Approved April 26, 1988
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by SENATOR AUGUST "GUS" BOGINA at
Chairperson

1:30 ~~a.m.~~/p.m. on March 29, 1988 in room 123-S of the Capitol.

All members were present except:

Committee staff present:
Research Department: Scott Rothe, Gloria Timmer
Revisor's Office: Norman Furse
Committee Office: Judy Bromich, Pam Parker

Conferees appearing before the committee:
Ted Ayres, General Counsel, Kansas Board of Regents
Bob Gottschalk, Executive Secretary, Kansas State Fair
Vickie Thomas, General Counsel, Kansas University Medical Center (KUMC)
Marlin Rein, Associate University Director for Business and Fiscal Affairs, KUMC
Dr. Jane Henney, Acting Dean of the School of Medicine, KUMC
Jerry Slaughter, Kansas Medical Society
Dr. Larry Cheung, M.D., KUMC

SB 711 - Police officers at universities and community colleges law enforcement officers under treatment act for mentally ill persons.

Ted Ayres presented testimony. (Attachment 1) There were no others wishing to appear before the Committee on SB 711.

SB 712 - Authorizing capital improvements and easements on or near state fairgrounds.

Mr. Gottschalk reviewed SB 712. Senator Talkington moved, Senator Feleciano seconded, to amend SB 712 by including the phrase "and the Joint Committee on State Building Construction" on line 0028 after the word "Services" and before the period. The motion carried on a voice vote.

The Chairman pointed out that historically bills introduced for the purpose of state property divestiture have had a defined description of the property. SB 712 is lacking that type of description. Senator Feleciano moved, Senator Gannon seconded, to amend SB 712 by adding the phrase "defined and described" in line 0036 after the word "deed", and in the same line insert the phrase "for street and roadway purposes" after the word "property". The motion carried on a voice vote.

Senator Kerr moved, Senator Gannon seconded, to amend SB 712 by adding ", Reno County" after the word "Kansas" and before the period in line 0038. The motion carried on a voice vote.

Senator Kerr moved, Senator Talkington seconded, to recommend SB 711 favorably and SB 712, as amended, favorably, for passage. The motion carried on a roll call vote.

SB 741 - Full-time physician faculty self-insured under helath care provider insurance availability act.

Ms. Thomas reviewed SB 741. In answer to questions, Ms. Thomas stated that KUMC in Wichita is included in the amended language in Section 1(s), lines 0141 through 0145.

Mr. Rein stated that they would like, in part, to duplicate for physicians the legislation enacted several years ago in which the state paid for basic malpractice coverage and the surcharge for residents at KUMC through the Health Care Stabilization Fund. He feels the state has saved General Fund

expenditures in excess of $2.5 million for resident's insurance over the four years. He distributed information relating to the distribution of salaries for selected departments and an aggregate in Kansas City. (Attachment 2) Mr. Rein stated that unfortunately over the last several years there has been an increasing emphasis on patient care at KUMC to the detriment of student education and research. One of the causes has been the cost of malpractice insurance. The second sheet of information which Mr. Rein distributed was a summary of malpractice costs by clinical specialty for Kansas City only for the past four years. (Attachment 3) During discussion, he pointed out that the amount the Department of Obstetrics and Gynecology will have to pay for malpractice insurance will be one and one-half the level of state support for payment of faculty salaries.

Dr. Henney presented her testimony (Attachment 4) and copies of written testimony by Dr. Price, Head of the Department of Family Practice, for the record. (Attachment 5)

Mr. Slaughter told the Committee that the Kansas Medical Society supports the concept of SB 741.

Dr. Cheung pointed out that overall fifty percent of his, and his staff's, time is spent in non-patient care, i.e., teaching, research, administration. Malpractice insurance premiums are exactly the same whether they handle one patient case per year or 300 cases per year. He said he understood that their chances of being sued are probably less but this is what creates more of a problem for those full time physicians at the University.

The meeting was adjourned.

