, prohibiting the doctor from prescribing amphetamines or similar substances. Six months later, when the Board's investigator discovered the doctor was still prescribing these drugs, the Board's executive secretary wrote the doctor a letter reminding him of the requirements of the stipulation. A later review by the investigator showed that the doctor had stopped the prescriptions.

The Board Does Not Handle Multiple Complaints Against Doctors Differently Than Other Complaints

To determine whether licensees with multiple complaints were given greater attention by the Board, the auditors reviewed the complaint files of all licensees with three or more complaints filed against them during fiscal years 1984 and 1985. This group consisted of 13 licensees with a total of 42 complaints. Six of the licensees were medical doctors and seven were chiropractors. There were no osteopaths in the group.

The types of complaints included in the auditors' sample are shown in the table below:

Types of Complaints in Multiple Complaint Sample

Type of Complaint	Number
Charges and Billing Practices	18
Patient Care	10
Professional Conduct or Ethics	8
Handling of Prescription Drugs	3
Advertising Practices	1
Criminal Conviction	1
Licensure and Scope of Practice	1
Total Complaints in Sample	42

Most complaints in this sample have received consideration beyond the screening stage, but none has resulted in disciplinary action by the Board. Of the 42 complaints in the sample, the auditors found that 26 (61 percent) had either been formally investigated, submitted to a review committee, or submitted to a subcommittee of the Board. The auditors compared these figures with the sample of complaints selected randomly, and found that only eleven (44 percent) of the 25 complaints in that sample received consideration beyond the screening stage.

Despite the greater level of attention given to multiple complaints by the Board, none of the 42 complaints has yet resulted in disciplinary action being

taken. Most of the closed complaints were dropped by the Board's administrative staff after being screened or formally investigated. Four chiropractic cases were dropped after review by the chiropractic members of the Board, and six complaints were considered by review committees and found to have no probable cause. Complaints were generally dropped because there was insufficient evidence of a violation of the Healing Arts Act. The amount of time taken to resolve complaints ranged from one to 14 months, with 3.3 months being the average.

The Board has no procedure for handling multiple complaints differently than other complaints. According to the Board's attorneys, all complaints are handled according to their individual merits, on a case-by-case basis. The past complaints against a licensee may be reviewed by the Board's staff, and this may influence how much attention is given to subsequent complaints. However, the Board has no formal policy or procedure for using licensees' complaint history in allocating resources or resolving cases. In some cases, several complaints against a licensee may be consolidated during the investigation and review process, but each complaint is usually resolved independently.

The Board's recordkeeping system does not allow tracking of licensees' disciplinary problems over time. In reviewing files in this sample, the auditors found that the Board maintains records on past complaints and disciplinary actions, but does not maintain summary records to show the history of complaints, malpractice petitions, criminal convictions, impairments, and disciplinary actions against individual licensees.

The Board's disciplinary counsel indicated that he obtains licensees' past complaint histories by reviewing the Board's files each time a new complaint is received. However, the auditors found that files for a single licensee were often stored in three separate offices, and there was no index to indicate how many files had been created or what they contained. In addition, the contents of individual files were not maintained in chronological sequence. In some cases, the auditors found records for three or more separate complaints mixed together in licensees' file folders with no apparent organization. Given these conditions, the auditors found it difficult to determine the disposition and current status of some complaints in the sample.

HIGH NUMBER OF COMPLAINTS
DOES NOT ALWAYS MEAN DANGER
TO THE PUBLIC

According to the Board's attorneys, licensees with large numbers of complaints are not necessarily the most dangerous or most worthy of the Board's attention. The licensee with the largest number of complaints in the auditors' sample was a chiropractor who had six complaints filed against him during fiscal years 1984 and 1985. All six complaints involved allegations or questions concerning the licensee's charging practices.

Generally, the Board assigns a low priority to such complaints because they do not involve an immediate threat to public safety. However, in this case the Board had already received five similar complaints (prior to fiscal year 1984) which had not yet been investigated. In response to the apparent pattern of problems with the licensee, the Board initiated investigations into these five complaints, plus four of the six complaints in the auditors' sample. None of these investigations have resulted in disciplinary action against the licensee. Although the Board's attorneys say they find the licensee's charging practices questionable, they have thus far found no clear evidence of a violation of the Healing Arts Act. As of July 1985, only one complaint remained open and under investigation by the Board: the other complaints had been closed.

Most complaints in this sample did not appear to involve serious danger to the public. As shown in the table on page 15, 19 (45 percent) of the 42 complaints in the sample involved charging or advertising practices. While these complaints may be of concern to the patients involved, they do not generally present a danger to public health or safety.

The remaining 23 complaints related to patient care, conduct and ethics, prescribing of drugs, licensure, and criminal charges. The auditors found that the degree of seriousness of these complaints differed widely from case to case. For example, the complaints regarding conduct and ethics ranged from rude behavior toward patients to allegations of sexual harrassment and rape, while the complaints concerning patient care ranged from improper treatment of scabies to misdiagnosis of Alzheimer's disease. The auditors found few examples of the more serious type of complaint. Only two of the 13 licensees in the sample appeared to show repeated instances of serious complaints. These two licensees are profiled below.

BOARD PROCEDURAL ERRORS CAUSE LENGTHY DELAY

One of the Board's primary concerns is to ensure that licensees being reviewed for disciplinary action receive due process of the law. According to the Board's general counsel, this concern has arisen largely as a result of mistakes made by the Board in handling a disciplinary action in July 1980. The subject of this action was a medical doctor accused of overprescibing amphetamines. The Board convened a hearing panel which found that the licensee had used poor judgment in his prescribing practices, and ordered that he not prescribe drugs for one year in lieu of having his license revoked.

The licensee appealed to the district court, which returned the case for a new hearing. According to the court, due process was denied the licensee because he was not given "a full and fair hearing....as guaranteed by the 5th and 14th Amendments." Before further action could be taken, the licensee filed suit against the Board in federal court. Eventually, the case reached the U.S. Supreme Court, which found in favor of the Board. Throughout these proceedings, which lasted more than four years, the Board continued to receive numerous complaints about the licensee's prescribing practices, but no action was initiated for fear of jeopardizing the Board's legal position. These complaints are now being investigated by the Board's disciplinary counsel.

BOARD SOMETIMES CANNOT TAKE ACTION WITHOUT CREDIBLE WITNESSES

In some instances, the Board's investigative and enforcement efforts are hampered by a lack of cooperative and credible witnesses. In one such case, a psychiatrist had a history of complaints regarding sexual misconduct with female patients. In October 1980, the Board received a complaint from one of the licensee's former patients alleging sexual harrassment and exploitation. Because the complainant was willing to testify before the Board, formal charges were filed and a formal hearing was conducted in June 1981. In his defense, the licensee stated that the complainant's accusations were fantasies symptomatic of her mental problems. Due to the complainant's lack of credibility, the Board found the licensee had not violated the Healing Arts Act.

In November 1983, the Board received a complaint of sexual harrassment regarding another former patient of this licensee. In this case, the complaint originated with the patient's current psychiatrist because the patient was reluctant to make an accusation. In December 1983, after the patient alleged she was raped by the licensee, she filled out a formal complaint. Although the case was referred to the local police, the complainant refused to testify against the licensee. The complainant's psychiatrist indicated that he believed the complainant, but neither the police nor the Board was able to proceed without her cooperation. Due to lack of evidence, the case was dropped.

These findings indicate that the number of complaints alone is not an accurate indicator of a licensee's potential danger to the public, or a valid criterion for allocating the Board's investigative resources. Because there is wide variance in the seriousness of complaints, each licensee's complaints must be evaluated individually (in light of that doctor's history) to identify meaningful patterns.

The Board's Handling of Complaints Can Be Improved

The auditors' review of complaints received by the Board showed that some aspects are handled well by the Board, while other aspects had serious shortcomings. For example, the complaint cases reviewed by the auditors were generally closed within four months, although some cases remained open for much longer periods.

In reviewing case files, the auditors found that the Board and its attorneys had been very thorough in providing due process to licensees under disciplinary review. Although the Board's thoroughness and caution made the disciplinary action process more lengthy, it reduced the chance of procedural errors that might have resulted in even greater delays and further litigation, such as described in the first profile on page 17.

Fieldwork by the Board's investigator appeared to be both thorough and timely. Most investigations were conducted within a matter of days, and the investigator filed detailed and complete reports of the investigations. The Board has also developed effective procedures for following up on disciplinary actions.

In contrast to these positive aspects, previous sections of this report have shown that the Board's case files are not well organized and do not allow each licensee's disciplinary history to be tracked over time. Better recordkeeping would allow the Board to quickly evaluate which new complaints should be investigated or given priority. Furthermore, the Board has not used malpractice petitions to generate investigations of licensees who may have been negligent in their medical practice.

The Board has not made full use of malpractice petitions received from the Insurance Department. One of the statutory duties of the disciplinary counsel is to investigate licensees who have allegedly committed gross negligence or repeated instances of ordinary negligence. Although the Board has been receiving copies of malpractice petitions from the Insurance Department since the new reporting law went into effect in July 1983, the Board has not yet developed a system for using malpractice petitions to generate investigations and disciplinary actions. In reviewing the Board's correspondence files, the auditors found that the disciplinary counsel has been working on a plan to screen and prioritize malpractice petitions since November 1984.

The Board's Disciplinary Actions Do Not Always Go Far Enough to Protect the Public Interest

As part of their effort to determine whether the Board has been effective in protecting the public interest, the auditors reviewed the disciplinary actions

taken in recent years. Disciplinary actions taken by the Board included license revocation or suspension, stipulation agreements, and informal admonishments. Taken together, the annual number of disciplinary actions has generally increased during the past five years.

Fiscal Year	Total Number of Disciplinary Actions
1981	12
1982	14
1983	7
1984	24
1985	20

According to the Federation of State Medical Boards, Kansas ranked 17th in the number of disciplinary actions per thousand doctors in 1984. However, this ranking is not necessarily indicative of a board's effectiveness in protecting the public. Therefore, the auditors looked closely at the types of disciplinary actions taken during the last two fiscal years.

The Board took disciplinary action against less than 14 percent of the doctors who had complaints lodged against them. In fiscal year 1984 and 1985, a total of 44 disciplinary actions were taken against 35 doctors (23 medical doctors, 9 osteopaths, and 3 chiropractors). These 35 doctors represent less than 14 percent of the 262 doctors who had complaints filed against them during the two-year period, and less than one percent of all active doctors in Kansas.

Nearly all of the disciplinary actions taken were in the form of stipulation agreements. Of the 44 disciplinary actions taken in fiscal years 1984 and 1985, 35 (80 percent) were stipulations, which generally allowed the licensee to continue practicing under certain mutually agreed restrictions, and three (7 percent) were informal admonishments, which allowed the licensee to continue practicing without any restrictions. Only six actions (13 percent) resulted in the loss of the licensee's ability to practice. These actions included four surrenders of license (which the Board categorized as revocations) and two suspension orders by the Board. In reviewing case files, the auditors found that the more stringent penalties were usually applied when less severe punishment had already been attempted unsuccessfully. This may indicate a reluctance on the part of the Board to use the stronger penalties available.

Most of the disciplinary actions taken against doctors related to overprescription of drugs or excessive use of alcohol or drugs. The table on the next page shows the reasons for disciplinary action taken against doctors during fiscal years 1984 and 1985.

Reasons for Disciplinary Action Against Doctors	Number of Doctors
Handling of Prescription Drugs	15
Impaired Physician	8
Licensure and Scope of Practice	4
Patient Care	3
Professional Conduct or Ethics	2
Criminal Charge or Conviction	2
Advertising Practices	1
Total	35

The auditors found that 23 (66 percent) of these 35 doctors had either overprescribed drugs or had been impaired by use of alochol or drugs. The Board's attorneys indicated that, in these types of cases, violations of the Healing Arts Act can often be proven by documented drug records or by observed instances of impairment due to alochol or drugs. In such cases, violations are generally easier to prove than in cases of alleged medical negligence.

A sample of disciplinary actions showed that most seemed to adequately protect the public, but nearly a third of the cases did not appear to fully protect the public interest. The auditors reviewed the files of 19 of the 35 doctors disciplined during the past two years. In 13 of these cases sampled, they found that the cases were generally resolved so that the public was protected from incompetent or improper practice of the healing arts. In the remaining six of the 19 cases sampled, the auditors found that one or more aspects of each case could have been improved to better protect the public. These six cases are discussed in the following paragraphs.

In two of these cases, the Board was unable to take strong disciplinary action (although some Board members apparently wanted to do so) because review committees recommended informal admonishment of the licensees. (Under the law prior to July 1, 1985, the Board had to accept these recommendations.) One of these doctors was convicted of mail fraud for aiding "patients" to make unfounded injury claims against insurance companies. The other doctor was informally admonished for not maintaining any malpractice insurance for at least seven years, although he certified to the Board that he had the necessary coverage. This doctor has one malpractice suit pending, which could possibly result in a judgment that the doctor would be unable to pay.

In another case related to insurance coverage, the Board noted that a licensee's malpractice insurance did not appear to comply with the limits required by Kansas law. Although the Board did write a letter to the licensee and attempted to notify the Insurance Department, twelve months passed without any change in the coverage. As of mid-July 1985, the licensee had still not demonstrated compliance with the insurance law. While this is not a violation of the Healing Arts Act, the Board is required by law to notify the Attorney General of any licensee who is practicing in Kansas without the required insurance coverage. The Board has not given such notice, so the licensee has been allowed to continue his practice.

In three other cases in the sample, the auditors found that the Board appeared to have been lenient in dealing with the licensees' violations of the Healing Arts Act. In all three cases, the doctors have been allowed to continue their practices while the Board has attempted to get them to change practices that had created problems for the past 1-4 years. These doctors entered into stipulation agreements regarding their problems—overprescribing diet pills, overprescribing scheduled drugs, and chronic alcoholism. The stipulation agreements allowed them to continue practicing under restrictions set by the Board. Stronger disciplinary actions, such as revocation or suspension of a license, are considered to be a last resort, as indicated by this quote from the Board's letter to the doctor who had violated two stipulations regarding use of alcohol:

> "The Board simply felt that it had given you every chance to show that you would refrain from the use of alcohol. It decided that it could no longer be lenient and thus, concluded that an indefinite suspension was its only viable choice."

The sample of disciplinary actions also showed that follow-up by the Board was generally sufficient to determine whether stipulation agreements were being followed. After disciplinary action is taken by the Board, the Board's attorneys and its investigator monitor the licensee to ensure that the licensee is in compliance with any stipulation agreement or any stronger orders. Licensees practicing under stipulation agreements were monitored according to a regular schedule, including random drug screens and other tests for licensees with drug and alcohol impairment. Further investigation, such as reviewing prescription records and other medical records, was also conducted as needed.

The 19 doctors in this sample did not have a history of malpractice actions against them. Only one doctor in this group had a petition filed against him in the past two years. Because these doctors did not seem to be the most dangerous in terms of past malpractice, the auditors also reviewed three other active files of doctors who have been sued for malpractice but not disciplined by the Board. These cases are included in the profiles in this section of the report.

The one doctor in the sample who had a malpractice petition filed recently did not have any malpractice liability insurance at the time. This case led the auditors to look at the system for monitoring doctors' malpractice insurance coverage.

Current procedures are not adequate to ensure that all doctors have malpractice liability insurance as required by law. Kansas law places duties on the Insurance Department and the Board of Healing Arts to assist each other in maintaining compliance with malpractice insurance requirements. In two cases profiled on page 22, the auditors found that licensees had been able to practice without proper insurance coverage for long periods of time. When they were detected it was because they became involved in malpractice cases or failed to complete insurance information when applying for renewal of license. In one of these cases, the licensee apparently was still practicing without adequate insurance one year after the Board learned of his status.

