REPORT

OF THE

NORTH CAROLINA PROFESSIONAL LIABILITY INSURANCE STUDY COMMISSION

MARCH 12, 1976

RALEIGH, NORTH CAROLINA

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The Honorable James B. Hunt, Jr.
President of the North Carolina Senate

The Honorable James C. Green
Speaker of the North Carolina House of Representatives

Dear Lieutenant Governor Hunt and Speaker Green:

On behalf of the members on the Commission, I am pleased to submit to you and the North Carolina General Assembly the Report of the North Carolina Professional Liability Insurance Study Commission.

Part One of the Report contains the findings made by the Commission, an analysis of insurance and legal concepts relevant to the professional liability insurance situation in North Carolina, and the Commission's recommendations for positive legislative action by the General Assembly. Part Two contains a Minority Report by Senator Thomas H. Suddarth, Jr., who disagrees with the Commission's recommendations concerning the statute of limitations and pretrial screening panels. Part Three contains an appendix of information and data concerning the study effort of the Commission.

We recommend that these proposals be considered by the Session of the General Assembly which convenes on May 3, 1976.

Sincerely,

Ernest B. Messer
Rep. Ernest B. Messer, Chairman

Bob L Barker
Sen. Bob L. Barker, Vice Chairman

Sen. Julian R. Allsbrook

Mr. Robert R. Martin

**Rep. John R. Gamble, Jr.

Mr. Bernard H. Parker

Dr. Ira Hardy

Rep. Thomas B. Sawyer

Mr. John Henderson

Rep. Benjamin D. Schwartz

Sen. John T. Henley

*Sen. Thomas H. Suddarth

* Senator Suddarth disagrees with the Commission's recommendations concerning the statute of limitations and pretrial screening panels and is submitting his Minority Report in Part Two.

**Representative Gamble strongly opposes the Commission's recommendation that legislation regulating attorneys' contingency fees not be enacted.

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SUMMARY OF RECOMMENDATIONS AND CONSIDERATIONS

Considered and Recommended

Recommendation #1. The Commission recommends that legislation be enacted to establish a new statute of limitations for professional malpractice actions which would not exceed a period of four years from the occurrence of the malpractice. (See page 26 of the Recommendations and Findings and page 1 of the proposed legislation in Appendix VI.)

Recommendation #2. The Commission recommends that legislation be enacted to make the proposed limitation period in Recommendation #1 applicable to all minors seven years of age and older. (See page 28 of the Recommendations and Findings and page 2 of the proposed legislation in Appendix VI.)

Recommendation #3. The Commission recommends that legislation be enacted to establish an informed consent law which will provide both (1) a rebuttable presumption that a consent in writing is valid if the health care provider followed the "same or similar community" standard in obtaining the consent and (2) a test of reasonableness when considering whether the patient has a general understanding of the medical procedure and the usual and most frequent risks involved. (See page 29 of the Recommendations and Findings and page 3 of the proposed legislation in Appendix VI.)

Recommendation #4. The Commission recommends that legislation be enacted to extend the present "good samaritan" law to any unexpected emergency situtation that does not occur in the ordinary and normal course of the business or profession of the person rendering treatment. (See page 30 of the Recommendations and Findings and page 6 of the proposed legislation in Appendix VI.)

Recommendation #5. The Commission recommends that legislation be enacted for the purpose of codifying the present case law "same or similar communities" standard of care required of all health care providers. (See page 31 of the Recommendations and Findings and page 3 of the proposed legislation in Appendix VI.)

Recommendation #6. The Commission recommends that legislation be enacted to eliminate the ad damnum clause (the statement of the specific amount of money demanded) from the pleadings in professional malpractice actions. (See page 32 of the Recommendations and Findings and page 6 of the proposed legislation in Appendix VI.)

Recommendation #7. The Commission recommends that legislation be enacted to establish a collateral source rule that requires reduction of the award if it duplicates public collateral sources of compensation or benefit and reduction for any collateral source not derived from premiums paid by either the plaintiff or on his behalf. (See page 34 of the Recommendations and Findings and page 5 of the proposed legislation in Appendix VI.)

Recommendation #8. The Commission recommends that legislation be enacted to provide for periodic payments of malpractice awards where future damages are found to equal or exceed $100,000. (See page 35 of the Recommendations and Findings and Appendix VII.)

Recommendation #9. The Commission recommends that all professional associations advise their members that the Uniform Arbitration Act, G.S. 1-567.1 through G.S. 1-567.20, can be employed for the disposition of professional malpractice claims. The Commission further recommends that the public be made aware of this fact. (See page 37 of the Recommendations and Findings.)

Recommendation #10. The Commission recommends that legislation be enacted to establish the Patients' Compensation Fund which will provide excess liability coverage for health care providers in exchange for (1) the filing proof of financial responsibility of $100,000 or more (per individual occurrence) and (2) the payment of a surcharge into the Fund. (See page 37 of the Recommendations and Findings and page 7 of the proposed legislation in Appendix VI.)

Recommendation #11. Self-Insurance Plans for State Medical Centers. The Commission recommends that the North Carolina House and Senate Committees on Insurance consider the self-insurance plan proposed by the officials at North Carolina Memorial Hospital and the UNC School of Medicine. The Commission has not had sufficient time to explore the details of the plan, but endorses the concept.

- Considered But Not Recommended -

Consideration #1. The Burden of Proof: The Commission does not recommend the enactment of legislation concerning the plaintiff's burden of proof in malpractice actions. (See page 26 of the Recommendations and Findings.)

Consideration #2. Counterclaim Procedures: The Commission does not recommend the enactment of legislation changing the present Rules of Civil Procedure concerning counterclaims. (See page 33 of the Recommendations and Findings.)

Consideration #3. Attorneys' Contingency Fees: The Commission does not recommend the enactment of legislation regulating attorneys' contingency fees in malpractice actions. (See page 33 of the Recommendations and Findings, and note Representative Gamble's dissent on page 2 of the Letter of Transmittal.)

Consideration #4. Limitations on Recovery: The Commission does not recommend the enactment of legislation placing a ceiling on the amount of damages an injured person can recover in a malpractice action. (See page 32 of the Recommendations and Findings.)

Consideration #5. Pretrial Screening Panels: The Commission does not recommend the enactment of legislation providing for any pre-trial procedure for the assessment of the merit of malpractice claims. (See page 35 of the Recommendations and Findings; and see Senator Suddarth's dissent on page 2 of the Letter of Transmittal, the Minority Report in Part Two and Appendix X.)

PART ONE

RECOMMENDATIONS AND FINDINGS

I. INTRODUCTION

The North Carolina Professional Liability Insurance Study Commission was created by House Bill 567 and directed "to make a thorough and comprehensive study on any and all aspects of professional liability insurance...." Senate Bill 901 further directed the Commission to examine the impact of proposed legislation dealing with the statute of limitations, informed consent of patients and the standard of care of health care providers. (See Appendix I.)

The Commission members were duly appointed and began meeting on October 10, 1975. (See Appendix II.) Between that initial meeting date and through October 23, 1975, the Commission held five days of public hearings, during which representatives from all interested groups and agencies were given opportunities to address the problems of writing and obtaining professional liability insurance in North Carolina and to make specific recommendations to the Commission to guarantee the availability of insurance and thus guarantee the provision of health care to the people of the State. (A list of persons appearing before the Commission appears in Appendix III, and information concerning malpractice insurance rates and claims is contained in Appendix IV.)

The Commission, after issuing an interim report to the Speaker of the House and the Lieutenant Governor (See Appendix V), continued to monitor the situation and reviewed the various options and proposals put forth for its consideration. The final product of

the Commission's study is explained in the Recommendations and Considerations beginning on page i of Part One of this report and also appears in bill form in Appendices VI and VII.

This report is designed to acquaint the reader with the concepts behind the malpractice insurance problem, and therefore provide the necessary information base upon which important policy decisions may be made by the legislator. With this in mind, Sections II through VIII of the Recommendations and Findings are designed to establish the foundation necessary for careful analysis of the Commission's recommendations.

II. THE NATURE OF THE TORT LAW AND THE PROFESSIONAL LIABILITY SYSTEM.

The tort law system in which professional malpractice claims are tried is one that has evolved from the English common law and developed in the United States through case law decisions and some statutory modification. The system has basically a twofold purpose: First, to find fault for alleged negligent acts or omissions and compensate the person injured by such negligence; second, to reach the assets of the negligent party to pay for the injured person's damages and provide the wrongdoer with the incentive to avoid bad results in the future.

The increasing presence of liability insurance within the last half-century has somewhat changed the tenor of the second facet of the fault system. By protecting the insured's assets through indemnification for losses incurred by the insured in exchange for the payment of policy premiums, the burden of the cost of injury to a claimant has been shifted away from the wrongdoer's

assets to those of the insurer. Thus, at even enormous premium rates the wrongdoer's assets are fairly well protected from a claim of malpractice, and the insurance premium cost is actually borne by the persons paying for the professional services.

Although the North Carolina courts have maintained a rather conservative attitude toward malpractice litigation, the general trend in a number of states has been toward an expectation of compensation to injured persons for adverse or unfortunate medical results. Symptoms of this new theory seem to include an increase in the number and dollar demand of claims, higher jury awards, liberalized rules of civil procedure and some fundamental changes in the substantive tort law. Accompanying these symptoms are diminishing availability and increasing costs of liability insurance for the professional on a nationwide basis; and compounding the situation are escalating costs for health care services.

The response to the malpractice situation by the states has been to provide alternatives to litigation, reform in the licensing and regulation of professionals, changes in the tort laws and in the rules of civil procedure which arguably will make the courtroom more equitable, and changes and innovations which hopefully will guarantee the availability of insurance, which include reinsurance, joint underwriting associations, mutual companies owned by professionals, and state-operated (but not state-funded) patients' compensation funds for excess coverage.

A more detailed discussion of the problem and possible solutions follows in Sections III through VIII of the Recommendations and Findings.

III. THE NATIONAL MALPRACTICE EXPERIENCE

A person researching the medical malpractice phenomenon need go back only ten years to witness the great proliferation of problems in insuring providers of health care. The frequency of malpractice suits has increased dramatically. For example, the number of malpractice suits filed in the United States increased 70% from 1973 to 1974. The size of malpractice awards increased 20% during the same period. The first award in excess of one million dollars was handed down in 1968, and in the past seven years approximately thirty more million dollar verdicts have been rendered.

Concomittant with the increase in claims and the size of awards is the rise in the cost of professional liability insurance. The national total of malpractice premiums paid in 1974 was five hundred million dollars and was projected at one billion dollars for 1975. In states where the cost of professional liability insurance has shown the greatest increase, some health care providers have reduced their practice or retired. Others have relocated to states with more favorable claims atmospheres or have entered areas of health care with a lower risk.

It follows that the persons paying for health care services are bearing the cost of liability insurance which, although a small element of the total rising costs of health care in the United States, is quite significant if the 1975 projections are correct.

In arguing for higher premium rates, insurers of health care providers are citing the combination of increasing claims and declining insurance company investments as the cause of inadequate premiums and the reason for an increase. Another factor that insurers claim complicates the matter is the fact that claims

against health care providers may be instituted long after the occurrence of the alleged negligent act or omission which allegedly caused the injury. This "tail period," insurers argue, makes the projection of claims for malpractice more difficult and increases the costs of handling claims and litigation. The recent increase in claims filed compounds the difficulty of projection, since future obligations of indemnification for acts presently occurring may exceed premium income.

One measure has been taken by some insurers to meet the "tail period" problem, although they say it is a temporary one. It is basically a change in the policy form, from "occurrence" policies to "claims-made" policies. Under the traditional "occurrence" policy, the policy owner is insured for all acts or omissions creating liability during the year of policy coverage. The insurer is obligated to pay for claims arising out of those acts or omissions no matter when the claim is filed and finally settled or adjudicated. Under the new "claims-made" policy, the policy owner is insured only for claims reported against him during the year of policy coverage, regardless of when the act or omission giving rise to the claim took place. Insurers who have converted to "claims-made" policies state that unless the claims climate improves, "claims-made" policies won't solve the fundamental malpractice problems.

Many different factors are said to have caused the national malpractice crisis. Some persons point to the advances in medicine and the biological sciences in recent years which have created more complex treatments and procedures, which in turn have increased the likelihood of error. These advances also have

created greater expectation of satisfactory results from health care treatment. Many patients who experience unsatisfactory results, failure to respond to treatments or even medical injuries think that the cause is negligence of the health care provider when in fact there may be no negligence involved. The doctor-patient relationship has eroded due to the decline in number of general practitioners and the increase in specialists and higher health care costs.

Other factors are said to be changes in legal doctrines which have arguably favored plaintiffs' causes, and the fact that people are more lawsuit-conscious than ever before. It has been estimated by the insurance industry that 90% of all malpractice suits in the legal history of the United States have been filed since 1964.

The remedial legislation enacted by other states has concentrated on the relevant legal doctrines and on guaranteeing the availability of professional liability insurance. These insurance and legal concepts will be discussed in detail in Sections VI and VII of the Recommendations and Findings.

IV. THE NORTH CAROLINA MALPRACTICE EXPERIENCE

The malpractice dilemma which had been pervading the more populous states in the nation began to surface in North Carolina in 1974. The St. Paul Fire and Marine Insurance Company, which at that time insured 48,000 doctors in 44 states, requested an 82.03% increase in its malpractice rates from the Commissioner of Insurance and threatened to withdraw from the North Carolina market if the increase was not granted. St. Paul was the principal malpractice insurer in North Carolina, underwriting policies for over 90% of the physicians and surgeons practicing in the state as well as 75 hospitals.

The Department of Insurance held rate hearings from July to December, 1974, at which time the rate increase request was approved. These rates were to expire on June 30, 1975, when they would be subject to review. It was hoped that by that time the General Assembly would arrive at a solution to guarantee the availability of malpractice insurance. The Commissioner's position was that the North Carolina experience did not justify the 82.03% increase that was requested. The bulk of the increase was for reserves for what St. Paul called IBNR ---claims that were "incurred but not reported."

On June 30, 1975, House Bill 74 was ratified (Chapter 427, 1975 Session Laws), and the North Carolina Health Care Liability Reinsurance Exchange was created. H.B. 74 was designed in theory along the same principle as the Motor Vehicle Reinsurance Facility in Article 25A of General Statutes Chapter 58. Under the Reinsurance Exchange, all companies offering general liability insurance in the state are required to offer and provide malpractice insurance policies. High risk policy holders would be ceded to the Exchange, thereby spreading these ceded risks and premiums among all of the companies in the Exchange. Losses in the high risk pool would be shared by the companies, each company's share being proportionate to its share of the total North Carolina liability insurance market.* Meanwhile, St. Paul was given an extension on its rate approval until August 15, 1975.

The legislation created a Board of Governors which would manage the Reinsurance Exchange. In accordance with the provisions of H.B. 74, the Board of Governors submitted a plan of operation for the Exchange to the Commissioner of Insurance for his approval. The

***Exclusive of automobile insurance**

Commissioner approved most of the plan, except for one item that was crucial according to the insurance companies. The Board of Governors, in Article XVII of the Plan of Operation, proposed a stabilization reserve fund to cover any losses in excess of premium income. The stabilization reserve fund would have been funded by a 25% surcharge on the premiums paid by the policyholders. This would have hopefully guaranteed the companies against losses and assured them of breaking even. The Commissioner submitted his own plan of operation on August 6, 1975, which was substantively similar to the Board of Governors' plan but without the reserve fund and the premium surcharge.

The Reinsurance Exchange legislation provided that any insurer with obligations under the Act could elect, with the approval of the Exchange, to assign the underwriting, issuance of policies, and claims handling to a designated carrier approved by the Board of Governors, and the Plan of Operation provided means for the selection and approval of one or more carriers to act as a designated carrier. The approved carrier would have to have extensive underwriting experience in professional liability insurance. No insurance carrier in the State was willing to undertake such a task before a Plan of Operation was in effect, and therefore, each and every company was bound by H. B. 74 to write and handle professional liability insurance.

Meanwhile, St. Paul requested another premium rate increase (which rates would vary according to specialties) and a change in policy form from "occurrence" to "claims-made." St. Paul had been

able to put "claims-made" policies into effect in 34 of the 44 states in which it was writing professional liability insurance. The "claims-made" policy form was more desirable than the "occurrence" policy form because the underwriters could better project claims under "claims-made." Under the "claims-made" policy, as discussed earlier in this report, the policyholder is insured for all claims reported against him during the year of insurance coverage, regardless of when the alleged act or omission giving rise to the claim occurred. Of course any policyholder who retires, ceases to practice his profession, moves to another state where the company does not provide insurance on a "claims-made" basis or any insurance at all, or decides to change to a company offering "occurrence" policies, must be covered in some way for future claims arising out of past and present alleged acts or omissions. In order to provide this extended coverage for future claims, St. Paul proposed a three year reporting endorsement or "buy out" provision whereby the policyholder who wanted to terminate his "claims-made" coverage (for reasons other than death, disability or retirement) would pay three annual installment premiums at rates to be set after his policy period ended. This would assure the policyholder of future coverage.

