NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

REPORT

AND

RECOMMENDATIONS

TO THE

1987 N.C. GENERAL ASSEMBLY

ROOM 2111 STATE LEGISLATIVE BUILDING, RALEIGH, NC 27611 (919) 733-3460

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

REPORT AND RECOMMENDATIONS

TO THE 1987 GENERAL ASSEMBLY

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NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

March 25, 1987

The Honorable Robert B. Jordan III
President of the Senate

The Honorable Liston B. Ramsey
Speaker of the House of Representatives

Dear Lieutenant Governor Jordan and Speaker Ramsey:

On behalf of the Members of the Commission we are pleased to present to you and the North Carolina General Assembly our REPORT AND RECOMMENDATIONS.

We were charged by Chapter 792 of the 1985 Session Laws to "make a thorough and comprehensive study on any and all laws affecting medical malpractice liability and insurance" and to report to the 1987 General Assembly.

The Commission held 13 meetings, all open to the public. The many representatives of medicine and other health professions, the bar, insurance, business and consumer groups who made presentations to the Commission contributed to the facts, discussion and recommendations.

Developing a rational public policy for government's role in addressing the concerns associated with medical malpractice is a difficult challenge. We examined the complex interaction among the multiple interests in this issue. There is neither a consensus on the causes nor agreement on the solutions, although we heard many views.

We attempted to respond to problems in these areas: lack of data about the nature and extent of medical liability claims, frictions that have arisen in specific areas of health care delivery, need for improvements in peer review and self-policing of the health care professions, and need for improvements in the litigation process. We think our recommendations will contribute to near-term adjustments acceptable to all interests.

You will note our request for authorization to continue to study two innovative proposals addressing birth injury compensation and promoting private contractual use of alternative dispute resolution.

Senator Tom Taft
Co-Chairman

Representative Dwight W. Quinn
Co-Chairman

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NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

LISTING OF RECOMMENDATIONS

1. Improve the Childhood Vaccine-Related Injury Compensation Program in order to permit manufacturers to lower vaccine prices in this State and assure continuation of the State immunization program through both health departments and private physicians. (See Draft Bill No. 1)

2. Authorize the Commissioner of Insurance to collect more information from insurers and to conduct a closed claim study. (See Draft Bill No. 2)

3. Strengthen the Board of Medical Examiners to monitor and discipline physicians. (See Draft Bill No. 3)

4. Promote peer review activities of all health care providers and require risk management programs and effective hospital privilege review procedures in hospitals. (See Draft Bill No.4)

5. Punitive damages in medical malpractice actions should be limited to intentional, willful or wanton infliction of harm or injury on the plaintiff, and certain fraudulent actions of health care providers should be made criminal, resulting in automatic revocation of license. (See Draft Bill No. 5)

6. Improve the litigation process by requiring reasonable notice of medical malpractice claims and closer court supervision of the disposition of medical malpractice actions. (See Draft Bill No. 6)

7. Require court approval of the fees to be paid to the attorney for each party. (See Draft Bill No. 7)

8. Change the statute of limitations for medical malpractice actions on behalf of minors to permit actions to the age of ten with exceptions for delayed discovery and for later suits when the minor has been judged abused or neglected. (See Draft Bill No. 8)

9. Extend the legislative authorization for the Commission so that further study can be conducted on proposals to provide early compensation for birth injuries and to promote private contracts for alternative dispute resolution. (See Draft Bill No. 9)

NOTE: For a discussion of the Commission's deliberations on these recommendations, see SUMMARY OF RECOMMENDATIONS.

SUMMARY OF COMMISSION PROCEEDINGS

Organization and Approach

The Commission was created by the 1985 General Assembly to study the numerous public issues and concerns associated with medical liability in this State. Specifically, the Commission was directed by Chapter 792 of the 1985 Session Laws to "make a thorough and comprehensive study on any and all laws affecting medical malpractice liability and insurance" and to report to the 1987 General Assembly.

After appointments were made to the Commission by the presiding officer of the General Assembly and the Co-Chairmen were named, the Commission held an organizational meeting in December 1985. Senator Tom Taft (D-Pitt) and Representative Dwight Quinn (D-Cabarrus) were the Co-Chairmen. David Warren, a lawyer and a professor in the Duke University Medical Center, was hired on a part-time basis to be the Executive Director of the Commission. Sybil Barnes was appointed as Clerk. The Commission offices were in 2111 State Legislative Building.

The Commission sought advice and information from all interested sources. Every association and group in North Carolina which was contacted provided full cooperation, including medical and health care associations, bar groups, insurance companies and consumer organizations. In addition, several offices in Washington were helpful in providing information and reports during the whole course of the Commission's study. Especially noteworthy was the interest of the U. S. General Accounting Office, the Federal Trade Commission and the office of Congressman John Porter (R-Ill).

Studies were conducted by the Commission staff, including part-time staff members from Duke University and UNC-CH, Jonathan Stewart, MHA, and Sally Marshall, JD (pursuing MPH degree). (See APPENDIX C: BACKGROUND PAPER: RECENT DEVELOPMENTS IN THE FIELD OF MEDICAL MALPRACTICE IN THE UNITED STATES.) In addition, an independent insurance actuary, James Wilson of Winston-Salem, served as a consultant to the Commission to analyze insurance data. (See APPENDIX E: ACTUARIAL STUDY OF NC INSURANCE DATA.)

Meetings of the Commission were held approximately every month and all were open to the public and news media. The meetings were held in the State Legislative Building except one meeting was held in the Area Health Education Center at Charlotte-Mecklenburg Hospital Authority in Charlotte.

Presentations to Commission (December 1985 - May 1986)

During these meetings and public hearings and in communications received by the Commission, a considerable amount of data was collected (see SUMMARY OF FACTS PRESENTED TO COMMISSION) and numerous proposals were developed in response to the data presented (see LISTING OF PROPOSALS CONSIDERED). After a presentation of the general background and history of the medical liability problem by the Commission staff, the Commission heard from several groups of health care providers about how liability insurance and other concerns were affecting them (see LISTING OF WITNESSES).

Particularly compelling were the pressures felt by obstetricians and family physicians about liability

associated with delivering babies and the fear of liability expressed by pediatricians and family physicians in administering State-required vaccinations to children. Nurse midwives, nurse anesthetists (CRNA) and other nurse specialty groups revealed that adequate liability insurance protection was becoming unavailable. (Later during the year the Commission learned that suitable coverage had been arranged for some groups.)

Podiatrists, dentists, physical therapists, nurses, nurse anesthetists, nurse midwives, and hospitals all expressed their concerns about increasing liability suits and insurance costs. None of these concerns, however, were as severe as those expressed by physicians about medical liability and associated insurance rates and availability.

The Board of Medical Examiners said that it lacked certain powers to carry out its responsibilities of ensuring the public about the competency of all licensed physicians.

The Medical Society presented an analysis of the concerns of many members of the medical profession about sharply rising insurance rates, expensive defensive medicine practices, impediments to effective peer review, increasing signs of the breakdown of the doctor-patient trust, and the devastating emotional impact of medical malpractice litigation on a physician and the irritation of frivolous suits and trial tactics of attorneys. Evidence of the medical malpractice crisis was presented in various national studies done by the AMA and other organizations and in reports from other states. Both the NC Medical Society and

the NC Hospital Association presented the Commission with background information and formal proposals for consideration, including more professional peer review and several tort law reforms. (See APPENDIX D: POSITION PAPERS)

Members of the Bar, and particularly trial lawyers, furnished arguments to the Commission on behalf of the victims of medical malpractice and described the difficulties in assisting clients who pursued their claims (unavailability of expert witnesses, unpredictability of litigation, general effectiveness of defense counsel). Several attorneys insisted that the cause of the medical malpractice insurance problem is continued instances of medical malpractice. Others said that the poor management practices and cyclical swings in the investment market caused liability insurers to create volitile premium rate patterns. It was observed that NC has traditionally been a low jury-award state and that there was no hard evidence of a medical malpractice crisis here.

Consumers groups, including the NC Chapter of American Association of Retired Persons, Common Cause and an organization called PAIN (Persons Against Incompetence and Negligence) attended the Commission meetings and presented information. (See SELECTED CORRESPONDENCE.) One former patient who had been injured during gynecological treatment told her personal story, emotionally describing her pain and suffering and in addition her frustration in attempting to bring a medical malpractice lawsuit.

Representatives of the major insurers of health care providers in NC presented an assortment of data about claims severity and frequency patterns, rate making procedures and other insurance market information suggesting that sharp rises in premium rates for several classes of insureds was due to actuarial necessity. They told the Commission about their efforts to use new approaches (e.g., claims-made type policies replacing occurrence type policies) and loss control activities (risk management education for physicians and hospitals) to hold down premium increases. They claimed that the Commissioner of Insurance already had sufficient regulatory power and that adequate insurance data was being made available to the public. They said that they, as primary insurers, were limited in their freedom to set reasonable rates by the high cost and restricted availability of reinsurance on the international market.

During the course of the Commission's work several important developments occurred. In January 1986 St. Paul Companies told the Commission it was adopting a national freeze policy, not accepting new applications from physicians except those joining already covered group practices. In February Medical Mutual announced it was henceforth reclassifying family doctors based on their obstetrical services. Thus some family doctors chose to stop delivering babies rather than pay increased insurance rates. The Academy of Family Practice Physicians presented survey data to the Commission showing the adverse impact of availability of medical services in North Carolina. In April a new

insurance company announced that it was selling policies in this State. Medical Protective of Ft. Wayne, Indiana, told the Commission that it found the market here to be attractive. Finally, in October the Congress enacted the Risk Retention Act which permits considerably more flexibility for groups and associations of similar entities to self-insure, without establishing an off-shore captive company.

Preparation of Interim Report

During the meetings from December 1985 through May 1986 the Commission was unable to reach consensus on findings that would indicate the extent of the malpractice and insurance problems, since the data and information available to the Commission was mixed and inconclusive. Neither was the Commission able to reach concensus on all the interim measures that might be recommended to address the various concerns and problems that had been described to the Commission. Nevertheless, there was agreement in three areas of concern and recommendations were presented on (1) insurance claims reporting, (2) medical discipline, peer review and risk management, and (3) vaccine injury compensation.

The Commission also made recommendations about changes in the rules of tort liability, but some members of the Commission dissented from these proposals.

(See APPENDIX J: INTERIM REPORT.)

The Commission recommended two bills. One (S. 858)

would have implemented a range of recommendations relating to insurance, medical practice and tort law, as follows:

(a) Increased monitoring and analysis of claims data from insurers by the Commissioner of Insurance and reports by him to the General Assembly.

(b) Provide more disciplinary powers to the medical licensing board.

(c) Require insurers to report awards, settlements and policy cancellations to Board of Medical Examiners.

(d) Require hospitals to report details of privilege revocations and suspensions to appropriate occupational licensing board.

(e) Promote peer review by all licensed health care providers.

(f) Require risk management programs in hospitals.

(g) Create criminal penalties for falsifying medical information, destroying records and interfering with testimony.

(h) Make selected tort law changes (eliminate punitive damages, place a $250,000 cap on non-economic damages, penalize frivolous pleadings and motions by either party).

The second bill (S. 859) would have created a childhood vaccine-injury compensation program to be administered by the Industrial Commission which would determine causation of injuries and liability of health care providers and manufacturers. Awards of compensation would be limited to $1 million, including a maximum of $100,000 for noneconomic damages. No punitive damages could be awarded. If the cause

of the injuries is determined to be vaccine related but no party is found to be liable based on principles of fault, then the injured child could receive care and treatment through the services of the Department of Human Resources.

Action by 1986 Session

The first bill (recommendations for insurance, health care providers and liability Law changes) received consideration in a Judiciary Committee of the Senate and passed the Senate in revised form. It was not taken up in a Judiciary Committee of the House and S. 858 died for lack of further action. One of the bill's provisions (relating to frivolous actions) was enacted as part of another bill applying to civil actions in general, not only medical malpractice litigation. Another part of the bill (relating to a closed claims study) was not enacted but the Commissioner of Insurance, on his own initiative, undertook in late 1986 to begin a closed claims study with the cooperation of the liability insurance companies.

The second bill (childhood vaccine-related injury compensation program) also passed the Senate with revisions. In a House Judiciary Committee a committee substitute was drafted which extended the vaccine-related injury concept to shift the responsibility for compensation directly to the Department of Human Resources after the Industrial Commission makes a determination of causation. Both the health care provider and manufacturer are shielded from suit by the vaccine-injured child, but the State retains specified

subrogation rights against them for negligence. The committee substitute for this bill was enacted in July, with an effective date of October 1, 1987.

Presentations to the Commission (September 1986 - Jan. 1987)

After the July adjournment of the 1986 session, the Commission resumed hearings and meetings in September. At the request of representatives of the NC Medical Society, consideration of the tort reform proposals which were before the Commission at its May meeting was deferred so that new proposals could be presented and studied.

The Commission focused primarily on private adjudication possibilities and alternative dispute resolution (ADR) ideas. The NC Bar Association made a special presentation to describe several forms of ADR: arbitration, summary jury trials, mediation, mini trials and private adjudication. Professors Clark Havighurst from Duke University Law School advocated the promotion of private contractual arrangements for dispute resolution. Professors Tom Metzloff and Benjamin Foster from the Duke Private Adjudication Center described a proposed study of private adjudication methods which would use NC medical malpractice experience. Professor Jeffrey O'Connell from University of Virginia Law School presented his "medical offer and recovery plan" which would provide early compensation for medical injuries. It would create incentives for health care providers to come forward promptly with an offer to pay all net economic losses in return for not being sued.

Returning to a consideration of proposals for changes in the civil liability system, representatives of the NC Medical Society first suggested that all the proposals that had been on the agenda in May be reconsidered. Then they proposed that only three specific proposals be considered by the Commission: narrowing the qualifications of expert witnesses, shortening the statute of limitations for minors and eliminating punitive damage awards. They noted that various other tort reforms were currently being considered by the Liability and Property Insurance Markets Study Commission, headed by Senator Hardison and Representative Hasty. As earlier promised by Representative George Miller, he formally proposed three changes in civil procedure which would speed up discovery and calendering, require reasonable notice of a claim, and provide for court review of attorneys' fees.

Near the end of the Commission's meeting schedule, the NC Bar Association presented its Report on the Tort Liability System. (See APPENDIX D: POSITION PAPERS.)

All of these proposals were discussed and staff was requested to embody the proposals, as revised, in draft bills for further discussion.

In addition the Commission studied the impact of the Vaccine-Related Injury Compensation Program, enacted in July, and found that the price of vaccine had not yet been lowered. After further discussions with the Division of Health Services and representatives of Lederle Laboratories, it was determined that amendments were needed in the legislation

creating the Program in order to expect to achieve the desired results.

Preparation of Final Report and Recommendations.

At its final meeting on March 16, the Commission approved this Report and Recommendations. A motion was adopted to request authorization from the 1987 General Assembly to have more time to study two innovative proposals (early compensation for injured infants and contractual alternative dispute resolution) and to make a later report on these topics during the Session.

SUMMARY OF RECOMMENDATIONS

1. IMPROVE THE CHILDHOOD VACCINE-RELATED INJURY COMPENSATION PROGRAM IN ORDER TO PERMIT MANUFACTURERS TO LOWER VACCINE PRICES IN THIS STATE AND ASSURE CONTINUATION OF THE STATE IMMUNIZATION PROGRAM THROUGH BOTH HEALTH DEPARTMENTS AND PRIVATE PHYSICIANS.

(See Draft Bill No. 1)

Early in the work of the Commission it was urged to take steps to ensure the continuity of the childhood immunization program of G.S. 130-152 which requires children to be vaccinated against diptheria, tetanus, pertussis (whooping cough), poliomylitis, rubeola and rubella. In particular, there was a threat to the availability of DTP (diptheria, tetanus, pertussis) vaccines and the willingness of private physicians to administer them.

Manufacturers have been increasingly concerned about the number and size of product liability lawsuits brought against them for the rare but devastating effects of reaction to the DTP vaccine (particularly, the pertussis component). Despite being manufactured in accordance with rigid FDA standards and numerous inspections, there remains a statistical probability that about 1 of every 310,000 doses will result in a serious reaction (death or permanent brain damage). A market result has been that only two commercial manufacturers continue to manufacture the DTP vaccine in the U.S. (Lederle Laboratories of American Cyanamid Co., and Connaught Laboratories, Inc.). Both have been increasing their prices at an alarming rate to

cover their expected liability losses. Prices per vial have increased over the past 10 years from about $4 to $160 per vial (containing 15 doses). In May 1986 Lederle increased their per dose price from $4.29 to $11.40 which included $8.00 for a company reserve fund to anticipate product liability losses. There were hints from the manufacturers that regardless of price they might cease manufacturing DTP vaccine altogether.

An associated problem across the country and particularly in North Carolina was the developing unwillingness of physicians to administer the DTP vaccine because of their fears of medical liability for reactions. Dr. David Tayloe of the NC Pediatric Society described a highly publicized 1985 lawsuit by the parents of an infant with vaccine-related brain damage which resulted in a $3.5 million jury verdict against a pediatrician. (See Forehand v. Tayloe, Nos. 83-32-CIV-4 and 84-71-CIV-4, US Dist.Ct. EDNC, June 4, 1985, setting aside the verdict as excessive; later settled by parties for $1.1 million.) While there was considerable evidentiary doubt about both causation of the injury and any negligence of the physician, the case pointed up the sympathy of the public for vaccine-related victims and the vulnerability of physicians to non-defendable charges of liability.

It was reported to the Commission that the long-standing cooperative effort between public health departments and private practitioners to immunize infants was in danger of collapsing. Local health departments would not be able to carry out the program without physician cooperation;

additionally, the supply of vaccines for health departments was in question. Despite the existence of a federal contract enabling State purchases (currently with Connaught at a below-market price of $40 per vial) both availability of supplies and the limited budgets of health departments put into question continuation of the immunization program. The possible dire results of contagion did not have to be described to the Commission.

Therefore, the Commission in its Interim Report to the Legislature in June 1986 (See APPENDIX J) urged enactment of a NC Childhood Vaccine-Related Injury Program to remedy the concerns of both manufacturers and physicians in order to ensure continuation of the childhood immunization program. The Commission's proposal was improved under the guidance of Representative Alex Hall in the House Judiciary Committee and, after several late compromises were reached, a committee substitute bill was enacted into law in July 1986.

Since the rather swift enactment, there has now been time to study the implications of the act and to discuss how to deal with its shortcomings. In addition, there have been other developments, including a new federal law ("Health Care Quality Improvement Act of 1986," Public Law 99-106) attempting to address the same problem, which the Commission has studied. Another more startling development was the failure of the manufacturers to respond to the expectation that they would lower their prices in North Carolina, recognizing their greatly minimized risk of liability exposure here. Finally, a news story (USA TODAY, Mar. 7, 1986)

reported a research study at Case Western Reserve School of Medicine which showed that putting off babies' DTP shots for a few months to avoid possible reactions would increase new cases of whooping cough.

Under the new North Carolina act, children with vaccine-related injuries, as determined by the NC Industrial Commission, could not sue either manufacturers or physicians but would be compensated and provided services directly by the State. The State could pursue negligent manufactuers and physicians for reimbursement by bringing a subrogation claim within two years.) While Lederle in fall 1986 submitted a bid to the State nearly a third below their market price, they offered no price break to NC physicians who therefore are obliged to pass along the high cost of vaccines to their private patients.