LICENSEES FAIL TO MAINTAIN
REQUIRED MALPRACTICE INSURANCE

In two cases sampled by the auditors, Board licensees did not maintain malpractice liability insurance as required by Kansas law. In both cases, the licensees were originally brought to the Board's attention because of impairment—one from alcoholism, the other from drug abuse.

In the first case, the Board did not become aware that the doctor had no malpractice insurance until February 1985, after a lawsuit was filed against the doctor. The lawsuit alleged that the doctor failed to properly diagnose and treat a pregnant woman (now deceased) who had cancer. If this lawsuit is resolved in favor of the paintiff, the doctor may be unable to pay the amount of the judgment.

After the Board learned that this doctor had not maintained any malpractice insurance for at least seven years, a review committee recommended that the doctor be informally admonished. According to the disciplinary counsel, some Board members would have preferred stronger action but, under the law prior to July 1985, the Board had to accept the review committee's recommendation of informal admonishment.

In the second case, the Board learned in June 1984 that a doctor had insufficient liability insurance to meet the requirements of State law. In July 1984, the Board notified the doctor's insurance agency of the problem, but received no response until May 1985. As of July 1985, the licensee has still not demonstrated compliance with the insurance requirements, and the Board has neither taken disciplinary action nor notified the Attorney General as required by K.S.A. 40-3416.

These two cases indicate that the current system, as operated by the Board of Healing Arts and the Insurance Department, does not always assure that doctors are maintaining the required malpractice liability insurance.

These problems have occurred partly because there is no assurance that all active licensees of the Board are recorded in the compliance files at the Insurance Department. Although the Board requests licensees to identify their insurance carrier and policy number when applying for license renewal, the Board's informal attempts at providing this information to the Insurance Department have not been successful concerning all active doctors.

Even if a violation of the insurance requirements can be proven, the Board of Healing Arts cannot take disciplinary action unless the doctor used fraud to obtain the license. By itself, a licensee's failure to maintain the required malpractice insurance is not a violation of the Healing Arts Act, and is not a ground for disciplinary action. Under present law, the Board is required to report any such violation to the Attorney General so that the licensee can be prevented from practicing medicine without the required insurance.

Responsibility for managing the Board's disciplinary activity is not entirely clear. In reviewing the Board's disciplinary action process, the auditors noted that the responsibility for managing the Board's disciplinary activity is not clearly defined by statute or regulation. During the two-year period reviewed by the auditors, responsibility for the disciplinary action process was shared among the Board's secretary, general counsel and disciplinary counsel. During fiscal year 1985, review committees also shared responsibility for the process because their decisions could be legally binding upon the Board. Under the Administrative Procedures Act which went into effect July 1, 1985, review committees will become strictly advisory bodies. In addition, the Administra-

tive Procedures Act allows the Board to designate a presiding officer to manage its formal disciplinary activities. According to staff of the Board, this role will probably be filled by the secretary. However, no steps have been taken by the Board to formally define the secretary's new role.

HEALING ARTS BOARD TAKES NO ACTION AGAINST A SURGEON FOLLOWING EXTENSIVE REVIEW

A complaint was filed against a surgeon alleging that the need for surgery was misdiagnosed and that the surgeon's actions caused major problems for the patient. The Board then learned of several similar cases, some involving patients' deaths. The doctor was suspended by the hospital, then later reinstated under certain restrictions. The doctor appeared before the Board's hearing panel, which met several times and heard from numerous witnesses. The hearing panel found that the surgeon had relied on pathological reports, so no action was taken against the surgeon's license.

The doctor continued to do surgery at the hospital under the supervision of a monitoring committee with monthly reviews. After three years of monitoring the surgeon, the hospital committee issued its report and recommendations. Within two weeks after the report was completed, the doctor submitted a letter of resignation from the hospital medical staff.

In June 1985, the secretary for the Board wrote to another state—where the doctor has applied for licensure—indicating that the Board had considered this case and determined that the doctor had not violated the Healing Arts Act. Although Board counsel are still reviewing at least one case against this doctor, the other state was not informed of this because of confidentiality provisions in the Act.

Public representation on the Board of Healing Arts is less than half the national average of similar boards. The auditors obtained membership data for 60 boards that regulate doctors (medical doctors, osteopathic physicians, or both) in other states, and found that the average public representation for these boards was 16.3 percent. While 11 boards had no public members, eight had at least 30 percent public members. The Kansas Board of Healing Arts has only one public member (7.7 percent) on the 13-member Board.

The Board of Healing Arts has taken some steps to improve protection of the public. The Board has supported legislation to overcome some of the obstacles it encounters in protecting the public. One obstacle has been the difficulty involved in proving medical negligence against licensees. In the absence of clear standards, the Board must rely on costly expert witnesses to evaluate whether the quality of care in a given case was adequate. To overcome this difficulty, the Board has taken steps to incorporate specific medical standards into the law. For example, in 1984 the Board supported legislation requiring licensees to inform their patients about alternatives to breast surgery, and setting standards for ordering and dispensing amphetamines.

The Board has also taken some steps toward using malpractice petitions for identifying doctors who may be dangerous to the public or may have violated the Healing Arts Act. With the help of the Insurance Department, the

Board's disciplinary counsel has identified 14 licensees with four or more claims against the Health Care Stabilization Fund since its creation in 1976. The disciplinary counsel has indicated that these licensees will be investigated once the necessary records and closed claim reports have been obtained. The remaining licensees with malpractice claims will not be investigated until the Board has categorized and evaluated all of the petitions on file. The Board recently hired a law clerk to assist the attorneys with this process.

NUMEROUS LAWSUITS FOLLOWING BREAST SURGERIES

The Board initially received a complaint from an attorney in March 1983 that a doctor had unnecessarily performed a mastectomy with breast reconstruction. The complaint stated that the surgery was ineffective: the implants were too large, the breast sizes were unequal, corrective surgery by the doctor was unsuccessful, and the woman had to undergo further surgery by other doctors.

By June 1983, the Board was aware of seven malpractice lawsuits naming this doctor as the defendant, with a potential for at least 11 additional suits not yet filed. In September 1983, a doctor who reviewed these cases at the request of the Board reported that the doctor's technical judgment was questionable, that only a few biopsies were performed, that the mastectomy specimens did not indicate cancer, and that it is more common to delay or stage the reconstructive surgery. A second physician reviewed the cases for the Board in early 1984 and found that the doctor made poor patient selection, failed to record informed consent, and used questionable techniques. In May 1985, the general counsel for the Board recommended that the Board enter into an adversary hearing in regard to possible revocation, suspension, or limitation of the doctor's license. The doctor is still licensed to practice by the Board, although a Board attorney indicated that the doctor was no longer performing mastectomies. The Board attorney told the auditors that the doctor had performed a total of about 250 mastectomies.

This case provided the imeptus for 1984 legislation requiring doctors to inform their patients of alternatives to breast surgery. The Board has prepared booklets summarizing the alternative treatments, and doctors must give this booklet to each patient for whom breast surgery is recommended.

In a memorandum to the Special Committee on Medical Malpractice, the Board's general counsel has made a number of other recommendations to improve the Board's ability to deal with malpractice. One of these recommendations is to allow the Board to assess fines against licensees who violate the Healing Arts Act, as proposed in 1985 Senate Bill 375. The general counsel also recommended that the Board's budget be increased to allow employment of investigators, law clerks, expert witnesses, and hearing officers.

Conclusion

The Board of Healing Arts has a difficult task in regulating the practice of the healing arts by doctors in Kansas. The auditors found that, in many cases, the Board has achieved the primary goal of protecting the public against unprofessional, improper, or unauthorized practice of the healing arts, while at the same time giving due process to the licensees under investigation. In other cases, the auditors found that the Board did not go far enough in its efforts to

protect the public interest. Significant problems were noted in several areas, including the following:

--the Board's recordkeeping system does not allow adequate tracking of disciplinary cases
--complaints most commonly relate to patient care problems, but most disciplinary actions relate to overprescription of drugs or impaired physicians
--malpractice petitions are not being used as intended to generate investigations of allegedly negligent doctors
--current procedures do not ensure that all doctors practicing in Kansas have the required malpractice liability insurance.

Recommendations

1. In considering complaints and in taking disciplinary actions against doctors who may have violated the Healing Arts Act, the Board should ensure that the public interest takes priority over the interests of the doctor or any other party.

2. The Board of Healing Arts should develop a recordkeeping system that allows tracking of licensees' disciplinary problems over time. Using this tracking system, the Board should evaluate each new complaint and malpractice petition in light of any past problems to determine what level of priority should be assigned to the case and what type of further action is appropriate.

3. To protect the public and minimize the number of future malpractice cases, the Board of Healing Arts should give high priority to investigating and taking disciplinary action against doctors who have had multiple malpractice petitions filed against them, or who have allegedly committed an act of gross negligence.

4. To assure that all doctors have liability insurance as required by State law:

   (a) The Board of Healing Arts and the Insurance Department should prepare a joint plan to assure that all active licensees of the Board are in compliance with liability insurance requirements of the Health Care Provider Insurance Availability Act. This plan should be submitted to the Special Committee on Medical Malpractice prior to the 1986 legislative session.

   (b) The Board of Healing Arts should seek legislation making it a violation of the Healing Arts Act for an active licensee to fail to comply with the liability insurance requirements of the Health Care Provider Insurance

Availability Act. Under this legislation, any failure to maintain the required insurance should be a ground for possible revocation, suspension, or limitation of a license.

5. To clarify the responsibility for supervising disciplinary activities, the Board of Healing Arts should formally designate the secretary of the Board as its presiding officer for proceedings conducted under the Administrative Procedures Act, and should define the secretary's role in deciding how disciplinary cases will be handled.

6. To give the Board of Healing Arts an additional tool for disciplining doctors who violate the Healing Arts Act, the Special Committee on Medical Malpractice should consider allowing the Board to levy fines against licensees who have violated the Act. These provisions are found in 1985 Senate Bill 375. Such fines should not be used as a substitute for revocation, suspension, or limitation of licenses as allowed by current law.

7. To ensure adequate representation of the public interest, the Special Committee on Medical Malpractice should consider legislation adding one or more public members to the Board of Healing Arts.

What is the Trend in the Balance of the Health Care Stabilization Fund?

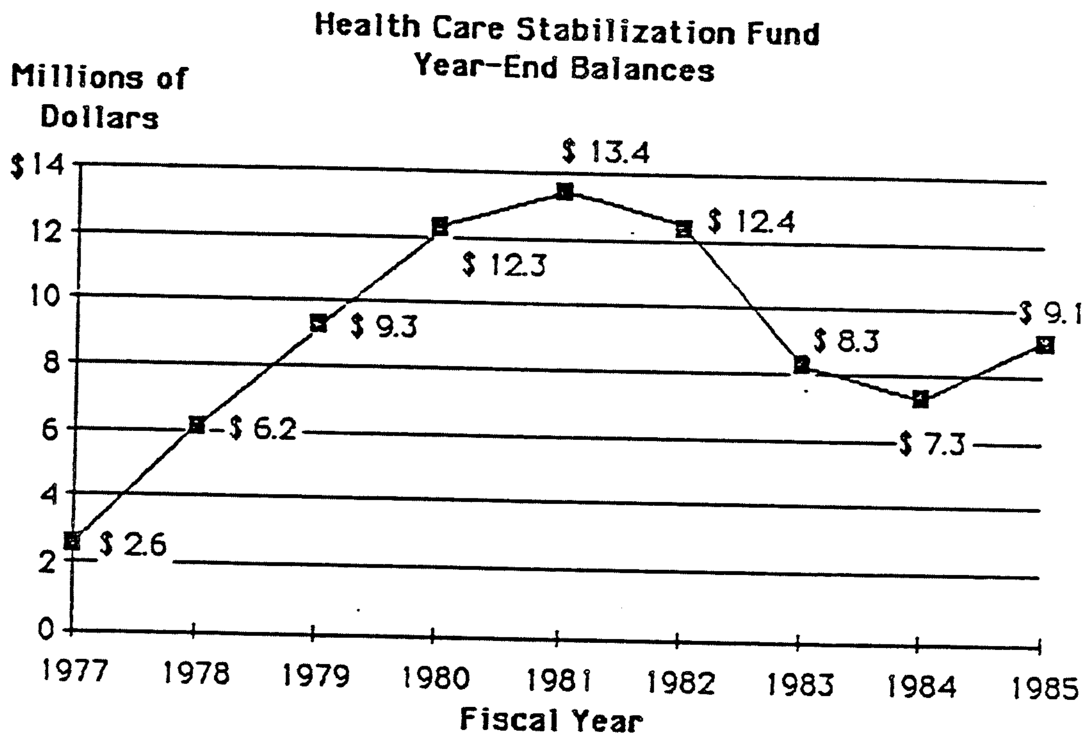
One of the concerns that prompted this audit relates to the solvency of the Health Care Stabilization Fund, which was established in 1976 to pay amounts due from any judgment or settlement in excess of the basic coverage liability each health care provider is required to carry. Before July 1984, each health care provider was required to carry basic insurance coverage of at least $100,000 per occurrence, subject to an annual aggregate of $300,000. In July 1984, the basic coverage requirements were raised to $200,000 per occurrence and $600,000 annual aggregate.

The Health Care Stabilization Fund is administered by the Insurance Department, under the procedures set forth in the Health Care Provider Insurance Availability Act (K.S.A. 40-3401, et seq.). The primary source of revenue for this Fund is the premium surcharge levied on each health care provider who has obtained basic coverage. The premium surcharge is set annually by the Insurance Commissioner, in an amount deemed sufficient to pay anticipated claims against the Fund. Another source of revenue is the interest income from investment of moneys in the Fund.

After Declining for Three Years, the Balance in the Health Care Stabilization Fund Increased Significantly in Fiscal Year 1985

To determine the trend in the balance of the Health Care Stabilization Fund, the auditors obtained data from the Insurance Department and verified

that data with the Kansas Annual Financial Reports. The chart below shows the total balance of the Fund at the end of each fiscal year.



The chart shows that the Fund's balance grew steadily in the initial years, reaching a peak of $13.4 million at the end of fiscal year 1981. In each of the next three years, the Fund paid out at least $1 million more than it took in each year, reducing the Fund balance to about $7.3 million at the end of fiscal year 1984. In 1985, the downward trend was reversed, as the balance closed at $9.1 million. The main reasons for these changes in the Fund's balance are discussed below.

The annual number of claims filed against the Fund has increased each year since fiscal year 1979. The following table shows the number of claims filed against the Fund each year, and the percentage increase per year.

Fiscal Year	Number of Claims	Percent Increase Per Year
1979	26	—
1980	82	215%
1981	100	22%
1982	124	24%
1983	156	26%
1984	179	15%
1985	230	28%

During the past five fiscal years, the annual number of claims against the Fund has nearly tripled, going from 82 claims in 1980 to 230 in 1985. According

to Insurance Department statistics, about 24 percent of past claims have resulted in awards being paid from the Fund.

The number of claim awards paid by the Fund has increased each year since fiscal year 1980, and the average amount per award has also risen sharply. The table below shows how the number and amounts of claim awards paid by the Fund have risen.

Fiscal Year	Total Number of Claim Awards	Total Amount of Awards	Average Amount Per Award
1980	0	$ -0-	$ -0-
1981	8	1,773,182	221,647
1982	24	3,060,126	127,505
1983	25	6,515,250	260,610
1984	34	10,456,454	307,542
1985	41	13,124,260	320,103

The table clearly shows that the total amount of awards paid by the Fund has increased by $3 million to $4 million each year during the past several years. If this trend continues, claim awards of $16 million to $18 million could be expected in fiscal year 1986.