The dispute between St. Paul and the Commissioner of Insurance arose out of this proposal. The Commissioner agreed to all of St. Pauls' requests (rates and policy forms) except for the three year reporting endorsement proposal. The policyholder would not know the amount of the three premium installments for such future coverage until he was billed for them. The Commissioner of Insurance suggested a one year reporting endorsement whereby the policyholder would only pay a certain amount one time after his "claims-made" coverage ceased

and thus avoid the situation of being bound to pay uncertain amounts in the three years following termination of coverage. The Commissioner also wanted to reserve the right to review in advance the rates for the "buy out" premiums in accordance with his prior approval authority set out in the General Statutes. The parties could not reach a mutually satisfactory agreement on the reporting endorsement provisions, and a stalemate ensued.

It was at or about this time that the insurance industry mounted its attack on the Reinsurance Exchange in the Superior Court of Wake County. The companies filed complaints with the court challenging the constitutionality of the Reinsurance Exchange Act and of its application by the Commissioner, seeking a declaratory judgment that the law and its application were unconstitutional and therefore void and without effect, and seeking temporary injunctions against the requirement of the companies' participation in the Exchange while the court was deciding on its constitutionality. The temporary injunctions were granted thus relieving over 100 insurance carriers from any participation in the Exchange's Plan of Operation.

During this period of the stalemate between the Commissioner of Insurance and St. Paul and of the legal challenge to the Reinsurance Exchange, the North Carolina Medical Society and North Carolina Hospital Association pursued alternative methods of insurance. The Medical Society initiated plans to establish its own mutual insurance company to provide coverage to health care providers, and the Hospital Association considered setting up a three million dollar insurance trust to insure against losses sustained by its member hospitals, with excess coverage for high losses provided by Lloyds of London.

The necessity for these alternative plans became more real when St. Paul, dissatisfied with the Commissioner's order concerning the "claims-made" policy forms, decided on September 29, 1975, to cease offering coverage in North Carolina. This meant that as their St. Paul policies expired, health care providers would be forced to seek coverage elsewhere. St. Paul also joined the other insurance companies in the court challenge of the Reinsurance Exchange. By that time 240 of the state's 350 general liability carriers had joined in the suit.

Despite the fact that no professional liability insurance was available in the state and the fact that a fair number of St. Paul policies had expired and would be expiring within the near future, there was no immediate curtailment of health care services across the state. Temporary coverage for hospitals of $250,000 per occurrence was provided by the Hospital Association's self-insurance trust while the Association officials sought an arrangement with Lloyds of London for excess coverage. The Medical Society worked toward the establishment of its mutual company by seeking $500 subscriptions from the Society's members and setting up the administrative details for the operation of the company. Some doctors whose St. Paul policies had expired were able to secure coverage from some of the insurance companies still subject to the provisions of the Reinsurance Exchange, which was still viable in spite of the loss of carriers from its plan of operation.

It was in this atmosphere that the North Carolina Professional Liability Insurance Study Commission convened to first try to solve the problem of the availability of malpractice insurance and then examine the

long-range solutions to the problem that had been suggested by interested persons and organizations. There was the possibility of a special legislative session if the malpractice situation grew critical and forced any significant reduction in health care services, and the Study Commission was told by the Speaker and Lieutenant Governor to draw up an emergency proposal in the event a special session was required because the self-insurance proposals did not succeed. The Study Commission passed two resolutions: The first requested that the attorneys representing all litigants in the Reinsurance Exchange case "do everything possible to bring about the earliest determination by the courts of the issues and questions involved in the litigation;" the second resolution urged the North Carolina Medical Society "to endorse the formation and operation" of the Society's proposed mutual insurance company.

Reports of curtailments in health care services by some doctors and a few hospitals in the state were received by the Study Commission as it began to explore ways to increase the availability of insurance. During the week of October 20, 1975, the Study Commission held daily meetings, and it was during that time that a major breakthrough in the stalemate between St. Paul and the Commissioner of Insurance was effected, and the immediate crisis was abated for the time being.

Due largely to the efforts of various members of the Study Commission, an important compromise was reached between the Commissioner of Insurance and the St. Paul Fire and Marine Insurance Company. A compromise position was established on the issue of the "claims-made" policy reporting endorsement and the two sides decided to meet there. The language finally agreed to is as follows:

"The option of purchasing claims made reporting coverage

on a single premium purchase basis is made available to the estates of deceased doctors and other medical providers and to doctors and other medical providers who retire; become disabled; move to another city, state or country, enter the armed services; take a sabbatical; or have some other similar and sudden discontinuity of medical practice.

The option of purchasing claims-made reporting coverage on a single premium purchase basis is made available to doctors and other medical providers who have maintained claims-made coverage with the company for a continuing period of three years or less; provided, however, this option shall be available only to those having new or renewal policies issued by the company on or after December 1, 1978."

St. Paul resumed its business in the state for its policyholders; the North Carolina Medical Society established its mutual insurance company which offered "occurrence" type policies; and the North Carolina Hospital Association, despite the fact that Lloyds of London declined to provide excess coverage, continued to fund and administer its self-insurance trust.

The Study Commission submitted on October 23, 1975, its Interim Report to the Speaker and Lieutenant Governor, stating that "the crisis created by the lack of availability of medical malpractice insurance has abated," and that a special session of the General Assembly was unnecessary at that time. (See Appendix V.) The Study Commission then turned to consideration of "changes or innovations in the procedure for handling malpractice suits and in the

tort law....so as to provide a better climate for both providers and insurers of health care without compromising the basic rights of our citizens. The Commission believes that some changes might be necessary if future crises in the availability of professional liability insurance are to be avoided." (See Appendix V). The Study Commission continued to monitor the professional liability insurance situation.

Mr. John L. Henderson, a Study Commission member, conducted a survey of North Carolina's medical malpractice insurance market in December, 1975. His conclusion is that "there is a very limited market for the writing of this type of insurance" in North Carolina. He is of the opinion that "as insurance companies consider (1) the existing overall market problems, (2) the improbability of rapid legislative change, and (3) the publicity which has produced a claims-conscious public, they are reluctant to broaden a market for professional liability insurance in North Carolina. Furthermore, this limited private market will place an even greater burden upon the recently-created, doctors' Medical Liability Mutual Insurance Company, inasmuch as this company must accept <u>all</u> health care risks applying to them for this vital coverage." (See Appendix VIII)

On October 29, 1975, Insurance Commissioner John Ingram submitted to Representative Ernest Messer, Chairman of the Study Commission, a report on the malpractice insurance market in North Carolina. According to the Commissioner's report, "Uninterupted health care is now guaranteed by three choices of malpractice insurance: (1) Medical Mutual Company writing 'occurrence' coverage, (2) North Carolina Hospital Association 'self-insurance' plan, and (3) St. Paul's 'claims-made' coverage." The report goes on to explain the

conceptual differences between the three plans and compares the options provided by each. (See Appendix IX)

Professional liability insurance is presently available to health care providers in North Carolina, although there is concern and argument about the stability of the market; and although coverage is available, the present cost of insurance to North Carolina health care providers is extremely high as compared to previous years. The frequency of reported malpractice claims and the amount per claim have increased in North Carolina over the past seven years.
(See Appendix IV for comparison tables of rates and reported claims.)
It is the Study Commission's hope that its recommendations, if enacted, will assure the availability of insurance and alleviate the insurance burden on health care providers and other professionals in North Carolina in the near future.

V. 1975 NORTH CAROLINA LEGISLATION

When the 1975 General Assembly convened on January 15, 1975, there was already a growing concern about the malpractice insurance problem in the United States and how North Carolina could avoid the pitfalls of a "malpractice crisis." The major carrier, the St. Paul Fire and Marine Insurance Company, after threatening to leave the North Carolina market if no rate increase was granted, had been granted a substantial 82.03% rate increase just one month earlier. This increase was to expire on June 30, 1975. It was the hope of the Commissioner that before the expiration of his order granting the increase, the General Assembly would enact legislation that would guarantee the availability of malpractice insurance and stabilize the market.

To accomplish this, House Bill 74 was introduced, proposing the creation of the North Carolina Health Care Liability Reinsurance Exchange. Ratification of the bill was strongly advocated by the Commissioner of Insurance as the solution to the present and future problems of assuring the availability of malpractice insurance and keeping premium costs down. The history of the Reinsurance Exchange was discussed earlier in Section IV of the Findings.

On November 3, 1975, Wake County Superior Court Judge James H. Pou Bailey found the Reinsurance Exchange Act to be unconstitutional on its face and in its application and implementation by the Commissioner of Insurance, and therefore of no force and effect. A motion has been filed with the North Carolina Court of Appeals seeking permission to bypass that Court and take the appeal directly to the North Carolina Supreme Court. Even if the Court of Appeals is bypassed, the earliest date oral arguments can be heard before the Supreme Court is April 10, 1976; but it is unlikely that arguments will be heard before the end of April, 1976. This litigation has created much uncertainty about the survival of the Reinsurance Exchange Act as it presently reads in G.S. 58-173.34 through G.S. 58-173.51. There has existed a "wait and see" attitude among decision makers. It is possible that the final word on the constitutionality of the act may come from the Supreme Court after the 1976 Session of the 1975 General Assembly adjourns. It is hoped that the Court's opinion will be filed before adjournment so the General Assembly might take appropriate action if necessary. The Reinsurance Exchange and other insurance mechanisms and concepts will be discussed and compared in Section VI of the Findings.

A total of fifteen bills affecting the area of malpractice was introduced during the 1975 legislative session; eight of them were identical bills. Aside from the enabling and funding legislation related to the Study Commission, the only other bill that was ratified dealt with the authority of the North Carolina Board of Medical Examiners. Senate Bill 900 (Chapter 690, 1975 Session Laws) rewrote G.S. 90-14, giving the Board the power to revoke, suspend, annul or deny a license to practice medicine when the Board finds that an applicant or licensee has been guilty of "unprofessional conduct, including, but not limited to, any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice, ..., irrespective of whether or not a patient is injured thereby ...," or "lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients." Prior to the ratification of S. B. 900, the only language in G.S. 90-14 that approached such grounds for revocation or rescission of a license were "any unprofessional or dishonorable conduct unworthy of, and affecting, the practice of his profession ...." Thus S. B. 900 added considerable criteria for the Board's regulatory powers over its licensees and clarified other grounds for denial, suspension, revocation or annulment of licenses to practice medicine.

Other bills were introduced relating to the statute of limitations, informed consent, the standard of care, malpractice evidence and procedure, pretrial screening panels for malpractice claims, and a patients' compensation fund; but none of these were ratified.

VI. INSURANCE CONCEPTS.

(Portions of the following analysis have been reprinted from "A Legislator's Guide to the Medical Malpractice Issue," published jointly by the Health Policy Center at Georgetown University and the National Conference of State Legislatures, whose assistance is deeply appreciated.)

A. Joint Underwriting Associations.

Joint Underwriting Associations (JUA) were one of most common substantive responses to medical malpractice problems, with more than twenty states passing legislation in 1975 to authorize their creation. The underlying concept is to have insurers provide malpractice coverage and share (pool) any resulting losses which may or may not be subject to recoupment.

The basic format of this type of legislation is to authorize establishment of a temporary JUA composed of all liability insurance carriers in the state. Some states have opted for longer periods and a few states do not specify a time frame. However, in all cases the intent appears to be the achievement of an interim solution which would be continued only if no better plan emerges in the next few years.

Under the authorizing legislation the JUA is either formed but not operational or it remains unformed until the Commissioner of Insurance (or an equivalent administrative official) determines that medical malpractice insurance is not available in a voluntary market on a reasonably competitive basis. Upon this finding the JUA becomes an underwriting agent for medical malpractice within the state and commences underwriting operations for "risks" (i.e., insureds, in

this case health care providers) not otherwise able to obtain malpractice insurance. In addition, in many states insurance companies may reinsure existing policies with the JUA or "cede" (i.e., assign) liability responsibility for these policies directly to the JUA. In some states the JUA is or may become the exclusive agent for the issuance of medical malpractice insurance and insurers may be required to cede all policies to the JUA. Generally, a JUA will cease underwriting when the statutory authority lapses (usually two years) or when the Commissioner determines a competitive voluntary market exists.

Except in a few states where the JUA will automatically service all health care professionals, the determination to form and operationalize the JUA and to begin underwriting is to be made separately, and as needed, for each major category of licensed health care providers. The major categories (e.g., physicians and surgeons, nurses, dentists, etc.) are generally to be kept intact under these plans to minimize adverse risk selection against the JUA. This might occur if an insurer, by careful selection, were to rid himself of all policies likely to produce a claim while keeping only policies with a high probability of profit, thus forcing the JUA to absorb higher than average losses.

With a few exceptions the intent is that JUA's be self-supporting. For example, Idaho's JUA is to be made self-supporting by a three stage process of recoupment:

1. A nonprofit group retrospective rating plan by which the the final premium for all policyholders as a group will be equal to the administrative expenses, loss and loss adjustment expenses and taxes, plus a reasonable allowance for contingencies and

and servicing;.

2. A stabilization reserve fund charge equal to 1/3 of the premium due; this fund then to be utilized to pay off the group retrospective rating plan charge, returning any excess to policyholders;

3. Should the stabilization reserve funds be exhausted, the Director of Insurance is to authorize the recoupment of any further JUA loss by one of the following methods:

a. maximum 2% surcharge on annual premiums on future policies;

b. deduction by the association members of their share of the deficit from past or future premium taxes due to the state.

While a group retrospective rating plan and a stabilization reserve fund (Steps 1 and 2) similar to Idaho's are common, many states have taken different approaches to recoupment of further losses. A number of states have set up a separate Patients' Compensation Fund (discussed below) to finance large judgments. Other states have set more flexible limitations on recoupment by retrospective assessment or prospective rate increases. Several states appear to anticipate the possibility that insurers may sustain unrecouped losses through the JUA after recoupment procedures are exhausted. A few states make no provisions for recoupment.

The JUA is to be run by a board of directors, usually composed of insurance industry representatives. The actual plan of operations (administrative and management details) of the JUA is to be set by the

JUA itself, subject to the approval of the Commissioner of Insurance (or equivalent official). Failing submittal of a satisfactory plan, the Commissioner may implement a plan of his own. The JUA or the Commissioner may be authorized to set rates or establish physician rating categories. In many states, once the plan of operations is approved, a management contract to run the JUA may be given to an insurer without his incurring any additional liability for operating losses.

The amount of coverage available under the JUA is generally set by the plan of operation. Usually a maximum amount is fixed by the legislation, most often one million dollars for each claimant under one policy and three million dollars for all claimants under one policy per year. However, in several states the maximum is much lower than these figures. Whether policies will be written on a "claims-made" or "occurrence" basis, or both, is usually set by the legislation. The "claims made" basis generally is permitted where insurers commit themselves to continuing coverage.

A model JUA has been circulated by the National Association of Insurance Commissioners and organizations like the American Insurance Association have advocated the JUA. Although the model JUA has been adopted to a varying extent in many states and JUAs have been less controversial than many other proposed changes, nonetheless the enacted JUAs reflect tremendous individuality of detail--a result of the state to state variation in political forces, perceived needs, and basic circumstances. Among the many variations not previously noted, Rhode Island has created a JUA by administrative order, claiming preexisting authority in the event a JUA is needed. West Virginia and the District

of Columbia have asked insurers to voluntarily create a JUA. Nevada allowed large administrative leeway in the approach to be taken by the Commissioner of Insurance, the primary criteria being relief from non-availability of insurance. South Carolina required the Insurance Commissioner to bind coverage in the JUA on an emergency basis to doctors and hospitals whose malpractice insurance had been cancelled or non-renewed. The binder would be effective until the JUA became operational and a retroactive policy could be issued. Maine's JUA specifies that insurers with less than five million dollars in assets cannot be required to participate.

B. Reinsurance Exchanges

Arkansas and, as discussed earlier, North Carolina authorized reinsurance exchanges, a pooling device similar in effect to a JUA but differing in several significant respects. Since the enactment of the exchange in Arkansas, the authority granted has been interpreted to permit formation of a JUA instead and this has been done.

The details of the North Carolina plan suggest the differences from a JUA. An Exchange is created to reinsure (up to a fixed dollar maximum per policy) medical malpractice insurance policies written by member insurers. Any profit or loss from these policies is to be apportioned on an equitable basis among Exchange members with no provision for recoupment. Whether reinsured or not, all policies are written and serviced by the insurer. To the extent that a policy can be reinsured, no policy may be terminated or refused by an insurer except for nonpayment of premium, non-residency, or suspension or revocation of license. If losses match a particular formula, the Exchange

must require 100% reinsurance of policies. As can be seen, the primary difference between this plan and a JUA is that the administrative and underwriting responsibilities remain with the insurance company rather than being centralized into the Association.

C. Patients' Compensation Funds

A small number of states set up state funds instead of, in addition to, or as a back-up to the joint underwriting associations. These schemes essentially meet two general purposes: plans designed to avoid potential constitutional problems involved in requiring insurance companies to participate in a joint association, and reducing costs of excess liability coverage.

Indiana and Louisiana each created two state funds: a Patients' Compensation Fund and a Residual Malpractice Insurance Authority (discussed below in Subsection D). The Patients' Compensation Fund is an excess loss plan to cover the differential between absolute maximum liability under the states' new laws ($500,000) and the maximum health care provider liability ($100,000). To qualify for this protection, a health care provider must be insured for the first $100,000 of liability and pay into the fund a surcharge, not to exceed a fixed percentage of his premiums (10% in Indiana, 20% in Louisiana). The surcharge is to be reduced when reserves build up to $15,000,000. The Indiana plan also limits attorneys' fees to 15% of the amount recovered from the fund. It is expected that the fund will reduce malpractice insurance costs by providing an alternative to relatively expensive excess liability coverage.