GUEST LIST

COMMITTEE: SENATE WAYS AND MEANS DATE: 3-29-88 (PM)

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
		3/29/88 PM
[illegible]	DOD	Topeka
Larry Cheung MD	Kansas City	U. of K. Med. Center
Jane E. Henney	Kansas City	KUMC
Marlin Rein	Law	KU
Vicki Thomas	Lawrence	KUMC
TED D. AYRES	TOPEKA	KS. BOARD OF REGENTS
Jack Hawn	Topeka	KPERS
Marshall Crowther	Lawrence	KPERS
Craig Grant	Topeka	K-NEA
Mike O'Neal	Topeka	Leg.
Bob Wunsch		Leg.
Bob Gottschalk	Hutchinson	Ks Fair
Rosemary Gottschalk	"	Public
Michael Woolf	Topeka	KTLA
TED FAY	TOPEKA	Ks Ins. Dept
BOB HAYES	"	" " "
[illegible]	Topeka	KS MED. SOCIETY
Jon Josserand	Lawrence	" "
		SWAM 3-29-88 (PM)

ATTACHMENT 1
SWAM 3/[illegible]88 (PM)

KANSAS BOARD OF REGENTS
SUITE 609 • CAPITOL TOWER • 400 SW EIGHTH • TOPEKA, KANSAS 66603-3911 • (913) 296-3421

TESTIMONY TO SENATE WAYS & MEANS COMMITTEE
CONCERNING SENATE BILL 711
TED D. AYRES, GENERAL COUNSEL, KANSAS BOARD OF REGENTS
MARCH 29, 1988

My name is Ted D. Ayres and I presently serve as General Counsel to the Kansas Board of Regents. I am here to testify in support of Senate Bill 711, which was introduced by the Senate Committee on Ways & Means at the request of the Board.

By way of background, I would refer you to Article 29 of Chapter 59 of the K.S.A. (1987 Supp.) which is the treatment act for mentally ill persons. The act presently provides statutory authority to "law enforcement officers" to take various actions in emergency situations with regard to individuals considered to be mentally ill persons. For example:

(i) K.S.A. 59-2908(a) permits any "law enforcement officer who has reasonable belief upon observation that any person is a mentally ill person and because of such person's illness is likely to cause harm to self or others if allowed to remain at liberty may take the person into custody without a warrant.

(ii) K.S.A. 59-2909(b) allows a treatment facility to admit and detain any person for emergency observation and treatment upon written application of any "law enforcement officer" having custody of any person pursuant to the above statute.

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(PM)

(iii) K.S.A. 59-2912(a) permits a district court to issue an order of protective custody upon the verified applicant of any "law enforcement officer."

While our university police officers could, on occasion, benefit by taking advantage of these laws, it has been determined by Attorney General Stephan that Article 29 is not applicable to them (A.G.O. 87-105, July 16, 1987). In reference to K.S.A. 59-2902(f), the Attorney General said:

"The definition is specific rather than giving just a general description of law enforcement officers. So, although university police officers are considered law enforcement officers in many instances, they are not for purposes of Article 29."

Our Regents institutions have occasion to deal with individuals who could be considered to be suffering from a severe mental disorder to the extent that such person is in need of treatment; lacks capacity to make an informed decision concerning treatment; and is likely to cause harm to self or others. These could be students. They could be employees. More than likely, they would be transient individuals who find the university campus as a convenient place to "hang out," stay warm, or rest their head.

Therefore, at the request of our chief executive officers, student affairs personnel and law enforcement personnel, the Board of Regents agreed to seek an amendment to Article 29 of Chapter 59 to allow our campuses to take advantage of the provisions of the bill. Senate Bill 711 is the response to this request. S.B. 711 seeks to amend the

definition of "law enforcement officer" to include any:

> ". . . regularly employed police officer of any university, community college or Haskell institute."

Clearly, this language is broader than that requested by the Board. We do believe it addresses our concerns and needs and thus, I express (i) my appreciation for its introduction and (ii) and the support of the Board for Senate Bill 711.

I would be happy to stand for questions.

ATTACHMENT 2
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KANSAS UNIVERSITY MEDICAL CENTER

Funding For Clinical Faculty

Department	FTE	Distribution of Funding		
		State	Foundation	Other
Anesthesiology	17.0	6.9%	93.1%	--%
CT Surgery	2.0	10.9	89.1	--
Diag. Radiology	18.0	18.1	74.8	7.1
Family Practice	14.9	52.1	21.6	26.3
Medicine	51.6	34.0	35.4	30.6
Ob-Gyn	15.3	33.8	61.6	4.6
Pediatrics	33.0	62.5	15.6	21.9
Surgery	30.0	16.6	67.5	15.9
Totals - All Depts.	256.7	31.5%	50.7%	17.8%

ATTACHMENT 2
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(PM)

ATTACHMENT 3
SWAM 3/88
(PM)