Despite the significant increase in awards paid in 1981, 1982, and 1983, no premium surcharge was assessed during those years because of a statute directing the Commissioner of Insurance to maintain the Fund at an approximate balance of $10 million. The absence of a surcharge contributed to the decline of the Fund balance from $13.4 million in fiscal year 1981 to $8.3 million at the end of fiscal year 1983. (See the Fund balance graph on page 27.) Following repeal of the statute in 1983, the surcharge was reimposed in fiscal year 1984.

Reimposition of the premium surcharge has stopped the decline in the Fund balance. Premium surcharges are assessed as a percentage of the annual premium paid by each health care provider for the basic liability coverage required by law. Each doctor pays the surcharge along with the premium for basic coverage, then the insurer forwards the surcharge to the Insurance Department. The table below shows the surcharge assessment since the Fund was established.

Fiscal Year	Percent of Annual Premium for Basic Coverage
1977	45%
1978	45
1979	40
1980	15
1981	0
1982	0
1983	0
1984	50
1985	80
1986	110

The imposition of the 50 percent surcharge in fiscal year 1984 was not sufficient to stop the decline in the Fund balance, as expenditures exceeded receipts by about $1 million. However, in fiscal year 1985, the 80 percent surcharge enabled the Fund balance to grow by about $1.8 million. The 80 percent surcharge generated more than $15.2 million in fiscal year 1985.

The continuing increase in the surcharge, which is 110 percent for the current fiscal year, reflects the actuarial estimation of future payments to be made by the Health Care Stabilization Fund. The 110 percent surcharge is expected to produce more than $24 million for the Fund in fiscal year 1986. Actuarial estimates are for the surcharge to remain at about 100 percent for the next two years. These high surcharges, in conjunction with higher rates for basic coverage, have generated great concern in the medical and insurance industries. Although there is no easy solution to the problem of medical malpractice injuries and costs, close scrutiny of impaired and incompetent doctors by the Board of Healing Arts should help to minimize the number of malpractice actions in the long run.

APPENDIX A

Kansas Board of Healing Arts

Name	Position	City of Residence
James W. Bruno, M.D. (a)	Member	Garden City
James R. Croy, D.C.	Vice President	Junction City
F.J. Farmer, D.O. (a)	Member	Stafford
Helen Gilles, M.D. (a)	Member	Lawrence
Frederick J. Good, D.C.	Member	Benton
Cameron D. Knackstedt, D.O.	Member	Phillipsburg
Gordon E. Maxwell, M.D.	Member	Salina
Betty Jo McNett	President	Wichita
Forrest A. Pommerenke, M.D.	Member	DeSoto
Harold J. Sauder, D.P.M.	Member	Independence
Richard A. Uhlig, D.O.	Secretary	Herington
David Waxman, M.D.	Member	Lenexa
Rex A. Wright, D.C.	Member	Topeka
Edward J. Fitzgerald, M.D. (b)	Member	Wichita
John Hiebert, M.D. (b)	Member	Lawrence
John White, D.O. (b)	Member	Pittsburg

(a) Term expired June 1985
(b) Appointed July 1985

APPENDIX B

Agency Response
Board of Healing Arts

STATE OF KANSAS

BOARD OF HEALING ARTS

OFFICE OF
RICHARD A. UHLIG, SECRETARY
ELIZABETH W. CARLSON, EXECUTIVE SECRETARY
DONALD G. STROLE, GENERAL COUNSEL
503 KANSAS AVENUE, SUITE 500
TOPEKA, KANSAS 66603-3449
PHONE: (913) 296-7413

MEMBERS OF BOARD

BETTY JO MCNETT, PRESIDENT, WICHITA
JAMES R. CROY, D.C., VICE-PRESIDENT, JUNCTION CITY
RICHARD A UHLIG, D.O., SECRETARY, HERINGTON
JAMES W. BRUNO, M.D., GARDEN CITY
F.J. FARMER, D.O., STAFFORD
HELEN GILLES, M.D., LAWRENCE
FREDERICK J. GOOD, D.C., BENTON
CAMERON D. KNACKSTEDT, D.O. PHILLIPSBURG
GORDON E. MAXWELL, M.D., SALINA
FORREST A. POMMERENKE, M.D., DE SOTO
HAROLD J. SAUDER, D.P.M., INDEPENDENCE
DAVID WAXMAN, M.D., KANSAS CITY
REX A. WRIGHT, D.C., TOPEKA

August 6, 1985

Meredith Williams
Legislative Post Audit
109 West 9th St., Suite 301
Mills Building
Topeka, KS 66612

RE: Post Audit Report
Healing Arts Board

Dear Mr. Williams:

Thank you very much for my copy of the recent audit report of the Healing Arts Board. The following paragraphs represent my informal personal response to the audit report. Enclosed is a formal response prepared by the Board's Staff with which I am in total agreement.

First of all I would like to congratulate the auditors involved and especially Mr. Green for what appears to be a very complete, fair and in-depth audit of the Healing Arts Board. The auditors were very courteous and friendly during the audit and went out of their way not to disrupt the work at the Healing Arts Board. I feel Mr. Green is very concerned with his work and showed a great concern for the Healing Arts Board and its problems. He was willing to listen to our problems and I think the results of the audit will help us solve some of the problems we are facing.

In general I agree with the analysis and recommendations concerning the reporting of cases to the Healing Arts Board. I think the Federation has some excellent guidelines and if these could be worked into legislation it would benefit the Board in its functions. As you are aware, the State Board of Healing Arts has little authority or power over hospitals, HMOs and other organizations in compelling them to report promptly to the Healing Arts Board. In the future I think the Board should report non-compliant organizations to their respective peer organizations such as the Kansas Hospital Association, the Joint Commission on Hospital Accreditation, or the Kansas Department of Health and Environment.

There is one area of the reporting law which I feel needs to be modified and that concerns impaired physicians. Experts in this area have reported to the Board that the problem of physician impairment by drugs and alcohol is quite pervasive in our society. Estimates have been made that possibly as high as 20% of practicing physicians are impaired either due to drugs or alcohol. Because of the new reporting law established in 1983, impaired physicians now fail to seek help through impaired physician organizations and other standard medical facilities for fear that they may be reported to the Healing Arts Board. Psychiatrists have informed the Board that physicians do quite well following in-patient care for impairment and they have a cure rate of approximately 85%. Physicians graduating from an in-patient treatment for impairment usually return to their practice as better physicians. The State Board of Healing Arts has the power and ability to force a physician to seek in-patient treatment once an impaired physician is found and the State Board has probable cause to believe he is impaired. However, under the current reporting laws most of the impaired physicians existing in the State of Kansas go unnoticed by the Healing Arts Board. Last year we held meetings concerning this problem and discussed it at length with the impaired physician organizations. The general concensus is the Board needs to modify its reporting law so impaired physicians who have had no difficulties with patient care or malpractice cases could enter into a program and seek treatment without fear of the Board revoking their license. We have several ideas concerning this problem and are planning on drafting legislation to implement them.

Concerning the effectiveness of the Board in protecting the public, I would like to mention one aspect of this problem which was not considered in your report and which many members of the Board feel is quite important. The Board has received complaints in the past and is aware of a number of Kansas citizens being treated by lay people and other types of therapists who are not licensees of the Board, i.e. reflexologists, health food store employees, vitamin companies, naturopaths, therapists of no particular title, medical technologists, midwives, etc. The Board has no power over these practitioners or therapists and when we believe they are practicing the healing arts illegally we report them to the prosecuting attorney in the county in which they reside. However, in the past we have felt prosecuting attorneys have taken little interest in these cases. I feel that if the scope of the Board could be broadened to somehow encompass these problems the public may be better protected.

On page 11 of the audit report there is a chart which shows the three divisions of the Healing Arts Board and the number of complaints lodged against each division in 1984. It is noted that the percentage of complaints against the osteopathic physicians and the chiropractic doctors are higher than their percentage of all doctors

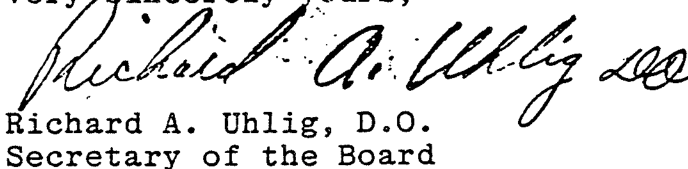
active in Kansas. Concerning the chiropractic doctors in Kansas, a large number of their complaints relate to advertising and billing. There is a significant portion of the medical doctors in Kansas who are working in institutions, administrative positions and in teaching facilities which have a lower level of patient contact. Almost 100% of the osteopathic physicians in the State of Kansas are in general practice with a high level of patient contact. There are very few osteopathic physicians in the secondary specialties such as pathology, radiology and in subspecialty areas where there is lower patient contact.

The Board's physical facilities are quite limited and this has hampered our recordkeeping system to some extent. We are looking forward to a modern computer recordkeeping system in the near future and I think this will help the Board immensely with its recordkeeping problems.

Concerning the recommendations, I am in essential agreement with all of them and plan at the next Board meeting to carryout recommendation number 5 by asking the Healing Arts Board in the form of a motion to designate the Secretary of the Board as Chief Presiding Officer for proceedings conducted under the Administrative Procedures Act prior to the filing of formal disciplinary charges.

I personally feel that the audit of the Board will be most helpful not only to the legislature but to the Board itself. I feel the recommendations of the audit are quite appropriate and will help the Board function better in the future.

Very sincerely yours,



Richard A. Uhlig, D.O.
Secretary of the Board

RAU/sl

Enc. - 1

STATE OF KANSAS

BOARD OF HEALING ARTS

OFFICE OF
RICHARD A. UHLIG, SECRETARY
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REX A. WRIGHT, D.C., TOPEKA

RESPONSE OF THE BOARD OF HEALING ARTS TO THE LEGISLATIVE POST AUDIT REPORT

The Board in general has no disagreement with the history and the description of the Board as set out in pages 1-3 of the audit report. Also, the Board has no disagreement with the statistics on page 4 of the report. The profile on page 5 is essentially correct, and the Board feels that it typifies what occurs with many cases involving negligence at a hospital. The last sentence of the first paragraph on page 5, although correct, is not a complete account of the problem. State law does grant immunity to persons reporting to the Board. The major problem, however, is that no law can prevent a person from being sued and the State cannot grant immunity from liability under federal law. In the next few pages the audit report discusses various reporting laws of other states and the guidelines of the Federation of State Medical Boards. Essentially, the Board has no disagreement with the suggestions that the Federation of State Medical Board's guidelines be adopted by the legislature and that Senate Bill 374 introduced last session be passed which requires that hospitals or other health care organizations report <u>information</u> regarding violations of the Healing Arts Act to the Board instead of waiting until <u>findings</u> are made. The Board also supports any legislation which would allow either the Board or some other state agency to enforce by penalties the reporting laws that are enacted.

On pages 8 & 9 the report sets out several recommendations. As noted above, the Board supports recommendation (1) in its entirety. Even further, the Board would support legislation requiring licensees to report acts of negligence of other licensees or support staff of a hospital to the appropriate quality control program in that hospital. It is essential in order for the Board to be effective to have vigorous peer review conducted at hospitals. With regard to recommendation (2) on page 9 it should be noted that the Board has worked in the past with various private associations of health care providers to publicize the reporting laws which have been enacted. The Board will continue to work with these associations to publicize any new changes that may be enacted, as well as sending direct mail to our licensees to provide them the information (within the limits of our budget). With regard to recommendation (3), this audit has disclosed a problem the Board was not aware of. That is, that it had not received all petitions the Insurance Department was required to send to it. The Board is presently working with the Insurance Department to ensure that the Board has received all petitions.

HOW EFFECTIVE IS THE BOARD IN PROTECTING THE PUBLIC AGAINST UNPROFESSIONAL, IMPROPER OR UNQUALIFIED PRACTICE OF THE HEALING ARTS

At the outset it is important to point out the various changes that have occurred with the Board in the past three fiscal years, the years which the auditors have examined. In fiscal year 1983 the Board only had a part-time attorney and one investigator to do all the legal work, both disciplinary and licensing. In fiscal year 1984 the Board was authorized to hire a full-time attorney but still only had one investigator. In fiscal year 1985 a disciplinary counsel was added to the Board who was in charge of initially handling all complaints and investigation of these complaints. In addition a three-member review committee process was instituted. From this background it is easy to see that there has not been any continuity in the staff or the manner in which disciplinary cases were handled in the past three years. With the adoption of the Kansas Administrative Procedures Act, which went into effect July 1, 1985, the Board will be able to proceed on a fairly uniform basis. Hopefully, therefore, in the future there will be continuity in the way cases are handled.

In the first paragraph under this section on page 9, the report implies that the primary activity of the Board is to receive, investigate and resolve complaints against doctors. It should be noted that the Board's duty to protect the public also includes the licensing of doctors, adoption of rules and regulations and various legislative activities. Obviously, if vigorous procedures are instituted regarding licensing of individuals and sufficient standards are adopted regarding the practice of medicine, the public will be better protected than if the Board tries to take care of the problems after-the-fact by disciplining doctors. Certainly, a major part of the Board's activities include matters other than discipline.

In the first paragraph on page 10, the auditor's report indicates that the Board has performed well in some areas but that the auditors have various concerns that are mostly procedural or organizational in nature. The Board will attempt to address these concerns in turn.

On pages 10-13 the report set out procedures used by the Board to respond to complaints against doctors and gives statistics on the number and type of complaints received by the Board in the last two fiscal years. The Board is essentially in agreement with both the procedures and the statistics indicated in the report.

On page 13, a profile of a doctor addicted to cocaine is set out. Although most of the profile is correct, certain statements in it are not sufficiently complete. It is true that the Board allowed the doctor to return to his practice for two weeks to close it down. However, the inference should not be made that he was allowed to practice unconditionally. The Board sought to get the doctor to stop practicing as soon as possible. During this two week period, random urine screens were taken, the doctor was in an out-patient program, he was attending Cocaine Anonymous and the Board had closed down his ability to purchase cocaine from his usual sources. Thus, the Board believes that it had the problem sufficiently under control while the doctor was closing his practice down and transferring his patients to other doctors.

The Board has no disagreement with the statistics set out on page 14. However, further explanation needs to be given for the cases profiled at the top of page 15. In cases 1 and 2, the review committees, appointed pursuant to Senate Bill 507, found no probable cause and the Board was bound by those decisions. Even so, the Board was able to reach agreements with those licensees requiring them to cease and desist from the practices which caused concern. If the Board had not vigorously pursued these cases, given the decisions of the review committees, the licensees would have been able to continue the activities in question. In response to such cases, the legislature in this past session repealed that part of the statute which made the decisions of the review committees binding on the Board. Hopefully, this change will allow the Board to be more vigorous in its attempts to protect the public in the future. Case number 3 profiled on top of page 15 is a relatively unimportant case. The case involved an elderly doctor who was simply not up on the type of prescriptions that should be given and was probably being used by some obese people to obtain weight control drugs. It is important to note, however, that the doctor was prescribing a Schedule III amphetamine-like drug, not a Schedule II amphetamine. The Board signed a stipulation with this doctor in May of 1984 prohibiting him from prescribing Schedule II or III amphetamine or amphetamine-like drugs. However, the legislature in the past session had passed the bill allowing the prescribing of Schedule III amphetamine-like durgs for short term use. Pursuant to the adoption of this legislation, the Board sent out a flyer to all of its licensees indicating that Schedule II drugs could not be prescribed for obesity but that Schedule III or IV could for short term use. This was sent out with the renewal application in June of 1984. The doctor profiled in case 3 simply became confused upon receipt of this flyer and thought that his prior stipulation was now modified by the new law. In response, he proceeded to write a few Schedule III amphetamine-like drugs. It should be noted that this doctor was only seeing approximately 2-3 patients a day and that now he is retired from practice completely.