In order to be able to expect that the manufacturers of childhood vaccines will promptly lower the price of vaccines in this State to health departments and to private physicians, as was intended by the enactment of the NC Childhood Vaccine-Related Injury Compensation Program, certain changes are indicated in that act. These changes represent a cooperative effort by representatives the Division of Health Services, NC Academy of Pediatrics and Lederle Laboratories. (Note: Connaught Laboratories have not made any contact with the Commission).

The proposed amendments are a response to concerns expressed in Commission hearings about the possible impact of the newly enacted but as yet unfunded federal program to

shield manufacturers (but not physicians). Also, changes are recommended to satisfy concerns of the manufacturer about definition of defective product, diversions to other markets and the limited length of the program. Finally, concerns of the Division of Health Services about clarifying some aspects of administration of the program are addressed. In addition, it has become clear to the Commission that it is impossible to realize any positive effects from the operation of this Program under the short 3 years permitted by the original sunset provision. The Commission notes that it is within the power of the General Assembly to repeal this Program at any time it becomes clear that it is not an effective or appropriate method for ensuring the public of the continuity of the NC childhood immunization program.

Specifically, these are the recommended changes in the Act:

(a) an accommodation of the NC program to the federal vaccine compensation program that may be established (if funded) under a new federal law and the prevention of duplicate liability and awards,

(b) a revised definition of "defective product" based on negligence or violation of federal standards,

(c) prohibition of diversions of NC-designated vaccines outside the State for profit, with severe penalties for conviction (Class J felony, 3 years imprisonment and fine of $25 per diverted vial, up to $100,000; automatic license suspension for a health care provider convicted of diverting more than 300 doses),

(d) clarification of the authority of the Secretary of Human Resources to enter into contracts with vaccine manufacturers and suppliers, including other public entities (note: at least one state government, Michigan, is now a manufacturer); and to charge a cost-based fee for providing vaccines to private practitioners for administration,

(e) removal of the sunset provision so as to let the Program have a fair impact on the problem, while the General Assembly continues to monitor its effectiveness over the near term, and

(f) minor technical revisions.

2. AUTHORIZE THE COMMISSIONER OF INSURANCE TO COLLECT MORE INFORMATION FROM INSURERS AND TO CONDUCT A CLOSED CLAIM STUDY.

(See Draft Bill No. 2)

Lack of claims data in North Carolina has been the main impediment to the Commission in analyzing the nature and extent of problems that health care providers are experiencing with rising premium rates for liability insurance. Inability of the Commission to find or obtain consistent, reliable and understandable data, even when data was furnished by the insurers, hampered the Commission in making a finding about the seriousness of the liability insurance problem in this State.

This frustration was further compounded when we received the inconclusive results of a study conducted on this data by the Commission's own expert consultant, James A. Wilson,an independent insurance actuary familiar with both NC insurers and the field of professional liability. (See APPENDIX E, ACTUARIAL STUDY OF NC INSURANCE DATA.) Our consultant noted that each company applies its own interpretations in reporting data to the Department of Insurance. This made comparisons unreliable, although he concluded that the reported data "reveals that the insurance companies have increased their rates by substantially less than is indicated by the experience they have reported." He also observed that the reporting method "tends to understate the losses and needed premiums when inflation and volume growth are present (but)

when inflation or volume growth are reduced or decline, the indicate losses are overstated."

The available data about frequency and severity was not fully usable in analyzing the factors underlying the affordability and availability concerns of health care providers. Even the report of the General Accounting Office on the North Carolina insurance situation was limited in its findings. (See APPENDIX F, GAO REPORT: MEDICAL MALPRACTICE CASE STUDY ON NORTH CAROLINA.)

Despite the presentation of survey information and personal observations by various representatives of health care provider groups, there is no hard and current statistical basis for validating the expressed concerns that claims are being filed unfairly or that awards are being made disproportionately.

In order to remedy the problem of unavailable, inconsistent or unusable data which prevents a thorough and accurate analysis of the insurance aspect of the medical malpractice problem, it is clear that a central, controlled and ongoing data base of claims information is required.

It is appropriate for the Department of Insurance to perform this function. The Commissioner has already undertaken to begin an innovative, computer-based, closed claim study but has been frustrated with the lack of cooperation of the insurers. (See APPENDIX H, SELECTED NEWS STORIES.) The information that this type of study will provide should be the basis for ongoing monitoring of problems in special areas, such as obstetrics, as well as certain

practices, such as trial and settlement procedures. It should remedy the problem that the Commission found in analyzing the true picture of liability insurance. Other states have been confronted by the same problem of lack of useable data and some (e.g., Florida) have taken steps to improve their reporting systems. None, however, have been as ambitious as North Carolina intends to be in conducting a comprehensive closed claims study. We expect this effort will be important in the future in developing responsible public policies about medical malpractice liability and compensation.

Therefore, in order to

(a) assure the public that this type of study will be conducted on a continuing basis,

(b) provide direct authority to the Commissioner to perform this function,

(c) institute sanctions for insurance company non-compliance with reporting requirements,

(d) prevent disclosure of the identification of parties in the claims data, except to the medical licensing board, and,

(e) provide summaries of the study results to the General Assembly and the public,

it is recommended that the Commissioner of Insurance be given specific authorization to conduct closed claim studies of medical malpractice claims and to report the results of these and other Department studies on medical liability insurance to the General Assembly and to the public.

The professional liability insurance reporting law

(G.S. 58-21.1) enacted in 1975, specifying 10 separate information categories, was rewritten in 1985 to make NC law conform to the recommendations of the National Association of Insurance Commissioners for a medical malpractice supplement. Therefore, now medical and hospital professional liability insurers submit "Supplement A to Schedule T" along with their annual statements to the Department. This report shows (a) number of exposures, (b) direct premiums written, (c) direct premiums earned, (d) direct losses paid, both amount and number of claims, (e) direct losses incurred, (f) direct losses unpaid, both amount and number of claims, and (g) direct losses incurred but not reported. This information is not privileged and is open to the public. Because of the potential utility over a period of years of the malpractice insurer reports required by current law, the Commission recommends that G.S. 58-21.1 continue to require the medical malpractice insurance supplement to be submitted by insurers.

3. STRENGTHEN THE BOARD OF MEDICAL EXAMINERS TO MONITOR AND DISCIPLINE PHYSICIANS.

(See Draft Bill No. 3)

One of the recommendations from the American Medical Association (AMA) in its 3 recent reports collectively entitled "Professional Liability in the '80s" is to "strengthen state licensing boards." They note that boards must have effective investigative and disciplinary powers and adequate resources to fulfill their functions. The AMA encourages state medical societies and hospital staffs to report flagrant and recurring negligence by particular physicians to the state licensing board. The AMA is particularly concerned about finding ways to indentify physicians who have lost their license in one state but remain licensed in others.

It was reported by the Association of State Boards of Medical Examiners that physician disciplinary actions increased in 1986 over 1985. During 1986 the NC medical licensing board began releasing to the public the details about its disciplinary actions. This interest by the profession in greater public accountability is commendable and should be supported. In addition, it should be noted that the American Bar Association at its meeting on February 17, 1987, in the context of making several recommendation about changes in certain tort law concepts, adopted a resolution calling for closer disciplinary scrutiny of <u>all</u> licensed professionals.

The NC Board of Medical Examiners, upon request of the

Commission, came forward to present a series of suggestions about fulfilling its functions more effectively as the statutory supervisor of the medical profession. Each of the proposed changes in its powers and duties was examined closely from the standpoint of assurance to the public that medical competency was being promoted and that, at the same time, the legal rights and professional ethics of licensed physicians were being protected.

It was concluded by the Commission that these expanded powers and duties of the Board should be enacted:

(a) extend subpoena power of the Board over all relevant materials when investigating a physician (now, Board can subpoena only patient related documents),

(b) require automatic revocation of license when physician is convicted of felony, with due process protections for appeals (now, felony is merely grounds for license revocation in the discretion of the Board)

(c) permit Board to require restitution of physician fees to patients for exploitation of patient (now, exploitation is merely grounds for license revocation)

(d) add as grounds for revocation or suspension of license the failure to make timely response to Board (new grounds are for the purpose of expetiting investigations)

(e) permit Board to recover costs in disciplinary actions (now, Board incurs considerable expenses in some cases)

(f) permit Board to release to other governmental agencies confidential information about disciplinary actions, including voluntary license surrender and investigative

reports, and require Board to notify the physician about such disclosure (now, no authority to cooperate with other license boards in tracking bad doctors)

(g) protect Board in carrying out its responsibilities (now, no specific immunity for acting in good faith)

(h) require physician liability insurers to report to Board details of awards, settlements, cancellations and non-renewals (now, insurers make no reports but hospitals report to Board revocations and suspensions of physician's privileges)

(i) permit board discretion to reexamine physician before reinstating license previously suspended for failure to register (now, Board required to reinstate license of absentee doctor merely upon payment of fees)

(j) permit Board investigators to review prescriptions for controlled substances, without subpoena, when investigating a physician (now, Board must obtain subpoena to review prescriptions)

(h) require applicants for license examination to pay the cost of the test materials (now, Board absorbs increasing cost of national boards)

(i) increase per diem expense payment to Board members up to $100 to perform their duties (now, per diem shall not exceed $10).

With these additional powers and responsibilities, the Commission believes that the Board can better serve both the public and the profession in promoting high standards and performance of medical practitioners and in minimizing

incompetency and inaptitude.

In the federal "Health Care Quality Improvement Act of 1986" (Public Law 99-660) it is noted that "there is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance." The Act establishes a national data bank to be constructed and maintained by the government (or under contract to a private organization, such as the AMA) which will collect information about physician disciplinary actions, including licensure and hospital privileges. The Commission urges the medical licensing board, NC Medical Society and hospitals in this State to cooperate fully with this national data bank project of the federal government.

4. PROMOTE PEER REVIEW ACTIVITIES OF HEALTH CARE PROVIDERS AND REQUIRE RISK MANAGEMENT PROGRAMS AND EFFECTIVE HOSPITAL PRIVILEGE REVIEW PROCEDURES IN HOSPITALS.

(See Draft Bill No. 4)

Peer Review

The Medical Society of North Carolina has been for the last several years conducting a voluntary program to assist physicians whose performance is impaired by reason of addiction to alcohol or drugs. It has been publicized that physicians, and other health care providers, are more prone to addiction than other similar groups due to both the high stress levels of medical practice as well as the easier availability of drugs. During the deliberations of the Commission the case of a respected Charlotte pediatrician was publicly reported, noting that he had been unsuccessfully fighting his addiction over the course of the last 20 years. In addition to impairment by addiction, a health care provider's competency to practice may be affected by other factors, such as mental illness, emotional instability, stress, age, and other personal factors that can be identified and addressed by professional assistance. Further, continuing competency to practice is affected by how well a practitioner stays current with both knowledge and techniques, and how well he or she responds to peer critiques and constructive criticism. Thus, it is seems unassailable that peer review and collegial criticism is essential for the

assurance of high quality performance by providers.

Nevertheless, no evidence has been presented to the Commission, nor reported by the AMA, that there is a proven correlation between professional impairment and medical malpractice. Yet it is obvious that the efforts of the profession to help itself should be supported. Peer review activities have slowed down in the last several years due to several factors, including physicians' fears of being charged with antitrust for collaborative activities, lack of organizational incentives and natural disinclination to meddle.

The Commission was encouraged that the Medical Society, with the implicit support of the other health professions, proposed that legislation be enacted to provide a boost to peer review activities, including impaired provider programs. On the assumption that some peer review programs are best done locally and voluntarily, the Society proposed that each of the health occupation licensing boards be authorized to enter into agreements with both the state and the local societies and associations of health care professionals. These voluntary agreements would establish various types of reporting, monitoring and investigative programs to identify practitioners whose performances were inadequate or could benefit from special attention.

Therefore, the Commission recommends that the licensing boards for each of the health care professions be encouraged and specifically empowered to enter agreements with voluntary professional societies, both state and local, to carry out

peer review activities. These activities should include programs for impaired providers, with responsibility to report to the boards relevant information about providers who are dangerous, uncooperative or otherwise subject to disciplinary action by the respective boards. These peer review activities when conducted in good faith should be protected from civil liability. (See Draft Bill No. 4, Sec. 1.)

Better Risk Management in Hospitals

One of the major recommendations of the American Hospital Association's Medical Malpractice Task Force Report on Tort Reform in May 1986 was that "implementation of systems for the screening and reporting of adverse hospital incidents is strongly recommended as a means of reducing adverse patient occurrences and hospital exposure to potential liability."

The Report goes on to set out a "Compendium of Professional Liability Early Warning Systems for Health Care Providers." Adverse patient occurrences are those events which are not normally a natural consequence of a patient's disease or treatment. They are red flags which indicate undesired outcomes which may have resulted from a breach of the standard of care or some breakdown of communication or falling through the cracks in a system. Examples are (a) unplanned removal, injury or repair of an organ during surgery or other invasive procedure, (b) neurological deficit present at discharge which was not present at admission, and (c) an elderly or sedated patient falling from a bed without

siderails.

The methods of data collection which are used to identify these events are generally called "incident reporting" whereby adverse events are reported to the risk manager and "occurrence screening" whereby all or a percentage of patients' medical records are reviewed at periodic times against specific criteria to spot problems. Analysis of these data by the hospital can be the basis for three important functions:

quality assurance and loss prevention activities (which would affect inservice education and hospital management decisions)
medical staff performance appraisal and monitoring (which would affect the reappointment process)
professional liability insurance underwriting (which would affect decisions about self-insurance or commmercial coverage, conditions and premiums)

The North Carolina Hospital Association Trust Fund encourages the vigorous use of risk management practices in the hospital members it insures; the Fund also provides ongoing technical and educational advice about operating loss control activities. The NC Hospital Association supports a statewide organization of professional risk managers and encourages their activities. Thus, risk management is already a function of most NC hospitals and to some extent medical clinics as well. In order to upgrade this critical element of assuring quality and avoiding patient injuries, several states have made risk management a requirement for state licensure of

hospitals.

Since it was reported to the Commission that 75-80% of all medical malpractice claims originate from injuries in hospital settings, it is indicated that both the problem of patient injuries as well as liability claims can be attacked through a progressive and continually improving system of risk management, including early warning mechanisms.

Therefore, the Commission recommends that a risk management program be required as a condition for hospital licensure and that the Division of Facility Services adopt progressive rules (reflecting state-of-the-art risk managment technology) to enforce this requirement.

(See Draft Bill No. 4, Sec. 4)

Closer Review of Hospital Privileges for Physicians and Other Professionals

Concern was expressed to the Commission about the process used by hospitals for review of credentials of health care providers applying for hospital privileges. It is recognized that hospitals are the first line of defense against bad doctors. By careful review of applicants and periodic reappraisal of those already holding privileges to practice in the hospital, the patient is best assured that the professional services received in a hospital are high quality and accountable. Knowing that the large majority of medical malpractice suits originate from injuries received in the hospital, it is clearly incumbent upon hospitals to monitor medical staff performance as a matter of public

policy as well as law.

NC courts already recognize the doctrine of "corporate liability" for the negligence of staff physicians - see Bost v. Riley, 262 SE2d 391 (NC App. 1980). The General Assembly has already provided in G.S. 131E-85 that the scope and delineation of hospital privileges to be granted to physicians, dentists and podiatrists shall be determined by the governing body of the hospital and that the determination shall be based on specified criteria. In addition G.S. 131E-95 encourages full and honest review of the competency and qualification of medical staff members by a "medical review committee" in the hospital by protecting the confidentiality of the committee's procedings in two ways: first, the confidential records and materials it produces are not subject to discovery or introduction into evidence, and second, members of the committee cannot be required to testify about the internal proceedings of the committee.

Existing NC law recognizes and addresses the importance of hospital privilege procedures, but there are three problems that need to be rectified:

(1) Under current law, as judicially interpreted [see Shelton v. Morehead Mem. Hospital, 347 SE2d 824 (NC, 1986)], the hospital governing body when reviewing privilege matters is not given the protections of a "medical review committee" under G.S. 131E-95 and thus is discouraged from a full and honest review of medical staff privileges; instead, the governing body tends to "rubber stamp" the recommendations of the medical staff committee.

Therefore, the Commission recommends that the definition of "medical review committee" be expanded to include the governing body, but only when acting on hospital privilege matters.

(See Draft Bill No. 4, Sec. 2)

(2) Under current law in G.S. 131E-87 the hospital CEO is required to report to the appropriate occupational licensing board any revocation, suspension or limitation of privileges and any medical staff resignation, but not the details of those actions. The licensing boards (e.g., medicine, dentistry, podiatry) are thus supplied inadequate information upon which to base any appropriate disciplinary investigation or licensing action.

Therefore, the Commission recommends that hospitals be required to report the details of hospital privilege limitations to the occupational licensing boards.

(See Draft Bill No. 4, Sec. 3)

(3) Current federal case law recognizes a state action exemption from antitrust laws for good faith peer review activities, including hospital privilege proceedings, only when a state mandates by law that peer review activities are required in hospitals. [See Patrick v. Burget, __F.2d__ (9th Cir., Sep. 30, 1986); and Marrosse v. Interqual, Inc., 748 F.2d 373 (7th Cir., 1984).]

Therefore, to clarify that it is the policy of North Carolina to require hospitals to follow effective and fair procedures for determining hospital privileges, hospital privilege procedures should be required as part of hospital

licensure. (See Draft Bill No. 4, Sec. 6)

(4) The new federal "Health Care Quality Improvement Act of 1986" (Title IV of Public Law 99-660) includes provisions which declare that the good faith activities of professional review bodies and their members, staffs and participants are not subject to civil actions under federal and state laws. Excluded are laws relating to civil rights. Also excluded is the enforcement of state and federal laws, including antitrust laws, by the United States or the State Attorney General. The federal law is effective on October 14, 1989, unless a state decides to opt for early coverage, or to opt out, as to state laws by enacting a state law specifically making the federal law applicable earlier. The new federal provisions are consistent with the intent of North Carolina to encourage more effective peer review activities by providing protection for good faith participation. Therefore, it would be advisable for this State to exercise the "early opt in" provisions of the federal law promoting good faith peer review activities. (See Draft Bill No. 4, Sec. 6)

such coverage. It was reported to the Commission that the major medical liability insurance companies continue to offer coverage of punitive damages at no extra premium charge, perhaps due to the competitiveness of the market.

Removal of insurance coverage would be consistent with the purpose of punitive damages which is to punish a wrongdoer in a civil damage suit and provide an effective civil deterrent to extremely unacceptable behavior.

Therefore, the Commission recommends that punitive damages in medical malpractice actions be limited. (See Draft Bill No. 5, Secs. 2 and 3.)

Fraudulent Deception of Patient

The Commission heard opinions that the pursuit of legitimate medical malpractice claims by deserving patients can be frustrated by the discovery by the plaintiff's attorney that the patient's medical record has been altered or destroyed. While specific proof of such deceptive acts by a physician or hospital can of course be quite damaging to any defense put forward by the parties involved, such a disincentive may not be realized soon enough by a potential wrongdoer.