Wisconsin, Oregon, Florida, and Pennsylvania have established the patient's compensation funds similar to those enacted by Indiana

and Louisiana. Except for Pennsylvania (which has relatively high liability limits for its fund), the primary difference is that the funds are not protected by absolute maximum liability and might have to pay multi-million dollar judgments. Under the Oregon fund, payments to the fund and provider's maximum liability are based on classes of physicians according to the risks and loss experience of their specialty. The Pennsylvania fund covers the entire judgment on claims made more than four years after the alleged incident, as well as providing excess liability coverage. Florida, Wisconsin, and Pennsylvania also authorized JUAs.

D. Residual Malpractice Authorities and Other State Funds.

The Residual Malpractice Insurance Authority, as created by Indiana and Louisiana, is designed to provide malpractice insurance coverage to health care providers who have been refused by at least two insurers. This residual insurance fund is to be supported by the premium payments of those insured by it. In Indiana, the Authority was initially appropriated $1,500,000.

In Michigan, a state malpractice insurance fund has been established. Like most of the JUAs, the operation of the fund is to be segregated by provider classes and the fund is to be activated only when the Commissioner of Insurance finds that a class of medical providers cannot readily obtain malpractice insurance. Upon such a finding, any member of the medical provider class may apply to the fund for malpractice insurance coverage and all members of the medical provider class will be required to pay an assessment to cover losses and expenses. New York has set up a somewhat similar state fund, except that it is not to be activated unless the JUA, in the process of providing medical and hospital malpractice insurance, fails financially or constitution-

ally. Financing is to be by a one-time premium charge, not to exceed 3 percent of premiums, on all new policyholders of the state fund, and any remaining capital of the JUA, if it fails constitutionally.

E. Physician-Owned Mutual Insurance Associations.

A few states authorized physician-owned mutual insurance associations in addition or as an alternative to other mechanisms designed to assure availability of liability insurance. Maryland produced the best known and most elaborate enactment of this kind. It created a nonprofit Medical Mutual Liability Insurance Society, with initial funding and reserves established by a one-time $300 tax on licensed physicians for the privilege of practicing medicine in Maryland. The eleven member board of directors, after an initial seven-month period, is to be elected by the membership. No more than five directors may be physicians and at least two directors must have substantial insurance experience. A doctor choosing to join the Society and obtain its malpractice insurance may deduct the $300 tax from his initial premium payments. In addition, members must pay into a stabilization reserve fund to cover any of the Society's losses in excess of income from annual premiums. The Society is required to participate in the Maryland JUA.

North Dakota passed a bill similar to Maryland's. Iowa and New Jersey authorized physicians to form their own mutual insurance companies.

VII. LEGAL CONCEPTS: EXPLANATIONS AND RECOMMENDATIONS

(Portions of the following analysis have been reprinted from "A Legislator's Guide to the Medical Malpractice Issue," published jointly by the Health Policy Center at Georgetown University and

the National Conference of State Legislatures, whose assistance is deeply appreciated.)

A. Substantive Modifications

1. Res Ipsa Loquitur

The burden of proof is the responsibility for convincing the jury by "clear and convincing evidence" as to particular facts alleged. Normally the primary burden of proving negligence rests with the plaintiff. Res ipsa loquitur ("the thing speaks for itself") is a legal doctrine which raises a rebuttable inference that a particular injury would not have occurred normally without preceding negligence by the defendant. If the court makes a res ipsa loquitur finding, the burden of proof usually shifts to the defendant to prove he did not act negligently. Health care providers and insurers have forcefully argued that this doctrine is inappropriately used in many malpractice cases, in particular that it is given more weight than in other types of tort litigation.

This doctrine is not generally recognized in North Carolina malpractice case law, unless the facts surrounding the injury leave room for no other conclusion but that there was negligence. Normally the plaintiff must satisfy the jury that there was negligence and the negligence was the proximate cause of his injury. Therefore, the Commission does not recommend legislation on this subject.

2. Statute of Limitations.

(a) Time Period

The statute of limitations governs the length of

time in which a person may bring suit to recover damages. The limitation is usually expressed as the shorter of two applicable periods--one running from the time the injury is discovered (or should have been discovered) and the other running an absolute maximum number of years from the time the injury occurred. Modifications upon this formula are common: usually the statute is longer for minors and other persons under legal disability; in some states the period is longer in cases where foreign bodies (such as sponges) are left in the patient; and in some states the statute is tolled (i.e., does not run) for the period in which the patient was prevented from discovering the injury by the fraud or misrepresentation of the defendant doctor or hospital. Most states which made changes in the statute of limitations shortened the applicable period, but a few states made changes in the applicability of the limitations.

The medical malpractice interest in the statute of limitations comes from its creation of a "long tail" or residue of cases which are not filed or litigated in the year in which the injury occurred. Reduction of the limitations period helps insurers better to predict claims and costs, and because cases are more recent also allows defendants better preparation for litigation. However, the statute must be long enough to provide reasonable opportunity for plaintiff-patients to discover latent or consequential injuries.

Under the present North Carolina law in G.S. 1-15(b) and G.S. 1-52(5), a person injured by the negligence of another has

three years from the date of the negligent act within which he must file suit to recover for his injuries. There is an exception where the injury is not apparent to the injured person at the time of the negligent act (for example, the hidden sponge cases in medical malpractice cases). In such a case the period of three years does not begin to run until that person discovers (or through due diligence should have discovered) the injury; the total period available to the injured person in this kind of situation is limited, however, to ten years from the negligent act. Therefore, in the hidden sponge case, a patient would have no more than ten years from the date of the operation to discover the sponge and file an action in court against the surgeon whom the patient believes is responsible.

The Study Commission recommends lowering this outside time limit to four years for actions based on professional malpractice. The three year period would still start running at the time of the act of negligence for injuries that are ascertainable at that time. Actions for injuries that are discovered between two and three years after the negligent act must be filed within one year after the discovery. In no event could an action be filed more than four years from the date of the negligent act.

(b) Minor's Disability

G.S. 1-17(1) presently provides that the time period within

which a person under the age of eighteen years must bring an action does not begin to run until the person reaches the age of majority. For a malpractice action, this provision means that a child injured at any age has until age 21 to bring suit (18 years old plus the 3 year statute of limitations). The Study Commission recommends removing the minor's disability for professional malpractice cases by putting minors seven years of age and older on the same footing with persons of majority age. This means that the time period mentioned earlier would apply to all persons of age seven years and older. The period would not begin to run for a person under seven until his seventh birthday.

It is hoped by the Commission that reductions of these time periods will help malpractice insurers to better predict claims and costs. Long time periods create a residue of cases which are not filed or tried in court soon after the injury occurred. Defendants and plaintiffs can better prepare for suit if cases are more recent, but the time period should be long enough for patients to discover latent or hidden injuries.

3. Informed Consent

Absent extenuating circumstances such as emergencies, medical standards generally impose a duty upon a physician to disclose the risks of treatment to the patient before treatment begins.

This is known as the doctrine of informed consent. This doctrine is an amorphous aspect of medical tort law, often subject to varying applications. As a result, several states made efforts to clarify and limit by statute the doctrine of informed consent. Several states provided that consent in writing is either presumptive (subject to rebuttal) or conclusive on the issue of informed consent. Some states enacted a standard that informed consent is to be evaluated by the "same or similar community" rule or by a test of reasonableness.

The Commission recommends the enactment of an informed consent law which will provide both (1) a rebuttable presumption that a consent in writing is valid if the health care provider followed the "same or similar community" standard in obtaining the consent and (2) a test of reasonableness when considering whether the patient has a general understanding of the medical procedure and the usual and most frequent risks involved. If all of these standards and tests are satisfied, a patient cannot recover from the health care provider on the ground of lack of consent to the treatment or surgery.

4. "Good Samaritan" Laws

There has been a trend over a number of years to improve malpractice protection for health care providers who provide emergency care outside of a hospital to persons with whom there is no previous doctor-patient relationship. Statutes to provide this kind of protection, known as "good samaritan" laws, were passed in several states in 1975. Although some were limited to specific health care providers or types of emergency treatment, they

generally provide immunity from civil liability. North Carolina has a "good samaritan" statute in G.S. 20-166(d), but it is limited to motor vehicle accidents on the public highways.

The Commission recommends extending this law to any unexpected emergency situation that does not occur in the ordinary and normal course of the business or profession of the person rendering treatment. Under a "good samaritan" law, a person who gives aid is liable only for acts of gross negligence (which entails wanton and reckless disregard of the consequences of his actions) or intentional wrongdoing. This will hopefully encourage needed emergency medical treatment without fear of being sued for an error made under extenuating circumstances.

5. Standard of Care

Traditionally, doctors have been required to exercise skill and a general standard of care equal to the prevailing acceptable level for their type of practice in their community. Because of better communications and greater uniformity in physician training there have been moves in some states and by many courts to require adherence to "similar communities" practices or even to regional or national standards of care. That movement was reversed by several states this year by codification of the locality rule. The motivation for this is probably mixed: a general feeling that "country doctors" shouldn't be held to a "big city" standard, a hope that the locality rule will produce fewer claims and smaller awards, and a contention that a broader spectrum of acceptable medical practice protects genuine and legitimate variations in

health care. A few states, not counted here, adopted a locality rule with regard to adequacy of informed consent.

At least one state, Arkansas, went counter to this trend. It provided that the hearing panels in its voluntary arbitration system are not to apply the locality rule.

The North Carolina Supreme Court has gone only as far as a "same or similar communities" standard of care, and the Commission recommends that this concept be enacted into the General Statutes to avoid further interpretation by the Supreme Court which might lead to regional or national standards for all health care providers.

6. Limitations on Recovery

Because of the question as to the constitutionality of an absolute limit on recovery for malpractice, the Commission does not recommend legislation placing a ceiling on damages.

B. Procedural Modifications

1. Ad Damnum Clause

The ad damnum clause is part of the initial pleadings in a legal action involving liability for damages. In this clause the plaintiff states the specific amount of monetary damages to which he believes he is entitled. Much has been made of the resultant publicity and the stigma upon the health care providers involved when the claim for damages is very high. It is often alleged that juries would award relatively smaller amounts if the ad damnum clause were eliminated. In states where this reasoning has been followed, the clause has been entirely eliminated. In Wisconsin, only a jurisdictional amount is named (e.g., the plaintiff claims in excess of $10,000 in damages). In Tennessee, the ad damnum

clause remains in the pleadings but is not revealed to the jury. In North Carolina civil practice the pleadings are not read to the jury unless the trial judge directs so. Therefore, there is no problem of juries awarding higher amounts because of a high dollar demand in the pleadings.

However, the Commission feels that elimination of the ad damnum clause in professional malpractice cases would avoid adverse press attention prior to trial, and thus save reputations from the harm which can result from persons reading about huge malpractice suits and drawing their own conclusions based on the money demanded. The Commission, therefore, recommends that the ad damnum clause be eliminated from pleadings in professional malpractice actions.

2. Counterclaims

In order to discourage non-meritorious or harassment claims, some states have provided that health care providers who are sued for malpractice can sue the patient for malicious prosecution (or abuse of legal process) in the same action. The Commission found no evidence of any significant number of harassment or unfounded claims and does not recommend any new counterclaim procedures.

C. Mitigation on the Impact of Awards

1. Attorneys' Contingency Fees

The most usual method of compensating the plaintiff's attorney in a medical malpractice case is by the contingent fee agreement. Under this arrangement the attorney receives a percentage of the award (sometimes as high as 30-40%) if he wins, and nothing if he loses. Health care providers view the contingency fee as a major

culprit in large awards and rising insurance rates. It also reduces the patient's actual dollar recovery, sometimes severely, and makes it unlikely that a patient with a small case will be able to get legal assistance because of the limited payment opportunity for the lawyer. On the other hand, the contingent fee system does allow patients to bring their cases without great financial strain, and with no personal loss if they should lose the suit. States enacting legislation on the attorney contingency fee system have set a ceiling on the percentage fee attorneys may collect, either by a reasonableness test (to be applied by the court) or by a sliding maximum percentage scale. An alternative to this was enacted in Wisconsin, which now requires attorneys to offer to work per diem or per hour at the time of employment, before accepting a contingency arrangement.

After hearing various medical, legal and insurance people, the Commission saw no problems concerning or evidence of abuse of contingency fees, and therefore does not recommend legislation to regulate attorneys' fees in malpractice actions.

2. Collateral Source Rule

The collateral source rule prevents introduction of evidence that a patient's injury-related expenses have been reimbursed by other compensation plans such as private insurance, workmen's compensation, etc. This sometimes results in a windfall recovery for the plaintiff. It has been suggested that elimination or modification of the collateral source rule will result in reduced liability for defendant's insurer and eventually reduce the cost of premiums. There were minor differences in the modification. In California

the defendant may introduce, at his option, evidence of collateral sources but this permits plaintiff to introduce evidence as to premiums paid. Pennsylvania requires reduction of the award if it duplicates public collateral sources of compensation or benefit. Ohio requires reduction for any collateral source not derived from premiums paid by either the plaintiff or his employer.

The Commission recommends a collateral source rule that requires reduction of the award if it duplicates public collateral sources of compensation or benefit and reduction for any collateral source not derived from premiums paid by either the plaintiff or on his behalf.

3. Periodic Payments of Awards.

In any large jury award a lump sum payment of damages is a tremendous burden on the defendant. The financially naive plaintiff may lose or be defrauded out of his money overnight. The Commission recommends provisions for periodic payments in cases involving future damages of $100,000 or more to (1) alleviate the burden on insurers of defendants and (2) provide a sufficient flow of money to compensate the injured plaintiff without the risk of unwise spending. The decision to change a lump sum award to periodic payments would rest with the trial judge, who would be able to evaluate the situation and the relative burdens on the parties to the suit.

D. Alternatives to Litigation

1. Pretrial Screening Panels

Two of the frequently cited reasons for excessive malpractice costs are the expenses of trial and the reputed tendency of juries to make awards larger than justified and sometimes when no award at

all is appropriate. However, state legislatures are extremely limited in the manner and extent they can limit accessibility to the courts because of federal and state constitutional principles.

Instead, interest has centered around promoting pretrial settlements by: 1) voluntary screening or arbitration of claims; 2) mandatory pre-trial claims review; and 3) civil practice law changes allowing certain pre-trial screening results to be admissible as evidence at trial. Arguments for this type of approach stress the societal benefits as well as the economic savings suggested above. They point to clogged court calendars and resultant civil trial delays which frustrate the need of all parties for a quick resolution. Criticism of this type of approach centers on whether it will be effective in decreasing the number and duration of trials, and whether it overly favors the physician and insurer.

Two states have created voluntary screening or arbitration programs, while 11 states have compelled pre-trial claims review. In a majority of the states the decision of the panel is admissible as evidence in a later trial and in some of these states other information from the screening process is also admissible. Variation of format in these 13 states is wide. For example, the composition of the panel is different in almost every state. To some extent this reflects local needs. In Nevada the panel's judgment is not admissible, but if the plaintiff prevails a doctor will be appointed to testify at the trial in his behalf as a medical expert. Much of this detail is noted in the state-by-state legislative summary.

The Commission does not recommend legislation to provide for the screening of malpractice claims. The sentiment of the Commission was that this would constitute an undue and costly burden on the parties and that most of the cases would go to court anyway.

2. Arbitration

The Commission investigated the possibility of arbitration of malpractice claims and found that the present Uniform Arbitration Act, G.S. 1-567.1 through G.S. 1-567.20, is adequate for this purpose.

Since the State cannot compel persons to arbitrate (and therefore lose their right to go to court), arbitration must be by consent of both parties. The Commission also found that few people in the medical profession were aware of the fact that our statutes today provide a method for arbitration of malpractice claims, and recommends that all professional associations advise their members that the Uniform Arbitration Act can be employed for the disposition of malpractice claims, and that the general public be made aware of this fact.

VIII. THE PATIENTS' COMPENSATION FUND: RECOMMENDATION

The North Carolina Professional Liability Insurance Study Commission recommends the establishment of the Patients' Compensation Fund. This is a new concept where a health care provider who qualifies is primarily liable after a judgment, settlement or arbitration award, for the amount of insurance coverage he has (not to be less than $100,000 per occurrence), and any amount over that is paid to the injured patient out of the Fund. The Fund is maintained in trust by the State Treasurer, but the money for the Fund comes from a surcharge levied

on health care providers who desire to be covered in this manner. No State money is involved in the funding or administration of the Fund. By filing proof of financial responsibility of $100,000 or more and by paying the surcharge (as determined by the Commissioner of Insurance), a health care provider will come under the provisions of the Patients' Compensation Fund plan. Those who do not wish to participate are not subject to the provisions of the plan and are subject to liability under the present laws.

This plan is designed to (1) avoid potential constitutional problems involved in requiring insurance companies to participate in a joint underwriting association (JUA) or a reinsurance exchange (HB 74 as implemented) and (2) reduce the costs of excess liability insurance. By establishing a threshold amount of $100,000 of insurance coverage, this plan would afford more certainty to insurance underwriters in rating health care providers and would hopefully solve most if not all of the malpractice problem from an insurance standpoint. The plan would also guarantee injured patients their just compensation.