On page 15 and 16 the report makes assertions that the Board handles all complaints similarly and does not take into account the prior history of the doctor in evaluating the individual complaint. This assertion is simply not correct. The Board does have a formal procedure, albeit not a written procedure, for evaluating the past history of a doctor when a new complaint is received against that doctor. The Board has a coding system that is used to identify all licensees who have had a prior complaint filed against them. Accordingly, whenever a complaint is received the licensee's records are checked to see whether a prior complaint has been filed against that licensee. If the records indicate that a complaint has previously been filed, the prior cases are examined to determine whether a pattern exists or in general whether the licensee should be practicing given his or her history. Although each complaint is reviewed independently, it is not reviewed in a vacuum, and the Board always takes into account the history of the licensee in determining what action to take in the pending case. As mentioned before, prior to fiscal year 1984 the Board only had one part-time attorney. Accordingly, some of the recordkeeping was not as good as it should have been. However, when a full-time attorney was hired and a secretary was made responsible solely to that attorney, a much better system has developed. In most cases each file contains either minutes of a Board's actions on the complaint filed against the licensee or a letter to the licensee and the complainant which summarizes the disposition of the case. In addition, since July, 1983 a card index is maintained on all cases re-

ferred to the investigator and the investigator has a summary in his files of every case he has investigated.

In the future, at the close of each case the Board will summarize the case so that a system will be developed by which the prior history of each licensee can be examined quickly. Also, when the Board obtains its computer system, some kind of summary will be entered into the computer to allow the Board to retrieve this information on each licensee.

On pages 16-18 of the report, the auditors indicate that many of the cases involving three or more complaints against a licensee do not appear to involve serious danger to the public. This has generally been the view of the Board as well, although there have been exceptions. The profile on page 16 and the summary at the top of page 18 are essentially correct. On page 18, the text under the first heading suggests that the Board has handled the substantive aspects of complaints adequately, but that it has fallen down on procedural and organizational aspects of handling cases. As noted above, the Board feels that it has done a fair job on these aspects, but it will seek to improve these areas in the future.

In response to the assertion that the Board has not made full use of malpractice petitions, the Board notes that one petition against a licensee is not statutorily sufficient for the Board to take action against that licensee unless there is an allegation of gross negligence involved. Also, as has been brought to the attention of the legislature many times, a petition on its face does not provide sufficient information to identify those doctors on whom the Board should be conducting an investigation. Hopefully, with the passage of Senate Bill 267 this past session the Board's efforts in this area will improve.

On pages 19 and 20 of the report, the assertion is made that the Board has not always gone far enough in disciplining licensees. In response, the Board notes that our primary duty is to protect the public as quickly as possible. If we are able to do this by the use of a cease and desist order, consent order or a stipulation the Board feels that it has adequately performed its duty. This is especially true when one considers that seeking a revocation or suspension involves going through a long drawn-out hearing and appeal process, which may take as long as four or five years, during which time the doctor is able to practice. The case profiled on page 17 is indicative of the problems that occur when the Board is involved in a full-blown hearing and appeal process.

On page 20, statistics are profiled which indicate that the majority of the actions taken against licensees involved the handling of prescription drugs, impaired physicians and licensure and the scope of practice. Oddly, a distinction is made between these and the category of patient care. It seems to the Board that all three of these categories directly involve patient care, and in fact may involve a much greater number of patients than one malpractice case. An impaired physician could detrimentally affect every patient that he or she treats. Accordingly, it seems to the Board that it is sensible to seek out and attempt to prevent such persons from practicing. In addition, as noted in the last paragraph on page 20, it is generally easier to prove the cases of impairment or misprescribing of drugs than cases of alleged medical negligence. Medical negligence cases are extremely costly, quite complicated and time consuming. The Board often has trouble obtaining expert witnesses to review the records and testify. Therefore, medical

negligence cases are going to take longer to handle and it will be more difficult to take action against licensees.

At the top of page 21, the allegation is made that the Board has been lenient with licensees who violate the Healing Arts Act. There have been cases where the Board has entered into a stipulation with a doctor, monitored that doctor and discovered that the doctor has violated the stipulation. Whenever this occurs, as the quote at the top of page 21 indicates, the Board takes definitive action to prevent the licensee from practicing until it has assurance the doctor can practice safely and competently. In addition, as noted in the middle paragraphs on page 21, most of these cases do not involve doctors who have had past malpractice problems, but rather are cases where strict monitoring is appropriate with definitive action being taken if the stipulations are violated.

On pages 21 and 22, the report indicates a possible problem with doctors practicing without the requisite malpractice insurance. In an attempt to prevent this from happening, the Board for several years has obtained a compliance report from the Insurance Department which indicates those doctors who have complied with the Health Care Stabilization Act. Every year the staff of the Board goes through the renewal forms of the licensees which indicate whether the licensee has obtained the necessary insurance. They compare the renewal information with the compliance report and add to the compliance report the names of active licensees who should have the necessary insurance or who do not have sufficient policy limits. In the two cases profiled on page 22 the Board added these names to the compliance report, returned the compliance report to the Insurance Department and assumed that the Insurance Department would check their records to see whether they had obtained the requisite insurance and if not either bring these persons into compliance with the Act or inform us that they were not in compliance. It must be noted that the Board never obtains notification of insurance from the insurance companies, thus there is no way for the Board to know whether a person has been brought into compliance after the Insurance Department has been notified of noncompliance. The Board never received any information from the Insurance Deparment that the two persons profiled were not in compliance. Accordingly, the Board could only assume that they had been brought into complinace until subsequent information indicated that they had not. When the information was received, the Board took action to bring them into compliance. In one case, the doctor immediately obtained the necessary insurance. In the other case, because of some confusion as to whether he was a resident or a nonresident of Kansas, the doctor has not yet been brought into compliance but his Insurance Agent has assured us that he will be in the near future. A letter has been sent to this licensee informing him that he has until August 13, 1985 to bring himself into compliance. If he fails to do so, the Board intends to suspend him from practice.

In the future the Board intends to provide to the Insurance Department a list of all active licensees in the State of Kansas who are required to maintain the necessary insurance. Hopefully by doing this the Insurance Department will be able to compare that list with their compliance records and determine those active licensees who are not in compliance and report those to us, at which time we will take appropriate action.

At the bottom of pages 22 and 23, the report notes that there was some confusion as to who directs and supervises disciplinary action. As noted before, much of this confusion resulted from changes in legislation and staff in the past three years. With the adoption of the Administrative Procedures Act, which became effective July 1, 1985, much of this

confusion should be resolved. At its June meeting, the Board, without objection, accepted the recommendation of the general counsel that the Secretary be the presiding officer prior to the filing of formal disciplinary actions. In August, the Board should formally appoint the Secretary to this position. Thus, until a formal hearing begins and a hearing officer or panel is appointed, the Secretary will direct and supervise all activities regarding discipline. This should bring more consistency to the way investigations and complaints are handled, and it should make the disciplinary activities more efficient.

On page 23 a case is profiled regarding a licensee's alleged negligence. The Board held an extensive hearing on that case at the end of which the panel decided that the evidence was not sufficient to show that the doctor had violated the Healing Arts Act. Essentially, the evidence showed that the main person at fault was a pathologist who had made incorrect tissue reports to the surgeon in question. In addition, the evidence showed that the tissue committee at the hospital realized this but failed to inform the physician of the problem with the pathologist. In retropsect, perhaps more evidence could have been obtained and admitted into evidence which would have shown that the doctor was at fault. But at this point in time that is speculation.

The last paragraph of the profile indicates that the Board is presently investigating this doctor again but has not informed another state of this investigation. The reason the Board has not informed the other state is that the Board is statutorily prohibited from disclosing to anyone information on a pending investigation until formal disciplinary proceedings are initiated.

The Board in general has no objections to any of the recommendations made on pages 25 and 26, and would support any legislative changes necessary to implement them. In regard to recommendations 1 and 2 the Board feels that it is already using the procedures recommended but will attempt to improve these procedures to make them more effective. Most importantly, it should be noted that the Board intends to vigorously pursue doctors who commit repeated instances of ordinary negligence or one act of gross negligence, but in order to do that as the report notes in various places it is necessary for the Board to receive information as early as possible so that it can take action to protect the public before the malpractice occurs.

One final point needs to be made. At various places, including the first recommendation on page 25, the report suggests that the public interest should take precedence over all other interests and that the Board at times may have been too lenient on its licensees. While it is true that the public interest is most important, it is necessary to remember that that interest includes the duty of the State to treat a licensee fairly and to provide him or her all the due process rights to which he or she is entitled. Accordingly, in every case the Board must balance the duty to protect the public against the duty to provide complete due process to the licensee. Although on occasion the scales may be tipped too far one way or the other, it is essential not to lose sight of the fact that in each and every case these competing interests must be considered and weighed.

APPENDIX C

Agency Response
Insurance Department

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KANSAS INSURANCE DEPARTMENT

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Division calls only

FLETCHER BELL
Commissioner

August 2, 1985

Mr. Meredith Williams
Legislative Post Auditor
Legislative Division of Post Audit
109 West 9th, Suite 301
Mills Building
Topeka, Kansas 66612

Dear Mr. Williams:

I have reviewed the draft performance audit regarding the Board of Healing Arts and the Health Care Stabilization Fund and have no suggested corrections.

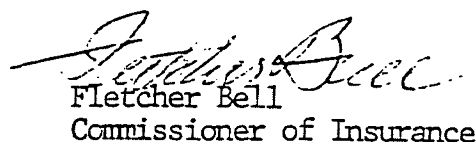
I do, however, have one comment in regard to Recommendation 4(a) of the report.

In 1976, this Department prepared a procedural manual which we provided to the Board of Healing Arts. The manual was intended to provide a system to guarantee that Kansas health care providers maintain proper insurance coverage. The manual included a detailed explanation of the computer printouts furnished by this Department to the Board of Healing Arts. In 1979, when it became clear that coordination with the Board was inadequate, Mr. Hayes prepared a supplement to the procedural manual. A copy of the procedural manual and supplement are attached as Exhibit A.

We agree with and support your Recommendation 4(a) and a meeting between my staff and the staff of the Board of Healing Arts has already taken place. I am informed that this meeting was successful in reaching some initial plans for better coordination. In accordance with your directions, I have asked my staff to prepare a proposed plan based upon their meeting with the Board of Healing Arts. The completed plan will contain the details necessary to implement the agreement of our Department and the Board of Healing Arts.

It is hoped that the above is responsive to the concerns expressed in your performance audit. However, if you should have any further questions or comments, please do not hesitate to contact this office.

Very truly yours,



Fletcher Bell
Commissioner of Insurance

FB:ks
LE/2037

1 argument of counsel. The Court's at recess.

2 (Whereupon, a recess was taken by the

3 Court, after which the following pro-

4 ceedings were had.)

5 THE COURT: You may proceed, Mr. Johnson.

6 MR. JOHNSON: Thank you, your Honor.

7 I think just before we took a break, we were

8 discussing the conversation you had with Terri Olsen

9 on the 12th of November. Do you recall that?

10 A. I don't recall the specifics of the conversation other

11 than the conversation.

12 Q. Do you recall that's what we were discussing before

13 the break?

14 A. Yes.

15 Q. And you do recall that during that conversation, you

16 would have advised Terri Olsen that Dr. Younglove at

17 least in your opinion did not do anything wrong during

18 her labor and delivery of Brent?

19 A. Yes, that was part of the conversation, I'm sure.

20 Q. Now, Dr. Jouvenat, you have in fact some opinions

21 with regard to whether the nurses did deviate from

22 appropriate standards of Labor and Delivery Room

23 nursing care, don't you?

24 A. Yes.

25 Q. And in fact, Doctor, do you have an opinion that there

8/15-16/85 Attachment VII

1 was a departure from minimum standards of obstetrical
2 care and Labor and Delivery Room nursing care for the
3 nurses in this particular case to disconnect
4 electronic fetal heart rate monitor at this point, which
5 was "84651," plus two, in the face of the bradycardia
6 that exists there?

7 MR. LARSON: Excuse me, if the Court please,
8 but I object to this line of questioning. Dr. Jouvenat
9 has not been listed as an expert with regard to the
10 degree of care of the nurses, your Honor.

11 THE COURT: Oh, I'm going to overrule the
12 objection.

13 MR. JOHNSON: Thank you.

14 THE COURT: The objection is overruled.

15 A. Do I have an opinion?

16 Q. (BY MR. JOHNSON) Yes.

17 A. Yes, I have an opinion insofar as the--I believe
18 that was the time when they were taking the baby--or
19 taking the mother to the delivery area.

20 Q. My question--

21 A. And it has to be disconnectcd at that time.

22 Q. My question is, Doctor, do you have an opinion as to
23 whether it was a departure from minimal standards of
24 obstetrical care and Labor and Delivery Room nursing
25 care to disconnect the fetal heart rate monitor in the

1 face of the pattern at "84651," plus two?

2 A. Yes.

3 Q. And what is your opinion?

4 A. That it's below the standard of care.

5 Q. It would be a deviation and below the standard of

6 care?

7 A. It would be a deviation in regard to the fact that it's

8 bradycardia that is existent at that time.

9 Q. And further, Doctor, do you have an opinion as to wheth

10 it would be a departure from minimal standards of

11 obstetrical care and Labor and Delivery Room nursing

12 care to disconnect the monitor at that point, at

13 "84651," plus two, and never hook it up again, in any

14 meaningful way, in the face of those bradycardia

15 tracings?

16 A. Yes.

17 Q. And what is your opinion?

18 A. That it is below the standard of care not to rehook it.

19 Q. And do you have an opinion as to whether it would be a

20 departure from minimal standards of Labor and Delivery

21 Room nursing care to fail to call a doctor and specifi-

22 cally Dr. Younglove in the face of those tracings from

23 "84648," plus two, to "84651," plus two?

24 A. Yes.

25 Q. And what is your opinion?

1 A. That is below the standard of care not to call the
2 physician.
3 Q. And you, in fact, concluded that a physician, Dr.
4 Younglove particularly, was not called in this particular
5 case, didn't you?
6 A. Yes.
7 Q. And, in addition, I assumed that you would agree that
8 calling a pediatrician and an anesthesiologist in
9 the presence of a pattern of persistent bradycardia
10 would be appropriate?
11 A. Yes.
12 Q. And do you have an opinion as to whether it's a
13 departure from minimal standards of obstetrical
14 care and Labor and Delivery Room nursing care to
15 fail to call a pediatrician and anesthesiologist
16 in such a pattern as one we've described here
17 between "84643," plus one and "84651," plus two?
18 MR. LARSON: If the Court please, I object to
19 the question, that assumes they had a responsibility to do
20 so, your Honor, and that would be a medical conclusion,
21 no proper foundation.
22 THE COURT: The objection is overruled.
23 Q. You may go ahead.
24 A. Yes, I have an opinion, insofar as the nursing require-
25 ments at that time, was really to notify the physician

1 responsible, insofar as their specific requirements
2 to call a pediatrician themselves, that was, I believe,
3 not their responsibility at that point.
4 Q. So the nurse's responsibility would have been to have
5 called the physician when they saw the bradycardia?
6 A. Yes.
7 Q. And then it would have been the physician's responsibi-
8 lity, in this case, Dr. Younglove's responsibility,
9 to call the pediatrician and anesthesiologist?
10 A. Yes.
11 Q. Because of the strong possibility that there
12 was going to be a depressed infant born?
13 A. Very possible.
14 Q. And in fact you formulated those opinions and those
15 conclusions after you had talked to Linda Carter,
16 after you had talked to Dr. Younglove, and after you
17 had reviewed the records at the time or near the time
18 that you talked to Terri Olsen?
19 A. In my best recollection, when I formulated my opinions,
20 it's really hard to put all of this together
21 insofar as the time that's gone by since that time.
22 However, I knew that it was my feeling and my--after
23 going over the record as briefly as I did and as best
24 I could at that time, I saw nothing wrong with what
25 Dr. Younglove had done at that specific time.