It is clearly unethical fora medical care personnel to give a patient false or misleading information about his or her diagnosis, condition or prognosis. The common and statutory law of informed consent (G.S. 90-21.13) strongly discourages this practice. The President's Commission on the Study of Ethics in Medicine in 1983 also condemned the

5. PUNITIVE DAMAGES IN MEDICAL MALPRACTICE ACTIONS SHOULD BE LIMITED TO INTENTIONAL INFLICTION OF HARM OR INJURY ON THE PLAINTIFF, AND CERTAIN FRAUDULENT ACTIONS OF HEALTH CARE PROVIDERS SHOULD BE MADE CRIMINAL, RESULTING IN AUTOMATIC REVOCATION OF LICENSE.

(See Draft Bill No. 5)

Punitive Damages

The Report of the North Carolina Bar Association Special Committee on the Tort Liability System (January 1987) recommends that while punitive damages should be retained, "the standards for awarding such damages should be revised so as to permit their award only where conduct is 'intentional' or 'willful or wanton' and only on the basis of 'clear and convincing evidence'." The report also says that insurance coverage for punitive damages should be barred.

The North Carolina Medical Society recommends that punitive damages should be entirely eliminated from medical malpractice actions, since the mere allegation of punitive damages is so threatening to physicians that plaintiffs can thus unfairly induce settlement negotiations.

In only one known medical malpractice case in North Carolina has a punitive damage award been made by a court [Mazza v. Huffaker, 61 NC App. 170, 300 SE2d 833, cert.denied, 309 NC 132, 305 SE2d 734 (1983).]

Under rules of the Department of Insurance issued in 1976 punitive damages were included in liability insurance coverage; rules adopted in 1986 permit, but do not require,

deception of patients. The President's Commission cited the frequent overuse and abuse of the "therapeutic privilege doctrine" which legally allows physicians to hide disclosure of medical information from a patient who would otherwise suffer adverse emotional or physical reaction to the "bad news," especially in cancer cases.

It should be the policy of the State to firmly discourage, in advance, any such misleading or fraudulent acts. Therefore, it should be a felony for a health care provider or other person to intentionally furnish false or inaccurate information, or to alter or destroy a patient's medical records, with intent to defraud or mislead a patient. Under other recommendations of the Commission a felony conviction will result in the automatic revocation of a medical license. (See Draft Bill No. 5, Sec. 1.)

6. IMPROVE THE LITIGATION PROCESS BY REQUIRING REASONABLE NOTICE OF MEDICAL MALPRACTICE CLAIMS AND CLOSER COURT SUPERVISION OF THE DISPOSITION OF MEDICAL MALPRACTICE ACTIONS.

(See Draft Bill No. 6.)

Testimony presented to the Commission at its hearings indicated that the litigation process could be improved in several respects without making fundamental changes in the substantive law of civil liability or major tort reforms.

Some of the aspects of current practice which seem particularly unfair to both plaintiffs and defendants involve the long periods of waiting time in many cases. Injured patients are not well served by long, drawn out litigation and it was dramatically shown to the Commission that defendant physicians suffer emotionally from delayed resolution of claims against them. In fact the NC Medical Society has announced the formation of a support program for physicians who are sued for medical malpractice.

Two specific proposals for improving the litigation process were presented to the Commission by Representative George Miller.

Reasonable Notice of Claim

The process of fair litigation is hampered from failure of potential claimants to make known their discovery of injuries which may eventually result in litigation against a health care provider. In some cases prompt notification by aggrieved patients might improve their opportunities for

corrective medical attention. In other cases it would help potential defendants assess the patients' condition and their own liability; there may then be some incentive for earlier resolution of the situation. In any event if litigation ensues, prompt notification should assist in ensuring full and fair presentation of evidence. Attorneys familiar with medical malpractice litigation practices suggested that a reasonable notice provision has precedent in both North Carolina case law [see Maybank v. S.S.Kresge, 302 NC 129, 273 SE2d 681 (1981).] and statutory law (see Uniform Commercial Code, G.S. 25-2-607(3)(a), "the buyer must within a reasonable time after he discovers or should have discovered any breach notify the seller of breach or be barred from any remedy").

Therefore, a claimant in a medical malpractice action should within a reasonable time after discovery of a claimed breach of duty give notice of such discovery to the health care provider or be barred from any remedy, in addition to any requirements of the applicable statute of limitations.
(See Draft Bill No. 6, Secs. 1 and 2.)

Closer Court Supervision

While it is clear that the courts have power to expedite any cases where they feel that justice is better served, the Commission was presented with suggestions that medical malpractice cases tend to drag on considerably longer than average civil liability cases. Whether this protraction is due to their complexity, trial tactics of the parties or other factors, it is thought that both parties would be better

served if measures could be instituted to make the litigation process more efficient and predictable. The use of statutory time schedules for discovery conferences and identification of expert witnesses, as well as overall closer court supervision and incentives for party compliance, is justified in this type of litigation. Medical liability cases characteristically involve the potential for very large awards, prolonged physical and economic suffering by the plaintiff and serious emotional stress by defendants.

Therefore, the Commission recommends statutory provisions which will provide for closer court supervision over the procedures and disposition of medical malpractice actions. (See Draft Bill No. 6, Secs. 3, 4 and 5.)

7. REQUIRE COURT APPROVAL OF THE FEES TO BE PAID TO THE ATTORNEY FOR EACH PARTY.

(See Draft Bill No. 7)

Several other states have approached the problem of public concern about the size and appropriateness of the fees which attorneys charge clients in medical malpractice litigation by imposing fees scales on the plaintiff's lawyers contingent fees. The American Medical Association has recommended this approach, claiming that such a measure would have a salutory effect on holding down litigation costs, and therefore liability insurance premiums.

The fee schedule enacted by California in its Medical Insurance Claims Reform Act in 1976 (with a 40% maximum contingent fee in smaller cases sliding to 10% in the largest cases) has been cited as a model, particularly since the U.S. Supreme Court let stand the California Supreme Court approval of the statutory sliding fee schedule [See Roa v. Lodi Medical Group, Inc., 211 Cal.Rptr. 77 (1985), appeal dismissed, 106 S.Ct. 421 (1985)].

The American Bar Association at its mid-year meeting in New Orleans on February 17, 1987, did not recommend fee scales for contingent fees, but did express some concerns about assuring the public of the fairness of fees. Specifically, the Association urged that all attorneys' fees be clearly stated in advance, in plain, unambiguous terms detailing the basis on which the fee is calculated. In cases in which contingent fees are appropriate, the clients should

be provided with a copy of the contingent fee form beforea signing the form. The content of the fee form should be specified in each jurisdiction and should include information on the maximum fees that could be anticipated. The ABA also said that lawyers' contingent fees should be based only on the net, not the gross, amount recovered. Finally, the ABA proposed that clients with complaints about fees have the opportunity to submit evidence of the fee arrangements in a closed court hearing.

The Report of the NC Bar Association Special Committee on the Tort Liability System (January 1987) also addressed the matter of contingent fees. The Report recommends that the State Bar should establish an impartial fee review committee and undertake to give wide publicity to the existence of the committee. The State Bar should also provide that contingent fee contracts be in writing.

The Commission is impressed with the recommendations of both the ABA and the NC Bar Association in attempting to provide assurance to clients and the general public that plaintiff attorneys' fees will be fair and appropriate. The Commission was also presented with concerns that a significant but sometimes overlooked part of the transaction costs in litigation are the fees charged by defense counsel.

Consistent with these recommendations and especially because of the sensitivity of litigants involved in medical malpractice actions, the Commission recommends that the trial court in medical malpractice actions shall conduct a hearing to approve the fee to be paid to the attorney for each party,

defendant as well as plaintiff.

The court should consider the extent of and the quality of the legal services rendered, the nature of the case, the fee usually charged in similar cases, and other evidence of the reasonable value of the services, including whether the parties had agreed on a contingent fee. Any fees in excess of what the court approves would be unlawful. It is noted that statutory provision for court approval of attorneys' fees has been upheld by state courts. [See Attorney General v. Johnson, 385 A2d 57 (Md. 1978); Prendergast v. Nelson, 256 NW2d 657 (Neb. 1977).]

(See Draft Bill No. 7.)

8. CHANGE THE STATUTE OF LIMITATIONS FOR MEDICAL MALPRACTICE ACTIONS ON BEHALF OF MINORS TO PERMIT ACTIONS THROUGH THE AGE OF TEN WITH EXCEPTIONS FOR LATER SUITS WHEN THE MINOR HAS BEEN JUDGED ABUSED OR NEGLECTED.

(See Draft Bill No. 8.)

One of the difficulties facing health care providers is the special hardship is defending medical malpractice claims for birth injuries when the claims are made many years after the event. The Commission was told that there is an impression that when cases are brought ten years or more after some injury associated with obstetrical care, juries are likely to side with the injured infant without regard for the strength of the plaintiff's evidence about proof of causation.

The case of Forehand v. Tayloe (U.S.Dist.Ct. EDNC, Nos.83-32-CIV-4, 84-71-CIV-4, June 4, 1985) was cited as one example. That case involved a 12 year old child who was allegedly injured by an immunization negligently administered when he was five months old. The case might have been brought much earlier so that if there was liability, the child could have received the care that the award in the case would have paid for. If there was not negligence, the defendant would be in a better position to defend himself and show alternate causation through fresher evidence.

Current law in G.S. 1-17(b) permits actions to be brought up to 19 years after perinatal injuries. This lengthy statute of limitations does not provide any incentives for

cases to be brought in a more timely fashion for these injuries. Children who have suffered some early injury may thus be deprived of compensation during the childhood years when they need it. The more years which pass also raise the risk that an inequitable result will be reached as to a defendant's liability, as well as increasing the burden of recordkeeping and exposure of insurers which is reflected in higher insurance premiums.

Two arguments have been raised about possible unfairness to injured minors if shorter time limitations are adopted.

First, there is the possibility that the child's birth injuries may go undetected until later years. The Commission was told that brain or neural injuries which may not be noticed during the pre-school years will invariably be identified during the course of preschool screening, entry to public schools or other contact with social and medical agencies in the elementary school years.

However, there may be an inequity where the child's parent or parents may abuse or neglect a child (especially where the child is "slow" or "unruly" perhaps due to birth injuries). These children would seem to be in a class more likely to suffer from inattention or deliberate neglect of parents either to promote the child's welfare or to protect the child's legal rights to sue for perinatal injuries. Because of the compelling nature of that circumstance, it may be wise policy to make an exception to a standard time limitation for children who at any time during their minority are judged to be abused or neglected under the Juvenile Code.

This exception would preserve any legal right to sue for early injuries which might come to the attention of the court or social agencies during the course of the proceedings to determine child abuse or neglect.

The second possible argument is that the minor ought to be allowed to become old enough to bring his own lawsuit. This argument is insubstantial. The present statute imposes an outside limit of the 19th birthday, leaving only one year after reaching the majority age of 18 during which the child would be legally competent to file his own suit. In fact, however, a severely injured or disabled child would likely not be filing his own suit anyway; a parent or guardian would do so, and they should be encouraged to bring any valid suit at a much earlier stage in the child's development.

Existing State policy on medical malpractice action limitations suggests that ten full years of age is an equitable maximum age to bring birth injury suits. For any injuries after birth, the minor would have the same time limitations as for other persons, except that no time limitation would be deemed to expire before his or her 10th birthday. Thus, any child under age 7 would have at least until the tenth birthday to bring an action, and longer if the discovery of the injury is delayed.

Currently, G.S. 1-15(c) limits all medical malpractice actions to 3 years after the event and if discovery of the injury is delayed, the claim is absolutely limited to four years. In the very special circumstance of delayed discovery of a non-therapeutic foreign object left in the body, the

person has one year after discovery with an absolute limit of 10 years after the event. (For example, if a 9 year old has surgery and does not discover the foreign object until he is 18, he still has one year to bring suit.) The Commission's proposal would bring more consistency to the medical malpractice action limitations.

One last argument has been raised against a special rule for minor plaintiffs in medical malpractice actions. Is it unconstitutional as a violation of equal protection? A negative answer is suggested in In Hohn v. Slate, 48 NC App. 624, 269 SE2d 307 (1980), cert.denied 301 NC 720, 274 SE2d 229 (1981). There the court upheld present G.S. 1-17(b), stating that there is a substantial difference between persons who have malpractice claims and those with other types of tort claims.

The Commission recommends that a medical malpractice action on behalf of a minor must be commenced within the time limitations of G.S. 1-15(c), as for all other medical malpractice actions generally, provided that the minor shall have up to the 10th birthday if any time limitations expire before his 10th birthday. This shall not affect any minor who has been adjudged abused or neglected under the Juvenile Code before reaching age 16. (See Draft Bill No. 8.)

9. EXTEND THE LEGISLATIVE AUTHORIZATION FOR THE COMMISSSION SO THAT FURTHER STUDY CAN BE CONDUCTED ON PROPOSALS TO PROVIDE EARLY COMPENSATION FOR BIRTH INJURIES AND TO PROMOTE PRIVATE CONTRACTS FOR ALTERNATIVE DISPUTE RESOLUTION.

(See Draft Bill No. 9)

At its final meeting on March 16 the Commission discussed two innovative proposals which might hold the seeds for long-term solutions to some of the problems surrounding the medical liability issue. Both were suggested to the Commission by distinguished law professors very knowledgeable in the field. (See APPENDIX B, MINUTES OF COMMISSION MEETINGS.) Both are voluntary and experimental and neither has been tried yet in other states. The Commission decided that discussion of such far-reaching measures should continue in the context of the base of information the Commission members have acquired during the past year's work.

The terms of Chapter 792 of the 1985 Session Laws state that the authorization for the Commission expires upon submission of its report to the 1987 General Assembly.

Therefore, the Commission recommends that legislation be promptly enacted in the General Assembly to permit the Commission to continue its work and make later recommendations about (a) providing for a pilot program for early compensation for birth injuries and (b) the promotion of private contracts for alternative dispute resolution.

(See Draft Bill No. 9)

The two proposals are described below, including the

draft bills currently before the Commission but not yet acted upon.

Voluntary Pilot Program to Provide Early Compensation to Infants Injured During or Prior to Delivery.

The Commission has heard presentations that suggest an innovative approach must be taken to the difficult and perplexing problem of obstetrical injuries, physician liability and related insurance coverage. The Minutes of the Commission meetings (See APPENDIX A) amply reflect the concerns about providing expeditious and adequate compensation for infants negligently injured during the provision of obstetrical care by obstetricians, family physicians and other health care providers. Babies should be promptly compensated when they are injured by hypoxia or other avoidable complications associated with poor management by attending physicians and hospital teams during the last stages of labor and delivery. The compensation will not restore them but will supply the money to provide appropriate remedial care and ongoing support for them, even when their life expectancy is relatively short.

There was no direct evidence submitted to the Commission about the frequency of these occurrences nor the average amounts of liability involved. Records provided by Medical Mutual Insurance Company indicated three such cases open in 1986. Also, during the fall of 1986 the case of Clark v. Dr. Dickstein and Moses Cone Hospital was being pursued by plaintiff's lawyer Grover McCain in a court in Greensboro.

News reports revealed that the suit alleged delays in delivery, improper use of forceps, failure to provide electronic fetal heart monitors during labor and oxygen deficiency during the 1984 delivery. The plaintiff, age 2, is severely brain damaged, almost paralyzed and might be blind and partially deaf. Conflicting evidence about causation and confusion about whether a spinal birth defect, rather than medical negligence, led to the jury finding no liability. The news reports pointed out that the damaged baby went uncompensated even after a long and expensive public trial which was emotionally devastating for all the parties involved.

Also compelling is the plea heard from physicians that they not be held hostage to every parental disappointment or unjustified expectation in the outcome of a pregnancy. The New England Journal of Medicine in September 1986 carried research study results demonstrating the the causation of birth injuries is particularly difficult to isolate under most conditions. It follows that public trials may in many instanceas provide neither the most equitable nor scientifically sound results either. Insurance companies are forced to set their actuarial projections about these cases on speculative grounds, resulting in fast rising premiums for physicians doing deliveries.

The impact in North Carolina of all of this uncertainty has been a sudden threat to the continued operation of prenatal clinics in local health departments, withdrawal or limiting of practices by obstetricians, announcements by

family physicians about ceasing their obstetrical services, and resulting general concern about continued poor ranking of this State in infant morbidity and mortality.

As presented by Professor Jeffrey O'Connell of the University of Virginia School of Law and a nationally known tort law expert, there is a possible answer to some of these interrelated problems. He advised the Commission in its November meeting (See SUMMARY OF PROCEEDINGS) about an untested but promising early compensation plan that would operate to induce physicians to come forward promptly with an offer to pay all net economic losses plus reasonable attorneys' fees when they determine that a potentially compensable injury has occurred, in return for being protected from later suit by that patient.

He said that his plan has been incorporated into bills introduced in the Congress as the Medical Offer and Recovery Act (H.R. 1370 and S. 1960) as a model for state initiatives. He added that a version of the proposal applying only to obstetricians had been introduced in the Massachusetts legislature last year but not enacted, even though a consultant's study (in Commission files) had indicated that the pland was economically beneficial.

If North Carolina were to adopt a pilot program, it would be necessary to study its impact during a sufficient time period (perhaps five years) in order to determine whether to continue it. The Commissioner of Insurance would seem to be the appropriate official to monitor the program and to make reports to the General Assembly.

(See Draft Bill No. 10.)

Private Contracts Between Health Care Providers and Patients

The NC Bar Association has promoted the wider use of alternatives to traditiona litigation, such as binding arbitration, mediation, mini-trials and summary jury trials. The Private Adjudication Center at Duke University has been developing various successful models for provate dispute resolution, including the use of neutral experts. The Center is also administering a mandatory, non-binding arbitration program for the Federal District Court (Middle District, North Carolina). A pilot program for court-ordered arbitration was authorized by the General Assembly and the NC Supreme Court issued implementing rules to be effective January 1, 1987. This program is inoperation in three judicial districts and applies to all claims of $15,000 or less.

Arbitration is a familiar alternative to litigation. This State adopted the Uniform Arbitration Act in 1973 (G.S. Chapter 1, Article 45A). Court cases have construed the Act to say that arbitration agreements in writing may apply to "any controversy" between parties and is valid, enforceable and irrevocable except with the consent of the parties, without regard to the justiciable character of the controversy. [See Crutchley v. Crutchley, 306 NC 518, 293 SE2d 793 (1982).] The purpose of arbitration is to reach a final settlement of disputed matters without resorting to litigation. [See McNeal v. Black, 300 SE2d 575 (1983) and

G.S. 1-567.2.]

The other and newer methods of dispute resolution described to the Commission at its October 1986 meeting (See APPENDIX B, MINUTES OF COMMISSION MEETINGS) also seem promising for use in medical malpractice claims. The best prospects for gaining widespread use and experience with ADR would be dependent upon groups of patients contracting with providers. The negotiation of fair and workable provisions in health care contracts by attorneys working with both sides could be achieved, if statutory encouragement were provided. Concerns about patients signing under duress or without an equal bargaining position are eliminated if the ADR provisions have been negotiated in an employee benefit package or HMO contract.

Professor Clark Havighurst of Duke Law School urged the Commission to stimulate the private sector to make use of voluntary contractual modification of existing tort rules, such as providing for periodic payment of awards or compensating on a no-fault basis for some types of events. This could be accomplished fairly by including optional clauses in health benefit plans and health service arrangements. The benefits to the patient in foregoing some traditional legal rights would need to be clearly articulated and tangible. For example, a group of patients who elect not to sue except for gross negligence might be given a scheduled compensation amount for certain designated events or adverse complications.