PART TWO

MINORITY REPORT

I. PREFACE

Being subject to human frailties, physical and psycological, this Senator has a compelling desire to please doctors and all members of the health care professions. Great satisfaction would result from being able to take a legislative posture which would be wholly acceptable to the medical community. In years gone by, I handled my first (and perhaps last) medical malpractice lawsuit; nevertheless, before election to the Senate there were countless members of the medical profession whom I was privileged to call my friends. I have nothing but the highest regard and respect for the dedication of those engaged in the healing arts. As a matter of fact I owe my life to the medical profession. Even now, it would be easy to follow the road of least resistance and vote for legislation based on political expediency rather than on the basis of deep-seated convictions after probing the inner recesses of the soul.

Be that as it may, every man worth his salt must draw the line as to where he shall take his stand. With extreme reluctance, I have drawn that line.

II. INTRODUCTION

Historically, the medical profession has been an overly protected class. The tremendous increase in the number of medical malpractice claims over the last few years is not because of lawyers as some would have you believe, but because of increasing

public awareness that doctors are in fact human, that they do make mistakes and these mistakes sometimes result in substantial injury to the patient. Further, in this day of consumer orientation, there is an increasing public awareness that every person should be held accountable for the consequences of his own wrong if another person is injured thereby.

The truth of the matter is that through the years and even up to this date, the medical profession has had the benefit of a protective shield and our court system is something less than inviting atmosphere for a medical malpractice claimant. The medical malpractice law of North Carolina and its restrictive rules of evidence, as developed by case law over the years, requires for an injured claimant to have his case considered by a North Carolina jury that a knowledgeable doctor testify in his behalf saying in effect that his fellow-physician, the defendant, in providing treatment to the plaintiff failed to comply with the required standard of care or otherwise failed to use his best judgment in providing care and treatment. There is the additional evidentiary restriction that the medical witness must have knowledge of the standard of care in the "same or similar community" where the treatment or mistreatment occurred.

The writer does not suggest for one minute that there is a grand conspiracy among North Carolina physicians and surgeons not to testify for would-be plaintiffs, but the unjustifiable protection of "silence" exists nevertheless.

For those who would suggest that justice is readily available

in North Carolina courts for the unfortunate victim of medical negligence, let them ask themselves the question. How does an injured patient learn that he has been injured by the negligence of a physician or other medical provider?

I challenge the members of the General Assembly, the news media, or others interested in basic justice for all of our citizens in North Carolina to do a poll so as to be satisfied as to where, and to what extent, medical and/or legal help is available in North Carolina to a patient injured by medical negligence. Fake an injury to yourself resulting from medical negligence and put a file under your arm and go incognito knocking on the doors of medical experts all across our beloved State and it is likely that you will walk yourself to death before finding any significant number of medical experts giving affirmative answer to the question, "will you testify in my behalf in a medical malpractice law suit?" The fact of the matter is that the overwhelming majority of physicians and surgeons will simply refuse to review the file when the possibility of a medical malpractice law suit is suggested. As a matter of fact, some hospitals have as established policy a prerequisite to their furnishing medical case histories that the requesting lawyer furnish a written certificate that the medical information is not sought with the intention of bringing suit against the hospital or any attending physician.

For the unfortunate victim of medical malpractice in North Carolina, there is little encouragement to be found in visiting

at random the law offices across the State. Lawyers are blamed for the increase in malpractice claims, but the sad truth of the matter is that the average lawyer in North Carolina is equipped neither by training nor experience to process a medical malpractice law suit. It is not to the credit of the legal profession that the overwhelming multitude of North Carolina lawyers has neither the medical or legal expertise nor the moral fortitude necessary to successfully handle a medical malpractice law suit in North Carolina courts. The medical profession by its silence, whether intentional or otherwise, has contributed greatly to the present day atmosphere of medical malpractice claims. The reluctance of the potential medical witness to testify has resulted in a widespread search by the conscientious practitioner of the law to find a reputable medical expert who is willing to testify even where negligence is evident. This has resulted in the importation into the State of the so-called "professional medical witness" for which practice small segments of the Bar have been criticized.

It is no accident that the St. Paul Insurance Company in defending medical malpractice claims over approximately twenty years has never lost a jury trial in the entire State of North Carolina.

There is no medical malpractice problem in North Carolina, only an insurance pricing problem resulting from losses in California, New York and other states where the claims climate is so much more severe than in North Carolina, and from investment losses incurred by the insurance company not unlike losses that

have been suffered by other corporate investors during this period of national economic instability and uncertainty.

The real issue before the Professional Liability Insurance Study Commission is not to promote legislation for the benefit of doctors or to withhold legislation on the basis of some projected benefit for lawyers. Personally, we should not be concerned except incidentally with what is good for doctors or what is good for lawyers, but what is in the best interest of all of the people. Doctors and lawyers are both a privileged class. A lawyer in North Carolina who is willing to work can earn a good living without handling a single medical malpractice claim during his entire professional career. Any doctor who is willing to work can make a good living and pay his medical malpractice insurance premium without gouging a single one of his patients.

Both the medical and legal professions have the privilege and distinction of making a determination as to those among the patient and client population whom they choose to serve. Both professions have as a common denominator in the unique opportunity of alleviating human suffering while having sufficient earning capacity to enjoy the good life. Both professions have the opportunity to charge for their services at least in some measure based on their own self-esteem. Neither profession is entitled to any special sympathy because of its downtrodden status in life.

Medical malpractice in this day and age is a reality. The major thrust of our inquiry as a Commission and of our legislation

as a legislative body should not be to further protect an already protected profession thus eliminating valid claims, but rather to equitably distribute the reasonable cost of medical malpractice over as broad a base as possible so that each segment of society bears its fair share of the cost of medical negligence.

Our interim report provides the real basis for our existence as a Study Commission. Our responsibility is and should be to recommend after thorough study such legislation as is needed to provide a wholesome climate in which medical care and treatment can be afforded without sacrificing the basic rights of our citizens. To this end, this Senator is steadfastly dedicated, but I am unwilling to aid and abet the building of an "impregnable fortress" to further protect an already protected profession.

I agree with the legislative direction given to the Commission to find a solution to the rising cost of health care liability insurance, so long as the legal rights of our citizen , (whose rights have been developed and preserved by free men in our free society over a period of 200 years) are not sacrificed.

It has been my privilege as a member of the Commission (attending every meeting) to make constructive suggestions, and I have supported many proposals that in my belief would result in a long-range reduction of malpractice insurance premiums. I cannot support even one single proposal which has as its net result an unjustifiable sacrifice of the rights of our citizens without any compelling need for such drastic measures. There should be an equitable distribution of the cost of medical malpractice without the abolition of precious legal rights. Surely

we as a sovereign people have sufficient ingenuity to find an equitable solution to the medical malpractice insurance problems.

In my considered view, one of the basic concepts of American justice is that all persons and all professions, lawyers, doctors, engineers, architects, contractors, et cetera, are fully accountable in the courts of a democratic society for the consequences of their own wrongful conduct to those who are injured or damaged by such wrongful conduct. Further, every person, professional or otherwise, should be held accountable at least for such length of time as is reasonably necessary for the injured party to have knowledge that he has been injured or damaged and at least until such time as the injured party has had a reasonable opportunity after discovery to initiate such process as will provide his grievance a fair and impartial hearing in a court of law.

III. STATUTE OF LIMITATIONS

A. Hidden injury or Damage

The majority recommends that in professional malpractice cases a person injured by the negligence of another have 3 years from the negligent act within which to file suit.

The exception that where the injury is not apparent at the time of the negligent act, an additional year is allowed from discovery in which to file suit, if discovery is made more than two years after the time of the alleged negligent act or omission.

Let there be no mistake. A plaintiff in a professional malpractice action commenced in the fourth year following the negligent act must be prepared to prove the following:

1. That his injury or damage was not readily apparent to him at the time of its origin.
2. That his injury or damage was not discovered within two years of its origin.
3. That his injury or damage was not reasonably discoverable within two years of its origin.
4. That his injury or damage was not discovered more than one year prior to commencement of the action.

The foregoing proof Items one through four manifests a clear invitation for perjured testimony. If a person knows himself to be injured by professional malpractice will he not feel the righteousness of his cause justifies "fudging" of the all important discovery date? What will be sufficient evidence of discovery? Will it suffice that plaintiff himself discovered a lump in his abdomen which sometime after two years was found by surgery to be a sponge left behind in the previous operation?

I have no quarrel with a 3 year statute of limitations on suits for injuries or damages readily apparent at the time of the negligent act. For those injuries and damages which are not readily apparent, however, there should be an entirely different rule applicable to all professions but allowing a more reasonable length of time for discovery.

It is contrary to my sense of basic American justice that the Statute of Limitations run before the injured party has knowledge of his injury. It is unconscionable that any claimant lose his right to have his grievance heard in a court of law before he becomes aware that he has a just grievance.

Accordingly, it seems only fair and just that every lawyer, doctor, engineer, architect, or other professional, be liable for the consequences of his own negligent conduct, at least until such time as the injured party has had a reasonable opportunity to know he's been injured and has had a reasonable opportunity to secure a fair hearing of his claim.

A lawyer searching a title whose client first learns of his error 4-1/2 years later should not be able to avoid legal responsibility by pleading a 4-year statute of limitations. He should be accountable for his negligence until discovery and a reasonable time thereafter within which his client can bring suit. Likewise, it is legally and morally indefensible that a sponge or pair of scissors discovered 4-1/2 years following surgery gives rise to no compensation against the surgeon whose negligence caused the injury.

Admittedly, there must be some absolute time limit for filing of claims resulting from negligent injury or damage. The same rule should be applicable to all professionals, lawyers, doctors, architects, et cetera, alike. Absent an absolute time limit the possibility of having to defend a lawsuit could go on forever. For hidden injuries and damages there should be a specified time limit after discovery with some absolute limit.

The present ten year limit for discovery and suit is too long. But the 4 year discovery limit advocated by the majority report is too short. An equitable solution might be to allow 1 year after discovery within which to file suit with an absolute

limit of 6 years from date of the negligent act. At least such provision would lessen the likelihood of negligent injury later discovered becoming uncompensible by operation of law.

It is significant to note that St. Paul reported not one single claim, made since enactment of the 10-year absolute limit of 1971, on the basis of discovery after 3 years. Manifestly, no statistics have been presented to demonstrate a need for the harsh 4-year limit on discovery as advocated by the majority report. The loss of rights by one injured claimant is too high a price for society to pay for the hope of what at best can only be a reduction of a few pennies in the cost of malpractice insurance.

B. Minor's Disability

The recommended removal of the disability to bring an action for minors of seven years or older is cause for great concern not only because of the highly questionable constitutionality of such a measure, but also because of the practical detrimental effect it would have on persons of seven years or older whose parents or guardians do not file suit within the limitation period for one reason or another. In such a situation, once the statute of limitations has run out, absent fraud or collusion on the part of the parents or guardians and the alleged negligent professional, the child is left without any remedies for the injuries caused by any alleged negligence.

The claims information concerning statutes of limitations that was furnished to the Commission does not demonstrate any need for the enactment of legislation restricting the rights of minors

who would not have the capacity to bring suit in their own behalf. This information appears in Appendix IV.

The three year period applicable to the child seven years of age and older as recommended by the Commission takes away rights from the child who by law has no capacity to enter into a contract of employment with an attorney or to institute a lawsuit in his own behalf. Under such a proposal no parent, guardian, foster parent, social services case worker, orphan's home president or any other person has any legal obligation to make any investigation or to make any claim or demand on behalf of the child, or to institute a lawsuit in the child's behalf.

The enactment of such a proposal may mark the first time in the history of North Carolina jurisprudence where one citizen, even suffering the legal disability of the status of minority, will suffer such indignity as will result from the catastrophic loss of his right to recover for his injury caused by the negligence of another. This loss will result not from his enlightened choice but from the failure of someone else to take proper action in his behalf.

The constitutionality of such a proposal is, to say the least, doubtful and in any event is an abomination to those who cherish fairness and equal justice for all citizens.

The orphan; the child incarcerated in a training school who is a ward of the State; the foster home child; the child whose parents are incompetent, illiterate, or whose parents' extreme religious convictions preclude litigation; the child whose parents are purchased or persuaded by unscrupulous insurance

adjusters or claims handlers loses his right to have his just grievance heard in a court of law, all under the pretense of saving at most a modest increment in the cost of malpractice insurance. This is repulsive to my sense of fairness, my concept of justice, and contrary to everything I have come to hold dear in the fabric of the law. Such a concept should be reprehensible to free men everywhere.

It is not enough to say that the loss of these rights will infrequently occur. In the words of one of the physician members of the Commission, "Surely somebody will look after the rights of the injured." If it should infrequently occur it will have little effect on the overall malpractice insurance rates. The St. Paul Fire and Marine Insurance Company presented statistics showing that since 1970 only eight claims on behalf of minors were made more than three years after the occurrence of the alleged negligent act. Infrequent occurrence however, is no cause for the sacrifice of basic legal rights. Even for one child to walk on a stump for the remainder of his life uncompensated for the loss of a leg caused by professional negligence is far too high a price to pay for the unnecessary protection of the medical community. The injured child should not alone bear the cost of medical malpractice, but each segment of society should bear its fair share of this cost. Surely we can find equitable solutions to our malpractice insurance problems without sacrificing one single individual and requiring him to pay so dearly for the mistake of another.

Advocates for drastic reduction in the time limit within which a minor may bring suit rely on the premise that such drastic reform of the law is mandatory to help insurers better predict future claims and costs. Such argument is without weight and not persuasive when one considers that the St. Paul Companies and the Medical Society's Mutual Company both offer insurance on a "claims-made" basis. Thus, it will no longer be necessary for actuaries to establish huge reserves (and possibly hide profits) to cover unreported claims from "long-tail" situations. At each rate hearing the Commissioner of Insurance has authority to set rates that are reasonable based on losses that were actually paid in the previous reporting period.

It is thus consoling that the medical community will no longer be victimized by fallacious reserve presentations in the rate making process. Increased accuracy may thus result in savings sufficient to offset the cost of preserving the sanctity of "minors' rights" under the law.

IV. THE PATIENTS' COMPENSATION FUND

It would seem to me that there is considerable merit in the Patients' Compensation Fund proposal of the Commission as a

means of spreading over a broad base the risk and consequent costs of medical malpractice. However, the recommendations that (1) the State Treasurer serve as trustee of the Fund and (2) the Office of the Attorney General provide legal defense of the private interests of the medical community participating in the Fund are, at best, of questionable constitutionality. Also these features of the proposal are in the opinion of this Senator, a thinly-veiled attempt to create a psychological barrier to the plaintiff in a medical malpractice action who has a claim against the Fund, in that he is placed in an adversary position with the State of North Carolina rather than with the health care provider whose alleged negligence caused the injury.

The fund is reputed to be self-supporting, but why should taxpayers' money be spent to recruit in the Treasurer's office persons qualified to administer the Fund and in the Attorney General's office the legal staff with expertise in the defense of malpractice actions? The State of North Carolina should have no authority to interfere in private litigation between private parties as opposed to actions involving the public interest.

V. PRETRIAL SCREENING PANELS

What we need in North Carolina is not legislation that bars valid claims or protects doctors from actual justifiable malpractice claims. If we want to do what is right and just for all people, we need to develop a process whereby unjustified claims are eliminated and justifiable claims settled or litigated. Regardless of legislation reducing the time limit or restricting the number

of witnesses who can qualify as a witness, there will continue to remain for doctors and health care providers the vexing problem of harassment by unjustified claims which must be defended or settled to avoid unnecessary damage to the reputation of the doctor. On the other hand the legal profession has an almost insurmountable problem of securing a qualified medical witness under the restrictions of present and proposed North Carolina law. Even where qualified, it is only in the most aggravated case against perhaps the unscrupulous practitioner that the qualified witness is willing to testify, and not in a malpractice situation which in all fairness is actionable because malpractice actually exists.

Accordingly, the real need in North Carolina can only be met by the establishment of a Medico-Legal Review Board with statutory authority to review all medical malpractice claims. This board should consist of doctors, lawyers and others all of whom are knowledgeable and of the highest integrity. The mechanics should be worked out by the North Carolina State Bar and the North Carolina Medical Society. Frivolous and unwarranted claims of malpractice should be discouraged by sanctions of the Bar where the Review Board has honestly found, after full investigation, no reasonable possibility of negligence.

A full investigation of the facts by the Review Board would tend to protect the doctor from unfair publicity damaging to his reputation and prevent the unscrupulous lawyer from proceeding with an unjustifiable claim. On the other hand where a reasonable possibility of negligence is found by the Review Board to

exist, the medical profession as part of its duty to the public should in all fairness assume responsibility for providing expert medical testimony in a court of law if necessary in order to see that a just claim for negligent injury is compensated by a settlement, arbitration or otherwise.

In other words, reputable lawyers would not need to go out of the state to try to find a medical witness for what he knows to be negligence but could rely upon the integrity of the Medical Society to furnish medical testimony where justified. Health care providers, on the other hand, through their Society would have assurance that the stigma of having to testify against a fellow health care provider would be removed and at the same time he and his fellow health care providers would be protected against frivolous claims.

At the direction of the Chairman of the Study Commission, this Senator with staff assistance spent weeks in research, data collection and drafting, and proposed legislation to provide for the pretrial screening of all malpractice claims. This document, which appears in Appendix X of the Report, was given long and careful study, and represents a composite of all of the best features included in similar proposals adopted by many states. In addition, the proposal contains new and innovative concepts to guarantee the integrity of the screening panel and also to limit the cost to the potential litigants. When the finished product was presented to the Commission the members, without having prior access to its contents and within less than 15 minutes consideration, voted not to recommend any pretrial

screening procedure that did not involve binding arbitration.