1 Insofar as talking with Linda Carter, I do not remember
2 the exact conversation insofar as that goes. The
3 best I can ascertain is that my opinion is the fact
4 that he was not called and he was anywhere, where he
5 could make a change in the particular thing that was
6 going on at that time, so he wasn't called.
7 Q. And the opinion that you've just given us with regard
8 to the deviations or minimal standards of Labor and
9 Delivery Room nursing were opinions that you would
10 have formulated at or near that time?
11 A. It's after the fact.
12 Q. Yes, after the fact, but at or near the time within
13 the first days or weeks after Brent Olsen's work?
14 A. As far as my best recollection is the fact that we were
15 dealing with a specific problem with a baby that
16 may have been infected at that time as well.
17 Q. That's not my question, Dr. Jouvenat. The opinion
18 that you had with regard to the Labor and Delivery
19 Room nursing care that you've just expressed to us,
20 the deviations from those standards of care that you've
21 just expressed to us for the failing to call, for the
22 failing to note, et cetera, those were opinions that
23 you had formulated at or near the time of Brent's
24 birth?
25 A. Yes, but I'm saying that I didn't have that particularly

1 in mind at that time when I talked with her.

2 Q. Now, we've talked about Dr. McGuire, and we've

3 identified him as being the head of the obstetrics

4 department at Suburban Medical Center?

5 A. Yes.

6 Q. And he was the head of the obstetrics department on

7 November 11th, 1979, wasn't he?

8 A. Yes.

9 Q. And he was the person who you would direct any complai

10 to with regard to any of the care that was given of

11 any of the patients of your professional corporation?

12 A. Yes.

13 Q. Did you ever talk to Dr. McGuire, concerning the

14 deviations from appropriate standards of nursing care,

15 that you have just testifed about here today?

16 MR. HOLM: I object, your Honor. There's

17 no foundation that there's any requirement at all for

18 Dr. Jouvenat to report to Dr. McGuire with regard to

19 nursing care.

20 THE COURT: How is this relevant, Mr.

21 Johnson?

22 MR. JOHNSON: Your Honor, it's relevant

23 because the fact that we have--one of our allegations

24 here is that there was not proper control over the

25 quality of medical care given in the obstetrics unit,

1 both nursing and medical.

2 THE COURT: The objection is overruled.

3 Q. Thank you. Did you ever report your opinion after

4 doing your investigation of this matter that there

5 were deviations of appropriate standards of medical

6 care on the part of the nurses to Dr. McGuire?

7 A. No, I did not.

8 Q. Do you know who Janine Elias is?

9 A. Yes.

10 Q. Who is Janine Elias?

11 A. She's the head nurse in charge of the labor, delivery,

12 and postpartum nursing.

13 Q. So she would be the nurse who would be in sort of the

14 equivalent position of Dr. McGuire as in charge of

15 the nursing care and the nursing care that was being

16 delivered to your patients, who would be there at

17 Suburban?

18 A. Yes.

19 Q. Did you ever tell Janine Elias or ever talk to Janine

20 Elias concerning your opinions or your findings from

21 your little investigation you did concerning why

22 Brent Olsen was born so depressed and your opinion

23 that there were deviations from appropriate standards

24 of nursing care?

25 A. No, I did not. I don't recall talking with Janine

about this specifically?

Q. Did you ever talk to anyone about the review of the records that you made, your conversations with Dr. Younglove, your conversation with Linda Carter, did you ever talk to anyone at Suburban Medical Center with regard to your concerns about the deviations from appropriate standards of nursing care?

MR. HOLM: I'm going to object, your Honor. Again, I think it's irrelevant and immaterial to the issues in this case.

THE COURT: Mr. Johnson, I don't quite understand where you're going with this. What is it you're--

MR. JOHNSON: Let me rephrase the question, your Honor.

You've indicated you did not talk to Dr. McGuire who's the head of OB-gyn. You did not talk to Janine Elias. My real question is, Dr. Jouvenat, did you ever talk to anybody else at Suburban Medical Center to inform them of the results of your investigation and the fact that you felt that the nurses had deviated from the appropriate standard of nursing care?

MR. HOLM: Same objection.

THE COURT: I'm going to overrule the objection.

1 A. No, I didn't. I guess, I need to--can I go back
2 just a moment?
3 Q. If you're going to explain, I'm sure your counsel
4 will ask you those questions.
5 A. Okay, fine.
6 Q. In fact, Dr. Jouvenat, did you know the full story
7 about everything that had occurred until this lawsuit
8 was filed and during this trial?
9 A. No, I didn't know every detail, of course not.
10 MR. JOHNSON: That's all the questions we have
11 THE COURT: Cross-examination, Mr.
12 Larson.
13 CROSS EXAMINATION
14 Q. (BY MR. LARSON) Dr. Jouvenat, you'd mentioned that
15 Dr. Younglove was an employee at Hickman Mills Hospi-
16 tal, or employed by them?
17 A. Hickman Mills Clinic, Incorporated.
18 Q. I mean, clinic, yeah, okay. He was not so employed
19 at Suburban, was he?
20 A. No.
21 Q. Okay. Nor were you, nor were Dr. Tutera or your
22 corporation?
23 A. That's correct.
24 Q. You are all individual practitioners?
25 A. That's correct.

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PROFESSIONAL REGULATION AND THE STATE MEDICAL BOARDS

IN this issue, Dr. Richard Jay Feinstein, a recent former chairman of the Florida State Medical Board, discusses professional regulation and tells us how his state has reorganized its procedures to deal with the problem.* To my mind, the most noteworthy feature of his provocative essay is the table showing the rates of disciplinary actions reported by the different states.

According to the Federation of State Medical Boards, the approximate number of disciplinary actions in 1982 ranged from 0 to 7.4 per thousand licensed physicians, with the rates between those extremes varying by more than 20-fold. Whereas 17 states reported 3.0 or more actions per thousand, 15 reported 1.0 or less. Of the states with 10,000 or more licensed physicians, Florida had the highest rate (7.4) and Pennsylvania the lowest (0.5).

How are we to explain this extraordinary variation in the rates of disciplinary actions reported in different states? One obvious possibility is that the frequency of medical incompetence and malfeasance differs greatly among states, but that cannot explain more than a minor part of the variation. Small differences of this kind are conceivable, but regional 10-fold or 20-fold variations in the percentage of unqualified physicians defy belief. Some of the variation could also be artifactual, perhaps caused by differences in the completeness of reporting, in the percentages of physicians in training, and in the numbers of physicians licensed but not currently practicing. However, these confounding variables could at most account for only a small additional fraction of the heterogeneity.

It seems to me that the primary explanation must lie in the relative vigor and effectiveness of the regulatory apparatus in each state. Dr. Feinstein tells us that disciplinary actions increased threefold immediately after his state reformed the organization and operation of its regulatory boards. That must have been due to the change in procedures rather than any sudden decline in the quality of medical practice in Florida. Given the present variations among the state boards in administrative organization, legal process, and professional participation, it should not be surprising that there are such wide differences in regulatory activity.

Interstate variations of this magnitude might represent overzealous enforcement in some states and laxity in others, but that seems unlikely. Disciplinary actions are far too painful and difficult for them to be overused. They often involve loss or suspension of the license to practice — a decision that can be made only after due process, under the legal protection of the state, and with the full participation of professional peer judgment. Everything works in favor of the accused, who always has the right to appeal. Even the highest reported rates among the states are still less than 1 per cent per year, which would imply a remark-

*Feinstein RJ. The ethics of professional regulation. N Engl J Med 1985; 312:801-4.

8/15-16/85

Attachment VIII

able degree of competence and integrity for a profession that must contend with so much occupational stress and is so diverse in composition. All the evidence suggests, therefore, that most if not all the states have been too lax — not too strict — in their enforcement of medical professional standards.

The public has long been hearing reports of incompetent, unethical, or impaired physicians who somehow manage to escape disciplinary action by their peers. The evidence in Dr. Feinstein's report will lend credence to popular suspicions that the medical boards have not been dealing effectively with this problem and that some jurisdictions are more derelict than others. Experienced physicians might not have predicted such wide variations among states but will not be surprised to learn how few disciplinary actions have been taken in most places. They know, all too well, how difficult and distasteful it is to monitor and discipline one's colleagues.

The legal authority for enforcement rests with the state government, but the responsibility and practical initiative rest with the medical profession. Physicians are best qualified to evaluate professional competence, and they are in the best position to recognize deviant medical behavior when it first occurs. More important, the medical profession has an implicit contract with the state, which grants it a licensed monopoly and a considerable degree of autonomy in exchange for a commitment to serve patients and maintain its own professional standards. The latter objective requires more than positive enforcement through education, exhortation, and collegial support; it also needs policing. Few physicians relish the idea of being a policeman, and fewer still are willing to assume that role by initiating a formal complaint against an errant colleague. Yet their obligation is clear and they avoid it at risk of serious damage to the standing of their profession.

Of course, physicians cannot do the job without support from the state. State governments must do more to facilitate the regulatory efforts of the medical profession and protect conscientious whistle blowers from legal retaliation by the accused or other vested interests. The new legislation in Florida is a good example of what can be done to strengthen the functions of medical boards. In the last analysis, however, the profession itself must take the lead in reforming its disciplinary procedures, and it is here that we have not done as much as we could.

Where new legislation is needed, state medical societies should take their case to the public and to the state legislatures. Such political initiatives have the best chance of success if the public and the state legislature are fully informed and if the state societies join with other interested citizen groups in drafting proposals. The Federation of State Medical Boards has recently produced a revised guide to the essentials of a modern medical practice act, which should be helpful in this effort. Where the cooperation of practicing physicians needs to be improved, other kinds of educational and consciousness-raising programs should be undertaken. The American Medical Association has recently established a procedure to help the Federation notify all concerned state boards when a physician licensed in two or more jurisdictions loses his license in one of them. The Federation and the AMA also work with state and federal agencies to identify physicians with fraudulent credentials. These efforts should help eliminate some of the loopholes in the present system, but cannot substitute for more rigorous action at the state and local levels.

There is, in short, much that we physicians could do to assure the public that we are meeting our professional obligation to regulate ourselves. Judging from the varied past performance of our state boards, there is plenty of room for improvement.

ARNOLD S. RELMAN, M.D.

FENDING OFF THE POTASSIUM PUSHERS

OVER the past few decades the recommendations of many therapeutic enthusiasts have remained the same — namely, to prevent hypokalemia in diuretic-treated hypertensive patients by administering either potassium supplements or potassium-sparing agents. The putative rationale for this approach, however, has changed dramatically. Treatment was recommended initially simply because potassium deficiency was considered unhealthy, later because it might induce carbohydrate intolerance and hypercholesterolemia, and a few years ago because it might produce malignant arrhythmias in hypertensive patients, particularly those who sustained an acute myocardial infarction.[1] Though cogent arguments have been adduced against these concerns,[2,3] and though serious questions have been raised about whether the net cost of therapy exceeds the net benefit, some still recommend potassium therapy fervently.[4] Mountains of potassium are still prescribed and consumed at enormous expense.[3]

In the past few years, proponents of potassium therapy have developed a new rationale — namely, that potassium has hypotensive properties. Recommendations that potassium might be used as specific therapy for hypertension have already appeared.[5] Two decades ago, when the only oral forms of potassium therapy available were liquid salts or coated tablets, the prospect of widespread treatment of hypertensive patients with potassium might have been viewed with little concern: the liquid preparations were so poorly tolerated that most patients refused to take them; the tablets were so insoluble that little of the electrolyte was absorbed. Today, however, the wax matrix and microencapsulated forms on the market are well tolerated and more or less completely absorbed; the potassium-sparing drugs represent another potent therapeutic approach. The fact that all these treatments can raise serum potassium concentrations, sometimes to levels above normal, raises the concern that blanket use of potassium might be proposed as a standard practice for hypertensive patients. This prospect de-

PLASTIC SURGERY

A course entitled "Eighth Annual Practical Plastic Surgery for Practitioners" will be held in Tapatio Springs in Boerne, Tex., April 17–20. The fee is $275.

Contact Medical School Continuing Education Services, The University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Dr., San Antonio, TX 78284; or call (512) 691-6295.

SUICIDE

The American Association of Suicidology will hold its 18th annual meeting entitled "Suicide — A Critical Perspective" at the Sheraton Centre in Toronto, April 18–21.

Contact Julie Perlman, American Association of Suicidology, 2459 S. Ash, Denver, CO 80222; or call (303) 692-0985.

COCAINE SYMPOSIUM

The University of Wisconsin-Extension, the Wisconsin Institute on Drug Abuse, and the National Institute on Drug Abuse will sponsor a program entitled "Cocaine: A Symposium" at the Marriott Hotel in Milwaukee, April 17–19.

Contact Sarah Z. Aslakson, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705; or call (608) 263-2856.

UNIVERSITY OF PENNSYLVANIA

The University's Department of Anesthesia will sponsor a conference entitled "Start Up and Management of a Day Surgery Unit: Anesthesia, Nursing and Administrative Considerations" in Philadelphia, April 19–21.

Contact Dr. John H. Lecky, Hospital of the University of Pennsylvania, 3400 Spruce St., Philadelphia, PA 19104; or call (215) 662-3733.

CALL FOR ABSTRACTS

Abstracts are now being accepted for the European Society of Pneumology's Fourth Congress, entitled "Bronchitis and Emphysema," to be held in Milan and Stresa, Italy, September 23–28. The deadline for receipt of abstracts is April 20.

Contact Dr. Rosaria Marmo, Masson Italia Congressi, Via Baldissera, 4-20129, Milan, Italy; or call (02) 228404.

ECHOCARDIOGRAPHY

Yale University School of Medicine will hold a conference entitled "The Clinical Value of Echocardiography in the Adult, State of the Art Symposium" in New Haven, Conn., April 15 and 16. The fee is $150.

Contact the Office of Graduate and Continuing Education, Yale University School of Medicine, 333 Cedar St., P.O. Box 3333, New Haven, CT 06510; or call (203) 785-4578:

ONCOLOGY CONFERENCE

The Alta Bates Hospital will hold a conference entitled "Frontiers in Oncology: for Oncologists and Primary Care Physicians" at the Hospital in Berkeley, Calif. on April 20. The fee is $75.

Contact Alta Bates Medical Education Dept., 3001 Colby St., Berkeley, CA 94705; or call (415) 540-1420.

INTERNATIONAL CLINICAL HYPERTHERMIA SOCIETY

The Society will hold its sixth annual meeting on Kiwah Island in Charleston, S.C., April 21–26.

Contact Dr. Harry LeVeen, Medical University of South Carolina, 171 Ashley Ave., Charleston, SC 29425; or call (317) 264-2524.

ANESTHESIOLOGY

The Dartmouth–Hitchcock Medical Center and the Neurological Institute-University of Munich will sponsor a symposium entitled "Cancer Analgesia with Intraspinal Narcotics" at the University of Munich, Germany, April 24–28. The fee is $80.

Contact Dr. Dennis Coombs, Dartmouth-Hitchcock Medical Ctr., Hanover, NH 03755; or call (603) 646-5922.

SPECIAL REPORT

THE ETHICS OF PROFESSIONAL REGULATION

CHAPTER 458 of the Florida Statutes (The Medical Practice Act) begins: "The Legislature recognizes that the practice of medicine is potentially dangerous to the public if conducted by unsafe and incompetent practitioners. The Legislature further finds that it is difficult for the public to make an informed choice when selecting a physician and that the consequence of a wrong decision could seriously harm the public health and safety. The sole legislative purpose of enacting this chapter is to ensure that every physician practicing in this state meets minimum requirements for safe practice. It is the legislative intent that physicians who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in this state."