UNIVERSITY OF KANSAS MEDICAL CENTER

MEDICAL MALPRACTICE PREMIUMS

Foundations	84-85		85-86		86-87		87-88	
	Basic	Surcharge	Basic	Surcharge	Basic	Surcharge	Basic	Surcharge
Anesthesiology MD	$ 46,567	$ 23,289	$ 92,728	$ 74,180	$119,248	$131,174	$134,787	$ 99,227
Anesthesiology CRNA	$ 2,591	(included)	$ 8,573	(included)	$ 7,561	$ 8,318	$ 26,656	$ 20,567
Cardio/Thor Surg.	$ 13,342 (two doctors)	$ 10,673	$ 3,072 (one doctor)	$ 3,380	$ 12,683 (two doctors)	$ 11,414	$ 23,900 (two doctors)	$ 21,511
Diag. Radiology	$ 43,818	$ 35,054	$ 43,009	$ 51,741	$ 69,412	$ 57,847	$ 70,413	$ 58,340
Family Practice	$ 18,123	$ 13,371	$ 24,598	$ 23,406	$ 28,359	$ 22,297	$ 38,089	$ 34,279
Internal Medicine	$ 90,362	$ 65,119	$ 91,669	$100,824	$119,817	$107,835	$119,045	$107,155
Neurology	$ 10,350	$ 8,281	$ 16,679	$ 15,107	$ 22,133	$ 16,408	$ 23,193	$ 16,758
OB/GYN	$ 75,550	$ 60,443	$110,343	$121,738	$128,206	$115,384	$207,129	$186,416
Ophthalmology	$ 5,558	$ 4,446	$ 6,276	$ 6,904	$ 11,176	$ 10,058	$ 12,198	$ 10,479
ENT	$ 18,943 (2½ doctors)	$ 15,155	$ 21,128 (2½ doctors)	$ 23,240	$ 50,900 (5 doctors)	$ 45,810	$ 30,540 (3 doctors)	$ 27,486
Pathology	$ 23,570	$ 16,807	$ 27,608	$ 30,369	$ 29,172	$ 26,255	$ 47,180	$ 42,462
Pediatrics	$ 28,209	$ 11,283	$ 49,009	$ 53,909	$ 46,274	$ 41,646	$ 63,158	$ 56,842
Psychiatry	$ 18,394	$ 15,150	$ 23,556	$ 25,916	$ 25,311	$ 23,033	$ 37,298	$ 28,414
Radiation Therapy	$ 38,943	$ 11,786	$ 16,406	$ 18,049	$ 26,422	$ 23,699	$ 26,023	$ 23,420
Rehab. Medicine	$ 4,941	$ 3,953	$ 8,590	$ 9,267	$ 8,046	$ 7,900	$ 10,332	$ 9,299
Surgery	$198,496	$158,797	$194,108	$215,823	$330,142	$286,484	$356,271	$320,644
TOTAL	$637,757	$453,607	$737,352	$773,853	$1,034,862	$935,562	$1,226,212	$1,063,299

ATTACHMENT 3
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(PM)

ATTACHMENT 4
SWAM 3-29-88
(PM)

Mr. Chairman, members of the Committee, it is a privilege to appear before you to discuss an issue of utmost importance to the Medical Center and speak in support of Senate Bill 741.

As you are well aware, the escalating costs of malpractice insurance has become an issue that threatens the delivery of health care in this country. One aspect of these increased costs is unique to educational institutions such as the University of Kansas School of Medicine. It is at these institutions, physicians serve dual roles--as teachers and as clinicians. These functions are inseparable as the model for teaching medicine to students and residents is one of supervised responsibility. The physicians who make up our clinical faculty must have continued clinical contract with patients to keep up their own skills. Students, as they develop the knowledge and technical skills to become fully competent, are supervised by these faculty. In addition, this configuration also provides for a center of clinical excellence which produces critically needed tertiary services to residents of the state.

Our physicians, are employed by the institution primarily for the role they play in carrying out the educational mandate of the school, but within the context of their clinical practice they remain subject to the same increasing malpractice costs which face our professional colleagues in the private sector. In the past, some recognition for the unique role of the University-based physician was given by the provision of an educational discount given by insurance companies to recognize the time these individuals spend in educational rather than clinical pursuits. This has been discontinued in recent years, and the Clinical Foundations or practice plans of the Medical Center are now expected to pay the full surcharge for malpractice coverage.

ATTACHMENT 4
SWAM 3-29-88 (PM)

Testimony Before

The Senate Ways and Means Committee

March 29, 1988

James G. Price, M.D.

I would like to thank the members of the Senate Ways and Means Committee for the opportunity to have this testimony introduced today. I am James G. Price, M.D., Chairman of the Department of Family Practice at the University of Kansas Medical Center in Kansas City.