The pretrial screening panel proposal has much merit for the future settlement of medical malpractice claims in North Carolina, and I strongly urge its careful scrutiny, not only by members of the General Assembly but also by the leadership of the medical and legal professions.

One of the criticisms expressed by one Commission member was that any non-binding pretrial screening procedure would simply add another costly tier to the malpractice litigation process. A cursory examination of the pretrial screening panel proposal (see page 8 of the pretrial review panel bill in Appendix X) will clearly demonstrate that such criticism is without merit. Even the modest cost involved would be more than offset by the defense costs which would be avoided by the elimination of malpractice claims having no merit.

Another criticism, and one which belongs exclusively to the medical community, is that a pretrial screening procedure would result in more malpractice claims being made. Obviously the real thrust of this criticism is not that more claims will be made or that more cases will be submitted for panel review, but that somewhere in the process more instances of negligent injury will be uncovered. If so, so be it! If the medical community is sincere in its desire for the self-policing of its professionals, why should negligent injuries remain uncompensated because of the absence of an impartial claim evaluation process? Is it unjust that negligent injuries be discovered? Is the objection to this proposal merely another mechanism to perpetuate

the potential injustice that can result from reluctance of members of the medical profession to become a witness for the plaintiff in a medical malpractice lawsuit?

VI. THE 1976 "MINI-SESSION" OF THE GENERAL ASSEMBLY

Letters recently have been forwarded to members of the General Assembly suggesting that the recommendations of the Study Commission be considered, after an enabling two-thirds vote, by the abbreviated 1976 Budget Session of the General Assembly.

One letter contained statements that some physicians "have to pay as much as $12,000 for medical malpractice insurance coverage" and "that insurance for hospitals is now costing $200 per bed." Reference is made to the fact that cost of malpractice insurance is thus increased nine hundred per cent. May I suggest that the letter paints the picture of a dire emergency which in fact does not exist. The communication does not reflect the true status of either malpractice claims or malpractice insurance availability in North Carolina.

It is respectfully suggested that the letter is politically oriented and reflects the political climate of the day. Physicians paying $12,000 per year for medical malpractice insurance are so insignificant in number that the requested information was not readily available from the Medical Society's Mutual Insurance Company. The coverage provided by the indicated premium is that for an "occurrence" type policy for the high risk surgeons and the same limit of coverage is available for a "claims-made" type policy for approximately $3,600.00. The surgeon or surgeons paying the $12,000 sum is thus paying that amount because he

chooses to do so and probably in anticipation of early retirement. Thus it can be seen that the 900% figure is grossly misleading as to the urgency for legislative action. In addition, it should be pointed out that $200 per bed per year for hospital liability insurance premium does not add any significant increment to the costs of medical care and treatment for our citizens. If that hospital bed is used for forty weeks by forty different patients it is elementary that each patient would have added to his hospital bill $5.00 for one week's stay. This cost would in most events be covered by hospitalization insurance.

If members of the General Assembly give in to political pressure and vote to consider the recommendations of this Study Commission at the 1976 Budget Session, it is a foregone conclusion that the members of the General Assembly will further yield to political pressure and in the words of a recent editorial, we will have "a half baked loaf."

If the 1976 Session of the General Assembly enacts legislation in the field of medical malpractice, it will, in my opinion, be a sad day for justice in North Carolina. We will see one of two things. If the recommended legislation is introduced, by two-thirds vote of the General Assembly in 1976, in my opinion it will result in drastic changes in the tort law of North Carolina which has developed over a period of two hundred years. Most likely these changes would be effected without careful and extensive review and analysis by a single Judiciary committee of either House. Two or three weeks of consideration by insurance committees will not provide adequate safeguards for the protection

of all segments of our society. It is not enough to say that long and careful consideration has been given by the Professional Liability Insurance Study Commission. Meaning no disrespect, the regular voting membership of the Study Commission during its extended deliberations consisted of 2 doctors, 2 insurance company representatives, a hospital administrator, and a pharmacist. Some members of the Study Commission have no more reason to be familiar with the concepts of due process in the courts of a free democratic society where basic American justice is meted out to our citizens than this writer has with the operative procedures in corrective surgery for coarctation of the aorta.

If the General Assembly votes to consider the recommendations of the Study Commission in the 1976 Session, we will have either chaos or the greatest railroad job in the history of North Carolina. The choice is ours.

Respectfully submitted,

Tom Suddarth

H. B. 567 **CHAPTER 623**

AN ACT TO CREATE A NORTH CAROLINA PROFESSIONAL LIABILITY INSURANCE STUDY COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. Commission created, purpose. There is hereby created a Professional Liability Insurance Study Commission. The commission shall have the responsibility to make a thorough and comprehensive study on any and all aspects of professional liability insurance including but not limited to the following:

(1) The problems which insurance companies face in writing professional liability insurance in North Carolina and other states of the Union.

(2) The problems which professionals (particularly professionals in the health care professions) have in obtaining professional liability insurance in North Carolina, including problems dealing with the adequacy of coverage, limits of coverage, availability of coverage and reasonableness of rates.

(3) The desirability and feasibility of: (a) Affording professional liability insurance through the establishment of a State-operated fund or insurance company; (b) Creating a State Administrative Board or Commission with the necessary expertise to hear and determine questions of fact relating to professional malpractice and the amount of damages injured persons are entitled to recover resulting therefrom; (c) Implementing compulsory arbitration procedures for the determination of professional malpractice disputes; and (d) Improving the quality of professional services through strict supervision and control by State licensing boards.

(4) The desirability and feasibility of (a) amending the Statute of Limitations with reference to professional malpractice claims; (b) eliminating contingent fee contracts between attorneys and clients in malpractice claims; and (c) implementing a joint underwriting association or reinsurance pool underwritten by insurers or the State or federal government.

Sec. 2. Appointment of membership; composition; tenure of office. The commission shall consist of 12 members who shall be appointed as follows: The Speaker of the House shall appoint six members, four persons from membership of the House, one person representing insurance companies writing professional liability insurance in this State and one person who shall be a professional in the delivery of health care services in this State. The President of the Senate shall appoint six members, four from the membership of the Senate, one person representing insurance companies writing professional liability insurance in this State, and one person who shall be a professional in the delivery of health care services in this State. The members shall serve until the termination of the commission. If a vacancy occurs in the membership, the appointing authority shall appoint another person to serve until the termination of the commission. Members of the commission shall take office upon their appointment. The commission shall terminate upon the filing of a report with the General Assembly.

Sec. 3. Duty to report. The commission shall submit a written report and recommendations, including recommended legislation, to the General Assembly on or before March 15, 1976, or as soon thereafter as practicable.

Sec. 4. Organization of commission; employment of professional and clerical staff. The members of the commission shall elect one of their members as chairman and one member as vice-chairman. The chairman shall preside at all meetings of the commission and in his absence the vice-chairman shall act as chairman. The commission is authorized to employ such professional and clerical staff and assistants as are necessary to the performance and execution of its duties from such funds as shall be made available for this purpose.

Sec. 5. Compensation and reimbursement of members. (a) Legislator members of the commission shall be reimbursed for subsistence and travel expenses at the rates set out in G.S. 120-3.1 from funds available to the commission.

(b) The other members of the commission who are not officers or employees of the State shall receive compensation and reimbursement for travel and subsistence expenses at the rates set out in G.S. 138-5 from funds available to the commission.

(c) The members of the commission who are officers or employees of the State shall receive reimbursement for travel and subsistence expenses at the rates set out in G.S. 138-6 from funds available to the commission.

Sec. 6. State departments and agencies to cooperate. Upon request of the commission, State departments and agencies shall provide the commission with any information and assistance that the commission shall deem helpful to its inquiry.

Sec. 7. This act shall become effective upon ratification.

In the General Assembly read three times and ratified, this the 16th day of June, 1975.

S. B. 901 **CHAPTER 861**

AN ACT TO DIRECT THE PROFESSIONAL LIABILITY INSURANCE STUDY COMMISSION TO STUDY: SHORTENING MALPRACTICE SUIT TIME, REQUIRING INFORMED CONSENT BY PERSONS TO BE TREATED BY HEALTH CARE PROVIDERS, AND CHANGING THE HEALTH CARE MALPRACTICE STANDARD.

The General Assembly of North Carolina enacts:

Section 1. The North Carolina Professional Liability Insurance Study Commission created by 1975 North Carolina Session Laws Chapter 623 is directed to study, and to make recommendations for such consideration as it deems necessary, the matters contained in this act. In addition to dealing with the issues specified in Section 1 of its createing act, the Liability Insurance Study Commission shall report to the session of the General Assembly held in the 1976 calendar year on its study and recommendations on the following:

(1) Shortening malpractice suit time (SB901/HB1240) as follows:

(a) The desirability of amending G.S. 1-15(b) by providing that the subsection shall not apply to an action arising out of the furnishing or failure to furnish medical, dental, or other care by a provider of health care, and that such an action shall be deemed to accrue at the time of the occurrence of or the failure to provide such care, except as otherwise provided by statute.

(b) The desirability of amending G.S. 1-17 by providing that an action on behalf of a minor arising out of the medical, dental, or other care by a provider of health care shall not be instituted after the expiration of five years after the cause of action accrued or after such minor becomes seven years of age, whichever is later.

(2) Requiring informed consent by persons to be treated by health care providers (SB902/HB1239) by enacting legislation as follows:

(a) No recovery shall be allowed in any court in this State against a physician, dentist, or other provider of health care for examining, treating, or operating upon a patient without the patient's informed consent where:

1. The action of the physician, dentist, or other provider of health care in obtaining the consent of the patient or of another person authorized to give consent for the patient was in accordance with an accepted standard of medical or dental practice among members of the medical or dental profession with similar training and experience in the same or similar medical or dental community; and

2. A reasonable individual from the information provided by the physician, dentist, or other provider of health care under the circumstances would have a general understanding of the procedures or treatment and of the medically or dentally acceptable alternative procedures or treatment and of the substantial risks and hazards inherent in the proposed procedures or treatment which are recognized by other physicians, dentists, or similar providers of health care in the same or similar community who performs similar treatments or procedures; or

3. The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure of which he complains had he been advised by the physician, dentist, or other provider of health care involved, in accordance with the provisions of paragraphs (a) and (b) of this section.

similar training and experience in the same or similar medical or dental community; and

2. A reasonable individual from the information provided by the physician, dentist, or other provider of health care under the circumstances would have a general understanding of the procedures or treatment and of the medically or dentally acceptable alternative procedures or treatment and of the substantial risks and hazards inherent in the proposed procedures or treatment which are recognized by other physicians, dentists, or similar providers of health care in the same or similar community who performs similar treatments or procedures; or

3. The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure of which he complains had he been advised by the physician, dentist, or other provider of health care involved, in accordance with the provisions of paragraphs (a) and (b) of this section.

(b) A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or another authorized person, shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such signature and consent was obtained by fraud, deception or misrepresentation of a material fact.

(3) Changing the health care malpractice standard (SB903/HB1241) by enacting legislation providing that in any action for damages for personal injury or death arising out of the furnishing or the failure to furnish medical, dental, or other health care, the defendant or defendants shall not be liable for the payment of damages unless the trier of the facts is satisfied by the greater weight of the evidence that the care of such provider or providers of health care was not in accordance with the practices and procedures which were approved and accepted by the providers of such care in the community in which the action arose or in similar communities at the time such action arose.

Sec. 2. This act shall become effective upon ratification.

In the General Assembly read three times and ratified, this the 26th day of June, 1975.

S. B. 915 **CHAPTER 893**

AN ACT TO APPROPRIATE GENERAL FUNDS TO THE NORTH CAROLINA PROFESSIONAL LIABILITY INSURANCE STUDY COMMISSION AND TO FUND SPECIAL STUDIES THROUGH THE LEGISLATIVE SERVICES COMMISSION.

Whereas, House Bill 567 establishes a commission to study professional liability insurance in North Carolina; and

Whereas, without positive legislative action in this important area there is a probability that essential medical services would be seriously curtailed if the availability of professional liability insurance is reduced or terminated; and

Whereas, there is a need for the commission to employ professional and clerical staff with competence in the field of professional liability insurance; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. There is hereby appropriated from the General Fund of the State to the North Carolina Professional Liability Insurance Study Commission the sum of twelve thousand five hundred dollars ($12,500) for fiscal year 1975-1976 and the sum of twelve thousand five hundred dollars ($12,500) for fiscal year 1976-1977 for purposes of employing professional and clerical staff in support of the commission, and to defray all other related travel and subsistence expenses of the commission and its staff.

Sec. 2. The sum of twenty-five thousand dollars ($25,000) is appropriated to the Legislative Services Commission to be used, on the express approval of the commission, to pay the expenses of study commissions or study efforts authorized by the 1975 General Assembly but for which no specific funding was authorized. The funds appropriated by this section may be expended in the 1975-1976 fiscal year, and any amount remaining may be expended during the 1976-1977 fiscal year.

Sec. 3. This act shall become effective July 1, 1975.

In the General Assembly read three times and ratified, this the 26th day of June, 1975.

APPENDIX II

MEMBERS

NORTH CAROLINA PROFESSIONAL LIABILITY INSURANCE STUDY COMMISSION

Representative Ernest B. Messer, Chairman
44th House District - Haywood, Madison, Swain and Jackson Counties

Senator Bob L. Barker, Vice-Chairman
14th Senatorial District - Wake, Harnett and Lee Counties

Senator Julian R. Allsbrook - 6th Senatorial District
Halifax, Edgecombe, Martin and Pitt Counties

Representative John R. Gamble, Jr. - 38th House District
Lincoln and Gaston Counties

Dr. Ira Hardy - Greenville, North Carolina

Mr. John Henderson - Goldsboro, North Carolina

Senator John T. Henley - 10th Senatorial District
Cumberland County

Mr. Robert R. Martin - Laurinburg, North Carolina

Mr. Bernard H. Parker - Raleigh, North Carolina

Representative Thomas B. Sawyer - 23rd House District
Guilford County

Representative Benjamin D. Schwartz - 12th House District
New Hanover County

Senator Thomas H. Suddarth - 21st Senatorial District
Davie, Rowan and Davidson Counties

APPENDIX III

NAMES OF PERSONS APPEARING BEFORE THE NORTH CAROLINA PROFESSIONAL LIABILITY INSURANCE STUDY COMMISSION

Lt. Governor James B. Hunt, Jr.
President of the Senate

The Hon. James C. Green, Speaker
House of Representatives

Dr. James E. Davis, President
N. C. Medical Society

Mr. Marion J. Foster, President
N. C. Hospital Association

Mr. I. B. Hudson
Attorney General's Staff

Dr. William J. Reeves, Pres.
Cabarrus County Medical Society

Mr. William Mills, Attorney
Cabarrus Memorial Hospital

The Honorable John Ingram
Commissioner of Insurance

Miss Vella Nelson
N. C. Association of Nurse Anesthetists

Dr. Roy Agnew, private physician
Salisbury, N. C.

Dr. Norman Sloop, private physician
Rowan County

Mr. Ben W. Aiken, Ass't. Secretary
N. C. Dept. of Human Resources

Dr. Archie Johnson, Ass't. Sec.
N. C. Dept. of Human Resources

Mr. James Long
Chief Deputy Commissioner
N. C. Department of Insurance

Senator Lawrence Davis
20th Senatorial District
Forsyth County

Mr. James Bethune
Independent Insurance Agent

Mr. Jim Chambers, N. C. Manager
The St. Paul Companies

Mr. Tom Thompson, Claims Manager
The St. Paul Companies

Dr. Ed McKenzie, Member
Rowan-Davie Medical Society

Ms. Harriet Loucas, Instructor
Physician Assistant Program
Bowman-Gray School of Medicine

Dr. Odell C. Kimbrell, Jr.,
Pres. of the Board of Trustees
Wake County Hospital System, Inc.