Most states have medical-practice laws with similar preambles. Intertwined in the regulation of the medical profession by states are two purposes that have not always been compatible. The ethical conflict in professional regulation involves the rights of the profession as opposed to the rights of the government and its citizens. The profession seeks to maintain its integrity and independence from bureaucratic control, and the state seeks to protect its citizens from incompetent practitioners and from monopolistic behavior, such as the exclusion of new practitioners and the control of fees.

According to sociologist Elliot Freidson,* members of professions make three claims that distinguish them from other types of workers. First of all, they claim to possess such an unusual degree of skill and knowledge that nonprofessionals are not equipped to evaluate or regulate the members of the profession. Secondly, they claim that the professional is responsible and can be trusted to work conscientiously without the supervision that is necessary for other types of workers. Thirdly, they claim that on the rare occasion when a member is found to be incompetent or unethical, the profession itself can take proper regulatory and disciplinary action, without outside interference.

Professions have been likened to the medieval guilds from which they evolved. Their members generally believe that the professions are doing an excellent job of maintaining high standards and regulating their members. Professions change slowly because they tend to perpetuate the status quo.

The public once believed Freidson's definition and allowed the profession to follow the rule he described. Few members of the public did possess enough education and skill to challenge the integrity of the profession, and the regulation of members was carried out in

*Freidson E. Profession of medicine: a study of the sociology of applied knowledge. New York: Dodd, Mead, 1970:170.

private, creating the appearance of a conspiracy of silence.

Over the past quarter century, however, it has become increasingly evident that society wishes to change its definition of professionals, especially as that definition relates to physicians. Public opinion has changed for a variety of reasons, including the increasingly common belief that physicians, far from being divine, are not basically different from other people. The press has been quick to report the many cases of physician incompetence and the allegations of conspiracy that were made when the profession was allowed to regulate itself in secrecy.

It should be evident to all observers that the medical profession can no longer live up to its own definition of a profession, as interpreted by Freidson. First of all, physicians no longer possess such unique knowledge and skill that only other physicians are capable of judging their work and competence. Many other health-care workers, including nurses and technicians, have achieved high levels of sophistication in specialized areas of medical practice. The general public itself is more educated and sophisticated and can often tell when a physician is guilty of medical incompetence or fraud.

The second claim, that professionals can work unsupervised, has been impugned by the many documented instances of medical incompetence. There have been estimates that as many as 5 to 15 per cent of doctors are not fully competent to practice medicine, either from a deficiency of medical skills or because of impairment from drugs, alcohol, or mental illness.

The third claim, that the profession can be trusted to discipline members on the rare occasions when misconduct has occurred, is also no longer acceptable to society. Numerous examples of attempts to cover up professional misconduct have been documented by the media.

Professional regulatory boards were developed as a mechanism for meeting society's need to have professional groups licensed and disciplined, in order to protect its citizens from harm. The state governments, beginning with Virginia in 1639, took on the power of licensing authority and with it the responsibility of policing those who were licensed. As in the case of other licenses, states resisted federal intervention in the process.

For many years, state professional boards were controlled to a great extent by the professional medical association of the state, which offered names to the governor when there were vacancies on the board. This "old-school-tie" system continued as the mechanism of professional regulation under the guise of state control. Executive directors of medical boards and state board chairmen were virtual lords, completely controlling the granting of medical licenses and the imposition of medical discipline. Individual physician members of the boards also wielded great authority in determining who would get a medical license and who would be charged with a statutory violation.

In Florida, a period of drastic change began in 1979. The *Miami Herald* had published a series of articles that documented the fact that doctors who had harmed patients and who had violated the law had continued to practice because the state medical board had been unable or unwilling to perform its disciplinary role effectively.

At the same time, Florida's Medical Practice Act was terminated under the provisos of the state's "sunset law," which terminates all state regulatory boards and their governing legislation on a periodic basis, usually about every five to six years.

A new governor was elected in Florida at the same time, and he used the opportunity offered by the passing of a new medical-practice act and the public demand for change to appoint all new board members. I was appointed then as one of the nine physician members of the board.

The legislature completely revamped the regulatory process by empowering the Department of Professional Regulation (DPR) to oversee the licensing and discipline of 27 different regulatory boards and their 750,000 licensees, including physicians. The secretary of the DPR is a member of the governor's cabinet.

Under the old system, the medical board had great autonomy and power. Board members and their staff handled all complaints filed against medical licensees and initiated an investigation when it was deemed appropriate. Board members then decided whether probable cause existed, and a member also served as the hearing officer in the disciplinary trial of the accused licensee. The full board itself, with one public member, ultimately determined findings of fact, conclusions of law, and an appropriate penalty on the basis of the hearing officer's recommendation at the trial.

There were charges that individual board members had too much authority in cases involving violations of the medical-practice act, often serving as the investigator, hearing officer, and final judge. Individual physicians who seemed to have been guilty of gross statutory violations were acquitted of all charges and allowed to practice without restraint or any requirement that they improve their competence.

Under the present system, the individual professional boards, including the medical board, share the responsibility for licensing and discipline with the DPR. DPR complaint analysts receive and analyze all telephoned or posted complaints, and together with a prosecuting attorney, who is employed by the state as an assistant attorney general, determine whether the complaint has merit and is worthy of an investigation.

The investigation is handled by DPR investigators who are assigned to medical-board activities. The investigative file is then presented to the Probable Cause Panel, which is composed of physician members of the medical board, and they analyze the case with a DPR

attorney. If probable cause is found, DPR issues an administrative complaint against the respondent, who is provided with an election-of-rights form on which he or she can admit guilt, seek out a full disciplinary hearing, or seek to plead his or her case directly before the medical board without having a disciplinary hearing before a hearing officer. Due process is best served by the hearing process.

The hearing officer is employed by the Division of Administrative Hearings of the state's separate Department of Administration, and is an attorney and a judge. The respondent is entitled to be represented by counsel, and the state is represented by a prosecuting attorney from the attorney general's staff who handles only medical matters.

The hearing officer issues his findings of fact, conclusions of law, and a recommended penalty on the basis of his interpretation of the testimony of witnesses and other evidence presented at the hearing. The documents from the hearing are then presented to the 11 members of the medical board, who review the file and interview the respondent at a public meeting of the board. These meetings are scheduled six times a year and last three days each. The board may not alter the hearing officer's findings of fact, since board members were not present at the hearing to observe and cross-examine witnesses. The board may, however, differ with the hearing officer's conclusions of law and recommended penalty. This occurs quite often because the hearing officer, who is an attorney, may not perceive the statutory violations in the same manner as do the physician members of the board, or even the public members. A licensee who is unhappy with the board's decision in a disciplinary action against him or her may seek relief from the District Court of Appeals. The court may issue a stay of the board's final order pending a full appellate review.

The board is statutorily composed of nine physicians and two public members, and they represent a cross-section of Florida's multiethnic population, from both rural and urban areas. Members serve for four years and may serve an additional four if they are reappointed by the governor.

Under the "sunshine law," Florida's government is required to give public notice of all its activities and to carry them out in public view. Some states do not have sunshine laws, whereas others, like Colorado, exempt the activities of medical disciplinary boards from the rules. All medical-board meetings in Florida and all subcommittee meetings, including those of the Probable-Cause Panel, are open to the public and press. Board members are forbidden by law to discuss state business in private with other board members, and they may not meet at any time in any official capacity without proper notice to the public.

The state's DPR and the professional members of the board share responsibility for the system. The rights of the profession are protected to a great degree by the nine physicians, whereas the rights of the citizens are protected by ensuring that no conspiracy of professionals seeks only to protect its members.

If a complaint is determined to be frivolous and without merit, it will be dismissed before it is made public. If probable cause is found for a justified complaint, an administrative complaint is issued within 10 days and made known to the press and public. A physician licensee is therefore spared the public condemnation and notoriety that may result from a frivolous complaint, but his or her misdeeds are publicized if a statutory violation has truly occurred.

The presence of 9 physicians on the 11-member board guarantees that misconduct by physicians can be properly evaluated by colleagues who understand the stresses of practicing medicine in our state. The profession is responsible for its own discipline and may set guidelines for the level of professional competence and morality required of physicians in the state. High standards can be maintained by strict enforcement of the statutes and by putting dishonest and incompetent practitioners on notice that inferior medical care will not be tolerated.

According to the Federation of State Medical Boards, Florida carried out 147 disciplinary actions against physician licensees in 1982 (Table 1). Since reorganization in 1979-1980, the board has revoked the licenses of 58 physicians, suspended those of 46 more, and accepted the relinquishment of another 51. This represents a threefold increase in the number of disciplinary actions as compared with the four-year period before 1979.

In the same year, California disciplined 144 physicians at a time when over 50,000 licensed physicians practiced in that state. New York, with over 40,000 licensed physicians, disciplined only 51. Five states did not discipline a single physician in 1982 (Table 1). These data refer to actions reported to the Federation and may have minor inaccuracies due to deficiencies in reporting.

It would be naive to suggest that the relative number of physicians disciplined by a state regulatory board should be the sole indicator of the effectiveness of the disciplinary system in maintaining high professional standards. However, few other objective criteria can be used. It is difficult to believe that in any given year any state or territory would not have at least one physician per thousand who posed a threat to the health and safety of its citizens, and yet in 1982, 14 states reported less than that number of disciplinary actions. Has the balance of interests in these states tipped too far in the direction of protecting the profession to the detriment of its citizens? Almost everyone will concede that physicians are not saints, are capable of error, can be evaluated to some degree by nonphysicians, and have been guilty, at times, of trying to cover up the misdeeds of their colleagues or themselves. The only way to deal with these facts is to do the best possible job of protecting the profession, while at the same time protecting the public from dangerous doc-

tors. The overwhelming majority of physicians are competent and honest professionals. By identifying and disciplining the few who are not, we meet our public and professional responsibilities.

State medical boards must share responsibility for medical licensing and discipline with agencies of their state governments. All states and territories currently have medical regulatory boards that are state financed and mandated by state law. Medical disciplinary meetings should be held in public view to dispel myths about cover-up. Public members should continue to serve on boards to offer a nonphysician's perspective on the disciplinary process and to allay public anxiety.

Table 1. Disciplinary Actions Taken against Medical Doctors in 1982.*

State	No. Licensed M.D.s (in State)	No. Disciplined per 1000 M.D.s
Florida	20,100	7.4
Arizona	5,000	7.0
Nebraska	2,500	6.8
Mississippi	3,000	6.0
South Dakota	842	5.9
Iowa	4,000	5.5
Wyoming	663	4.5
South Carolina	4,500	4.4
Georgia	7,500	3.3
New Mexico	2,400	3.3
Idaho	1,200	3.3
New Jersey	22,000	3.1
Kansas	2,957	3.1
Louisiana	6,500	3.1
Missouri	9,000	3.0
Oklahoma	4,000	3.0
Utah	2,000	3.0
Wisconsin	8,500	2.9
West Virginia	3,500	2.9
California	51,000	2.8
Minnesota	7,000	2.6
Maine	1,900	2.6
Alaska	411	2.4
Indiana	6,000	2.3
Nevada	1,300	2.3
Maryland	11,000	2.0
Michigan	14,500	1.9
Virginia	10,000	1.9
Oregon	5,270	1.9
Colorado	6,500	1.8
Alabama	4,880	1.8
Hawaii	1,900	1.6
Tennessee	7,000	1.4
Illinois	20,000	1.2
Washington	7,850	1.2
New York	45,000	1.1
Kentucky	5,250	1.1
Montana	1,000	1.0
Texas	24,500	0.9
Ohio	19,000	0.9
Vermont	1,160	0.9
North Carolina	8,800	0.8
Massachusetts	17,500	0.7
New Hampshire	1,546	0.6
Rhode Island	1,782	0.6
Pennsylvania	30,000	0.5
Connecticut	6,500	0.3
Arkansas	3,100	0.0
Delaware	752	0.0
District of Columbia	3,500	0.0
North Dakota	939	0.0
Puerto Rico	4,057	0.0

*Source: Federation of State Medical Boards. Data represent the number of reported actions and are only approximations because reporting may be incomplete in some states.

These boards, however, must continue to include a majority of physicians, who can better understand the doctor's position. They can empathize with sick colleagues, and they can mete out strict discipline to incompetent and dishonest physicians when it is appropriate. The single overriding goal of state medical boards must continue to be the protection of the public from incompetent and unethical doctors. A second goal, and one of increasing importance in the past decade, is the rehabilitation of the impaired physician.

State medical boards can serve as the arbiters of medical practice in their states by defining minimally acceptable levels of conduct and practice. In so doing, they must adhere strictly to the statutes that govern the practice of medicine in their state.

Florida, California, and many other states periodically publish newsletters that are distributed to all physician licensees, hospitals, county medical societies, and other interested parties. In Florida, the newsletter is used to educate physicians about the medical laws of the state so that ignorance of the law will not lead to statutory violations. The newsletter, published four times a year, also lists the names and addresses of doctors who have been found guilty of breaking the law and have been disciplined by the medical board. The newsletter has been well received and has served as an invaluable asset in identifying physicians who may have to be more closely watched by hospitals, colleagues, and patients.

We realize that some physicians who have lost their medical licenses in Florida, because of revocation, suspension, or voluntary relinquishment in the face of impending discipline, will travel to other states in which they still possess a valid medical license. They may practice there until the new state is notified of their administrative difficulties in Florida and chooses to initiate an investigation. The board in Florida attempts to find out in which other states a physician is licensed to practice medicine and notifies those states of its action by mailing a copy of the board's final order. Reports of all disciplinary actions are also sent to the Federation of State Medical Boards, which has the responsibility of notifying all other states and territories. Each state will usually look into the reason that a physician was disciplined in another state and act appropriately.

Most states use similar applications for a medical license to be granted on the basis of an examination given in another jurisdiction. These applications contain questions about prior disciplinary actions in other states, and an affirmative response is always investigated before a license is granted.

3361 S. Miami Ave.
Miami, FL 33133

Richard Jay Feinstein, M.D.

It is also possibly a valid criticism that we should have used as controls a larger number of IgM monoclonal antibodies directed against other antigens. We have therefore added to the controls described in the paper four IgM monoclonal antibodies raised against human myelin and six against cardiac myosin, and the observation still holds.

Another concern implied by Drs. Smith and Hammarström, although not explicitly stated, is that the epitopes recognized by BK57 and 77F may be ubiquitous, and therefore the fact that they are shared by the acetylcholine receptor and the bacteria may be of little specific importance. We have looked at the binding, on immunoblots, of BK57 and 77F to electrophoretically treated proteins from homogenates of liver, spleen, kidney, testis, thyroid, brain, peripheral nerve, retina, and aorta; the bacterial proteins and the α-subunit of the acetylcholine receptor remain the only proteins to which we can demonstrate binding of these antibodies. Hence, the sharing of these two epitopes by the acetylcholine receptor and the bacteria appears to be specific.

In response to Dr. Dwyer, in the paper we state unequivocally that we used both torpedo acetylcholine receptor and acetylcholine receptor isolated from denervated rat skeletal muscle. Therefore, the rat anti-receptor monoclonal antibodies are "true autoantibodies." The paper by Gomez et al., to which Dr. Dwyer refers when he says that "they" had shown that 77F does not bind to muscle acetylcholine receptor, does indeed describe the binding of 77F to acetylcholine receptor on frog skeletal muscle and does not contain a description of an unsuccessful attempt to show binding to rat acetylcholine receptor. The paper under discussion here describes successful attempts to demonstrate the binding of these monoclonal antibodies to rat acetylcholine receptor. It is true that preliminary attempts to induce experimental myasthenia in rats with monoclonal antibodies BK57 and 77F were unsuccessful. However, these attempts were made not with purified antibodies but with culture supernatants from hybridomas containing unspecified amounts of immunoglobulins and can in no way be considered conclusive. It is also possible that even though BK57 and 77F may not induce myasthenia in rats, IgG antibodies directed against the epitopes recognized by these monoclonal antibodies would do so. More definitive studies of the pathogenic potential of monoclonal antibodies BK57 and 77F are under way. In brief, the paper under discussion describes the sharing of epitopes by some bacterial proteins, on the one hand, and acetylcholine receptor from both *Torpedo californica* and denervated rat skeletal muscle, on the other.