It may be that some innovative solutions are perhaps not

appropriate for universal application (especially some restrictive changes in tort law). But private parties should be allowed to devise workable and effective mechanisms for dealing with problems in the provider:patient relationship.

The Commission will consider whether imaginative approaches to finding satisfactory compensation schemes can be expected by providing public policy support of private solutions.

(See Draft Bill No. 11)

TITLES OF BILLS DRAFTED FOR MEDICAL MALPRACTICE STUDY COMM'N

1. An act to make certain changes in the North Carolina Childhood Vaccine-related Injury Compensation Program.

2. An act to authorize the Commissioner of Insurance to conduct closed claim studies of medical malpractice claims.

3. An act to amend the powers and duties of the Board of Medical Examiners.

4. An act to promote peer review activities of health care providers and to require risk management programs and hospital privilege procedures in hospitals.

5. An act to create criminal penalties for certain intentional actions of health care providers and to limit punitive damages in civil actions.

6. An act to require reasonable notice of a medical malpractice claim and to provide close court supervision over disposition of medical malpractice actions.

7. An act to require court approval of post-trial attorneys' fees.

8. An act to alter the statute of limitations for medical malpractice actions on behalf of minors.

9. An act to extend the authorization of the North Carolina Medical Malpractice Study Commission.

NOTE: The following two draft bills are included for discussion only. Consideration of them was postponed by the Commission pending extension of the legislative authorization of the Commission.

10. An act to provide a voluntary pilot program of early compensation for infants injured during or prior to delivery.

11. An act to promote the use of private contracts for alternative dispute resolution of medical malpractice claims.

DRAFT

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

(1)

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87W-LF-41
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Child Vaccine Program Changes-3. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO MAKE CERTAIN CHANGES IN THE CHILDHOOD VACCINE-RELATED INJURY COMPENSATION PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. G.S. 130A-423 is amended in the catchline by inserting the phrase "; relationship to federal law; subrogation" immediately before the period, and by adding the following new subsections to read:

"(c) Nothing in this Article prohibits any individual from bringing a civil action against a vaccine manufacturer for damages for a vaccine-related injury or death if the action is not barred by federal law under subtitle 2 of Title XXI of the Public Health Service Act.

(d) If any action is brought against a vaccine manufacturer as permitted by subtitle 2 of Title XXI of the Public Health Service Act and subsection (c) of this section, the plaintiff in the action may recover damages only to the extent permitted by subdivisions (1) through (3) of subsection (a) of G.S. 130A-427. The aggregate amount awarded in any such action may not exceed

the limitation established by subsection (b) of G.S. 130A-427. Regardless of whether such an action is brought against a vaccine manufacturer, a claimant who has filed an election pursuant to section 2121 of the Public Health Service Act, as enacted into federal law by Public Law 99-660, permitting such a claimant to file a civil action for damages for a vaccine-related injury or death, or who is otherwise permitted by federal law to file an action against a vaccine manufacturer, may file a petition pursuant to G.S. 130A-425 to obtain services from the Department of Human Resources pursuant to subdivision (5) of subsection (a) of G.S. 130A-427 and, if no action has been brought against a vaccine manufacturer, to obtain other relief available pursuant to G.S. 130A-427.

(e) In order to prevent recovery of duplicate damages, or the imposition of duplicate liability, in the event that an individual seeks an award pursuant to G.S. 130A-427 and also files suit against the manufacturer as permitted by subtitle 2 of Title XXI of the Public Health Service Act and subsection (c) of this section, the following provisions shall apply:

(1) If, at the time an award is made pursuant to G.S. 130A-427, an individual has already recovered damages from a manufacturer pursuant to a judgment or settlement, the award shall consist only of a commitment to provide services pursuant to subdivision (5) of subsection (a) of G.S. 130A-427.

(2) If, at any time after an award is made to a claimant pursuant to G.S. 130A-427, an individual recovers damages for the same vaccine-related injury from a manufacturer pursuant to a judgment or settlement, the individual who recovers the damages shall reimburse the State for all amounts previously recovered from the State in the prior proceeding. Before a defendant in any action for a vaccine-related injury pays any amount to a plaintiff to discharge a judgment or settlement, he

shall request from the Secretary of Human Resources a statement itemizing any reimbursement owed by the plaintiff pursuant to this subdivision, and, if the reimbursement is owed by the plaintiff, the defendant shall pay the reimbursable amounts, as determined by the Secretary, directly to the Department of Human Resources. This payment shall discharge the plaintiff's obligations to the State under this subdivision and any obligation the defendant may have to the plaintiff with respect to these amounts.

(3) If:

a. an award has been made to a claimant for an element of damages pursuant to G.S. 130A-427;

b. an individual has recovered for the same element of damages pursuant to a judgment in, or settlement of, an action for the same vaccine-related injury brought against a manufacturer, and that amount has not been remitted to the State pursuant to subdivision (2) of this subsection; and

c. the State seeks to recover the amounts it paid in an action it brings against the manufacturer pursuant to G.S. 130A-430;

any judgment obtained by the State under G.S. 130A-430 shall be reduced by the amount necessary to prevent the double recovery of any element of damages from the manufacturer. Nothing in this subdivision limits the State's right to obtain reimbursement from a claimant under subdivision (2) of this subsection with respect to any double payment that might be received by the claimant.

(f) Subrogation claims pursued under the National Childhood Injury Act of 1986 shall be filed with the appropriate court, not with the Industrial Commission."

Sec. 2. G.S. 130A-425(b) is amended by deleting the period at the end of subdivision (5), by substituting a semicolon, and by adding the following new subdivisions:

"(6) Supporting documentation and a statement of the claim that the claimant or the person in whose behalf the claim is made suffered a vaccine-related injury and has not previously collected an award or settlement of a civil action for damages for this injury. This supporting documentation shall include all available medical records pertaining to the alleged injury, including autopsy reports, if any, and, if the injured person was under two years of age at the time of injury, all prenatal, obstetrical, and pediatric records of care preceding the injury, and an identification of any unavailable records known to the claimant or the person in whose behalf the claim is made."

Sec. 3. G.S. 130A-425(b) is further amended in the third paragraph by adding the following after the first sentence: "The Rules of Civil Procedure as contained in G.S. 1A-1 and the General Rules of Practice for the Superior and District Courts as authorized by G.S. 7A-34 apply to claims filed with the Industrial Commission under this Article."

Sec. 4. G.S. 130A-430(b) is amended by adding the following sentences to the end to read:

"For purposes of this subsection a defective product is a vaccine that was manufactured in a negligent manner or that otherwise violated the applicable requirements of any license, approval, or permit, or any applicable standards or requirements issued under section 351 of the Public Health Service Act, as amended, or the Federal Food, Drug, and Cosmetic Act as these standards or requirements were interpreted or applied by the federal agency charged with their enforcement. The negligence or other action in violation of applicable federal standards or requirements shall be demonstrated by the State, by a

preponderance of the evidence, to be the proximate cause of the injury for which an award was rendered pursuant to G.S. 130A-427, in order to allow recovery by the State against the manufacturer pursuant to this subsection."

Sec. 5. G.S. 130A-431 is rewritten to read:

"§ 130A-431. **Certain vaccine diversions made a crime.**-- Any person who (i) receives a vaccine designated by the manufacturer for use in the State, (ii) directly or indirectly diverts the vaccine to a location outside the State, and (iii) directly or indirectly profits as a result of this diversion is guilty of a Class J felony and fined twenty-five dollars ($25) a dose of the diverted vaccine or one hundred thousand dollars ($100,000), whichever is less. A conviction of a health care provider for 300 or more doses of the diverted vaccine shall result in the suspension of his professional license for one year.

Sec. 6. G.S. 130A-432 is amended by rewriting the last sentence to read:

"This Article applies to all claims for vaccine-related injuries alleged to have been caused by covered vaccines administered within the State, regardless of where an action relating to the injuries is brought and regardless of where the injuries are alleged to have occurred."

Sec. 7. G.S. 130A-433 is rewritten to read:

"§ 130A-433. Notwithstanding any law to the contrary, the Secretary of Human Resources may enter into contracts with the manufacturers and suppliers of covered vaccines and with other public entities either within or without the State for the purchase of covered vaccines and may provide for the distribution or sale of the covered vaccines to health care providers. Local health departments shall distribute the covered vaccines at the request of the Department of Human Resources. The Secretary may charge a fee for providing a covered vaccine to a health care provider. The fee shall be set at an amount that covers the cost of the vaccine to the Department, plus the cost to the Department of storing and distributing the vaccine. The Secretary shall adopt rules to implement this Article.

A health care provider who receives vaccine from the State may charge no more than the cost of the vaccine and a reasonable fee for the administration of the vaccine. Vaccines provided by the State to local health departments for administration shall be administered at no cost to the patient."

Sec. 8. Section 5 of Chapter 1008 is rewritten to read:

"Sec. 5. This act shall become effective October 1, 1986."

Sec. 9. This act is effective upon ratification, except that Section 1 shall become effective only on and after the effective date of subtitle 2 of Title XXI of the Public Health Service Act, as enacted into federal law pursuant to Title III of Public Law 99-660, and only if this federal law on its effective date contains language that forbids a State from establishing or enforcing a law prohibiting an individual from bringing a civil action against a vaccine manufacturer for damages for a vaccine-related injury or death if this action is not barred by federal law.

DRAFT

(2)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

S D

87-LCK-2
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Closed Claim Studies-Med. Malpract. (Public)

Sponsors: Senator Taft.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO CONDUCT CLOSED CLAIM STUDIES OF MEDICAL MALPRACTICE CLAIMS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-21.1 is amended by adding at the end:

"Every insurer authorized to write professional liability insurance for health care providers* in this State shall also file, upon the request of the Commissioner, a report containing information for the purpose of allowing the Commissioner to analyze closed claims. The report shall contain the information about each claim closed for each insured, including claims closed without payment and reopened cases, and shall be in *the form, both as prescribed by the Commissioner. The information which identifies persons in these reports is privileged and shall not be open to the public. A copy of these reports shall be made available to the Board of Medical Examiners for their official use and these reports shall not be available to the public. The Commissioner shall analyze these reports and may contract with

* and every entity authorized to self insure for professional liability insurance for health care providers

consultants to analyze them. The Commissioner shall file statistical and other summaries based on these reports with the General Assembly within three months after receipt of the ~~annual statements~~ reports and shall make copies of these summaries available to the public."

Sec. 2. This act shall become effective October 1, 1987.

* "Violation of this requirement by an insurer or self-insurance entity is prohibited and shall result in a civil penalty of $1000 for each day the violation continues."

DRAFT

(3)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

S D

87-LCKX-3
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Medical Board Powers and Duties. (Public)

Sponsors: Senator Taft.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AMEND THE POWERS AND DUTIES OF THE BOARD OF MEDICAL EXAMINERS

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-8 is rewritten to read:

"§90-8. Officers may administer oaths, and subpoena witnesses, records and other materials.--The president and secretary of the Board may administer oaths to all persons appearing before it as the Board may deem necessary to perform its duties, and to summon and to issue subpoenas for the appearance of any witnesses deemed necessary to testify concerning any matter to be heard before or inquired into by the Board, and to order that any documents or other material concerning any matter to be heard before or inquired into by the Board shall be produced before the Board or made available for inspection."

Sec. 2. G.S. 90-14(a)(7) is rewritten to read:

"(7) Conviction in any court of a felony or a crime involving moral turpitude, or of the violation of a law

involving the practice of medicine; and a felony conviction shall result in the automatic revocation of a license issued by the Board, unless the Board orders otherwise or receives from the person within 60 days of the conviction a request for a hearing to be held in which case the provisions of G.S. 90-14.2 shall be followed."

Sec. 3. G.S. 90-14 is amended by rewriting subsection (a)(12) to read:

"(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient for financial gain of the physician; and upon a finding of the exploitation for financial gain, the Board may order restitution be made to the patient by the physician."

Sec. 4. G.S. 90-14(a) is amended by adding a new subdivision to read:

"(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the Board concerning any matter affecting the license to practice medicine."

Sec. 5. G.S. 90-14 is amended by adding a new subsection to read:

"(c) The Board may assess the costs of disciplinary proceedings on any person against whom the denial, revocation, restriction, or suspension of license, or other disciplinary action, is applied."

Sec. 6. G.S. 90-14 is amended by adding a new subsection to read:

"(d) The Board and its members and staff may release confidential or nonpublic information to any licensure board or governmental agency in this State, another state or the federal government about the issuance, denial, annulment, suspension, or revocation of a license, or the voluntary surrender of a license by a physician, including the reasons for the action, or an investigative report made by the Board. The Board shall notify

the health care provider within 60 days after the information is transmitted. A summary of the information that is being transmitted shall be furnished to the provider. The notice or copies of the information shall not be provided if the information relates to an ongoing criminal investigation by any law enforcement agency, or authorized Department of Human Resources personnel with enforcement or investigative responsibilities."

Sec. 7. G.S. 90-14 is amended by adding a new subsection to read:

"(e) The Board and its members and staff shall not be held liable in any civil or criminal proceeding for exercising, in good faith, the powers and duties authorized by law."

Sec. 8. G.S. 90-14.13 is amended by adding a new second paragraph, to read:

"The chief administrative officer of each insurance company providing professional liability insurance for physicians who practice medicine in North Carolina, the administrative officer of the Liability Insurance Trust Fund Council created by G.S. 116-220, and the administrative officer of any trust fund operated by a hospital authority, group, or provider shall report to the Board any award of damages or settlement affecting or involving a physician it insures or any cancellation or nonrenewal of its professional liability coverage of a physician. The Board may request details about any action and the officers shall promptly furnish the requested information. The reports required by this section are privileged and shall not be open to the public. The Board shall report all violations of this paragraph to the Commissioner of Insurance."

Sec. 9. The last sentence of G.S. 90-15.1 is rewritten to read:

"Upon payment of all fees and penalties which are due, the license of the physician may be reinstated, subject to the Board requiring the physician to appear before the Board for an interview and to comply with other licensing requirements."

Sec. 10. The first sentence of G.S. 90-107 is rewritten to read:

"Prescriptions, order forms and records required by this Article, and stocks of controlled substances included in Schedules I through VI of this Article shall be open for inspection only to federal and State officers whose duty it is to enforce the laws of this State or of the United States relating to controlled substances included in Schedules I through VI of this Article, and to authorized employees of the North Carolina Department of Human Resources with enforcement and investigative responsibilities, and authorized employees and representatives of the Board of Medical Examiners of the State of North Carolina in conjunction with an investigation under Article 1."

Sec. 11. The first sentence of G.S. 90-15 is rewritten to read:

"Each applicant for a license by examination shall pay to the treasurer of the Board of Medical Examiners of the State of North Carolina a fee which shall be prescribed by said Board in an amount not exceeding the sum of four hundred dollars ($400.00) plus the cost of test materials before being admitted to the examination."

Sec. 12. The sixth sentence of G.S. 90-15 is amended by deleting "ten dollars ($10.00)" and substituting "one hundred dollars ($100.00)".

Sec. 13. This act shall become effective October 1, 1987.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 1987

4

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

S D

87-LCK-4

(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Medical Peer Review. (Public)

Sponsors: Senator Taft.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROMOTE PEER REVIEW ACTIVITIES OF HEALTH CARE PROVIDERS AND TO REQUIRE RISK MANAGEMENT PROGRAMS AND HOSPITAL PRIVILEGE PROCEDURES IN HOSPITALS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 is the General Statutes is amended by adding a new article to read:

"Article 1D.

"Peer Review.

"§90-21.22. Peer review agreements.--(a) Each board that issues licenses, registrations, or certifications to health care providers pursuant to this Chapter may, under regulations adopted by each board in compliance with Chapter 150B of the General Statutes, enter into agreements with State and local professional societies or associations of health care providers of the same

type for the purpose of conducting peer review activities. Peer review activities to be covered by such agreements shall include investigation, review, and evaluation of records, reports, complaints, litigation and other information about the practices and practice patterns of health care providers, and shall include programs for impaired health care providers.

(b) Peer review agreements shall include provisions for the society or association to receive relevant information from the board and other sources, conduct the investigation and review in an expeditious manner, provide assurance of confidentiality of nonpublic information and of the review process, make reports of investigations and evaluations to the board, and to do other related activities for promoting a coordinated and effective peer review process.

(c) Each society or association which enters a peer review agreement with a board shall establish and maintain a program for impaired providers for the purpose of identifying, reviewing, and evaluating the ability of providers to function as providers and to provide programs for treatment and rehabilitation. Boards may provide funds for the administration of impaired provider programs and shall adopt regulations with provisions for definitions of impairment; guidelines for program elements; procedures for receipt and use of information of suspected impairment; procedures for intervention and referral; monitoring treatment, rehabilitation, post-treatment support and performance; reports of individual cases to the boards; periodic reporting of statistical information; assurance of confidentiality of nonpublic information and of the review process.

(d) Upon investigation and review of a provider, or upon receipt of a complaint or other information, a society or association which enters a peer review agreement with the board shall report immediately to the board detailed information about any provider if:

(1) the provider constitutes an imminent danger to the public or to himself;

(2) the provider refuses to cooperate with the program, refuses to submit to treatment, or is still impaired after treatment and exhibits professional incompetence; or

(3) it reasonable appears that there are other grounds for disciplinary action.

(e) Any confidential patient information and other nonpublic information acquired, created, or used by a society or association pursuant to this section shall remain confidential and shall not be subject to discovery or subpoena. No person participating in the peer review or impaired provider programs of this section shall be required to disclose any information acquired or opinions, recommendations, or evaluations acquired or developed or to testify about any matter involved, in the course of participating in any agreements pursuant to this section.

(f) Peer review activities conducted in good faith pursuant to any agreement under this section shall not be grounds for civil action under the laws of this State and are deemed to be State directed and sanctioned and shall constitute State action for the purposes of application of antitrust laws."

Sec. 2. G.S. 131E-76(5) is amended by adding this sentence, at the end:

"The hospital governing body or a committee of the governing body shall also be considered a medical review committee when engaged in hospital privilege determinations. Nothing in this definition is intended to affect the application of antitrust laws as they may apply to hospital governing bodies."

Sec. 3. The first sentence of G.S. 131E-87 is rewritten to read:

"The chief administrative officer of each licensed hospital in the State shall report to the appropriate occupational licensing board the details, as prescribed by the board, of any revocation, suspension, or limitation of privileges of a health care provider to practice in that hospital."

Sec. 4. Article 5 of Chapter 131E of the General Statutes is amended by adding a new Part E to read:

"Part E. Risk Management.

"§131E-96. Risk management programs.--(a) Each hospital shall develop and maintain a risk management program which is designed to identify, analyze, evaluate, and manage risks of injury to patients, visitors, employees, and property through loss reduction and prevention techniques and quality assurance activities, as prescribed in rules promulgated by the Commission.

(b) The Department shall not issue or renew a license under this Article unless the applicant is in compliance with this section."

Sec. 5. G.S. 131E-85 is amended by adding a new subsection to read:

"(e) The Department shall not issue or renew a license under this Article unless the applicant has demonstrated that the procedures followed in determining hospital privileges are in accordance with this Part and rules of the Department."

Sec. 6. For the purpose of making applicable in the State the early opt-in provisions of Title 4 of the "Health Care Quality Improvement Act of 1986," P.L. 99-660, the State elects to exercise on October 1, 1987, the provisions of Title 4, Section 411(c)(2)(A) of that Act to promote good faith professional review activities.