Mr. Ted Dick, Vice President
Collier-Cobb Insurance Agency

Mr. A. H. Williams, Vice-Pres.
Collier-Cobb Insurance Agency

Mr. Gene Phillips
N. C. Academy of Trial Lawyers

Mr. Southgate Jones, Jr.,
President-Elect
Independent Insurance Agents

Mr. Ruffin Bailey
American Insurance Association

Mr. Bernard H. Parker, Vice-Pres.
Nationwide Insurance Company

Appendix III

Mr. Steven Morrisette, Director
Governmental Affairs
N. C. Medical Society

Mr. Dennis R. Barry, Director
N. C. Memorial Hospital

Dr. William Easterling
Chief of Staff
N. C. Memorial Hospital

Dr. Christopher Fordham, III
Dean of the UNC School of
Medicine

Ms. Patricia Wagner,
Hospital Attorney
Office of the Attorney General
of North Carolina

Mr. William Holdford
N. C. Academy of Trial Lawyers

NORTH CAROLINA

APPENDIX IV

PROFESSIONAL LIABILITY COVERAGE

PHYSICIANS AND SURGEONS APPROVED RATES

Classification	(1) I.S.O. "Occurrence" Annual Rates				(1) I.S.O. "Claims Made" Annual Rates		
	$ 100/300 Previous I.S.O. Rates (2)	$ 100/300 St. Paul after Dec.'74(3)	$ 100/300 Present I.S.O. Rates (4)	$ 1,000,000 Excess(5)	$ 100/300	$ 1,000,000 Excess(5)	Single Premium Reporting Endorsement
GP - No surgery	$ 118.75	$ 175.00	$ 967.44	$ 1,934.88	$ 192.00	$ 384.00	$ 556.00
GP - Minor surgery	210.00	308.00	1,741.74	3,483.48	310.00	620.00	910.00
GP - Major surgery	357.50	524.00	2,952.36	5,904.72	497.00	994.00	1,468.00
General Surgeon	476.25	696.00	4,920.60	9,841.20	798.00	1,596.00	2,376.00
Cardiac Surgeon	476.25	696.00	4,920.60	9,841.20	798.00	1,596.00	2,376.00
Otolaryngologist	476.25	696.00	4,920.60	9,841.20	798.00	1,596.00	2,376.00
Vascular Surgeon	476.25	696.00	7,872.96	15,745.92	1,251.00	2,502.00	3,736.00
Thoracic Surgeon	476.25	696.00	7,872.96	15,745.92	1,251.00	2,502.00	3,736.00
Urologist	476.25	696.00	3,936.48	7,872.96	648.00	1,296.00	1,922.00
Anesthesiologist	595.00	871.00	4,920.60	9,841.20	1,197.00	2,288.00	2,376.00
Neurosurgeon	595.00	871.00	7,872.96	15,745.92	1,877.00	3,606.00	3,736.00
OB - GYN	595.00	871.00	5,904.72	11,809.44	949.00	1,898.00	2,830.00
Orthopedic Surgeon	595.00	871.00	7,872.96	15,745.92	1,251.00	2,502.00	3,736.00
Plastic Surgeon	595.00	871.00	5,904.72	11,809.44	949.00	1,898.00	2,830.00

(1) I.S.O. is the Insurance Services Office, a statistical agent and advisory rating bureau servicing North Carolina insurance companies.
(2) These rates were in effect until the approval of the June 20, 1975 I.S.O. filing was approved.
(3) These figures indicate the actual premium charged by St. Paul after the Dec. 1974 rate increase.
(4) These figures reflect the June 20, 1975 I.S.O. rate filing as approved.
(5) $100,000 excess (over and above $100/300 thousand) coverage premiums are normally twice the $100/300 premium.

NORTH CAROLINA

GENERAL CASUALTY COVERAGE

COMPREHENSIVE HOSPITAL LIABILITY RATES

Classification	Rating Basis	100/300 "Occurrence" Rates			100/300 "Claims Made" Rates
		Previous Rates	Present Rates		
			St. Paul	Medical Mutual	
		$	$	$	$
Hospitals					
For Profit	Per bed	44.55	221.94	353.16	110.97
	Visits *	4.46	22.19	35.64	11.10
Not for profit	Per bed	27.54	136.08	353.16	68.04
	Visits *	2.75	13.61	35.64	6.81
Mental Psychopathic Institutions					
For profit	Per bed	66.42	330.48	529.74	165.24
	Visits *	6.64	33.05	52.65	16.53
Not for profit	Per bed	55.08	273.78	529.74	136.64
	Visits *	5.51	27.38	52.65	13.69
Sanitariums or Health Institutions					
For profit	Per bed	33.21	165.24	264.06	82.62
	Visits *	3.32	16.52	26.73	8.26
Not for profit	Per bed	27.54	136.08	264.06	68.04
	Visits *	2.75	13.61	26.73	6.81

* Visits rating basis is per 100 outpatients' visits

Note: The minimum premium per location is normally ten times the per bed rate.

Appendix IV

NORTH CAROLINA MALPRACTICE LOSSES

THE ST. PAUL COMPANIES PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

LOSS AND LOSS EXPENSE EXPERIENCE

Accident Year	Claims Reported	Claims Closed No Payment	Claims Paid	Amount Paid	Paid Loss Expense	Claims Open At Year's End
Prior to 1969	N/A	N/A	91	$456,996	$297,107	79 (1)
1969	26	35	13	115,630	34,304	67
1970	16	28	5	19,520	9,114	69
1971	39	45	10	28,438	6,340	85
1972	35	20	11	58,861	8,809	105
1973	105	47	13	72,040	N/A	120
1974	168	71	19	277,339	N/A	158
1975(2)	143 (3)	37	23	361,783	N/A	227
Total since Jan. 1,1969	532	283	94	$933,611	N/A	

Notes:

(1) Indiciates claims open as of Dec. 31, 1968
(2) As of 10-16-75
(3) As of 7-1-75
N/A Not Available

Appendix IV

THE ST. PAUL COMPANIES

PHYSICIANS & SURGEONS CLAIMS

INVOLVING MINORS

01-01-71/10-28-75

Accident Date	Date Reported	Suit Filed
10-05-72 age 16	04-28-75 age 19	No
02-10-65 age 18	07-20-73 age 26	07-12-73 age 26
03-05-68 age 14	01-25-74 age 19	01-18-74 age 19
05-01-68 age 2	03-05-73 age 7	No
05-30-67 age 13	02-12-75 age 20	02-11-75 age 20
06-26-67 age 6	06-03-70 age 9	11-30-70 age 10
05-14-64 age 7	08-25-75 age 18	No

THE ST. PAUL
COMPANIES

Serving you around the world . . . around the clock

RALEIGH OFFICE
P. O. BOX 12225, 1620 HILLSBORO STREET
RALEIGH, N. C. 27605
PHONE 828-5075

Appendix IV

November 20, 1975

Senator Tom Suddarth
Legislative Study Commission
North Carolina Legislative Building
Raleigh, North Carolina

Dear Senator Suddarth:

To our knowledge, in North Carolina, we have not had any reported claims involving Senate Bill 572 which became effective July 21, 1971.

It is likely that an insufficient period of time has passed to properly evaluate the effect of the "10 year discovery statute."

If we can be of further assistance, please let us know.

Yours very truly,

THE ST. PAUL COMPANIES

John E. Foster
Claims Manager

cc: J. W. Thompson
Charlotte, N.C.

JEF/vlc

APPENDIX V

NORTH CAROLINA PROFESSIONAL LIABILITY INSURANCE STUDY COMMISSION

INTERIM REPORT

OCTOBER 23, 1975

TO: Lt. Governor James B. Hunt, Jr.
Speaker James C. Green, Sr.

In compliance with your joint directive to the Professional Liability Insurance Study Commission dated October 17, 1975, the Commission submits the following report:

The Study Commission has determined that the crisis created by the lack of availability of medical malpractice insurance has abated. The Commissioner of Insurance of North Carolina and the President of the St. Paul Companies have informed the Study Commission that they have reached an agreement whereby the St. Paul Companies will again provide insurance coverage for all clients insured before the St. Paul Companies' withdrawal from the State.

The North Carolina Medical Society has agreed, through the establishment of a mutual insurance company, to provide professional liability insurance to eligible risks, as defined in G.S. 58-173.32(4), who wish to be insured through that company. The Commission is of the opinion that these two insurance carriers will provide adequate coverage for North Carolina health care providers.

Inasmuch as the Study Commission concludes that a crisis no longer exists in the availability of medical malpractice insurance, the Study Commission does not recommend that a special session of the General Assembly be convened to consider this problem.

The Study Commission further recommends that at the next convening of the General Assembly, consideration be given to any changes or innovations in the procedure for handling malpractice suits and in the tort law that are recommended by the Study Commission, so as to provide a better climate for both providers and insurers of health care without compromising the basic rights of our citizens. The Commission believes that some changes might be necessary if future crises in the availability of professional liability insurance are to be avoided.

The Study Commission will make specific recommendations to the next convened General Assembly on those subjects it feels are appropriate for change or innovation, including but not limited to the following areas:

1. the statute of limitations
2. the standard of care
3. the doctrine of informed consent
4. the ad damnum clause
5. limitations on recovery for malpractice
6. attorneys' contingency fees
7. counterclaim procedures
8. the collateral source rule
9. periodic versus lump-sum payments of malpractice awards
10. pre-trial screening panels
11. the burden of proof in malpractice cases
12. limitations on liability through insurance coverage with a fund to back up judgments in excess of insurance coverage

13. immunity for health care providers involved in emergency medical care situations

The Study Commission will continue to monitor the professional liability situation in North Carolina. Should any problems arise which require the immediate attention of the Study Commission, the Commission will take necessary and appropriate action.

Respectfully submitted,

Rep. Ernest B. Messer, Chairman

Sen. John T. Henley

Sen. Bob L. Barker, Vice Chairman

Mr. Robert R. Martin

Sen. Julian R. Allsbrook

Mr. Bernard H. Parker

Rep. John R. Gamble, Jr.

Rep. Thomas B. Sawyer

Dr. Ira Hardy

Rep. Benjamin D. Schwartz

Mr. John Henderson

Sen. Thomas H. Suddarth

APPENDIX VI

A BILL TO BE ENTITLED

AN ACT TO REVISE AND PROVIDE FOR PROCEDURAL AND SUBSTANTIVE LAWS GOVERNING CLAIMS FOR PROFESSIONAL MALPRACTICE: TO SHORTEN THE STATUTE OF LIMITATIONS FOR ADULTS AND MINORS; TO PROVIDE FOR A STANDARD OF CARE, A DOCTRINE OF INFORMED CONSENT, A NEW COLLATERAL SOURCE RULE, AN EXTENSION OF THE GOOD SAMARITAN LAW, ELIMINATION OF THE AD DAMNUM CLAUSE; AND TO ESTABLISH THE PATIENTS' COMPENSATION FUND.

The General Assembly of North Carolina enacts:

Section 1. G.S. 1-15(b), as the same appears in the 1975 Cumulative Supplement to Volume 1A of the General Statutes, is amended by deleting the comma "(,)" following the word "death" in the second line and substituting the following:

"or one for malpractice arising out of the performance of or failure to perform professional services,"

Sec. 2. G.S. 1-15, as the same appears in the 1975 Cumulative Supplement to Volume 1A of the General Statutes, is amended by adding a new subsection (c) to read as follows:

"(c) Except where otherwise provided by statute, a cause of action for malpractice arising out of the performance of or failure to perform professional services shall be deemed to accrue at the time of the occurrence of the last act of the defendant giving rise to the cause of action: Provided that whenever there is bodily injury to the person, economic or monetary loss, or a defect in or damage

to property which originates under circumstances making the injury, loss, defect or damage not readily apparent to the claimant at the time of its origin, and the injury, loss, defect or damage is discovered or should reasonably be discovered by the claimant two or more years after the occurrence of the last act of the defendant giving rise to the cause of action, suit must be commenced within one year from the date discovery is made: Provided further, that in no event shall an action be commenced more than four years from the last act of the defendant giving rise to the cause of action."

Sec. 3. G.S. 1-17, as the same appears in the 1975 Cumulative Supplement to Volume 1A of the General Statutes, is amended by designating present G.S. 1-17 as subsection (a) and by adding a new subsection (b) to read as follows:

"(b) Notwithstanding the provisions of subsection (a) of this section, an action on behalf of a minor for malpractice arising out of the performance of or failure to perform professional services shall be commenced within the limitations of time specified in G.S. 1-15(c): Provided, that when the last act of the defendant giving rise to the minor's cause of action occurs while such minor is under the full age of seven years, the cause of action shall be deemed to accrue at the time such minor attains the full age of seven years, subject to such additional time as allowed by G.S. 1-15(c)."

Sec. 4. Chapter 8 of the General Statutes is amended by adding a new article to read as follows:

"ARTICLE 13.

"Medical Malpractice Actions.

"§ 8-92. Definition.--As used in this Article, the term "health care provider" means without limitation any person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, chiropody, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital as defined by G.S. 131-126.1(3); or a nursing home as defined by G.S. 130-9(e)(2); or any other person who is legally responsible for the negligence of such person, hospital or nursing home.

"§ 8-93. Standard of health care.--In any action for damages for personal injury or death arising out of the furnishing of or the failure to furnish medical, dental, or other health care, the defendant shall not be liable for the payment of damages unless the trier of the facts is satisfied by the greater weight of the evidence that the care of such health care provider was not in accordance with the practices and procedures for services which were provided in the same or similar communities by similar health care providers at the time of the alleged act giving rise to the cause of action.

"§ 8-94. Informed consent to health care treatment or procedure.--(a) No recovery shall be allowed against any health care

provider upon the grounds that the health care treatment was rendered without the informed consent of the patient or the patient's spouse, parent, guardian, nearest relative or other person authorized to give consent for the patient where:

(1) The action of the health care provider in obtaining the consent of the patient or other person authorized to give consent for the patient was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar community; and

(2) A reasonable person, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar community; or

(3) A reasonable person, under all the surrounding circumstances would have undergone such treatment or procedure of which he complains had he been advised by the health care provider involved, in accordance with the provisions of paragraphs (1) and (2) of this section.

(b) A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person, shall be presumed to be a valid consent.

This presumption, however, may be subject to rebuttal only upon proof that such signature and consent was obtained by fraud, deception or misrepresentation of a material fact.

(c) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

(d) No action shall be brought whereby to charge any health care provider upon any guarantee, warranty or assurance as to the results of any medical, surgical or diagnostic procedures or treatment performed by any health care provider unless the agreement or promise upon which such action shall be brought, or some note or memorandum thereof shall be in writing and signed by the party to be charged therewith or by some other person by him thereunto lawfully authorized.

(e) In the event of any conflict between the provisions of this section and those of Article 7 of General Statutes Chapter 35 and Articles 1A and 19 of the General Statutes Chapter 90, the provisions of those Articles shall control and continue in full force and effect.

"§ 8-95. Collateral sources of recovery.--In any action for malpractice arising out of the performance of or failure to perform professional services where the plaintiff seeks to recover for the cost of medical care, custodial care or rehabilitation services, loss of earnings or other economic loss, an award of damages shall not be reduced by insurance proceeds or payments or other benefits paid under any insurance policy or contract where the premium or cost of such insurance policy or contract was paid either by or for the person or on behalf of a dependent who has obtained the

award, but shall be reduced by any other collateral recovery for medical and hospital care, custodial care or rehabilitation services, loss of earnings or other economic loss.

"§ 8-96. First aid or emergency treatment; liability limitation. --(a) Any person who renders first aid or emergency health care treatment to a person who is unconscious, ill or injured,

(1) when the circumstances require prompt decisions and actions in medical or other health care, and

(2) when the necessity of immediate health care treatment is so apparent that any delay in the rendering of the treatment would seriously worsen the physical condition or endanger the life of the person,

shall not be liable for damages for injuries alleged to have been sustained by the person or for damages for the death of the person alleged to have occurred by reason of an act or omission in the rendering of the treatment unless it is established that the injuries were or the death was caused by gross negligence, wanton conduct or intentional wrongdoing on the part of the person rendering the treatment.

(b) Nothing in this section shall be deemed or construed to relieve any person from liability for damages for injury or death caused by an act or omission on the part of such person while rendering health care services in the normal and ordinary course of his business or profession.

(c) In the event of any conflict between the provisions of this section and those of G.S. 20-166(d), the provisions of G.S. 20-166(d) shall control and continue in full force and effect.

Sec. 5. G.S. 1A-1, Rule 8, as the same appears in the 1969

Replacement Volume 1A of the General Statutes, is amended by adding a new subsection to read as follows:

"(g) Ad damnum rule. --Notwithstanding any provision in this Chapter, a pleading which sets forth a claim for relief for malpractice arising out of the performance of or failure to perform professional services shall not state a demand for a specific amount of monetary relief: Provided that such pleading shall state that the relief demanded is to compensate the plaintiff for damages incurred or to be incurred and that the monetary relief requested is within or exceeds the court's jurisdictional requirements."

Sec. 6. Chapter 58 of the General Statutes is amended by adding a new Article 26B to read as follows:

"ARTICLE 26B.

"Patients' Compensation Fund.

"§ 58-254.20. Definition.--As used in this Article, the term "health care provider" means without limitation any person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, chiropody, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital as defined by G.S. 131-126.1(3); or a nursing home as defined by G.S. 130-9(e)(2); or any other person who is legally responsible for the negligence of such person, hospital or nursing home.

"§ 58-254.21 Qualification; applicability of Article.--(a) To be qualified under the provisions of this Article, a health care provider shall:

(1) File with the Commissioner of Insurance proof of financial responsibility as provided in subsection (e) of this section in the amount of one hundred thousand dollars ($100,000) or more; and

(2) Pay the surcharge assessed by this Article on all health care providers according to G.S. 58-254.23.

(b) Subject to subsection (f) of this section, a health care provider qualified under this article is not liable for a claim of malpractice for an amount in excess of the amount stated in his proof of financial responsibility.

(c) Any amount due from a judgment, "arbitration award" or court-approved settlement which is in excess of the total liability of all liable health care providers, subject to subsections (b) and (f) of this section, shall be paid from the Patient's Compensation Fund pursuant to the provisions of G.S. 58-254.23, and shall inure respectively to the exclusive benefits of all liable health care providers.

(d) A health care provider who fails to qualify under this Article is not covered by the provisions of this Article and is subject to liability under the law without regard to the provisions of this Article. If a health care provider does not so qualify, the patient's remedy will not be affected by the terms and provisions of this Article.

(e) Financial responsibility of a health care provider under this Article may be established only by filing with the Commissioner of Insurance proof that the health care provider is insured by a policy of malpractice liability insurance or is a participant in an insurance trust (which trust shall pay to or for the account of the participant), or is otherwise self-insured and files with the State Treasurer bond, collateral or other security, in the amount of at least one hundred thousand dollars ($100,000) per occurrence.