Kari Stefansson, M.D., Michael E. Dieperink, B.S.,
Christopher M. Gomez, M.D., Ph.D., David P. Richman, M.D.,
and Linda S. Marton, Ph.D.
Chicago, IL 60637 University of Chicago

THE ETHICS OF PROFESSIONAL REGULATION BY THE STATE BOARDS

To the Editor: In his report on professional regulation (March 21 issue),* Dr. Feinstein indicates that the Florida State Board of Medical Examiners took 147 disciplinary actions against licensed physicians in 1982. Before the readers of the *Journal* conclude that physician incompetence is being rooted out in Florida, Dr. Feinstein should offer them an analysis of the offenses that led to those instances of disciplinary action. I believe that such an analysis will document the courage of the Florida State Board of Medical Examiners in dealing with physicians impaired by alcohol and drug abuse, violators of prescription laws, and convicted felons. What do these figures tell us about the effectiveness of the board in dealing with professional incompetence? I do not think that we should congratulate ourselves on our success in protecting the public from "unsafe and incompetent practitioners" until we have frankly confronted the nettlesome problem of the incompetent physician.

Luther A. Youngs, III, M.D.
Lakeland, FL 33805 Lakeland Regional Medical Center

*Feinstein RJ. The ethics of professional regulation. N Engl J Med 1985; 312:801-4.

To the Editor: The Special Report on the ethics of professional regulation, by Feinstein,[1] and your editorial on professional regulation and the state medical boards[2] indicate that there is room for improvement if the public is to be assured that licensed physicians meet minimal requirements for safe practice. Few programs are actually in place to carry out this mandate systematically.

In 1981 the College of Physicians and Surgeons of Ontario established a peer-assessment program, which annually assesses 200 randomly identified physicians' office practices. In the first two years serious deficiencies were found in the medical records of, or the care provided by, 12 per cent of general/family physicians and 2 per cent of specialists, accounting for 8 per cent of the practices studied.[3] Thirty-five per cent of the physicians assessed and 88 per cent of the assessors indicated their willingness to participate as future assessors. Sixty-nine per cent of the physicians assessed found the experience of value. The third and fourth years of the program have revealed similar findings. To date, 787 physicians' office practices in Ontario have been assessed by practicing peers in 11 specialty fields and in general/family practice. Fifty per cent of the physicians with serious deficiencies had corrected their deficiencies when reassessed one year later. The cost of the 1984 program was $200,000 (U.S.). The average cost for each assessment was $556 (U.S.).

Our experience has demonstrated the need for, the feasibility of, and the acceptance of a peer-assessment program. State medical boards should consider similar programs to determine whether physicians practicing in their jurisdictions meet minimal requirements for safe practice.

R.G. McAuley, M.D., C.C.F.P.
Hamilton, Ontario L8L 2X2, Canada McMaster University
Hamilton General Hospital

1. Feinstein RJ. The ethics of professional regulation. N Engl J Med 1985; 312:801-4.
2. Relman AS. Professional regulation and the state medical boards. N Engl J Med 1985; 312:784-5.
3. McAuley RG, Henderson HW. Results of the peer assessment program of the College of Physicians and Surgeons of Ontario. Can Med Assoc J 1984; 131:557-61.

To the Editor: The performance of state medical licensing boards depends in large part on their resources. Missing from Dr. Feinstein's article is a comparison of the budget provided the Florida State Medical Board before and after the passage of the Florida Medical Practice Act in 1979, and especially in 1982, the year featured in Table 1 ("Disciplinary Actions Taken against Medical Doctors"). The budget for the Massachusetts Board of Registration in Medicine in 1982 was $22.00 per licensed physician; the licensing fee was $50.00! We appreciated a slight increase in 1984 and anticipate a substantial increase in 1985, which will permit expanded activity.

Leonard Morse, M.D.
Commonwealth of Massachusetts
Boston, MA 02202 Board of Registration in Medicine

The above letters were referred to Dr. Feinstein, who offers the following reply:

To the Editor: Although I am pleased that Florida was one of the most efficient states in maintaining professional discipline during 1982, it was not my intention to flaunt the data provided by the Federation of State Medical Boards. Florida, in fact, disciplined only 7.4 physicians per 1000 in the state, although it is believed that between 5 and 15 per cent of practicing physicians may be unable to practice with skill and safety. Our definition of a "disciplinary action" includes any penalty imposed on respondents, from revocation to reprimand. Other states may use different definitions, which could make them appear to be in a less favorable position. The federation is making plans to standardize reporting.

The intention of my article was to demonstrate that physicians, as

volunteers on state medical boards, can have a substantial impact on the practice of medicine and the health of patients in their state. State governments are often slow, inefficient, and relatively unresponsive to requests for increased funding and other kinds of assistance, even from legislatively mandated regulatory boards, and physician members must be intent on doing a good job despite such limitations.

Dr. Youngs is correct in asserting that most censored physicians in Florida are impaired or "prescription doctors" or convicted felons. We can only investigate and prosecute violators who have first been reported to us. Few acts of pure medical incompetence are reported for disciplinary action, and such acts are difficult to prove at a hearing. Perhaps the unwillingness of physicians to report incompetent colleagues, despite the presence of a "snitch law" in Florida, contributes to the fact that a relatively small number of physicians are charged with incompetence. Legislation was recently enacted that requires physicians who have lost or settled three malpractice suits of $10,000 or more within a five-year period to be reported for investigation, but there is some doubt whether defendants in malpractice suits are necessarily incompetent.

Dr. McAuley's project, which performs random audits of physicians' practices, is excellent, but I believe it is too expensive and time-consuming for a state regulatory board to perform. Although 88 per cent of Ontario physicians cooperated when invited to do so, I believe that U.S. physicians would be less willing to cooperate with a disciplinary board, considered to be a police arm of the state, and many doctors would refuse or consult their lawyers before answering any such inquiry.

Dr. Morse's concerns about funding are paramount in any discussion of regulatory boards, which are completely beholden to the state for the authority to obtain and use funds. Our board spent $667,000 for fiscal year 1978-1979, before reorganization, and $2.2 million for fiscal year 1983-1984 — a threefold increase. The latter figure represents $61 for each of our 36,000 licensees, or $104 for each in-state physician. Revenues come from biennial license renewal fees, which were $20 in 1978-1979 and $100 in 1983-1984, as well as from fines, examination and endorsement fees, and interest earned by the medical-license trust fund. Spending authority must be sought each year from the legislature.

RICHARD J. FEINSTEIN, M.D.
Miami, FL 33133 3661 South Miami Ave.

To the Editor: In your otherwise laudable editorial,* you make a statement that surprises me, and with which I must disagree: "Everything works in favor of the accused. . . ."

A little thought should make it apparent that when an individual goes up against an institution, particularly a government institution, everything is not in his or her favor. On the contrary, there will often be a monumentally destructive disruption of that person's entire life, whether deserved or not.

HARVEY E. FINKEL, M.D.
Dorchester, MA 02124 Oncology and Hematology Associates

*Relman AS. Professional regulation and the state medical boards. N Engl J Med 1985; 312:784-5.

To the Editor: The Oregon State Board of Medical Examiners wishes to express its appreciation for your editorial. The Oregon board also thought that Dr. Feinstein's article was quite good.

Unfortunately, the statistics you used for the state of Oregon were totally incorrect. For the year 1982, the Oregon board took 63 disciplinary actions, or a rate of 12.0 per 1000, putting the board 4.6 per 1000 higher than Florida and making it the leader in disciplinary actions in the nation. Dr. Feinstein's article, however, listed Oregon as 29th in the nation, which does the board a great disservice, since these inaccurate statistics may be used by others. The Oregon board is probably the most assertive in the country regarding disciplinary actions.

How did such a discrepancy in our statistics as opposed to yours occur? I am not sure, because Oregon has worked hard to report all disciplinary actions to the Federation of State Medical boards and has done so on a regular and timely basis for years. Perhaps it was the federation's computer, which was just being installed in 1982. I am pleased to report that the computer is now up and running and is providing very sophisticated, and much more reliable, information on disciplinary actions.

It is unfortunate that two excellent reports had to be marred by such inaccurate data regarding the Oregon Board of Medical Examiners. Nevertheless, the board appreciates the *Journal's* interest in this important subject.

JOHN J. ULWELLING
Portland, OR 97204-2584 Board of Medical Examiners

To the Editor: It would be impossible for the Federation of State Medical Boards to have provided Dr. Feinstein with an accurate assessment of the number of disciplinary actions taken against medical doctors in Alabama in 1982, because the Alabama State Board of Medical Examiners did not begin reporting until the middle of the year. Furthermore, the Alabama board reports only revocations, suspensions, or restrictions dealing either with the physician's Controlled Substances Certificate or license to practice medicine. Alabama and many other states do not use letters of censure, letters of reprimand or admonishment, or other such disciplinary procedures. Therefore, it would be very hard to compare a state that systematically sends out letters of reprimand or censure, and correctly refers to them as disciplinary actions in their reporting, with a state that only restricts, suspends, or revokes licenses.

Alabama's board also takes issue with the basic premise in your editorial that professional regulatory boards are still reluctant to discipline the profession. On behalf of the Alabama Board of Medical Examiners, I can only tell you that we spend a considerable amount of time investigating, discussing, and correcting disciplinary and licensure problems.

I hope you will lend your editorial voice to the Federation of State Medical Boards' national effort to convince all regulatory boards to report the same actions using the same computer codes, so that an accurate assessment of disciplinary actions can be made.

W. EARLE RILEY, M.D.
Alabama State Board of
Montgomery, AL 36102-0946 Medical Examiners

Editor's Reply: Dr. Finkel has a point. Physicians brought before a state board for disciplinary actions often do experience "a monumentally destructive disruption" of life. But that doesn't alter the fact that the proceedings are likely to give accused physicians every opportunity to clear the charges against them. They can also launch legal counteraction, which has a powerful dampening effect on the zeal of would-be accusers and judges.

I am glad to have the correction of the data from the Oregon Board of Medical Examiners and the clarification by the Alabama State Board of Medical Examiners of their reporting procedure. No doubt, variations in reporting procedures account for some of the interstate variation in the rate of disciplinary actions reported in Dr. Feinstein's article. However, the data provide convincing evidence that the boards are uneven in their performance.

Many states will need to strengthen the staffing and support of their boards. The Federation of State Medical Boards should ensure that the reporting system will be reliable in the future and should make annual statistical reports available to its constituents and the public. Our profession cannot expect to earn the continued trust of the public unless we improve the effectiveness of the disciplinary boards. To do this we will need the help of state governments and determined cooperation among all the members of the Federation.

ARNOLD S. RELMAN, M.D.

DEFENSE OF HEALTH CARE STABLIIZATION FUND

1. Require statutory procedures for assigning adequate defense.
2. Fund to be managed by experienced claims manager vs attorney.
3. Limit coverage by the Fund to one million dollars, or some other limit.

INSURANCE

1. Pricing of Insurance.
   a. Establish zones by geographic area that affect surtax on health care stabilization fund.
   b. Establish "variable" rate for surtax based upon frequency of type of medical operation.
   c. Rating of physicians by experience and claims made against physician.

2. Payment of Insurance Premium:
   a. Impose surtax on persons entering hospitals; impose a per day surcharge to be paid to a Health Care Stabilization Fund.
   b. Allow doctors to pass costs on through to patients i.e. health care coverage.
      --loosen DRG restraints--

REDUCE INCIDENCE OF NEGLIGENCE

1. Specify by statute the amount of time devoted to peer review by physician/by hospital.
2. Adopt recommendations of post audit regarding reporting of incidents to Board of Healing Arts.
3. Increase hospital's exemption from anti-trust to allow greater flexibility to control the level of care practiced in that hospital.
4. Risk management

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TORT REFORM

1. Screening panel's finding admissable in court (Indiana Plan).

2. Limit on amount of recovery
   a. Total limit on recovery
   b. Limit on pain and suffering and other non-permanent loss. (presumptive limits)
   c. Require structured settlements.
   d. Require all future medical, future income, be left "open" and modifiable by court on a periodic basis.

3. Settlement conference -- Panel of Judges/Attorneys who serve.

4. Attorney fees
   --statutory limit on fees i.e. schedule of contingent fee per coverages.
   --Require evidenciary hearing which both plaintiff and defendant's attorney must show fees "reasonable" regardless of the terms of contract; i.e. do they conform to ethical standards.

5. Change PIK instruction on "standard of care".

6. Require jury verdicts to itemize amount of award.

7. Modify standard for court to utilize remitter.

8. Certification of availability of expert opinion when petition filed.

KANSAS BAR
ASSOCIATION

1200 Harrison
P.O. Box 1037
Topeka, Kansas 66601
(913) 234-5696

Presentation to the
Special Committee on Medical Malpractice
of the Kansas Legislature

August 16, 1985

Mr. Chairman. Members of the Special Committee on Medical Malpractice. I am Ron Smith, Legislative Counsel for the Kansas Bar Association. KBA is grateful for the opportunity to present this material to help the Special Committee in its deliberations concerning the concept of tort reform.

KBA attorneys represent both plaintiffs and defendants in medical negligence actions. But medical negligence actions involve a very small number of attorneys statewide, for either the plaintiff or the defense.

All attorneys, however, have a healthy respect for how our tort system has evolved. I know many disagree as to the value of our system. But we know from trial and error over the centuries that while there are many other systems, there are none better than our adversarial tort system.

We believe two concepts are fundamental to your deliberations:

1. If changes in the adversarial tort law system are needed in order to affect a solution to the medical malpractice premium problems, the changes -- to be fair -- must be planned, orderly and progressive change, not regressive change. The resulting system must still fully compensate and continue to deter negligent behavior. If you do otherwise, you will do irreparable legislative damage to the entire system. This is a very long way of saying what Judge Kelly put very eloquently yesterday: if the system ain't broke, don't fix it.

2. You must not forget past legislative changes and their impact on the future. The legislature has not been insensitive to the plight of health care providers. Since 1976, look what you've done for them:

(a) You've reduced statutes of limitation. No other profession has been granted this reduced statute of limitation.

(b) You created a Health Care Stabilization Fund to help pay the large awards. For the first few years, you pledged the full faith and currency of the Kansas general fund towards the solvency of that Fund. No other profession has benefit of such a fund.

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(c) You expanded the powers of the Board of Healing arts, and beefed up their personnel. You created a Board of Governors of the Health Care Stabilization Fund, made up primarily of physicians, to help physicians implement their often-quoted request to "heal themselves."

(d) You allow physicians, through their attorneys, the right to have a judge review the reasonableness of contingent fee contracts between a plaintiff and the plaintiff's lawyer. You heard yesterday that apparently the judges are not reviewing those fees. However, defense counsel or the physicians are not requesting the review, either! No other Kansas common law personal injury defendant is allowed that privilege.

(e) This year, you limited a physician's exposure to punitive damages. No other Kansas common law personal injury defendant is allowed that privilege.

(f) You now require a plaintiff whose physician or hospital was grossly negligent in his treatment to contribute half of what a jury might award in punitive damages to a fund which directly benefits the pocketbook interest of every health care provider in Kansas-- even the grossly negligent physician.