Sec 7. This act shall become effective October 1, 1987.

DRAFT

(5)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

S D

87-LCK-5
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Health Care Criminal Penalties. (Public)

Sponsors: Senator Taft.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO CREATE CRIMINAL PENALTIES FOR CERTAIN INTENTIONAL ACTIONS OF HEALTH CARE PROVIDERS AND TO LIMIT PUNITIVE DAMAGES IN CIVIL ACTIONS.

The General Assembly of North Carolina enacts:

Section 1. Article 1B of Chapter 90 is amended by adding a new section to read:

"§90-21.15. Criminal penalties for certain intentional, willful or wanton actions.--(a) It shall be unlawful for a health care provider or other person to intentionally

(1) furnish to a patient or insert or place in the patient's medical record with intent to defraud or mislead the patient false or inaccurate information about diagnosis, treatment, or cause of the patient's condition; or

(2) alter, destroy, conceal, or remove a patient's medical records with intent to defraud or mislead the patient.

(b) Conviction for a violation of this section is a Class J felony."

Sec. 2. G.S. 90-21.11 is amended as follows:

(1) by rewriting the catchline to read:

"§ 90-21.11. Definitions."; and

(2) by adding a new paragraph to read:

"As used in this Article, the term 'medical malpractice action' means a civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care by a health care provider."

Sec. 3. Article 1B of Chapter 90 of the General Statutes is amended by adding at the end a new section to read:

"§ 90-21.15. Punitive damages limited.--Punitive damages may be awarded in a medical malpractice action only when the conduct of the defendant is shown by clear and convincing evidence to be intentional infliction of harm or injury on the plaintiff. Insurance indemnity of punitive damages for health care providers is prohibited."

Sec. 4. This act shall become effective July 1, 1987, and shall apply to actions filed on or after that date.

DRAFT

(6)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

S D

87-LCK-14
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Medical malpractice procedures. (Public)

Sponsors: Senator Taft.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE REASONABLE NOTICE OF A MEDICAL MALPRACTICE CLAIM AND TO PROVIDE CLOSE COURT SUPERVISION OVER THE DISPOSITION OF MEDICAL MALPRACTICE ACTIONS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-21.11 is amended:

(1) by rewriting the catchline to read:

"§90-21.11. Definitions."; and

(2) by adding a new paragraph to read:

"As used in this Article, the term 'medical malpractice action' means a civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care by a health care provider."

Sec. 2. Article 1B of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§90-21.1. Reasonable notice of claim necessary.--A claimant in a medical malpractice action shall, within a reasonable time after he discovered or should have discovered the

claimed breach of duty, give written notice to the health care provider of the discovery of the claimed breach or be barred from any remedy."

Sec. 3. G.S. 1A-1, Rule 3, is amended by designating the text of the rule as subsection (a) and by adding a new subsection to read:

"(b) The clerk shall maintain a separate index of all medical malpractice actions, as defined in G.S. 90-21.11. Upon the commencement of a medical malpractice action, the clerk shall provide a current copy of the index to the senior judge of the division in which the action is pending."

Sec. 4. G.S. 1A-1, Rule 26, is amended by adding after subsection (f) a new subsection (f1) to read:

"(f1) Medical malpractice discovery conference. In a medical malpractice action as defined in G.S. 90-21.11, upon the case coming at issue or the filing of a responsive pleading or motion requiring a determination by the court, the judge shall, within 30 days, direct the attorneys for the parties to appear for a discovery conference. At the conference the court may consider the matters set out in Rule 16, and shall:

(1) Rule on all motions;

(2) Order the plaintiff to identify within a period not to exceed 60 days all expert witnesses expected to give evidence for the plaintiff about the alleged breach of duty by the defendant and order the defendant to identify within a period not to exceed an additional 60 days all expert witnesses expected to give evidence for the defendant, unless good cause is shown for an extension of time.

(3) Order the plaintiff to make any expert witness identified available upon request of the defendant for deposition or other discovery pursuant to subdivision (b)(4) of this rule; and

(4) Establish by order an appropriate discovery schedule designated so that all discovery shall be completed within 180 days after the order is issued unless good cause is shown for an extension of time.

If the plaintiff fails to identify an expert witness as ordered, the court shall, upon motion by the defendant, impose an appropriate sanction, which may include dismissal of the action or exclusion of the testimony of the expert witness at trial."

Sec. 5. G.S. 1A-1, Rule 16, is amended by designating the text of the rule as subsection (a) and adding a new subsection to read:

"(b) In a medical malpractice action as defined in G.S. 90-21.11, at the close of the discovery period scheduled pursuant to Rule 26(f1), the judge shall schedule a final conference. At the conference, the judge shall rule on all pending motions and make other rulings as appropriate to ready the case for trial. The judge shall order that the case be calendered for trial at the next scheduled term of court unless he finds that for good cause the case should be calendered for trial at a later time."

Sec. 6. This act shall become effective July 1, 1987. Section 2 of this act shall apply to any breach of duty that is discovered or should have been discovered on or after that date.

DRAFT

7

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

S D

87-LCK-18
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Trial atty fees court approved. (Public)

Sponsors: Senator Taft.

A BILL TO BE ENTITLED

AN ACT TO REQUIRE COURT APPROVAL OF POST-TRIAL ATTORNEY'S FEES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 1A-1 is amended by adding after Rule 58 a new rule to read:

"Rule 58.1. Approval of attorney's fees.--In a medical malpractice action as defined in G.S. 90-21.11, upon entry of a judgment after trial, the trial court shall conduct a hearing to approve the attorney's fee to be paid to the attorney for each party. The court shall consider the extent of and quality of the legal services rendered, the nature of the case, the fee usually charged in similar cases, and other evidence of the reasonable value of the services as the court deems appropriate, including whether the parties had agreed on a contingent fee. After consideration of all relevant factors, the

court shall approve a reasonable attorney's fee for each attorney"

Sec. 2. G.S. 84-38 is amended as follows:

(1) By deleting the period at the end of the catchline and substituting the following: "; court approval of certain fees required."; and

(2) By adding after the second paragraph a new paragraph to read:

"It shall be unlawful for an attorney-at-law representing a party to an action in which judgment for damages has been entered after trial to charge for that representation a fee in excess of the attorney's fee approved by the court pursuant to G.S. 1A-1, Rule 58.1."

Sec. 3. This act shall become effective July 1, 1987, and applies to contracts for attorney's fees entered into on or after that date.

DRAFT

8

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

DRAFT

(DGW REVISION OF 87-LCK-17)

Short Title: Malpractice limitations/minors.

A BILL TO BE ENTITLED

AN ACT TO ALTER THE STATUTE OF LIMITATIONS FOR MEDICAL MALPRACTICE ACTIONS ON BEHALF OF MINORS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 1-17(b) is rewritten to read:

"(b) Notwithstanding the provisions of subsection (a) of this section, a medical malpractice action, as defined in G.S. 90-21.11, on behalf of a minor shall be commenced within the limitations of time specified in G.S. 1-15(c): Provided, that if said time limitations expire before such minor attains the full age of 10 years, the action may be brought until such time as the said minor attains the full age of 10 years. This subsection shall not apply to a minor if at any time before he reaches the full age of 18 years a court has entered a judgment or consent order under the provisions of the North Carolina Juvenile Code finding that said minor is an abused or neglected juvenile as defined in G.S. 7A-517.

Sec. 2. This act shall become effective July 1, 1987 and applies to causes of action that accrue on or after that date.

DRAFT

9

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

(DGW DRAFT)

Short Title: Malpractice Study Comm'n extension

A BILL TO BE ENTITLED

AN ACT TO EXTEND THE TIME OF REPORTING FOR THE MEDICAL MALPRACTICE STUDY COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. The Medical Malpractice Study Commission created by Chapter 792 of the 1985 Session Laws is authorized to extend the time for completing its work and making any further reports to the 1987 General Assembly until June 1, 1987.

Sec. 2. This act is effective upon ratification.

DRAFT
FOR DISUSSION ONLY

(10)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

DRAFT

87-LF-12

Short Title: Obstetric Injury Compensation Pilot . (Public)

Sponsors:

A BILL TO BE ENTITLED

AN ACT TO CREATE A VOLUNTARY PILOT PROGRAM TO PROVIDE EARLY COMPENSATION FOR INFANTS INJURED DURING OR PRIOR TO DELIVERY.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by inserting a new Article between Article 1C and Article 2 to read:

"Article 1D.

" Voluntary Early Compensation Pilot Program For Infants Injured During or Prior to Delivery.

"§ 90-21.50. **Pilot program; purpose; establishment.**-- The General Assembly finds that it is necessary to provide for early compensation for infants injured during or prior to delivery for the following reasons:

(1) To protect and promote the public health, safety, and welfare;

(2) To assure the continued participation of family physicians and obstetricians and other health care providers in the prenatal and obstetrical services that need to be provided to pregnant women all across the State;

(3) To provide incentives to liability insurers to reduce the premiums and increases in premiums for health care providers who participate in providing early compensation pursuant to this Article;

(4) To promote the prompt and early payment of fair and adequate compensation for infants for damages due to injuries sustained during delivery or during the provision of obstetric or prenatal services; and

(5) To improve the resolution of disputes over prenatal and obstetrical injuries by providing an alternative to traditional legal remedies, an optional procedure for health care providers to offer to pay all net economic losses resulting from the infant's injury in return for being protected from suit for those and other losses.

The General Assembly further finds that it is necessary to establish a voluntary pilot program to test the concept and the process of early compensation for infants injured during or prior to delivery before establishing such a program statewide.

(b) A voluntary pilot program to provide early compensation for infants injured during or prior to delivery is established. Any health care provider as described by G.S.90-21.51 may offer early compensation pursuant to this program.

Health care providers who do offer early compensation pursuant to this program shall furnish relevant information to the Commissioner of Insurance in a form prescribed by the Commissioner. These records shall be privileged and not open to the public. This Article does not affect the operation of the terms of insurance contracts. Failure to make an offer shall not constitute a basis for a claim of unwarranted refusal by the insurer to pay or settle a claim.

"§ 90-21.51. Nature of injury compensated for; offer of compensation.-- A health care provider who considers that he may be liable under North Carolina laws for having injured an infant during prenatal or obstetric services including the delivery of the infant may, subject to written approval of the provider's liability insurer, make an offer of compensation to the representative of the infant and to the parent or legal custodian of the injured infant within ~~180~~ 365 days of the event that resulted in the injury. This offer shall be in writing. The offer, and the compensation paid, may not exceed the amount of liability insurance coverage carried by the health care provider.

For purposes of this Article, the injury contemplated includes the death of the infant.

"§ 90-21.52. Scope of compensation.-- (a) The compensation paid by the health care provider includes;

(1) Actual and projected reasonable unreimbursed expenses of medical care, developmental evaluation, special education, vocational training, physical, emotional, or behavioral therapy, and residential and custodial care;

(2) Loss of earnings and projected earnings, not otherwise compensated for, determined in accordance with generally accepted actuarial principles; and

(3) Reasonable attorney's fees.

Noneconomic damages are not recoverable [unless Option B of G.S. 90-21.54 is selected.]

(b) Other health care providers, such as the hospital and other possible defendants, may join in the offer and participate in the compensation payment.

"§ 90-21.53. Effect of election to accept offer.-- If the person to whom the offer is made elects to accept the offer within 90 days, this person is foreclosed from bringing any civil action arising out of the injury against the health care provider making the offer, except that the person may either file a civil action or submit to arbitration pursuant to the Uniform Arbitration Act in order to settle the amount of compensation to be paid by the health care provider pursuant to G.S. 90-21.52.

"§ 90-21.54. Effect of rejection of early compensation offer.-- If the offer is made within 180 days and the offer is refused:

[Option A. The person to whom the offer is made is foreclosed from bringing any civil action arising out of the injury against the health care provider making the offer, except that the person may either file a civil action in a court with appropriate jurisdiction, or submit to arbitration pursuant to the Uniform Arbitration Act, in order to settle the amount of compensation to be paid by the health care provider pursuant to G.S. 90-21.52.]

[Option B. The person to whom the offer is made may file an action arising out of the injury in a court with appropriate jurisdiction. If the person to whom the offer was made prevails in this action, he may recover, in addition to other damages provided in G.S.90-21.52, noneconomic damages not to exceed two hundred fifty thousand dollars ($250,000). The total award may not exceed the amount of liability insurance carried by the health care provider. If the person to whom the offer is made does not prevail in the action, or is awarded less than the amount of liability insurance carried by the health care provider, this person is liable for the defendant's reasonable attorney's fees, the

defendant's reasonable expenses, and court costs.]

"§ 90-21.55 Health care provider's liability insurance coverage.-- In order to be able to provide early compensation pursuant to this Article, a health care provider shall carry a minimum of one million dollars ($1,000,000) in liability insurance.

"§ 90-21.56 Limitations on scope of early compensation.-- Nothing in this Article precludes any civil action arising out of the injury contemplated by this Article against a health care provider who does not make an early compensation offer as permitted by this Article or who does not carry the minimum amount of liability insurance required by this Article."

Sec. 2. The Commissioner of Insurance shall study the results of the voluntary pilot program established by this act and shall make an interim report to the General Assembly by May 1, 1989 and a final report by May 1, 1992. These reports shall include the Commissioner's recommendations as to the effectiveness of the pilot and as to the advisability of continuing the program.

Sec. 3. This act shall become effective October 1, 1987 and expires on September 30, 1992. It applies to injuries incurred on and after October 1, 1987 but before October 1, 1992.

DRAFT

For Discussion Only

(11)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

D

87-LF-57

(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Private Contract Arbitration. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROMOTE THE USE OF PRIVATE CONTRACTS FOR ALTERNATIVE DISPUTE RESOLUTION OF MEDICAL MALPRACTICE CLAIMS.

The General Assembly of North Carolina enacts:

Section 1. Article 1B of Chapter 90 of the General Statutes is amended by adding the following new sections:

"§90-20.17. **Private dispute resolution contracts; purpose; contract provisions.**--(a) The assurance of accessible and affordable personal health care in this State requires a recognition of the necessity of promoting the use of voluntary alternative dispute mechanisms and permiting parties to limit or avoid traditional litigation, in the interest of fostering early and efficient settlement of medical malpractice claims, stabilizing liability insurance rates, and preserving mutual trust in the provider-patient relationship. The purpose of this section is to encourage use of voluntary alternative mechanisms for compensating injuries incurred by patients in the course of receiving health care services.

(b) Any person who seeks or receives professional services from a health care provider as defined in G.S.90-21.11, or a health maintenance organization as defined in G.S.57B-2, may contract with that provider with regard to resolution of any disputes that may arise concerning the furnishing of, or failure to furnish, health care services. Any contract for dispute resolution is a valid and enforceable contract if it meets the following conditions:

(1) The person contracting with the provider is a competent adult,or the person contracting on behalf of a minor is the parent or legal guardian of the minor;

(2) The contract is in writing and contains the following provision, underscored, or otherwise printed so as to be readily noticed: "**I AM VOLUNTARILY SIGNING THIS AGREEMENT AND I CAN REVOKE IT WITHIN 60 DAYS BY NOTIFICATION IN WRITING.**";

(3) The contract is signed by the parties or their authorized agents; and

(4) The contract provides for a dispute resolution mechanism that is recognized in current legal practice, including:

a. Civil action in tort or contract;

b. Binding arbitration, conducted pursuant to the Uniform Arbitration Act, or as agreed by the parties;

c. Mediation;

d. Mini-trial;

e. Summary jury trial;

f. Private adjudication.

(c) The contract may provide for the dispute resolution process, including any civil action that may be filed, to be governed by contractual modification of existing substantive rules governing tort claims whether existing in statutes or at common law, as these rules affect the parties to the contract, including:

(1) Limitations on recoverable damages;
(2) Compensation offsets for any accounts received from collateral sources;
(3) Periodic payment of awards;
(4) Alteration of the legal standards of care determining liability;
(5) Specification of the types of proof or expert testimony admissable to establish negligence;
(6) Compensation for specified injuries or illnesses on a no-fault basis.

(d) The inclusion of any provisions that would have the effect of limiting the rights of a party under State or federal law is a voluntary waiver by that party and shall be recognized in any court proceeding related to the issues included in the contract.

(e) Nothing in this section limits the rights of persons under contract law."

Sec. 2. This act shall become effective October 1, 1987.

SUMMARY OF FACTS PRESENTED TO THE COMMISSION

1. INSURANCE - NATIONAL

The 900 property and casualty insurance companies took in $118 billion in premiums in 1984 - 1985 and reported net operating losses of $3.8 billion in 1984 and $5.5 billion in 1985 with an overall 1.18 loss ratio (1.61 loss ratio for medical malpractice).

The National Insurance Consumer Organization says that if insurance industry included tax credits and capital gains, it would show $6 billion profit in 1985.

St.Paul reported medical malpractice losses of $19,703,000 in 1984 and $45,522,000 in 1985.

Medical malpractice insurance premium costs for physicians average 5.1% of gross revenue for surgical specialists, 1.7% for non-surgical specialists and 2.7% overall.

The AMA socioeconomic national studies indicate that surgeons and anesthesiologists pay the highest average rates. Obstetrician-gynecologists have experienced the greatest average recent increases in rates.

2. INSURANCE CLAIMS EXPERIENCE - NORTH CAROLINA

Both the frequency and severity of medical malpractice claims in NC is rising, coupled with a corresponding rise in insurance premium rates. Unfortunately, details about these closed claims are not presently available in North Carolina. (See section 3.)

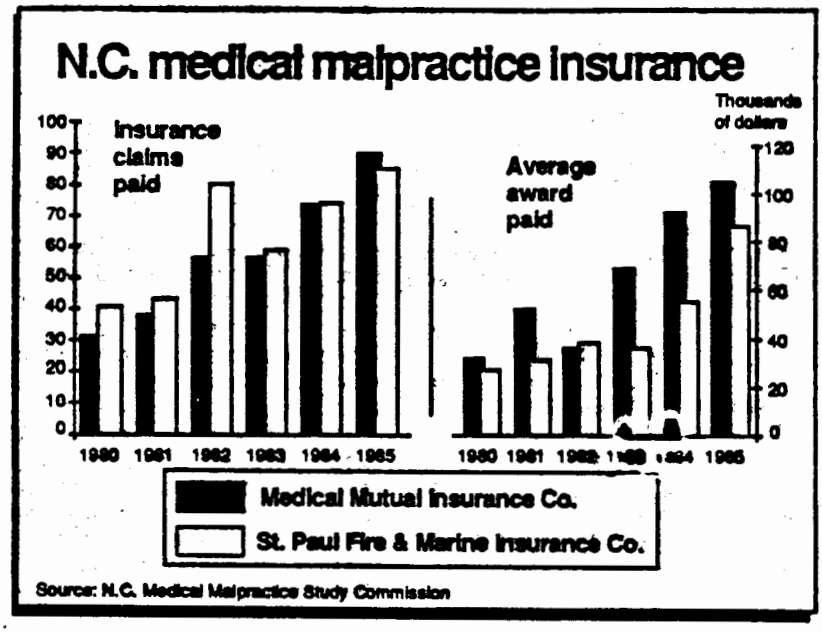
The following information was obtained from the limited data reported on the medical malpractice supplement (Supplement A to Schedule T) in the annual statement submitted by insurers to the Department of Insurance, in accordance with G.S. 58-21.1.