Family Medicine includes parts of almost all other specialties, and graduates of Family Practice Residency Programs are trained to provide competent and definitive care for about 90 % of the reasons that people go to doctors--and this includes normal obstetrics. Thus we are required by our accrediting agency to teach our residents obstetrics as well as pediatrics, general medicine, orthopedics, dermatology, etc.

Our department has 36 residents in training for Family Practice and we graduate 12 each year. Almost 50 % of our graduates settle in communities of under 50,000 population, and the majority of them, up to this time, have elected to practice obstetrics. To prepare them for this, they must receive specific training and supervision by Family Practice faculty who themselves do obstetrics. This means that these faculty teachers must have malpractice insurance covering obstetrics.

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At present, our department has ten such faculty, all of whom do and teach obstetrics. A year ago, the total malpractice premium for each of them was $5572. Now it is $9119. This represents a $35,460 increase in our departmental budget this year, and we've been told that premiums will likely be increased additionally in the future. Thirty five thousand dollars is a significant financial drain on a department which has a low profit margin on its services, and we are rapidly approaching the point where we won't be able to cover our faculty for teaching OB. This means they'll not be able to function as teachers of obstetrics for our residents.

As a Family Physician, I am most knowledgeable about the concerns of the Department of Family Practice. However, I want to emphasize that all the other clinical departments at KUMC have much the same problem--and the same need for a practical solution. Simply put, our problem is that if we are to be responsible for educating physicians, we have to be able to do those things and perform those procedures which the residents need to learn. For this, we must have appropriate professional liability insurance.

Keeping in mind that the problems of the Department of Family Practice are similar to those of most other departments, let me tell you a little about the involvement of our department in teaching obstetrics. Each of our 36 residents is required to have four months of obstetrical rotation in addition to the experience they gain from following and delivering women seen in the Family Practice Center. Last year we delivered 250 babies for these Family Practice Patients,

with every delivery being used for resident education. This number doesn't include the babies delivered on the four month's OB rotations. We believe that OB training is sufficiently important that we also offer additional elective time at Fort Riley and other nearby hospitals. Although these outside rotations are excellent, they do not offer the resident the opportunity to follow a woman throughout her entire pregnancy and delivery (and thereafter) as is done in the Family Practice Center experience.

If our Family Practice faculty cannot do OB for want of affordable liability coverage, not only will their skills deteriorate, but more important, they won't be able to teach residents, who in turn won't be able to provide this service when they enter practice.

Since the very essence of Family Medicine is broad medical practice, our inability to teach a subject as important as obstetrics will detract from our desirability as a training center. Residents who wish to do OB will select other training programs. Our ability to conduct an excellent teaching program in Family Medicine will unquestionably diminish if sound training in OB is not offered.

The effect of Family Practice programs in Kansas being unable to graduate residents skilled in OB will be felt throughout the rural portions of the state. I urge you to look at the maps prepared by the State Department of Health which indicate the location of physicians by specialty It's seen that major portions of the state are served primarily by Family Physicians--and that the nearest obstetrician may be hours away. To allow a situation where a laboring woman

has to travel long distances to find someone to assist in her delivery is not safe, acceptable or necessary.

In surveying the graduates of our residency program, I note what may be an early trend--and if so, it's alarming. Most residents who elect to practice in rural areas want to do OB. If they can't do this, for whatever reason, it appears that they are less likely to go to a rural area. The ability to practice obstetrics may be one of the determining factors as concerns practice site selection. When a physician leaves a community--or elects not to go there in the first place--all of his or her skills are lost--not just the obstetrical capabilities.

In summary, I would urge positive action towards allowing KUMC faculty to be allowed professional liability coverage similar to that which the KUMC residents currently have. This will allow us to continue to train physicians to serve the needs of the people of Kansas.

TRENDS IN OB PRACTICE BY FAMILY PHYSICIANS

A FOLLOW-UP SURVEY OF UKSM-KC FP GRADUATES

Background-In December 1985, all 105 graduates of the UKMS-KC F.P. residency program were surveyed relative to their practice activities. Seventy seven of the graduates responded and of these, 49 (64%) indicated that at that time they were delivering obstetrical services. The results of this original survey were published in **KANSAS MEDICINE** in May, 1987. (Vol. 88, No. 5)

The two years since this time have been marked by large awards for suits based on claims of birth injuries to infants and the resultant skyrocketing of premiums for professional liability insurance. The increases in the cost of liability insurance for physicians doing obstetrics have worked a financial hardship on all health care providers doing deliveries, including both obstetricians and family physicians. It is common knowledge that some physicians of both these disciplines have either ceased or restricted their obstetrical practices, but no assessment of the geographic location of the individuals stopping obstetrics has been reported. This is believed to be important since the loss of the obstetrical services of one physician in an area having other physicians still doing obstetrics has far different consequences than does loss of the obstetrical services of the only physician in an area doing obstetrics. This second survey gives information regarding geographical loss of such services.