(f) Nothing in this Article shall be deemed or construed to:

(1) limit the personal liability of any health care provider for malpractice arising out of the performance of or failure to perform professional services;

(2) limit the amount of compensation from any final judgment, arbitration award or court-approved settlement to any claimant injured as a result of said malpractice; or

(3) permit the filing by any claimant of an action against the Fund that is separate or independent from his action against a health care provider.

58-254.22. Advance payments; claims non-assignable.-- (a) Except as provided in G.S. 58-254.24, any advance payment made by the defendant health care provider or his insurer to or for the plaintiff, or any other person, may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice.

(b) Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the judgment to the plaintiff to the extent of the advance payment. The advance payment shall inure to the exclusive benefit of the defendant or his insurer making the payment. In the event the advance payment exceeds the liability of the defendant or the insurer making it, the court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs. In no case shall an advance payment in excess of an award be repayable by the person receiving it.

(c) A patient's claim for compensation under this Article is not assignable.

58-254.23. Patients' Compensation Fund; creation; surcharge; maintenance; claims against the Fund.--(a) There is hereby created the Patient's Compensation Fund (hereinafter referred to as the "Fund") to be collected and received by the State Treasurer for exclusive use for the purposes stated in this Article. The Fund and any income from it, shall be held in trust, deposited in a segregated account, invested and reinvested by the State Treasurer, and shall not become a part of the General Fund of the State.

(b) To create the Fund, an annual surcharge shall be levied on all health care providers who qualify under the provisions of G.S. 58-254.21(a). Subject to the provisions of subsection (f) of this section, the surcharge shall be determined by the Commissioner of Insurance based upon actuarial principles and shall not exceed fifty percent (50%) of the cost to each health care provider for maintenance of financial responsibility. The surcharge shall be

collected by the same method as premiums by each insurer and shall be forwarded to the Fund. If a health care provider is a participant in an insurance trust or is otherwise self-insured, the health care provider shall forward the surcharge to the Fund. On or before March 30 of each year, the Commissioner shall notify all participating health care providers, insurers and trust funds of the surcharge rates for that year.

(c) Such surcharge shall be due and payable within thirty days after the premiums for malpractice liability insurance have been received by the insurer, or, if the health care provider is a participant in an insurance trust or is otherwise self-insured, on or before April 30 of each year. Before the effective date of this Article, the Commissioner of Insurance shall send to each insurer a statement explaining the provisions of this Article together with any other information necessary for their compliance with this Article.

(d) If the annual premium surcharge has been established and is not paid within the time limited above, the certificate of authority of the insurer may be suspended until the annual premium surcharge is paid. If the health care provider is a participant in an insurance trust or is otherwise self-insured, and the annual premium surcharge is not paid on or before April 30, the Commissioner of Insurance shall notify the appropriate licensing, registration or certification authority.

(e) All expenses of collecting, protecting and administering the Fund shall be paid from the Fund.

(f) Following the effective date of this Article, the surcharge provided for in this section shall be established at 50% of

the cost to each health care provider for the maintenance of financial responsibility until the Fund reaches a level of four million dollars ($4,000,000). At that time, or, at the end of any calendar year after the payment of all claims and expenses, if the Fund exceeds the sum of four million dollars ($4,000,000), the Commissioner of Insurance shall reduce the surcharge provided in this section in order to maintain the Fund at an approximate level of four million dollars ($4,000,000).

(g) All claims against the Fund shall be computed on December 31 of each year in which the claims become final. All claims shall be paid on or before January 15 of each year. If the Fund would be exhausted by payment in full of all claims allowed during a calendar year, then the amount paid to each claimant shall be prorated. Any amounts due and unpaid shall be paid in the following calendar year or subsequent calendar years in the chronological order that the claims have reached final judgment or award, or have been settled and approved by a court pursuant to Subsection (h) of this section.

(h) The State Treasurer shall issue a warrant in the amount of each claim submitted by the Commissioner of Insurance to him against the Fund on December 31 of each year. The only claim against the Fund shall be a voucher or other appropriate request by the State Treasurer after he receives:

(1) a certified copy of a final judgment against a health care provider in excess of the amount stated in his proof of financial responsibility; or

(2) a certified copy of a court approved settlement between a claimant and a health care

provider in excess of the amount stated in the health care provider's proof of financial responsibility; or

(3) a certified copy of a final arbitration award against a health care provider in excess of the amount stated in his proof of financial responsibility.

"§ 58-254.24. Settlement procedure.--(a) If the insurer or trust fund of a health care provider has agreed to settle its liability on a claim against its insured or trust fund participant by payment of its policy or trust fund limits, or if a self-insured health care provider has likewise agreed, and the claimant is demanding an amount in excess thereof for a complete and final release, the claimant and the health care provider may agree to a settlement from the Fund, subject to the provisions of this section.

(b) Where the claimant and the health care provider have agreed to a settlement from the Fund, a petition shall be filed by the claimant and health care provider within twenty days after the agreement is reached, with the superior court of the county in which the cause of action arose, seeking approval of the agreed settlement and demanding payment of damages from the Fund.

(c) The judge of the court in which the petition is filed shall set the petition for hearing before the judge as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider and the State Treasurer.

(d) At the hearing the claimant, the health care provider and the attorney for the Fund may introduce relevant evidence to

enable the judge to determine whether or not the petition should be approved. The judge may refer any matter regarding the issue of damages to the Attorney General for his opinion pursuant to G.S. 114-2(5).

(e) In approving a settlement the judge shall consider the damages sustained by the claimant as established and render a finding and a consent judgment accordingly.

(f) If the settlement is not approved by the judge, the judge shall render a finding and judgment accordingly. In such case the claimant and the health care provider shall be left to their remedies at law. The finding and judgment shall not be admissible as evidence in any action pending or subsequently brought by the claimant in a court of law.

(g) Notwithstanding the provisions of Article 27 of General Statutes Chapter 1, any order disapproving an agreed settlement shall not be appealed: Provided that if the claimant has not commenced an action against the health care provider in a court of law, the applicable statute of limitations shall be tolled up to and including a period of 90 days following the issuance of the order disapproving the settlement.

"§ 58-254.25 Reporting of claims.--(a) All malpractice claims settled or adjudicated to final judgment against a health care provider that are in excess of the health care provider's insurance policy, trust or self-insurance limits shall be reported to the Commissioner of Insurance by the plaintiff's attorney and by the health care provider or his insurer within sixty days following

final disposition of the claim. The report to the Commissioner of Insurance shall state the following:

(1) nature of the claim;

(2) damages asserted and alleged injury;

(3) attorney's fees and expenses incurred in connection with the claim or defense; and

(4) the amount of any settlement or judgment.

(b) The information contained within the reports as required by this section is to be used for internal statistical purposes only. Therefore, such information shall be privileged and not be disseminated to the general public.

"§ 58-254.26. Acceptance of and compliance with Article.--(a) The filing of proof of financial responsibility with the Commissioner of Insurance shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of the provisions of this Article.

(b) Any provision in a policy attempting to limit or modify the liability of the insurer contrary to the provisions of this Article is void.

"§ 58-254.27. Incorporation of Article into policy provisions; revocation of approval of policy form.--(a) Every insurance policy issued or trust arrangement executed under this Article is deemed to include the following provisions, and any change which may be occasioned by legislation adopted by the General Assembly of the State of North Carolina as fully as if it were written therein:

(1) The insurer or trust fund assumes all obligations to pay an award imposed against its insured within the policy or trust arrangement limits

and under the provisions of this Article; and

(2) Any termination of the policy or trust arrangement by cancellation is not effective as to patients claiming against the insured covered hereby, unless at least thirty days before the taking effect of the cancellation, a written notice giving the date upon which termination becomes effective has been received by the insured and the Commissioner of Insurance at their offices.

(b) If an insurer fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails, or refuses to comply with any provisions of this Article, absent any material misconduct or noncompliance by its insured, in addition to any other legal remedy, the Commissioner of Insurance may also revoke the approval of its policy form until the insurer pays the award or judgment or has complied with the violated provisions of this Article and has resubmitted its policy form and received the approval of the Commissioner of Insurance.

(c) If a health care provider fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails, or refuses to comply with any provisions of this Article, in addition to any other legal remedy, the Commissioner of Insurance may also notify the appropriate licensing, registration or certification authority of his refusal to do so.

"§ 58-254.28. Protection of the Fund.--(a) The Office of the Attorney General shall provide one or more attorneys for the purpose

of representing the Fund in any action, arbitration proceeding or settlement procedure where the amount demanded by the claimant exceeds the limits of a health care provider's insurance policy, trust fund or self-insurance. The Fund shall reimburse the Office of the Attorney General for all expenses incurred in representing the Fund.

(b) Notice of any claim exceeding a health care provider's insurance policy, trust fund or self-insurance limits shall be given to the State Treasurer by the health care provider against whom the claim is made within 10 days after the health care provider receives notice or a statement of the total amount demanded by the claimant."

Sec. 7. Article 2 of General Statutes Chapter 58 is amended by adding a new Section 58-21.1 to read as follows:

"58-21.1. Annual statements by professional liability insurers.--(a) Every insurance company authorized to write professional liability insurance in the State shall file in the office of the Commissioner of Insurance, on or before the first day of February in each year, in form and detail as the Commissioner of Insurance prescribes, a statement showing the items set forth hereinafter, as of the preceding thirty first day of December, signed and sworn to by the chief managing agent or officer thereof, before the Commissioner of Insurance or some officer authorized by law to administer oaths. The Commissioner of Insurance shall, in December of each year, furnish to each of the insurance companies authorized to write professional liability insurance in the State forms for the annual statements. Provided, that the Commissioner may, for good and sufficient cause shown by an applicant company, extend the filing date of such annual statement for such company, for a reasonable period of time, not to exceed 30 days.

PROFESSIONAL LIABILITY INSURERS: ANNUAL STATEMENT

(1) Number of claims pending at beginning of year;

(2) Number of claims pending at end of year;

(3) Number of claims settled paid:

(a) Highest award

(b) Lowest award

(c) Average award;

(4) Number of claims settled no payment;

(5) Number of claims to Court in which award paid;

(6) Number of claims out of Court in which award paid;

(7) Average amount per claim set up in reserve;

(8) Total premium collection;

(9) Total expenses less reserve expenses; and

(10) Total reserve expenses.

(b) The information contained within the reports as required by this section is to be used for internal statistical purposes only. Therefore, such information shall be privileged and not be disseminated to the general public."

Sec. 8. If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or application which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Sec. 9. This act shall not apply to pending litigation.

Sec. 10. This act shall become effective on July 1, 1976.

APPENDIX VII

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR PERIODIC PAYMENTS OF PROFESSIONAL MALPRACTICE AWARDS INSTEAD OF LUMP SUM PAYMENTS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 1 of the General Statutes is amended by adding a new article to read as follows:

"ARTICLE 44B

"Periodic Payments of Malpractice Awards.

"§ 1-543.10. Definitions.--Unless a different meaning is required by the context, the following terms as used in this Article shall have the meanings hereinafter respectively ascribed to them:

(1) "Future damages" means without limitation damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

(2) "Periodic payments" means the payment of money or delivery of other property to the judgment creditor at regular intervals.

"§ 1-543.11. Periodic payments authorized; procedure.--(a) In any action for malpractice arising out of the performance of or failure to perform professional services, a superior court may at the request of either party, make a specific finding of damages sustained by the injured party as of the date of an award and a specific finding of future damages, as defined in G.S. 1-543.10(1), and may enter a judgment ordering that money damages or its equivalent

for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if it is found that such future damages equal or exceed one hundred thousand dollars ($100,000). In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to file with the court such bond, collateral or other security as the court deems adequate to assure full payment of such damages awarded by the judgment.

(b) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification upon proper motion and findings by the court that a change in circumstances justifies such modification: Provided that money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to the estate of the judgment creditor.

(c) The judgment ordering periodic payments shall provide that:

(1) All court approved taxable costs shall be paid in a lump sum;

(2) The fee of an attorney representing the judgment creditor shall be subtracted from

the recovery of the judgment creditor before the periodic payment recovery is computed as specified in subsection (b) of this section. This fee shall be paid in a lump sum within twenty days of entry of judgment unless the judgment creditor and his attorney agree to, and the court approves as being equitable, a plan which provides for the installment payment of this fee.

"§ 1-543.12. Actual default of judgment debtor.--In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments as specified in G.S. 1-543.11(b), the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

"§ 1-543.13. Anticipatory default of judgment debtor.--The court may accelerate the periodic payments or require additional bond, collateral or other security or both upon proper motion and findings that:

(1) the judgment debtor threatens or is about to remove or dispose of his property with intent to defraud the judgment creditor; or

(2) the prospect of payment by the judgment debtor is otherwise impaired.

"§ 1-543.14. Lien on real property of judgment debtor; recordation. --A certified copy of any judgment or order of any superior court of this State issued pursuant to G.S. 1-543.11, when recorded with the clerk of court of any county, shall from such recording become a lien upon all real property of the judgment debtor, not exempt from execution, in such county, owned by him at the time, or which he may afterwards and before the lien expires, acquire, for the respective amounts and installments as they mature, but shall not become a lien for any sum or sums prior to the date they severally become due and payable, which liens shall have, to the extent herein provided and for the period of 10 years from such recording, the same force, effect and priority as the lien created by recordation of an abstract of a money judgment pursuant to G.S. 1-234.

"§ 1-543.15. Satisfaction of judgment; reversion of security. --(a) The certificate of the judgment debtor, certified by him under penalty of perjury, that all amounts and installments which have matured under said judgment prior to the date of such certificate have been fully paid and satisfied shall, when acknowledged and recorded, be prima facie evidence of such payment and satisfaction and conclusive in favor of any person dealing in good faith and for a valuable consideration with the judgment debtor or his successors in interest.

(b) Whenever a certified copy of any judgment or order of any superior court issued pursuant to G.S. 1-543.11 has been

recorded with the clerk of court of any county, the expiration or satisfaction thereof made in the manner of an acknowledgment of a conveyance of real property may be recorded.

(c) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any bond, collateral or other security given pursuant to G.S. 1-543.11 shall revert to the judgment debtor.

"§ 1-543.16. Reserves for periodic payments. --Notwithstanding any other provision of law, reserve funds set aside by any indemnitor of a judgment debtor for the purpose of drawing therefrom the periodic payments specified in G.S. 1-543.11 may only be invested pursuant to the provisions of G.S. 58-79.1(c). Any and all interest accrued from such reserve funds shall inure solely to the benefit of the judgment creditor."

Sec. 2. If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or application of this act which can be given effect without the invalid provisions or application, and to this end the provisions of this act are severable.

Sec. 3. This act shall become effective on July 1, 1976.

APPENDIX VIII

MARKET SURVEY OF MEDICAL MALPRACTICE INSURANCE IN NORTH CAROLINA AS OF DECEMBER, 1975

By

John L. Henderson
Member of the N. C. Professional Liability Insurance Study Commission

In my recent market survey on the availability of medical malpractice insurance in North Carolina, the results lead me to conclude that there is a very limited market for the writing of this type of insurance in our State.

Submitted as supporting evidence is the following:

Below are portions of the testimony of Frederick W. Kilbourne, who is the President of Booz-Allen Consulting Actuaries, a division of Booz, Allen & Hamilton, a management consulting firm. This testimony was given at the trial testing the constitutionality of the Reinsurance Exchange on November 6, 1975.

> There is a long list of problems faced by these companies [entering the Exchange.] First of all they must write a line of business that most of them are not equipped to write. They must, or should tool up so-to-speak, for medical malpractice, which is a highly specialized line. They face a probability, based on recent history in this State, of having to divert a considerable amount of executive and administrative time to dealing with the problems, not only of medical malpractice as a difficult line, but also of North Carolina as a difficult State in medical malpractice insurance. Finally, they face the probability of severe financial losses if the rate levels promulgated are indeed those that are going to be affected. (Page 329)

> In my opinion if all physicians and surgeons liability insurance in North Carolina were written through the Exchange at ISO rates in effect early in 1975, the aggregate loss to the insurance companies participating in the Exchange, would be in excess of $5,000,000 per year. (Page 333)

> In my opinion the high ISO rate levels are themselves inadequate to the risk of writing physicians and surgeons liability insurance in North Carolina. It would be my expectation that a company that wrote that line of insurance in North Carolina, in the future, using the new rates as set forth in the October 27th order, would probably lose money rather than earn money. (Page 336)

> The rate filings that I have reviewed include projections of claim frequency trends that are based on historical statistics running through various periods of time, but in no case does this include statistics including 1975. Based on review of the Exhibits that are referred to and there has been a substantial amount of press attention to medical malpractice in 1975, and I would expect that there are patients who are now aware of medical malpractice who, under the identical circumstances a year ago, would not have been aware of the existence of the coverage; and that therefore the current claim frequency, or the previous claim frequency in this line would increase to some extent as a result of that increased awareness. If I could give you a little background; roughly speaking, medical malpractice claims result only in about one procedure out of perhaps, approximately 10,000 procedures performed by doctors in the State, leaving 9,999 procedures that do not result in medical malpractice claims. It is probable that there is a sufficient basis for a claim in some additional number out of that 10,000 beyond the one that historically has resulted in a claim. It would be my expectation that the number of "one" would increase to some extent. (Page 342)

Mr. Kilbourne also worked with the Auditor General of California in preparing an interim report on medical malpractice insurance. I submit quotes from the summary of that report because I believe the conclusions are illustrative of what may occur in this State unless ncecessary changes are made.