Closed claims experience for physicians in NC based on study by James Wilson, Insurance Consultant to NC Med. Malp. Study Comm'n, using data submitted by companies to Department of Insurance:

Med Mutual paid or settled 32 claims for an average of $32,608 in 1980 and 91 claims for an average of $105,897 in 1985

St. Paul paid or settled 41 claims for an average of $27,775 in 1980 and 86 claims for an average of $87,348 in 1985

During 1980-1985, the number of new claims in one year rose 134% for Med Mutual (from 312 in 1980 to 729 in 1985) and 180% for St. Paul (from 267 in 1980 to 749 in 1985).



3. FUTURE STUDY OF CLAIMS EXPERIENCE - NORTH CAROLINA

The closed claim study initiated by the Commissioner of Insurance in late 1986 will provide a set of data that can be used by the Commissioner and others to evaluate the trends and developments in the future on an informed basis. The difficulties experienced in gathering useful data by the Medical Malpractice Study Commission (here as well in other states) will be lessened by this new effort by the Commissioner. As the Commissioner reported to the Commission on September 5, 1986, that the "purpose of this (close claim) survey is to obtain information about the nature and disposition of claims, and factors that impact the cost of claims. It is not meant to determine other items such as the adequacy of rates or the profitability of insurers, which the Department will pursue through other means." The study will provide specific information about types of claims settled or awarded by courts, types of providers and the actions that caused the claim, detailed trial information (such as names of expert witnesses), details of the type and source of payments to a plaintiff and other useful data. (See the NORTH CAROLINA MEDICAL PROFESSIONAL LIABILITY INSURANCE UNIFROM CLAIMS REPORT in APPENDIX ____.) The issue of identification of the names of the parties involved with the claims has been raised by the Commissioner as a potential obstacle in obtaining the full cooperation of the insurers and the others involved with the study.

4. INSURANCE RATES - NORTH CAROLINA

[NOTE: The following material can be updated with 1986 figures after March 1, 1987, if the Department of Insurance receives new medical malpractice insurance reports from the insurers doing business in NC.]

St.Paul's claims experience reported to Study Commission:

	Claim frequency (per 100)		Claim severity (avg. claim)	
1980	2.7 (NC)	3.8 (US)	$12,000 (NC)	$15,000 (US)
1985	4.1 (NC)	6.0 (US)	$19,000 (NC)	$24,000 (US)

Medical Mutual's claims experience reported to Study Commission:

	Number of Claims/Suits	Accumulated total payments
1980	325 / 95	$ 1.47 Million
1985	650 / 210	$25.90 Million

Medical malpractice insurance rates ($1M/$1M, claims made)(1986):

	Med Protective*	St.Paul#	Medical Mutual
Family Phys	$ 4,180	$ 1,733	$ 2,873
Rural Fam Phys-OB	(with Surgeon backup and no OB-GYN)		3,756@
Fam Phys-OB	8,181	3,261	6,5876@
OBGYN	19,197	12,813	22,126

*Started writing policies in NC in April 1986
#Not writing new business as of Jan. 1986
@Applicants for this special situation reviewed individually by Medical Mutual, as of May 1986

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#Not writing new business as of Jan. 1986
@Applicants for this special situation reviewed individually by Medical Mutual, as of May 1986

5. THE SPECIAL PROBLEM OF OBSTETRICAL INJURIES IN NORTH CAROLINA AND THE PHYSICIAN RESPONSE

According to NC OBGYN Liaison Committee Survey and NC Academy of Family Physicians (in April 1986):

From 1980 - 1986, OB malpractice claims increased 387%
OB insurance premiums increased 577%

From 1983 - 1986, due to risk of malpractice litigation,
17% Obstetricians (OBGYN) stopped obstetrics
12% Family Phys/GP stopped obstetrics
21% OBGYN decreased high risk OB
27% OBGYN stopped services to health depts
51-68% OBGYN increased diagnostic procedures, c-sections, procedure charges, referrals, professional fees

From 1983 - 1986, due to cost of malpractice insurance,
15% OBGYN stopped obstetrics
91% Family Phys/GP will stop obstetrics
15% OBGYN decreased high risk OB
19% OBGYN stopped services to health depts
40-79% OBGYN increased diagnostic procedures, procedure charges, professional fees, referrals

According to Dr. Richard Nugent of the NC Division of Health Services, the impact of physician withdrawal from local health department prenatal clinic participation poses a serious threat to the effectiveness of prenatal care in NC. He said that the results of two surveys (March 1985 and Nov. 1986) of physician participation reflect continuing trends toward reductions in the availability and accessibility of our prenatal clinics. Specifically, he pointed out that the March survey revealed that 49 obstetricians and 31 family physicians had withdrawn from participation. leaving about 180 to 200 participating physicians. The November survey revealed that an additional 16 obstetricians and 20 family physicians withdrew in the seven month period. In March, 22 counties reported that obstetricians and 18 counties reported that family physicians had withdrawnin the previous twelve month period. In November the numbers were an additional 12 and 13, respectively. In addition, 35 counties responded that the problem was "important" or "very important." The Nov. report showed that 12 counties have no subsidized prenatal clinics, 18 counties report a waiting period for the first prenatal clinic visit of 3 or more weeks, and 76 counties report a lack of transportation as an "important" or "very important" problem.

6. LITIGATION - NATIONAL

Patricia Danzon, consultant for Rand Corporation, testified in March 1986 before U.S. Senate that medical malpractice claim severity increased at twice the rate of inflation (CPI) from 1975 to 1984.

OB/GYN has a high rate of being sued: 60% of them have been sued, and 20% have been sued three times or more.

7. LITIGATION - NORTH CAROLINA

NC Administrative Office of the Courts reported to the Comm'n on February 23, 1987, the following data about Superior Court filings under the category "Other Negligence" (defined as negligence cases "not due to the operation of a motor vehicle" and including, e.g., "professional malpractice (medical and legal), products liability, slip and fall". This is the only data the Commission was able to obtain which provides even surrogate conclusions about any increase in the actual number of medical malpractice cases filed in NC courts, since there is no marking of such cases by Clerks of Superior Court. Such information might become available if the Commissioner of Insurance pursues on an annual basis a closed claim study of medical malpractice claims.

SUPERIOR COURT - CIVIL - MALPRACTICE, PROD.LIAB, SLIP&FALL, ETC.

Reporting period	No. of filings	Percent of total civil cases
Jul 1984 - Jun 1985	2152	15.7% of 13,654 cases
Jul 1985 - Jun 1986	2053	13.5% of 14,088 cases

Medical Mutual reported that 10 years ago their insured doctors had a 1 in 20 annual chance of being named in a claim and 1 in 100 chance of being sued; now, the annual odds are 1 in 6 for claims and 1 in 16 for suits.

National Center for State Courts reported that during 1978-81 case filings (for all types of civil suits) in NC increased by 20% and during 1981-84 decreased by 12%; this is an overall 6% increase for case filings compared to 7% increase in population.

NC Academy of Trial Lawyers cites figures from Administrative Office of the Courts indicating civil suits in Superior Court (but no figures for medical malpractice) have stayed relatively constant, ranging from 2.0 suits per 1,000 population in 1975, to 2.3 suits in 1980, to 2.2 suits per 1,000 population in 1985.

8. CHANGES IN RULES OF CIVIL LIABILITY - NATIONAL

Rand Corporation's Pat Danzon conducted studies on impact of tort reforms over 1975-84 which indicate that medical malpractice claim frequency (number) and severity (size) has continued to rise despite reforms, but that specific reforms had apparently had these effects in states where reforms had been enacted.

Average changes in states over whole period of tort reforms, compared to states without reforms:

Caps on awards - reduced severity by 23%
Offset of collateral benefits - reduced severity by 11-18% and frequency by 14%
Shorter statutes of limitations and outer limits on discovery rules - generally somewhat less frequency
One year shorter statute of limitations for adults - reduced frequency by 8%
Arbitration statutes - increased frequency and reduced severity; increase in total claims costs but compensation to more patients

AMA commissioned Milliman & Robertson of New York to do a special actuarial prospective study on tort reforms which showed these savings:

Cap on awards ($250,000 limit for non-economic) - 12%
Offset of collateral benefits - 8%
Limit contingent fee (as in Calif.) - 9%
Periodic payment of future damages - 6%
Total combined effect - 28% plus 4% per year reduction in claim severity for first four years

Professor Frank Sloan, a Vanderbilt economist, used regression analysis to show these effects of tort reforms taken by states during 1974-78 on malpractice insurance:

Caps on awards - no effect
Offset of collateral benefits - no effect
Limit contingent fee - no effect
Shorten statute of limitations - no effect
Binding arbitration - increases premiums
Screening panels - slight decrease in premiums

Caps on awards. AMA reports that 17 states now have limitations on awards, for either malpractice or all cases, ranging from $250,000 to $1,000,000 for noneconomic losses, and from $500,000 to $1M for economic losses; 18 states have either changed or are considering changes in punitive damages:

Alaska - $500,000 cap on noneconomic damages, although not applicable in cases of disfigurement or severe physical impairment; burden of proof for punitive damages to a clear and convincing standard

Florida - $450,000 cap on noneconomic damages in most business and medical actions; for punitive damages, plaintiff must show by greater weight of the evidence that there is a legal precedent

Kansas - $250,000 cap on noneconomic damages and $1M total cap; punitive damage awards capped at 25% of guilty party's annual gross income or $3M, whichever is less. The standard of proof was raised from a preponderance of evidence to clear and convincing. Although punitive damages awarded in only one modern case, survey indicated that claims for punitive damages were a common trial tactic to encourage settlements.

Maryland - $350,000 cap on awards for noneconomic losses in all tort actions

Minnesota - new law places $400,000 limit on "intangible losses" and courts are prohibited from informing jury about the limit; complaint shall not seek punitive damages; however, after filing complaint, party may make motion to amend pleadings by alleging the applicable legal basis for punitive damages and present affidavits showing factual basis for judge to make ruling

Missouri - $350,000 cap on noneconomic damages

Utah - $250,000 cap on noneconomic damages

Virginia - $1M cap on total award amended to apply to hospitals (Held unconstitutional in federal district court in Oct. 1986)

Washington - limit on noneconomic damages in all tort actions, to be determined in each case by multiplying by 0.43 the average annual statewide wage and the life expectancy of the person (not less than 15 years) (expected average of about $250,000)

West Virginia - $1M cap on pain and suffering awards

Wisconsin - $1M cap on noneconomic damages, adjusted annually to reflect change in Consumer Price Index

States which enacted caps in 1975-76 were Calif., Ind., La., Neb., N.M., Ohio, S.D. and Va.

9. CHANGES IN RULES OF CIVIL LIABILITY - THE CALIFORNIA EXPERIENCE

In 1975 California enacted a broad set of medical malpractice reforms which included (a) strengthening the medical license board powers and required reporting of unprofessional conduct, (b) statewide system of local medical quality review committees, (c) reports of insurance settlements and awards resulting from unprofessional conduct, and (d) these seven tort law changes:

(1) $250,000 maximum on noneconomic losses (upheld in Fein v. Permanente Medical Group by Calif. Supreme Court as "rationally related to legislative purpose" of reducing costs for malpractice defendants and their insurers; appeal dismissed by U.S. Supreme Court for want of a "substantial federal question" in 106 S.Ct.214, Oct. 1985)

(2) limitation of contingent fees (40% of first $50,000, 33 1/3% of next $50,000, 25% of next $100,000, and 10% of amounts over $200,000

(3) 3 year statute of limitations for all persons over six years of age and with a 1 year discovery rule

(4) repeal of collateral source rule in order to permit evidence of collateral benefits to be introduced

(5) 90 days notice of intent to file suit

(6) periodic payment for future damages over $50,000 and upon death, paid to dependents

(7) specific language for arbitration clauses

Robert Elsner, Exec.VP of California Medical Society, in March 1986 reported the following results of Calif. reforms:

(a) average size of awards in 1985 rose by 200% to $396,000 (compared to nationwide average of $974,000)
(b) insurance premiums have increased 150% since 1975 (compared to 300% national average)
(c) insurance premiums increased 15% in 1984 (compared to 33% nationally)

NOTE: Calif's severity is relatively low but frequency very high, partly explaining why it still has the nation's highest rates.

St. Paul re-entered the California market in 1983 after withdrawing in 1974, citing the new stability in the market.

10. PEER REVIEW

Don Harper Mills, MD-JD, Counsel for Calif. Hospital Assoc. (CHA), asserts that peer review is the long run solution to the medical malpractice problem.

In 1977 study of medically-caused injuries, the CHA-CMA found:

1 in 20 hospital admissions resulted in injury, and
1 in 126 hospital admissions resulted in negligent injury

and of these negligent injuries,

1 in 10 resulted in a lawsuit, and
1 in 25 resulted in compensation

Peer review by local medical societies and hospitals can be strengthened by:

(a) increased statutory protection of confidentiality of records and immunity for personal participation (to prevent the chilling effect of fear of libel suits)

(b) provide for a state-mandated system (to be exempt from antitrust actions by adversely affected physicians) (Note: Court recognized peer review statutes in Indiana as state action, and thus exempt from Sherman Act, in Marrese v. Interqual, 748 F.2d 373 (6th Cir.1984); same in Patrick v. Burget, ___F.2d ___(9th Cir. 1986).)

Good faith professional review activities are protected from federal and state antitrust laws under the provisions of the federal "Health Care Quality Improvement Act of 1986," Public Law 99-660, signed by the President in November 1986. This law becomes effective for all activities after Oct. 1989, unless a state chooses to opt-in earlier by passing a law to that effect.

11. THE SPECIAL PROBLEM OF VACCINE-RELATED INJURIES

Lederle Laboratories currently faces over 200 vaccine related lawsuits totalling over $3 billion.

Lederle has increased charges for DTP vaccine to $11.40 per dose (was $4.29) which includes $8.00 for a company reserve fund for product liability after the company lost its commercial insurance coverage on July 1, 1986.

In the case of Forehand v. Tayloe a jury verdict of $3.5 million against the defendant North Carolina pediatricians for a DTP vaccination-related injury was set aside as being "definitely contrary to the clear weight of the evidence" and the award "shocking to the conscience of the court." The parties settled out of court for $1.1 million. (U.S. Dist.Ct. EDNC, Nos.83-32-CIV-4, 84-71-CIV-4, June 4, 1985)

North Carolina requires children to be immunized against diptheria, tetanus, whooping cough, poliomylitis, rubeola and rubella. (Gen. Stats. 130-152)

According to Dr. Ronald Levine, Director of the Division of Health Services, as of January 1987, neither Lederle nor Connaught have reduced their prices of vaccine for private physicians since the enactment last summer of the NC Childhood Vaccine-Related Injury Compensation Act. Lederle submitted a bid for State purchase of vaccine which was substantially reduced (market price less the $60 company reserve component) but still not as low as the current federal contract price. He reported that negotiations with Lederle lead him to believe that if certain amendments are made to the Compensation Act, Lederle might reduce the price for both the State and private physicians.

[NOTE: DOCUMENTATION AND REFERENCES FOR THE ABOVE CITED INFORMATION IS ON FILE IN THE COMMISSION RECORDS.]

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

REPORT AND RECOMMENDATIONS

TO THE 1987 GENERAL ASSEMBLY

APPENDICES

A. LISTING OF MEMBERS

B. MINUTES OF MEETINGS

C. BACKGROUND PAPER: RECENT DEVELOPMENTS

D. POSITION PAPERS FROM INTERESTED ORGANIZATIONS

E. ACTUARIAL STUDY OF NC INSURANCE DATA

F. GAO REPORT: MEDICAL MALPRACTICE CASE STUDY ON NC

G. SELECTED CORRESPONDENCE

H. SELECTED NEWS MEDIA STORIES

I. LISTING OF PROPOSALS CONSIDERED BUT NOT ADOPTED

J. INTERIM REPORT TO 1986 GENERAL ASSEMBLY

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

Membership

Appointed by the President of the Senate

Senator Tom Taft - Co-Chairman
P.O. Box 588
Greenville, N. C. 27834
919-752-2000

Senator J. Richard Conder
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Rockingham, N. C. 28379
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Senator Kenneth C. Royall, Jr.
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Senator R.C. Soles, Jr.
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Appointed by the Speaker of the House of Representatives

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David R. Fuller, Manager
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Appointed by Commissioner of Insurance

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Department of Insurance
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Sybil Barnes, Clerk
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919-733-3460

B

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

MINUTES

Thursday, December 12, 1985, 9:00 a.m. - 12:00

Room 1027, State Legislative Building

Commission Members Present: Representative Dwight W. Quinn, Co-chairman and Senator Tom Taft, Co-chairman; Senators J. Richard Conder, Kenneth C. Royall, Jr., R.C. Soles, Jr., Representatives Charles Cromer, George W. Miller, Jr., Edd Nye: Public Members: James Blount, David Bruton, M.D., Tom Dameron, M.D., David R. Fuller, Eric Munson, John Ritchotte, Deputy Commissioner of Insurance Fran DiPasquantonio. Absent: Representatives Frank Ballance and Paul Pulley.

Staff Present: David Warren, Executive Director; Sybil Barnes, Clerk

Representative Quinn opened the first meeting of the Commission and asked Commission Members, staff and others in the room to introduce themselves.

Senator Taft spoke about the goals and purposes of the Commission and read Part XVIII of Chapter 792, 1985 Session Laws, which created the Commission. He noted that the charge given by the Legislature was very broad and obligated the Commission to study all aspects of the medical malpractice issue as it affects North Carolina.

Senator Taft raised the question of the reporting date. He said that while the study commission bills as introduced indicated the Commission would report to the 1986 General Assembly, the ratified bill states that the Commission shall submit its written report and recommendations to the 1987 General Assembly. He noted he has been advised that the ratified bill is binding, regardless of prior versions. He suggested that if the Commission has any recommendations ready by the time the 1986 session convenes, the Commission could submit them and request consideration as an exception to the rules set out in the 1985 Adjournment Resolution. Senator Royall suggested that the Commission notify the legislative leadership now that there is a possibility the Commission will be making an Interim Report to the 1986 session and requesting special consideration of recommended legislation.

Senator Taft introduced Professor David Warren, who is an attorney and on the faculty of the Duke University School of Medicine. Mr. Warren has been named by the Co-chairmen as Executive Director for the Commission, in charge of the staff and responsible for the support of the Commission's work. He has been released from part of his university duties and will use Room 2111 (Senator Taft's office) of the Legislative Building. Senator Taft asked Mr. Warren to present his observations about the challenges facing the Commission. (See attached copy of Mr. Warren's remarks).

Mr. Warren introduced a videotape entitled "What Legislators Need to Know About

Medical Malpractice," a recent production of the National Conference of State Legislators. The film made the following points:

A. Problems that have been commonly described in studies

(1) Judicial and administrative process is low and inequitable

(2) Damage awards are often excessive

(3) System encourages costly defensive medicine

(4) Malpractice insurance is overpriced

(5) Assuring equitable compensation to malpractice victims is difficult

B. Solutions that have been proposed or adopted

(1) Encouraging claims resolution without trial

(a) pre-trial panels

(b) arbitration

(2) Limit extent of liability by limiting size of awards for non economic damages

(3) Changes in collateral source rule to offset the actual award to reflect other payments received by the plaintiff

(4) Periodic payment of damages; structured settlements

(5) Patient compensation funds; excess liability funds

(6) Changes in statutes of limitations, qualification of experts, tort law reforms

(7) Change Standard of Care: recognize local customs; permit deviations in good faith

(8) Limit Attorney Fees

(9) Malpractice Insurance Data Collection
(e.g., require insurance companies to submit information on frequency and severity of claims, etc.)