(g) You've capped punitive damages to be paid by grossly negligent health care providers to 25% of gross income. In the case of large, Fortune 500 for-profit hospital corporations, the cap is $3 million. No other Kansas common law personal injury defendants -- individual or corporations -- are allowed a cap on their punitive damages.

(h) In medical malpractice actions only, you allow the jury to hear evidence of collateral sources of reimbursement of the plaintiff's expenses or injuries. The effect of this law is that if the negligence of a surgeon causes additional corrective surgery by another physician, that additional cost is borne by society's general health insurance premiums, and, if the first surgeon is sued, even if found liable, he will not have to pay for this additional surgery. No other Kansas common law personal injury defendant is granted this monumental change in our law.

Now, less than two months after the most recent of these changes, the Kansas Medical Society has announced publicly and to this committee it intends to seek further caps on awards, and evidentiary changes in the law. We are gathered here today to discuss what else we can do to change the system to be even more fair to our health care providers and those that insure them.

KBA's Position on Tort Reform

KBA members have a straightforward position on tort reform. We believe it constitutes a springboard for your thoughts:

"The tort system should be preserved unless proponents of change can provide clear evidence of a public need for change, and that such change will provide clear public benefits."

Constructive Change

I do have some thoughts that I hope you'll find constructive to helping physicians reduce malpractice premiums.

Some advocate caps on awards. That doesn't reform our system; it merely limits the ability of the tort system to fully compensate some of those who come to the system seeking justice.

You've heard much discussion last month about the Indiana Plan. This involves caps on awards, caps on pain and suffering, and mandatory use of screening panels, etc. would just like to point out to you what many of you already suspect. The Indiana plan is a radical approach to finding a solution to the problem. It is what legislators like to call a "meat cleaver approach." Since it is appropriate to the issue being discussed, KBA prefers you please use a "scalpel."

With regard to the quality of medicine, limitations on the tort system cannot substitute for good risk management in hospitals, good peer review, good management of illness or injury, or sound medical judgment.

I have some ideas for you today. Some of these ideas are part of KBA's current Legislative Policy statements. Some are offered solely for your discussion. Those upon which KBA has no position at this time are scheduled for discussion at our late September midyear meeting. I don't make legislative policy with KBA, so if you are unclear as to our official position on these issues, please let me make them clear.

I. Post Judgment Interest Rates

KBA has and will support legislation to repeal the 15% post-judgment interest rate enacted in the early 1980s. We proposed the interest rate be tied to the current T-Bill rate, and adjusted every six months or so. HB 2459 is pending in the House Judiciary Committee and can be enacted next January.

We confidently believe it will save thousands of dollars of interest in the Health Care Stabilization Fund. No bank pays 15% for its money. Neither should the Health Care Stabilization fund.

Judge Chipman recommended you consider prejudgment interest legislation. KBA supports prejudgment interest legislation IF the effect of

the legislation, taken as a whole, encourages pretrial settlement by imposing penalties on any party unwilling to make progress towards a meaningful settlement.

HB 2459 has been suggested as a vehicle for an amendment for prejudgment interest on personal injury awards. While we favor a balanced bill, the issues regarding the post-judgment legislation are too important to be tied up with prejudgment interest considerations. Prejudgment interest should rise or fall on its own merits. Post-judgment interest changes, however, should be immediately enacted.

II. Screening Panels

KBA has no official position concerning screening panel reform. However, we will address this issue at our September meeting.

None of the four judges who addressed you yesterday were very enthusiastic about screening panels. They impose another layer of bureaucracy within our court system. With Chief Justice Burger's concerns about the overall cost of litigation to the consumer, screening panel costs duplicate trial costs, and therefore are contrary to the Chief Justice's concerns.

The panels are complicated to administer, reach limited results, and have generally not worked in Kansas. They have strengths, but mostly weaknesses. I think the problem stems from the fact that they were expected to do more that a screening panel rationally can do.

Currently, three physicians must find time to meet long enough to hear evidence and determine liability a colleague. The panel gets nominal pay for its work, and they lose income from lost time from their private practices. The results are inadmissible anyway.

The biggest drawback is that a screening panel is composed of three biased professionals with a financial stake in the outcome of the opinion they are asked to render on a colleague. What the Indiana Plan does, with its biased findings, is put them into a nice, neat report and dump that bias onto Indiana medical malpractice juries.

Here is why many believe screening panels are inherently biased.

To be an effective judge of any issue, it stands to reason the judge must not have a stake in the outcome of the decision. Screening panels of physicians violate that concept of neutrality.

Here is their financial stake. We require mandatory malpractice insurance of each physician. Last month, you heard the companies indicate they don't merit rate Kansas physicians on claim experience. Therefore, every time a physician is faced with a claim, every physician's premium is affected. And, every time a panel of physicians finds liability against their colleague, every physician's insurance is affected.

Juries and judges do not have a financial stake in the outcome of the liability determination. Because of this bias, plaintiff's counsel, by and large, don't use the screening panels.

You also heard St. Paul testify last month that they don't like screening panels because they duplicate defense costs. To be effective, they said, the results must be binding. They also acknowledge that if you make the results binding on the parties, you are substituting the judgment of medical professionals for the judge and jury, with attendant constitutional problems.

Even states that mandate use of screening panels have problems. Indiana, the "safe haven" for those who practice medical negligence, just passed a law where malpractice claims not exceeding $15,000 need not be submitted to the mandatory screening panel. While that may be only a very small number of cases each year, the purpose of the screening panel -- out-of-court determinations of malpractice lawsuits -- is entirely thwarted.

In Kansas you will see screening panels used when (1) an inexperienced attorney is unsure of liability, or (2) when an experience attorney has a novel case where liability is not clear, or (3) when a case comes into the office late in the statute of limitation period and you need to stop the running of the statute of limitations. This is a bonafide use, however. Because of Nelson v. Miller Kansas attorneys must independently investigate a claim before filing it, the screening panel request acts to stop the statute of limitation from running to give them time to investigate. There is nothing wrong with the use of a screening panel in these three instances.

However, even without a screening panel, some cases are screened out of the litigation process:

(a) The contingent fee process itself, according to Professor Patricia Danzon, ("Contingent Fees for Personal Injury Awards, Rand Corporation, 1980) screens out many cases before ever becoming a lawsuit. Her findings indicate: "Thus, in the absence of the contingent fee, the number of cases would certainly be less. Conversely, the common allegation that the contingent fee induces attorneys to bring claims with little legal merit has no basis in logic. The fact that the fee depends on winning provides an incentive to screen out cases with little legal merit — an incentive that is lacking with the hourly fee." (page viii).

(b) Experienced trial counsel for both sides often make screening panels unnecessary. I personally think this is the greatest single reason you don't see them used much in Kansas. Both counsel have expert witnesses on whom they can rely for meaningful determinations of liability. While insurance companies pay the bill for screening panels, they ordinarily listen to the own experts on whether there is liability before they'll listen to the finding of a panel of local physicians who are not schooled in litigation results in other states.

Sometimes, a pretrial discovery conference early in the life of the lawsuit can screen out a case. If a judge at a discovery conference

learns plaintiff's counsel doesn't have an expert lined up, he can give the attorneys a reasonable period of time, 3 to 6 months, to find one and depose the expert. If that deadline is not met, the judge has the option to dismiss the lawsuit. Many Kansas courts use early discovery conferences in a variety of litigation, including medical malpractice cases.

Some states mandate the use of screening panels, and allow their results to be used in subsequent court proceedings. No matter how tempting that might be, please remember one thing: even if you change to a mandated system -- which I am not recommending either officially or unofficially for the KBA -- you do not solve the weaknesses and biases of screening panels listed above.

III. Present Value of Future Damages

I would like to discuss a concept that is not yet part of KBA's legislative program, but which will be discussed this fall at our conference. This concept involves proving the present value of future damages.

You've heard the Medical Society say that it is not the $50,000 verdict that is a problem; it is the $5 million verdict that must be paid from the stabilization fund. If they could just "reform the big jury verdicts" premiums would stabilize.

Health Care Providers want to artificially cap the award. We've always maintained, however, that an injured person is entitled to be fully compensated for their injury.

When liability and causation of the injury is clear, and damages are large, the insurance company usually "settles" the lawsuit. There is no trial or jury verdict. Often they "structure" the settlement so that with a relatively small amount of money in today's investment market, they can fund large periodic awards out into the future.

Where you see big damages, the largest component are lost future income and future medical, living and therapeutic expenses. If you can control these costs, you can control the impact of large verdicts on the malpractice premium dollar.

The typical "Big Damage" case is a neurologically-deficient child. Experts agree the child will live to age 74. Economists say the child would have earn $X between ages 21 through 65. Others testify the child will require specialty care for life. If the jury finds there is liability, then they may determine all this future income loss and future medical is worth $5 million. The question is how much should we give the plaintiff TODAY which will pay that $5 million over the next 70 years?

Money invested at an average of 9% per year will double in value in about 8 years. We think the key is allowing the jury to find the amount

necessary to fully compensate a plaintiff for future wage loss and medical expense, then reduce it to a present value.

Technically, if such evidence is presented, juries are supposed to do that now. But with lump sum verdicts, you can't tell whether they've reduced the award to present value.

Kansas law is unsettled whether either party must prove the present value of future damages. The jury, if unschooled by experts, may assume that in order to provide $5 million in the future, it must award $5 million today.

The cleanest method of doing this involves the Special Verdict, which Judge Kelly handed out yesterday. The other three judges indicated they do not often use such verdict forms, but they would not be opposed to using them.

If you let the jury determine the amount of future costs necessary to fully compensate the injured plaintiff (lost income or future medical) and at a post-trial hearing, evidence can be offered from either party to establish the present value of that portion of the award representing "future" costs. The Judge then implements the jury's decision and awards appropriate amounts.

Two things happen: (1) the injured party is fully and adequately compensated, which is a main goal of our system, and (2) his ability to be fully compensated is not artificially limited by caps on awards. I think you can see that the main thing necessary in this system is the use of special verdicts, which are questions written by the judge as part of his instructions. The jury "itemizes" its verdict rather than returning a lump-sum verdict. Special verdicts can be used now, but are not mandatory.

The Special verdicts would need to be used only if the plaintiff was seeking future medical costs or lost future income.

We have tried to analyze this concept from all directions. What we think is certain is that requiring proof of present value of future damages will NOT increase the verdicts now rendered, and MAY lower overall verdict costs, which SHOULD have a positive effect on malpractice premiums.

The only drawback we see right now is if the growth of future interest rates is not adequately predicted, the award may not be accurate. But this is an inherent problem with structured, pretrial settlements, too.

IV. Periodic Payment of Judgments

This "reform" has been suggested. However, most agree it amounts to eternal litigation. Eternal litigation is costly to all parties. Further, it would keep cases active and not resolve the conflicts. That is

not healthy in this society. A goal of litigation must be to END conflicts, not keep them boiling.

This is one form of reform that, if being used somewhere else, you might want to wait and let the experience of other states give you an idea whether it will work. If not being used elsewhere, I don't think you want Kansas to be the experimenting state.

Insurance companies are divided over the concept. Some like it. Others, like Ralph Grundelfinger of Provider's Insurance company, had some interesting remarks at your last meeting. My notes indicate he said:

> "You should not require structured settlements. Leave them to the private sector. To require them will drive annuity companies out of the state. Each such settlement is geared to the facts of each case. The bookwork (for a required system) alone would be too much. The law should not concern itself with the gamble the annuity carrier takes. That should be kept in the private market."

That is good advice.

V. Contingent Fee Regulation

KBA opposes contingent fee regulation by the legislature. Such fees are part of the delicate balance needed to assure everyone has equal access to courts. This is not England, where such fees are outlawed, and, where consequently, only the wealthy can afford to litigate.

If such regulation is needed, we support a Supreme Court rule which sets guidelines for trial courts to review the attorney fee contracts of all parties and make determinations of reasonableness based on the difficulties and circumstances of each individual case.

The crux of the physician's complaint about their malpractice premiums is the cost of the premium. Their concern with the contingent fee is they want "more of the malpractice premium dollar to go to the injured patient, and less to the attorneys — including their own." A cynic might say if this motivation is honest, the quickest way to get considerably more money to claimants without raising premiums is to settle every claim without ever hiring a defense lawyer.

From a practical matter, pretrial settlements get more money to injured patients since the claimant doesn't have to go to trial and the attorneys' percentage is usually less than after trial.

Post trial fee "review", such as KSA 7-121b, can eliminate unconscionable contracts, if they are out there. But legislative fee regulation will not get more benefits to the injured party unless the contract is unconscionable.

Physicians know that if contingent fees are artificially capped, then some cases which have merit will not be brought because it is uneco-

nomical for trial counsel to pursue them. Yet in the same breath physicians say that the presence of unregulated contingent fees brings spurious litigation. If you allow physicians to continue to advance this inconsistent, two-headed argument, you will be giving them an unnecessary advantage in our courts.

None of the judges you heard yesterday indicate a problem with contingent fees in medical malpractice cases requiring pretrial legislative regulation. Their answers are supported by a 1980 Rand Corporation study entitled "Contingent Fees for Personal Injury Litigation" (Professor Patricia Danzon) makes some interesting findings:

> "The analysis disputes the allegation that contingent fees result in excessive (above competitive) rewards for attorneys. Rational allocation of time by an attorney between contingent fee and hourly rate cases and market competition both act to control fees. . . . (T)he effective hourly earnings of attorneys paid on a contingent fee basis are similar to hourly earnings of defense attorneys paid by the hour. . . . Competition will tend to drive attorneys who are risk-adverse out of the contingent fee sector." (page vi and vii)

Professor Danzon warns that public policy "with respect to Contingent fees should be evaluated in the light of its effects on the efficient functioning of the entire tort system." She indicates that tinkering with contingent fees may limit the ability of the tort system to (1) compensate and (2) deter negligent behavior. (Danzon, ibid, page 3)

Finally, while physicians, hospitals and insurance companies don't like the plaintiff's use of contingent fee contracts, physicians, hospitals and insurance companies hire attorneys using contingent fee contracts all the time. When physicians or hospitals need overdue bills collected, they hire attorneys or collection agencies and pay them a percentage of what is collected, sometimes up to 50% on small debts.

Insurance companies hire attorneys to prosecute subrogation claims against other insurance companies on a contingent fee basis.

Thus, their breastbeating on contingent fee contracts is more fiscal than philosophical.

VI. Standard of Care

No plaintiff in a medical malpractice case is EVER successful without a physician expert witness taking the stand and testifying under oath that the defendant doctor committed medical negligence. That witness must show, through textbooks or recognized medical procedures where the defendant departed from the "approved" standard of care.

Without this testimony, there are no cases, no trials, no settlements. Nada.

Physicians are concerned about the New York doctor who comes into town and testifies against them. What they don't tell you is that often defense counsel do not want their horizons limited in their search for an expert witness to testify for the defendant doctor. If the "best" witness is in New York, why would the physician want his attorney to be unable to secure the services of that witness because of a "locality rule?"

A board-certified physician is one trained to recognized and approved national standards. The question was asked why someone from John Hopkins School of Medicine ought to be allowed to come to Kansas to testify as to the Kansas standard of care is missing the point. The defendant physician may well have taken his residency at John Hopkins. Would that testimony be relevant then?

If, however, the standard of care in question revolves around whether a small Kansas hospital had access to an exotic medical machine, then a locality rule on what was "available" is important. This is an area of "reform", however, that does not need a statute. If asked, I'm sure the Bar Association and the Medical Society can work together on a model jury instruction to cover this situation and work with trial judges to implement it. We've not been asked, however.

Conclusion

In addition to what you heard from the judges yesterday, I hope this gives you some ideas for positive, constructive reform of the legal system without imposing artificial caps on awards or restricting a person's access to the court system.

If I can answer questions, I shall try.