Cessation of obstetrical activities affects the finances of a family practitioner more than it does the obstetrical specialist, since normal deliveries may be the sole major "procedural" activity of the F.P. who does no major surgery. An increase of each $1000 in premium may require caring for two or three additional obstetrical cases to offset the premium increase. Additionally, the loss of obstetrical patients is likely to result in the loss of patients for infant and child care, compounding the financial problems for the family physician. The finite nature of the "pool" of potential obstetrical patients, especially in sparsely populated areas, limits the degree to which the physician can "increase" this type of practice in order to afford insurance premiums. It appears that for some family physicians,

these losses make rural practice impossible since the revenue generated from performing normal deliveries is essential for a fiscally viable practice.

The effect on the public of the decision of a family physician to move away from a rural practice extends beyond the removal of obstetrical services, since when the physician leaves, his or her entire armamentarium of medical skills also leaves. This includes geriatric care, care for the non-emergent problems of daily life for all ages, and the occasional life-saving care given for emergency medical problems. The unavailability of these services may have serious health consequences for an entire community or area.

The Re-survey

Two years after the original survey, another was conducted, focusing only on those graduates practicing in Kansas who had previously indicated that they were actively practicing obstetrics. They were asked if they are still doing OB and whether there have been changes in the overall pool of family physicians in their areas as well as any change in the number of family physicians doing obstetrics. Since in two cases, more than one individual from an area responded, the results were adjusted so as to correct potential duplication of any physician counted.

The Re-survey Results

The re-survey revealed the following information:

1. In the entire database which includes nine respondents now practicing outside Kansas, seven of the 36 respondents (19.4 %) answered that they have stopped practicing obstetrics. An additional six physicians indicated that they would be ceasing OB practice in 1988, and seven others indicated that they may stop doing OB in 1988 depending upon the size of the malpractice premium increase. This means that 36% of all respondents will definitely not be doing OB by the end of 1988, and if the premium increase in judged to be non-affordable, this percentage will increase to 55.5.

2. Limiting the survey to those FP's practicing in Kansas, it is seen that six have stopped doing OB, five more will stop it in 1988, and eight more may stop it if the premium increase cannot be afforded. Together, these groups may total as high as 63 percent who have or will stop obstetrical practice, and at the least, will be 36 percent.

3. In Kansas communities of less than 50,000 population, two of the sixteen KUMC graduates has stopped doing OB, three more will do so in 1988, and six may do so--an aggregate total of 68 percent. In communities larger than 50,000 these same classifications total 57 percent.

4. The change in number of physicians doing obstetrics in the areas of surveyed respondents is significant. There are seven fewer family physicians available for obstetrics in communities under 50,000 population than there were two years ago; there are 18 fewer in the larger communities. Equally ominous is the counting of all family physicians in these areas, regardless of whether or not they are doing obstetrics. The smaller communities together show a net decrease of four family physicians in the past two years; the larger show an increase of more than 25! The diminished ability to afford obstetrical practice may contribute to this imbalance, since at the time of the original survey, half the graduates were locating in communities of 50,000 or less.

DISCUSSION

The 42 respondents answering this survey represent only a small fraction (approximately 8 percent) of the AAFP members in Kansas . However, as residency graduates of the last 15 years, they are more likely to desire to practice obstetrics than are their older colleagues.Thus the trends indicated in this study are likely to be magnified by the entire cohort. The loss of 25 to 50 percent of family physicians practicing obstetrics in underserved areas, where alternative sources of obstetrical care are scarce or entirely absent, imposes a worrisome and likely dangerous situation for the pregnant

women residing there.

Waiting until the "malpractice crisis" is resolved will not resolve this shortage, since many physicians, after not practicing obstetrics for several months or years, may opt not to resume it because of atrophied skills.

Comparing these results with the recent similiar survey of 610 members of the Kansas Chapter of the American Acadmey of Family Physicians, it is noted that the results are essentially the same regarding the percentages of family physicians who have or will soon discontinue obstetrical practice.