(10) Improved discipline of providers

(a) peer review

(b) reporting of complaints about physicians

(c) immunity for peer review proceedings

(d) required risk management

C. Innovative Solutions that have been proposed but not adopted

(1) Corporate liability (i.e., hospital take responsibility for medical malpractice)

(2) Scheduled Damages (i.e., pre-set awards for various types of injuries, as for workers compensation)

(3) Experience rating for setting insurance premiums for individual physicians

(4) No fault system, or payments for iatrogenic illnesses without determining negligence

(5) Private contracts between providers and patients to limit the standard of care, establish a dispute resolution mechanism, etc.

Senator Taft conducted a discussion of the organization and work of the Commission. There seemed to be consensus that the Commission should meet monthly and make decisions as a whole. Subcommittees might be used for special purposes such as proposing a data base system. The Commission should invite presenters on various aspects of the problem to address the Commission. It was suggested that most interested parties would be willing to come to Raleigh. The staff should assemble data in coordination with the Insurance Department and members of the Commission. The work of other groups both in North Carolina and other states should be monitored. It was emphasized that the Commission should remain independent and impartial in its deliberations and that its charge is to address the whole problem, not simply proposed tort reforms. Data is already available from the Department of Insurance but probably will be only a starting point for the Commission. While no actuary is on the Department staff, the Commission might use the actuary on the Legislative Services staff or contract for services. Various suggestions were made about the types of data to be collected, especially as to insurance company practices. Aside from insurance costs, it was noted that the medical malpractice problem has adversely affected the doctor-patient relationship and perhaps quality of care. It was decided that the next meeting of the Commission should begin addressing the question of the extent and nature of the problem and the workings of insurance companies.

Senator Taft next led a discussion about some of the immediate concerns of the members of the Commission in regard to the medical malpractice problem in North Carolina. Problems were noted about the increasing costs for less coverage in self insured institutions like NC Memorial Hospital, as well as dramatically increasing insurance rates for physicians doing obstetrics and for nurse midwives. The cost pressures due to the international reinsurance market were noted as being outside the control of individual states. Senator Taft suggested that before the Commission makes any specific recommendations, it should assess the potential impact of each and not simply make politically popular proposals.

Senator Taft asked Mr. Warren to describe the current status of public policy

research on the topic of medical malpractice. Mr. Warren's remarks about prior and contemporaneous studies at the federal and state level, as well as ongoing efforts in North Carolina, are attached.

Representative Quinn announced the next meeting of the Commission for January 16 and adjourned the meeting.

Attachment I

The Medical Malpractice Problem: A complex Matter Affecting Everyone
David G. Warren

The NC Legislative study is timely. It is a national issue. Other states are working on the problem. Congress has various proposals before it, notably the Hatch bill and the Moore bill. It has been 10 years since last NC study. The national media are giving the issue much attention.

The AMA considers it a serious matter, both the increasing price of insurance and the matter of inconsistent quality of care.

The Insurance industry feels caught by rising settlement trends and decreasing investment income.

Plaintiff attorneys are concerned about complexity and cost of bringing successful suits for injured patients.

Patients sense that cost of medical care is going up--and so is their health insurance while also worrying about whether they are going to be victims of new hi-tech and DRG cost containment.

Hospitals are fearful of holding the bag(increasingly being seen as the guarantor of good care)

Public - is confused by the doctors and lawyers blaming each other and both blaming the insurance industry

So the malpractice problem affects everyone.

What exactly is the problem? a crisis? a crisis of what--insurance? competency? confidence?

insurance premiums -- after 10 years of relatively small increases, this year some doubling, yet concern that small portion goes to injured plaintiff

insurance company loss ratios--after several years in the 70s of high investment income and depressed premiums, now a shift;

international reinsurance market--controlled by New York and London,

but more so by events--natural disasters such as Columbia and Mexico City and human failures like Bhopal, and even terrorism

physician fears of both increased insurance and greater risk of being sued--leading to defensive medicine, limited scope of practice, higher fees, less satisfaction, even early retirement

patient dissatisfaction with system of compensation for avoidable mishaps and doctor-caused injuries--odds are not in favor of plaintiff success if less than $10,000, difficult to find lawyer to file claim if a large award, takes long time to get it, and lawyer gets large portion

There are countless proferred solutions to whatever the problem is:

Over half the states have taken up a wide range of proposals--ranging from tort reforms

to insurance regulation

to medical profession discipline

to patient compensation schemes

to further study

Some solutions are beyond the power of a single state to implement -

like controlling the international reinsurance market

or making substantial changes in medical education

or changing the US constitutional rights of individuals to due process

or raising enough state funds to pay for all the medical care that might be required under a no fault scheme

Some solutions are long range -

like making adjustments in actuarial basis for setting premiums at levels that will assure future viability of insurance companies

like lowering patients expectations about miracle medicine

like devising effective quality controls and risk management in hospitals

But there are numerous contributions this study commission can make toward

stabilizing the insurance market

restoring physician confidence in the insurance industry and the legal system

assuring patients that their right to fair compensation for iatrogenic injuries will be respected

improving the public trust in the health services

addressing the bad practices that plague both the insurance and legal systems

- the inequity of inconsistent settlements

- the publicized windfalls for some, goose eggs for others

Before any contributions or solutions can be advanced,

the Commission must analyze the problem in its many dimensions

gather data about amount and type of injuries, costs of injuries and illnesses and conditions

learn about the real frequency of claims, and types, and the severity or amount of claims

hear about how the problem affects various parties

I believe this NC Study Commission can do better than other states have done and will make a real contribution toward both understanding the problem and finding some relief for all parties concerned.

Attachment II

Other Studies on the Medical Malpractice Issue

By David G. Warren

A number of studies have addressed various aspects of the medical malpractice issue during the past several years with a wide array of sponsors:

1. Secretary of Health, Education and Welfare -

   In 1972 a blue ribbon national panel contributed research and ideas in a voluminous study, still useful today

2. National Association of Insurance Commissioners -

   During 1975-78 a massive amount of data was collected from all the states on closed claims and published in numerous tables and charts; unfortunately the project was discontinued

3. California Medical Association and California Hospital Association -

   A study was done on "Medical Insurance for adverse outcomes to patients in the course of receiving health care," by analyzing a sample of 20,864 hospital charts from 23 representative California hospitals in 1974, in order to determine "potentially compensable events"

4. Rand Corporation (Patricia Danzon, 1982)

   A study which focused on the tort system and insurance showed that half of all claims are dropped without any payment

5. American Medical Association

   A 1985 study entitled "Professional Liability in the '80s" in three published reports contains numerous useful statistics

6. Congress

   Numerous hearings and staff reports are available, including "Defensive Medicine and Medical Malpractice" (July 10, 1984 hearing before Senate Committee on Labor and Human Resources)

7. U.S. General Accounting Office

   Currently conducting a national study which includes case studies in 6 states (NC is one of the states)

8. State legislatures

   a. In 1975 every state legislature addressed the medical malpractice insurance crisis, including North Carolina, and "A Legislator's Guide to the Medical Malpractice Issue" was produced by the Georgetown Health Policy Center and The National Conference of State Legislatures (1976)

   b. During the past two years about half the states have taken some action and 5 states in addition to North Carolina have study commissions in progress (Virginia's commission recently issued its report)

   c. A booklet, "What Legislators Need to Know About Medical Malpractice," has been published by the National Conference of State Legislatures in coordination with a videotape (both booklet and videotape have been presented to the North Carolina Commission)

9. Numerous commercial services report developments, including LRG's "Medical Liability Reporter, St. Paul Insurance Companies "Malpractice Digest," and Jury Verdict Research (Solon, Ohio)

10. Ongoing and Proposed studies -

   a. The Resolution establishing the Commission calls for the gathering of information and establishment of a data base

   b. Professor Havighurst at Duke has met with the State Medical Society to discuss a proposed study of iatrogenic injuries by analyzing patient records in North Carolina hospitals, with possible financial support from a foundation

   c. North Carolina Public Policy Center is planning a study on the problem in North Carolina, which will be made available to the Commission

   d. North Carolina Commissioner of Insurance is gathering data on the insurance aspects of the problem

   e. Ongoing studies are being conducted by the North Carolina Hospital Association, North Carolina Medical Society and the North Carolina Academy of Trial Lawyers, as well as others

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

MINUTES

Thursday, January 16, 1986 - 9:00 a.m. - 1:05 p.m.

Room 1027 State Legislative Building

Present: All members present except Representatives Dwight Quinn, Frank Balance; Public Members, David R. Fuller and Eric Munson.

Senator Taft called the meeting to order and welcomed 9 graduate students from Duke University who are assisting the Commission in its research under the direction of Mr. Warren.

Frank Greiss, MD, Chairman of the NC OBGYN Liaison Committee and Chairman of the Department of Obstetrics and Gynecology at the Bowman Gray School of Medicine of Wake Forest University, presented a written statement (In Members' notebooks). He described the crisis in the continued delivery of obstetrical services, especially threatening high risk patients. He cited both obstetricians and family physicians who are no longer delivering babies due to the drastic rise in malpractice insurance premiums. He also described the alarming social costs of the threat of malpractice suits for "bad babies" and the resulting

overuse of cesarean sections, distrust in the doctor-patient relationship, and uncertainty in maternal and infant care programs and in medical education. He said that the concern about the effect on obstetrics is more severe than in other specialities.

Dr. Greiss responded to questions about the high infant mortality rate, the ratio between insurance expenses and physician income, mechanisms for improvement of the situation (including more MD monitoring and analysis of incidents), the difficulty of finding physicians to testify in malpractice cases increased c-section rates, and concern about the reported decrease in prenatal care.

Senator Taft summarized some of the comments by observing that it is now not only a crisis of insurance costs but also it may become a crisis of availability and then a crisis of health care delivery services. He also noted that just as doctors don't like to tesitfy against each other, the same is true among lawyers.

Marion Foster, Executive Director of the N.C. Hospital Association Trust Fund, presented a written statement (in Members' notebooks) providing background on the formation of the Trust Fund through pooled funds of hospitals 10 years ago, now providing liability coverage to 65 hospitals (11,000 beds). He cited a 177% rate increase due to Lloyds reinsurance hikes and noted that some hospitals are going bare on excess coverage and D&O insurance.

Mr. Foster responded to questions about Trust not distinguishing between incidents of professional and general liability, corporate liability trends, concern about increasing cost of defense, size of awards (noting that largest jury award

against Trust was $150,000 and largest settlement was $850,000), claims (noting that about 1% of the 27,000 reported incidents in 1985 may result in claims and suits), premiums as part of hospital costs (noting that liability insurance is only 1.0-1.5% of hospital budget), and concluding that today's problems of insurance industry capacity are more severe than ten years ago due to the worldwide reinsurance market restrictions.

Senator Taft observed that institutional risk management and loss prevention is an area that might be explored by the Commission.

Douglass Phillips, Executive Vice President of Medical Mutual Insurance Company of NC, presented a written statement (in Members' notebooks) providing background (company covers 50% of all NC physicians and 70-80% of those in private practice), rate increases (in 1985, 346% over 1979 rate), claims (in 1975, 1 in 20 MDs; 1984, 1 in 7), suits (in 1975, 1 in 100 MDs; in 1984, 1 in 19), severity (average per claim in 1979 was $22,300; in 1985, est. $100,000), and saying that the crisis is largely from(a) excess carriers (e.g., Lloyds) dictating minimum premium increases for primary insurance carriers, (b) rising defense costs and (c) plaintiff lawyer payments. He noted that Lloyds also wants changes in the US tort system. He observed that his company used Tillinghouse, Nelson & Warren, who are actuaries for 50% of the medical malpractice field, and still the company has had losses every year of its ten year existence due to increasing frequency and severity trends.

He responded to questions about complexity of setting of reserves, company policy of trying for prompt settlements due

to inflation, problems in investment income decline due to lower interest rates, problems of large number of minor incidents going uncompensated due to plaintiff's inability to find attorneys to make claim (noting that company often settles small claims to protect physician's relationship with patient), selective coverage of physicians although all specialities are covered, nurse midwives and PAs (noting that they are covered if work for covered MD), and settlement practices (noting that company loses about 10% of cases, i.e., where jury award is greater than previous company offer).

Robert Trunzo, Director of Government Relations, The St. Paul Companies, presented a company brochure entitled "Physicians' and Surgeons' Update" (1985), with NC insert, and displayed information on slides. He stated that his company is the largest carrier of medical and hospital liability in the US, although medical liability annual premiums are $600 million of its $2.2 billion multiline total.

He announced that on Jan. 1 a company moratorium was placed on writing new business, nationwide, except for "servicing existing accounts" (i.e., they will provide coverage for new doctors joining covered groups). The company plans to reenter the market "when stability returns." He noted this will cause problems for many new medical graduates and for physicians changing geographical location or adding specialties.

Mr. Trunzo presented information showing that

(a) Since 1980, the claim frequency reported to The St. Paul in North Carolina has risen by 41.5 percent--from 6.5 claims per 100 doctors to 9.2 in 1984.

(b) North Carolina's severity has increased by 51.2 percent over the same five-year period--from $12,225 in 1980 to $18,489 in 1984.

(c) The combined effect of frequency and severity is reflected in North Carolina's pure premium which has jumped 113.2 percent--from $795 in 1980 to $1,695 in 1984.

(d) In addition, the actual number of claims reported to the St. Paul in North Carolina increased by 10.9 percent from 256 in 1980 to 284 in 1984.

He responded to questions about rates (St. Paul sets own; does not use ISO and bases NC rates on core states, excluding CA, NY, TX and FL, plus NC "trend lines," noting that NC's severity rise is causing increased premium rates), the possibility of experience rating (St. Paul is not in favor, since "there are too many claims against good doctors," nor does St. Paul impose surcharge on doctors with bad claims experience, but he noted that experience rating is used by St. Paul in VA and GA because of their good data base in those two states), settings (noting that 71% of all MD claims arise from hospital settings), reclassifying Family Practice as OB-GYN (noting St. Paul considers OB a "problem area").

He was asked to supply more specific and updated data about NC as to claims, reserves and trends.

Mr. Trunzo suggested that frequency problems should be approached with risk management and that severity problems can be addressed by tort reforms as in CA and IN.

Ann Shelton from Edenton presented a written statement (in

Members' notebooks) describing her problems as "malpractice victim" in receiving medical treatment which resulted in complications, referrals, costs, pain, embarrassment and frustration. She described her attempts to get answers to questions about competency of the physicians involved, as well as meeting a "conspiracy of silence" in her attempts to discover information about her physician's incompetency from the hospital and a state agency. She said her own medical malpractice case is on appeal and that she was here before the Commission "to ask that you remember the victims."

Elizabeth Kuniholm, a plaintiffs' attorney from Raleigh, presented a written statement (in Members' notebooks). Pointed out that 1/3 of her practice is medical malpractice cases, she described the difficulties and hurdles in preparing, trying and winning cases, both from on the technical side as well as in cost and time. She said that contingency fees "assure access to the courtroom for all plaintiffs, not just the wealthy," and "provide a disincentive for the filing of nonmeritorious claims." Special problems for attorneys in the current system include the high cost of medical evaluation of potential cases, frustrations in trying to find willing expert witnesses, and the high costs of trials and appeals. Special problems for patients is the initial bias of jurors in favor of doctors and hospitals, finding competent counsel and facing protracted litigation as well as the overall "slim chances" of winning. She noted that her firm declines 90-95% of all potential cases.

She responded to questions about the scarcity of expert witnesses and a member's comment that good trial attorneys can

find good witnesses. She suggested that solutions might include some sort of physician immunity for speaking out and change in attitude about policing their profession.

Tom Harris. a defense attorney from New Bern who also represents St. Paul, did not present a written statement but he observed that defendents have special problems in that juries are biased in favor of injured plaintiffs. He pointed out that many nonmeritorious cases are unfortunately settled by physicians who simply want to avoid adverse publicity. Other problems for physicians include the time consumption in preparing a defense, the threat of "runaway verdicts," the increasing expense of defensive medicine, the personal toll that stress takes on physicians who are sued, (noting that there ought to be support programs to help them get through it emotionally), the reluctance to use new and effective medical methods (noting that "tried and true" methods are thought to be safer legally), and even being forced out of the profession by fear of being sued.

Senator Taft thanked all the presenters, stated that there was no time left for further discussion and adjourned the meeting.

He directed Mr. Warren to make arrangements for the next meeting on February 13.

(Minutes prepared by Mr. Warren)

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

MINUTES
Thursday, February 13, 1986 - 9:00 a.m. - 12:30 p.m.
Room 1228, State Legislative Building

Present: Senator Tom Taft, Co-chairman; Senators J. Richard Conder, Kenneth C. Royall, Jr., R.C. Soles, Jr., Representatives Frank W. Ballance, Jr., Charles Cromer, George W. Miller, Jr., Edd Nye, W. Paul Pulley, Commissioner James E. Long; Public Members: James Blount, David Bruton,M.D. Tom Dameron, M.D., David R. Fuller, and John Ritchotte.

Absent: Representative Dwight W. Quinn and Eric Munson.

Co-chairman Taft opened the meeting and welcomed guests and observers.

Mr. Warren presented a staff report on research in progress, materials received by the Commission and a proposed work plan. (Attached). He also explained that the materials being distributed this morning were received in multiple copies; other materials received by the Commission are summarized and noted in the weekly Newsheets being mailed to members. Senator Royall requested that executive summaries be prepared for the large items that are distributed to the members.

George E. Moore, Executive Director of the North Carolina Medical Society, presented remarks on behalf of the Society's 7,000 physician members. He pointed out that new data need to be gathered on the problem; he offered to join with the Commission in surveying physicians. Noting that we have the best health care system in the world, he spoke about the causes of the malpractice problem being tied to rising patient expec-

tations, a more litigious society, a more activist judiciary, the state's rapid urbanization, breakdown of mutual trust, and the difficult of discipline and peer review within the medical profession. He said that the marginal practitioner is unwelcome. He added that the Medical Society is developing a number of initiatives to better identify and affect positively those members who overutilize resources, overcharge, practice substandard medicine, are impaired, etc., reflecting a serious commitment by the Society to effective self-policing. He noted the improved quality and competence of plaintiff's attorneys and the fact that the contingency fee system makes legal services much more available to plaintiffs. Mr. Moore discussed the cost of the malpractice problem in terms of access, quality and costs of health care, as well as the dampening effect on medical research. He cited statistics about increasing suits, awards, premiums, reinsurance deductibles, and vaccine costs. He offered to return at a later meeting with a series of proposals to addre the problem. (Statement on file.)

Mr. Moore responded to questions about the stress caused by frivolous suits (saying he will have later recommendations on that), non-cooperation of physicians as expert witnesses (noting the NC Medicolegal Code of Conduct is now being revised), proof of the litigiousness and deep-pocket attitude of NC citizens (responding that more non-meritorious claims are being filed), whether disciplinary actions have been taken against errant doctors (promising to furnish Commission with information from the Society's mediation committee), keeping bad doctors out of the state (replying that tracking is a problem) and tendency of physicians to increase number of patient visits may be decreasing quality (replying that accepting Medicare and medicaid patients is the physician's individual choice and that while most are dissatisfied with level of reimbursement, the majority accept assignment).