> The seven insurance companies we reviewed collected $262 million in physicians' malpractice insurance premiums in California during the 15 year period 1960 through 1974 and paid out approximately $115 million in claims and claim expenses from this revenue through December 31, 1975
>
> On the basis of our review of the payments made by the companies we reviewed and the trend of these payments, we estimate that these carriers will ultimately pay out $183 million more than they collected in premiums for physicians' malpractice insurance coverage for the years 1960 through 1974. This projected loss does not include any provision for insurance companies' indirect expenses, investment earnings on premiums held, inflationary factors in the amounts of physician malpractice claims, or increases in claim frequency. (Page 1)
>
> Premiums paid by California doctors for medical malpractice insurance have increased dramatically over the past fifteen years but have not kept pace with increasing claim costs. (Page 5)

> The medical profession in California over the past fifteen years has paid an inadequate amount for its medical malpractice insurance coverage. (Page 6)

As further evidence of the limited malpractice insurance market in North Carolina, I submit excerpts from the Judgment of Judge James H. Pou Bailey, dated November 7, 1975, in which he found the Reinsurance Exchange unconstitutional on its face.

> Because of the volatile nature of the medical malpractice insurance business and the rapidly mounting number and and severity of medical malpractice insurance claims, companies attempting to write medical malpractice insurance coverage without adequate experience and expertise and without qualified and experienced personnel could easily suffer serious losses in this line of insurance. (Page 6)

> A number of the companies which previously wrote medical malpractice insurance have withdrawn from the market, both countrywide and in North Carolina, and no company will accept all of the medical malpractice insurance business tendered to it. The great majority of the plaintiffs do not write medical malpractice insurance and are unwilling to do so. (Page 7)

> The most recent medical malpractice insurance experience data of ISO in North Carolina has been as follows:
>
> Over the past eight years, the frequency with which claims have been brought against physicians and surgeons, countrywide,has increased approximately 12% per year. The rate of increase has picked up in most recent years. In the past three years the annual rate of increase in claims frequency has averaged approximately 25%.
>
> In North Carolina the annual change in claim frequency is slightly in excess of the countrywide trend. It had averaged 13.5% over the eight year period. In the past three years there has been a very drastic increase in frequency of claims.
>
> On a countrywide basis, hospitals have also shown an increase in claims frequency of approximately 12% annually over each of the last seven or eight years. For North Carolina, the corresponding rate of increase is approximately 16%.

> With respect to the severity of claims, the dollar value of claims paid countrywide, has increased 10% per year over each of the most recent five calendar years. The North Carolina rate of increase over the same period has been 21% per year, so that the trend in the severity of claims has been significantly higher in North Carolina than countrywide.
>
> The trend with respect to defense costs, countrywide, increased at approximately the same rate as paid losses. (Page 9)
>
> Although North Carolina has had one of the lowest medical malpractice insurance rate scales in the country, the history of medical malpractice insurance regulation in North Carolina since January 1, 1973, with respect to rate filings shows numerous significant facts:
>
> (a) In the vast majority of cases, no public hearings have been called by the Commissioner of Insurance.
>
> (b) In many cases the filings have been disapproved by the Commissioner of Insurance without public hearing.
>
> (c) In many cases the filings have been ignored, and no action taken by the Commissioner of Insurance. (Page 12-13)

During the past week, I have had telephone conversations with several companies. These conversations, excerpts from which follow, lead me to believe the market will continue to be tight.

> We are currently providing a market for physicians and surgeons and hospitals. We are limiting our excess limits on those classifications to $1,000,000. We are not a market for miscellaneous medical malpractice insurance. There has not been a rate increase for miscellaneous malpractice since 1967 and we will not come back into the market using those rates. It is our understanding that ISO filed for new rates for miscellaneous professional liability November 1, and a hearing will be held about December 17, 1975. Should these rates be approved we would be interested in coming back into the market in most cases. (St. Paul)
>
> Our present plans are to handle our renewals at 25% above the new ISO rates, on a consent to rate basis only, for physicians and surgeons. Our rates for miscellaneous forms of malpractice will be the new ISO rates. We are not a market for any new business; however, we are trying to handle renewals for the very limited number of risks that we have been insuring. (Travelers)

APPENDIX IX

October 29, 1975

REPORT TO

REPRESENTATIVE ERNEST MESSER, CHAIRMAN

PROFESSIONAL LIABILITY INSURANCE STUDY COMMISSION

FROM: JOHN INGRAM -- NORTH CAROLINA COMMISSIONER OF INSURANCE

Uninterrupted health care is now guaranteed by three choices of malpractice insurance: 1)Medical Mutual Company writing "occurrence" coverage 2)North Carolina Hospital Association "self-insurance" plan and 3)St. Paul's "claims-made" coverage.

We had to go several extra steps to reach accord with St. Paul, including the rewriting of earlier orders issued regarding St. Paul and medical malpractice insurance. I had to allow St. Paul's "claims-made" form with open ended Guide "A" rates. Please see attached orders for details.

Because of the extra steps which had to be taken to meet St. Paul's demands to re-enter the medical malpractice insurance market in our state, it is essential that every doctor, hospital or other professional health care provider fully understand the St. Paul "claims-made" form and what it means.

They must understand the choice between St. Paul's "claims-made" form and the Medical Society's Mutual Company's "occurrence" form and the Hospital Association's "self-insurance" plan.

For example, in the case of St. Paul the Commissioner of Insurance does not have prior approval of the Guide "A" rates. I quote from a letter from St. Paul's attorney:

"Guide 'A' rates are rates that may be charged for a reporting endorsement, and may be charged at any time by St. Paul without the prior approval of the Commissioner of Insurance. The rates testified to in the hearing on September 22 and 23, 1975 are merely examples and are not binding on St. Paul and may be changed at any time by St. Paul without the prior approval of the Commissioner of Insurance."

A doctor who is considering buying professional liability insurance should realize that he or she has a choice between "claims-made" and "occurrence-type" coverage. The North Carolina Medical Society has formed a Medical Mutual Company which now is binding "occurrence" coverage.

Other factors related to this choice which should be considered are these:

A. 1. The Medical Mutual Company has assured the Commissioner that it will totally insure all doctors, hospitals, nurses and all others in health care professions.
2. St. Paul has said it will not insure all doctors, hospitals, nurses and other professionals in health care.

B. 1. The Medical Mutual Company will write at rates approved by the Commissioner of Insurance.
2. St. Paul would not agree to prior approval by the Commissioner of Insurance of Guide "A" rates.

C. 1. The Medical Mutual Company will protect on an "occurrence" basis against all claims which occur in the policy year even though reported in subsequent years.
2. St. Paul will protect on a "claims-made" basis only against claims occurring in the policy year, not against claims occurring the policy year which are reported in a subsequent year.

D. 1. The Medical Society's Mutual Company has assured the Commissioner it will abide by House Bill 74.
2. St. Paul has been granted an injunctive exemption from the provision of House Bill 74.

E. 1. The Medical Society Mutual Company is a North Carolina company operating only in North Carolina.
2. St. Paul may still withdraw anytime it chooses, a fact which was brought out by the Study Commission.

Everyone in health care now has a clear-cut choice between:

1. St. Paul's "claims-made" form with its open end Guide "A" rates and not subject to approval of the Commissioner and

2. the North Carolina Medical Society's "occurrence-type" coverage with rates approved by the Commissioner of Insurance and

3. the Hospital Association's self-insurance plan.

Every member of the health care professions should be encouraged to consider these choices which are now open to them, and to weigh them carefully.

If anyone should have any questions or need additional information regarding these choices, I would like for them to call our Consumer Insurance Information Division at this toll-free number 1-800-662-7975.

The reasons these choices must be carefully weighed is because in the long-run it is the citizens of North Carolina who must pay higher medical malpractice insurance rates through increased hospital room rates or physicians' fee.

APPENDIX X

A BILL TO BE ENTITLED

AN ACT TO CREATE THE NORTH CAROLINA MEDICO-LEGAL BOARD FROM WHICH PRETRIAL SCREENING PANELS MAY BE SELECTED TO HEAR MALPRACTICE CLAIMS.

The General Assembly of North Carolina enacts:

Section 1. Purpose.--The General Assembly of North Carolina recognizes that the mere filing of a malpractice action, whether meritorious or not, causes substantial harm to the reputation and practice of the health care provider concerned. The General Assembly also recognizes that persons having legitimate complaints against health care providers have often encountered difficulty in maintaining their claims with expert testimony in court. Therefore, the purpose of this act is to prevent where possible the filing in court of actions against health care providers for professional malpractice in situations where the facts do not permit at least a reasonable inference of malpractice; and, on the other hand, to make possible the fair and equitable disposition of such claims against health care providers as are, or reasonably may be, well founded.

Sec. 2. North Carolina Medico-Legal Board; membership and terms.--(a) There is hereby created the North Carolina Medico-Legal Board for the purposes and with the powers as set forth in this act. The Board shall consist of 30 attorneys, licensed to practice law pursuant to General Statute Chapter 84, and 30 health care providers. The President of the North Carolina State Bar shall appoint the attorney members and the President of the North Carolina Medical Society shall appoint the health care provider members to the Board. Members so appointed shall serve terms of one year and shall be

persons who demonstrate a capacity for objectivity, are dedicated to the concepts of fair decision after hearing and due process of law, and who are of high standing and integrity in their respective professions. In making their appointments to the Board, the respective Presidents shall attempt to create as even a statewide geographical distribution of appointees as possible, the purpose of which is to minimize travel and subsistence expenses of Board members when serving on the Medical Review Panels provided for in Section 3 of this act.

(b) Any appointment to fill a vacancy on the Board created by the resignation, dismissal, death or disability of a member shall be for the balance of the unexpired term. At the expiration of each member's term, the appropriate President shall reappoint or replace the member with a member of like qualifications. The Board shall designate annually by election one of its members as chairman and one of its members as vice-chairman to serve throughout the remainder of their terms.

(c) The Presidents of the North Carolina State Bar and the North Carolina Medical Society shall compile and maintain current lists of the Medico-Legal Board members and shall file said lists in the Offices of the Secretary of State, the Clerk of the North Carolina Supreme Court and the Clerk of the North Carolina Court of Appeals. On or by December 1 of each year, the Presidents shall update the lists and file such revised lists in these offices.

Sec. 3. Medical Review Panels. --(a) Provision is made for the establishment of Medical Review Panels to be selected from the

Medico-Legal Board and review all malpractice claims against health care providers.

(b) No action against a health care provider may be commenced in any court of this State before the claimant's proposed complaint has been presented to a Medical Review Panel established pursuant to this act and an opinion is rendered by the panel.

(c) The Medical Review Panel shall consist of three attorneys and three health care providers. One attorney shall act in an advisory capacity and as chairman of the panel, but shall have no vote. The Medical Review Panel shall be selected in the following manner:

(1) Only attorneys and health care providers appointed to the Medico-Legal Board pursuant to this act shall be available for selection.

(2) Each party to the action shall have the right to select one health care provider and one attorney, and upon selection, said health care provider and attorney shall be required to serve. The two attorneys thus selected shall select the third health care provider panelist. The two health care providers thus selected shall select the chairman of the panel, as provided for in this subsection.

(3) Where there are multiple plaintiffs or defendants, there shall be only one health care provider and one attorney selected per side. The plaintiff, whether single or multiple, shall have the right to select one health care provider and one attorney; and the defendant, whether single or multiple, shall have the right

to select one health care provider and one attorney.

(4) A panelist so selected shall serve unless for good cause shown he may be excused. To show good cause for relief from serving, the panelist shall be required to serve an affidavit upon a judge of a court having jurisdiction over the claim. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The court may excuse the proposed panelist from serving. A panelist who has served on five Medical Review Panels within the preceding 12 months shall not be required to serve.

(5) If there is only one party defendant, other than a hospital, one of the health care provider panelists selected shall be from the same class of health care provider as the defendant.

(6) Within ten days after notification of a proposed panelist by the plaintiff, the defendant shall select a proposed panelist.

(7) Within ten days of any selection, written challenge, without cause, may be made to the panel nominee. Upon challenge, a party shall within ten days select another panelist. If two such challenges are made and submitted by a party, the appropriate President shall appoint a panel consisting of three qualified panelists and each side shall strike one and the remaining member shall serve.

Sec. 4. Evidence; panel hearings and opinion of the panel. --(a) The evidence to be considered by the Medical Review Panel shall be promptly submitted by the respective parties in written form only. The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, affidavits or sworn statements of wit-

nesses including parties and any other form of evidence allowable by the Medical Review Panel. Affidavits or sworn statements of parties and witnesses may be taken prior to the convening of the panel. The chairman of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the opinion of the panel as provided in Section 4(d). A copy of the evidence shall be sent to each member of the panel.

(b) Either party, after submission of all evidence and upon ten days notice to the other side, shall have the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of their report. The chairman of the panel shall preside at all meetings. Meetings shall be informal and without stenographic record. No person shall record or otherwise communicate or publish the proceedings of said meetings or any portion thereof.

(c) The panel shall have the right and duty to request all necessary information. The panel may consult with medical authorities. The panel may examine reports of such other health care providers necessary to fully inform itself regarding the issue to be decided. Both parties shall have full access to any material submitted to the panel.

(d) After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within 30 days, render its opinion which shall be in writing, be signed by the panelists, and shall state whether or not:

(1) there are reasonable grounds to believe that the

act or acts of the defendant health care provider were not in accordance with the practices and procedures for services which were provided in the same or similar communities by similar health care providers at the time of the alleged act or acts giving rise to the claim; and

(2) there is a reasonable medical probability that the plaintiff was injured thereby; or

(3) there is a material issue of fact bearing on liability for consideration by the court or jury.

Sec. 5. Statute of limitations tolled; filing of request for review of claim.--The filing of the request for review of a claim shall toll the applicable statute of limitations to and including a period of 90 days following the issuance of the opinion by the medical review panel. The request for review of a claim under this act shall be deemed filed when a copy of the proposed complaint is delivered or mailed by registered or certified mail to the Commissioner of Insurance, who shall immediately forward a copy to each health care provider named as a defendant at his last and usual place of residence or his office.

Sec. 6. Opinion of panel not admissible; witnesses from panel; immunity of panelists.--Any report of the opinion reached by the Medical Review Panel or part thereof shall remain confidential and not be admissible as evidence in any action subsequently brought by the plaintiff in a court of law. Either party shall have the right to call, at his cost, any health care provider member of the Medical Review Panel to appear as an expert witness in a subsequent court action. If called, the witness shall be required to appear

and testify, provided that he qualifies as an expert witness. Panelists shall have absolute immunity from civil liability for all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by this act.

Sec. 7. Recommendations by panel after opinion rendered.--(a) In any case where the panel has determined that the acts complained of reasonably might be professional negligence and that the plaintiff reasonably may have been injured thereby, the panel shall further determine whether the interests of justice would be served by cooperation by the panel and the North Carolina Medical Society with the plaintiff in retaining a health care provider or providers qualified in the field of health care involved, who will consult with and testify on behalf of the plaintiff, upon his payment of a reasonable fee, to the same effect as if the said health care provider or providers had been employed originally by the plaintiff. If the panel resolves such determination in the affirmative, it shall so state in its opinion and shall make the necessary recommendations to the Medical Society. If the panel also determines that a review of the fitness of the health care provider to practice his profession is desired, it shall forward such recommendation to the appropriate licensing, registration or certification board.

(b) In any case where the panel has determined that there is no reasonable possibility that the acts complained of constituted professional negligence and/or no reasonable medical probability that the plaintiff was injured thereby, the panel shall further

determine whether or not it should recommend to the plaintiff's attorney that he should thereafter refrain from filing any court action based upon the matter reviewed by the panel unless said attorney is personally satisfied that strong and overriding reasons compel such action to be taken in the interest of his client, and that it would not be done to harass or gain unfair advantage in negotiation for settlement. If the panel recommends such refraining from filing a court action, it shall forward a copy of the recommendation to the North Carolina State Bar. It is not intended that submission of any case to the panel shall be considered as a waiver by the attorney or his client of their ultimate right to decide for themselves whether the case shall be filed in a court of law; however, every attorney who represents a client before the panel shall weigh the panel's conclusions in the greatest professional good faith.

(c) All recommendations made pursuant to this section shall remain confidential and shall not be communicated by any person to anyone other than the persons, organizations or agencies named in this section.

Sec. 8. Per diem and travel expenses.--Each member of the Medical Review Panel shall be paid at the rate of $25.00 per diem, not to exceed a total of $100.00, for all work performed as a member of the panel during the hearing provided for in Section 4 of this act, exclusive of time involved if called as a witness to testify in court, and in addition thereto, reasonable travel expense. Each side shall pay one-half of the fees of the panel including

travel expenses, unless the panel determines that the claim was frivolous and for the purpose of harassing the defendant or gaining unfair advantage in negotiation for settlement, in which case the plaintiff shall be assessed the fees of the panel.

Sec. 9. Applicability.--The provisions of this act shall apply only to causes of action arising on or after the effective date of this act.

Sec. 10. Severability.--If any provision or clause of this act or application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

Sec. 11. Effective date.--This act shall be effective on July 1, 1976.