Dr. Charles Sawyer, a family physician from Ahoskie, presented a brief paper he had written for the NC Academy of Family Physicians Journal explaining why his group of 5 Ahoskie family doctors had discontinued their obstetrical practice. After delivering over 5,000 babies in 25 years, they stopped last October due to escalating liability insurance premiums, parents' expectations of perfect newborns, increasing number of OB claims and suits, and progressive national distrust of medicine. He pointed out that the public will suffer from the termination of OB services from family physicians. He suggested that family medicine residencies should continue to include OB training and that family physicians attempt to restrict their practices to uncomplicated obstetrics. He said that Ahoskie pregnant women must now drive over an hour to seek care. He noted that his practice included many indigents and that his collection rate was 60% and fee was $450, compared to 92% collection rate for adult and pediatric care. His group's premium would have risen from $18,000 to $110,000 if they had not discontinued OB services. (Statement on file.)

In questioning Dr. Sawyer, Rep. Miller stated that only a few patients demand perfection. Dr. Sawyer also responded to questions about whether low collection rate was reason for discontinuing (answering that low fees and high insurance rates result in not making any money), whether family doctors are sued as frequently as obstetricians (deferring to Medical Mutual statistics and how large was his patient load (5 doctors in his group have 10,000 charts, suggesting that rural doctors have more patients to care for). Dr. Sawyer closed by suggesting that the money spent on National Health Service Corps physicians could perhaps better be spent on supplementing existing rural practices.

Dr. Frank Leak, a family physician from Clinton and an officer in the NC Academy of Family Physicians, presented a statement on behalf

of 1,000 family doctors in NC. He described the training they receive in pediatrics, internal medicine, obstetrics and in some aspects of surgery, pointing out that their income is less than other specialties. Family doctors presently provide about half of all physician prenatal and family planning services in the 95 local health departments and a high percentage of all indigent patient care. Dr. Leak cited statistics and personal observations to substantiate his points that the malpractice system has "gone out of control" and that unless remedied, "people are going to suffer." He said that family doctors are trained to do obstetrics and like to do it, but that many will discontinue because they cannot charge fees high enough to cover insurance premium increases. He presented the preliminary results of a survey recently conducted by the NC Academy of Family Physicians which shows that of the 146 returns, 107 are currently delivering babies, 39 had stopped during 1985, 84 will stop with rate increases and 9 will attempt to increase fees. (Statement and survey on file.)

Dr. Richard Nugent, Medical Consultant for Maternal and Child Health Services, presented information on the availability of prenatal care in NC. There are indications that the number of women receiving no prenatal prior to their deliveries will rise by 20 percent from 1984 to 1985 when complete data are available for 1985. He said that women without prenatal care in 1984 had 4 times the rate of low birthweight babies (under 2500 grams) and 5 times the rate of very low birthweight babies (under 1500 grams), compared to all births. Dr. Nugent presented October, 1984 data showing that 29 counties had family practitioners but no obstetricians. (Statement on file.)

Douglass Phillips, Executive Vice-President of Medical Mutual of North Carolina, Inc., appeared at the request of the Commission to explain the proposed increase in premium rates for family physicians doing obstetrics. He presented information saying that until 1983 there was no

problem with obstetrics but starting in 1984 there was a surge of OB claims. At present the company is projecting $5M in losses against $3M in premiums in the OB area. He said that "OB is OB is OB," in explaining why his Board of Directors decided that family doctors doing OB are to be reclassified on March 1 from class 4 to class 7 the same as obstetricians. He noted that new rate filings will increase all rates by 31-36%. He stated that if the 374% rate increase for family doctors were to be spread among all physicians, that the rate hike would have to be 11-13% more. He said the companies options were limited by the fact that London is the only reinsurance market; without a new treaty with the Lloyds on July 1, his company could write coverage only up to about $400,000, which is inadequate coverage for NC physicians. He observed that the $27M reserves the company had set were reviewed by three different auditors, all agreeing within $1M that the amount was adequate and appropriate. He presented figures showing that in the 221 suits filed against the company's insureds in 1985, known monetary relief sought so far is $113,684,413 against which the company has set up $5,291,500 in reserves. He also presented a "Summary of Losses" for family doctors, showing cumulative experience as of December 1985: (Statement on file.)

Cases	Family Doctors	Obstetricians
Closed with $ Paid	4 ($694,691)*	73 ($6,859,979)**
Open with Reserve	10 ($4,300,500)*	94 ($10,527,500)

*includes four cases with $1M or more reserves.
**includes three cases with $1M or more reserves.

Frequency

Family Doctors: 14 claims ÷ 164 insureds = 8.5 claims/100
Obstetricians: 167 claims ÷ 330 insureds =50.6 claims/100

Severity of Closed Claims

Family Doctors $ 694,691 ÷ 4 = $173,673
Obstetricians 6,859,975 ÷ 10 = 93,972

Severity of Open Claims

Family Doctors $ 4,300,500 ÷ 10 = $430,050
Obstetricians $10,527,500 ÷ 94 = $111,995

Mr. Phillips was questioned about the business decision of his company's Board of Directors (replying that even if tort reforms were to be made, there would be a surge of suits just before effective date and company would have to raise rates anyway; he also replied that his company's concern is the trend line for severity; further, that some of the other 36 physician-owned insurance companies have also reclassified family doctors as OB), the composition of his Board (answering that they are all MDs with business experience and assistance is received from consultants), the other options the Board considered (replying that the decision was made to spread the risk among those with the exposure), the family doctor withdrawal (replying that the premium pool would become smaller if family doctors withdrew), rate classifications (saying relativities are set nationally), company losses (replying that his company has lost money in 8 of its 10 years of existence, and had a 160% loss ratio in 1984), and settlements philosophy (company doesn't offer settlement unless it sees possible fault by insured).

Allan Head, Executive Secretary of the NC Bar Association, described the membership of the Association which includes 7,000 members who represent plaintiffs and defendants and who also are engaged in other forms of legal practice. Appearing in place of President-elect John Q. Beard, Mr. Head introduced Dean Kenneth Broun and Charles Blanchard to make presentations on behalf of the Association.

Kenneth Broun, Dean of UNC School of Law, stated that he had just been appointed Chairman of the Special Committee on Tort Liability Systems and had not yet had time to plan the Committee's work. He said that the membership represented different points of view and that it will look at all areas of civil justice, not just medical malpractice litigation, and will study the work of other states. He expects to make a report in one year. Dean Broun stated that he did not foresee any "quick fixes" since the tort system has been long in development.

Senator Taft introduced Commissioner Long at this point on the agenda since he had to leave for another meeting.

James E. Long, Commissioner of Insurance, reported on the bills considered by Insurance Committees and expected to be introduced at the Extra Session Tuesday, February 18. The bills would (1) extend the FAIR plan to make available property and casualty insurance in additional areas of the state (2) authorize the Commissioner to establish a Joint Underwriting Authority (JUA) to be "triggered by" unavailability (not unaffordability) of casualty and property insurance and (3) authorize the premium tax study commission, insurance markets study commission and the medical malpractice study commission to report and make legislative recommendations to the Special Session in June, 1986.

Commissioner Long responded to questions about a new medical malpractice insurance company (saying that it had originally filed in March, 1985 and was just now completing its form; noting that his office had requested additional information; noting also that he had heard that the company was planning an office in Charlotte) and whether the Commissioner has rate approval powers (replying that rate approval power for commercial liability lines was removed in 1977 but that he possibly will request that authority in the future, in addition to new staff to accomplish the review function).

Senator Taft observed that the state needs more data about malpractice insurance companies and that perhaps we should give more tools and money to the Commissioner to collect it.

Charles Blanchard, a Wake County Attorney and representative of the NC Bar Association, presented more information about the Association, saying that it has 7,000 members, including 1300 in the Litigation Section comprised of members representing plaintiffs, defendants and insurers. He reported that the 5 NC delegates to the midwinter meeting of the American Bar Association last week in Baltimore were among the 358 delegates

who unanimously approved the report of the ABA Special Committee on Tort Reform, on behalf of the 324,000 ABA membership. He cited two previous ABA studies "does not want to polarize the professions." Instead he would encourage the use of the medicolegal code. He noted that the ABA report rejects physicians' bid for special protection and also their assertion that a crisis exists. Mr. Blanchard stated that when a plaintiff loses, it does not necessarily mean that the suit was frivolous. However, he noted that both the ABA and NCBA condemn frivolous suits and also frivolous defenses, and that courts can sanction the lawyers involved. He suggested that accurate data must be obtained from the insurance companies before any solutions can be posed, noting that there is no evidence the insurance companies cannot produce profits.

Dr. Bruton stated that the tort system problems are a general societal problem and that doctors do not need special changes.

Mr. Blanchard added that the ABA report is a response to the AMA proposals and that the NCBA Board of Governors will vote on the ABA report later this month. (ABA report is on file.)

Dr. Dameron noted that the only positive point in the ABA report is the recommendation for structured settlements.

Representative Miller stated that the ABA report does not respond to the adverse impact of tort law on the health care system and that something should be done to relieve the problem.

Several members discussed the issue of punitive damages under NC law, noting a recent court case holding that punitive damages are covered by insurance.

Walt Baker, President of the NC Academy of Trial lawyers and practicing law in High Point, presented his perspective as representing the rights of victims. He asserted that there is no crisis in NC since there are so few suits, but there is a crisis in insurance. He said that medical malpractice cases are difficult to prepare, present and win and that a

plaintiff must prove a physician was negligent and breached the standard of care set by professional custom. The Academy feels that conscientious physicians need protection from being sued for slander when reporting incompetent peers. The Academy is concerned about frivolous suits and supports legislation to deter frivolous suits and encourage discipline of attorneys who file them or who pose frivolous defenses. Mr. Baker reported that the litigation rate in NC is declining on a per capita basis from 2.5 cases per thousand to 2.2 cases per thousand during the last four years. He said that the medical system is fine and the legal system is working; the problem is with the insurance industry. Better reporting is necessary before the General Assembly can make an informed decision about major changes in the justice system. He would propose that insurance companies be compelled to provide complete financial disclosure, the Insurance Commissioner be given more money for staff to improve regulation of the insurance industry, rate incentives be established for risk management, experience rating be used for physician premiums, and a business expense deduction be given for reasonable reserves set aside in self-insurance plans. (Statement is on file.)

Mr. Baker responded to questions about whether the liability insurance business is actually profitable (saying the figures so indicate), whether any suits are not accepted by plaintiff's lawyers (saying that many are not taken due to attorney ignorance in how to handle them and client ignorance about their true medical condition but merely being angry about something, and that he himself has taken only 2 cases out of hundreds of requests), whether some plaintiff's lawyers take only catastrophic cases because of the use of contingent fees (commenting on how defense lawyers are paid), whether there is a real crisis (saying that it is only a crisis of rising insurance premiums not of malpractice cases, although we need a prescreening mechanism to permit only valid claims into the system).

Senator Condor stated that the crisis is in the discontinuance of maternal and child health services in rural areas and that protection is needed for family phsicians.

Mr. Baker said that "quick fixes" are bad since they don't get repealed. He added that the tort system is not at fault but rather that the attitude of society is changing more toward consumerism.

Senator Taft announced that the next meeting of the Commission will be at 9;00 a.m., Thursday, March 13 in the State Legislative Building, and then adjourned the meeting.

(Minutes prepared by Mr. Warren)

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

MINUTES

Thursday, March 13, 1986 - 9:00 a.m. - 1:30 p.m.

Room 1027, State Legislative Building

Present: Senator Tom taft, Co-chairman, Senators J. Richard Conder, Kenneth C. Royall, Jr., R.C. Soles, Jr., Representatives Frank W. Ballance, Jr., Charles Cromer, George W. Miller, Jr., Edd Nye, W. Paul Pulley; Public Members: David Bruton, M.D., Tom Dameron, M.C., David R. Fuller, Eric Munson, John Ritchotte.

Abesent: Representative Dwight W. Quinn, Commissioner James E. Long, and James Blount.

Co-chairman Taft opened the meeting.

Mr. Warren reported on several matters: (1) Commission has received numerous letters from family physicians who do obstetrics and from their staffs and patients, asking the Commission to address the problem of possible discontinuance of their services. (2) Medical Mutual has notified the Commission that it has amended its rate filing to the effect that all family physicians doing obstetrics will move up from class 4 to class 7 (from $4840 annual matured premium to $22,126) on March 1, except for family physicians/general practitioners doing routine obstetrics in hospitals where there is no surgical specialists doing obstetrics. (3) Medical Protective Insurance Co. of Ft. Wayne, IN. has notified the Commission that it has made a rate filing with the NC Commissioner of Insurance and that it intends to begin selling policies as soon as possible, with slightly higher rates than Medical Mutual; it will offer policies to family practitioners doing obstetrics at a matured, fifth year rate of about $8400 for $1M coverage. (4) patients have contacted the Commission

about difficulties in obtaining information about their cases; one patient described the apparent intimidation of hospital employees by the hospital's insurance company whereby the nurses were told that if they talked to the patient or agreed to testify for the patient, they might not be defended in the event they were named in the lawsuit. (5) the Commission needs assistance in dealing with insurance matters; at Senator Royall's request I contacted Charles Dilts of Durham who explained that he was a life and health actuary and that we probably needed a property and casualty actuary; he named several: Milliman & Robertson in NYC (they did an actuarial study for the AMA on monetary savings due to proposed tort reforms); Tillinghast, Nelson & Warren in Atlanta (they assist Medical Mutual); Wyatt & Co. in Washington, D.C.; Huggins & Co. in Philadelphia; Allen Schwartz in NJ (currently doing considerable work for the NC Commissioner of Insurance). I hope to obtain assistance in order to frame a series of questions the Commission should send to St. Paul prior to the April 10 meeting. (An outline of legislative proposals will be sent to members prior to the next meeting to consist of possible tort reforms (e.g., limitations on awards, collateral source options, statute of limitations changes, periodic payments, punitive damages changes, civil procedure modifications, expert witness availability, arbitration, screening panels, attorney fee limits, frivolous suit penalties; hospital and medical discipline proposals (reporting, peer review immunity, risk management); insurance regulations (reporting, rate setting or approval powers for the Commissioner); and special situations (protections for child vaccination program). (7) Next meeting is scheduled to be held at Charlotte Memorial Hospital and will address business concerns, local recommendations and insurance matters.

Eric Munson volunteered that the NC Hospital Association Task Force on Liability Issues will have its report ready by the next meeting of the Commission. He described the establishment by NC Gen. Stats. 116-222 of the State Liability Trust Fund Council which is the self-insurance plan for NC Memorial Hospital and suggested that the actuary (Fred Kist, of Coopers & Lybrandt in Atlanta) which assists the plan may have data and experience useful to the Commission. Senator Soles requested that the staff obtain available information about the claims experience of the plan.

Senator Taft recognized Dave Murray, Vice President for Underwriting of Medical Protective Insurance Co. of Fort Wayne, IN. Mr. Murray stated that his company has completed its rate filing with the NC Commissioner of Insurance and intends to begin selling insurance to NC physicians as soon as the company's agent, Stuart Mitchelson, arrives in Charlotte to open the office there, perhaps the next week. The company will offer both occurrence-type and claims made policies at competitive rates. In answer to a question Mr. Murray said he did not bring the rate information to the hearing.

William Potter, General Counsel for the NC Dental Society, introduced Tom Bennett, the Society's new Executive Director, replacing Joyce Rogers. Mr. Potter stated that NC has the lowest incidence of dental malpractice suits and that insurance rates are relatively low. However, he said that rate increases of 100% are expected and there is a possibility of the withdrawal of some insurance coverage. Currently, there are 3 companies offering policies, the largest being the Protector Plan through Crumpler Insurance Agency. He said the Society wants to see tort reforms enacted.

Mr. Potter responded to questions about why change tort laws (answering, to allow insurance actuaries to predict losses with more certainty, causing premium rates to level off), current rates (the highest of three levels was $2200 in 1981, $4500 in 1986 and $5800 expected in 1987), claims (54 claims during past 5 years, with $13,000 average claim), and dentist responsibility (admitting some dentists may not always be as careful as they should be, he said the Dental Society is interested in promoting lower risk exposure) Mr. Potter agreed to furnish the Commission written data on claims and rates, numbers of dentists and available insurance. Mr. Fuller noted that St. Paul's basic rate for dentists is $185. Senator Royall suggested that the UNC Dental School may help explain why NC has a good record. Senator Taft pointed out that the rising rates for NC dentists is alarming if there has been as little claims incidence in NC and thus rates must be attributable to national data.

Sally Cameron. Executive Director of the NC Psychological Assoc. stated that there are 1900 private psychologists in NC and malpractice is becoming an issue. Mental Health professionsls in other parts of the country are being held liable in

suits based on duty to protect their patients from harm and duty to warn others about their patients' intended violence. Insurance is currently available, largely through the American Psychological Association's Insurance Trust. But rates have increased from $50 premium for $1M coverage in 1981 to $450 in 1986 for Trust policies, and $700 for commercial policies. No NC psychologists have been found liable during the past 5 years. The Associations D&O coverage has increased markedly and is now $5,000 for $250,000 coverage. In answer to questions, Miss Cameron agreed to furnish the Commission more data on national claims experience.

Davy Crockett, Vice President of the NC Nurses Association and Clinical Director for Nursing at Moses Cone Hospital in Greensboro, addressed the issue of malpractice concerns for nurses in North Carolina, saying that increased technology has raised nurses vulnerability. He said the principal problem was for nurse specialists, such as midwives who cannot obtain independent insurance coverage. It is available only through being added onto a physician's policy. Therefore, 4 have quit practice (2 in health departments) and no independent nurse midwives are now doing home deliveries. One birthing center is facing a rate increase from $850 to $4,000. The other birthing center lost its coverage in July, 1985 and has notified patients that it is going bare. Mr. Crockett cited a poll which estimated that NC nurse midwives have paid $80,000 in premiums during the past 10 years and only $2,000 has been paid out in liability claims. He stressed that the Association's fear is that the trends will spread to nurse practitioners, nurse anesthetists and other nurse specialists, thus deterring both quality and accessibility of care, concluding that legal reforms are necessary.

In answer to questions Mr. Crockett said that regular non-specialist nurse coverage is available for very low rates (Mr. Fuller said St. Paul charges $100). the NC court system has not covered problems for nurses, and there are about 45,000 nurses in NC, of which 3,000 are members of the Association, duplication of coverage by the nurse and the nurses employer is necessary to protect nurses in situations outside the work context and in cases where the employer may seek contribution from the nurse as a joint tort feasor.

Ruth Long, Chairman of the Malpractice Task Force of the NC Association of Nurse Anesthetists and a Certified Registered Nurse Anesthetist (CRNA) in Durham, presented a written report to the Commission (on file). She said that there are 900 CRNAs and 279 MD-anesthetists in NC, most CRNAs work in hospitals (47%), many for physician groups (38%) and some have independent contracts $12%). CRNAs administer over half of the 20M anesthetics given annually in the US. NC CRNAs have the lowest insurance premiums of any state (occurence rates in 1985 were $1393 for $1M/3M; in 1986, $1895; 1st year claims-made rates were $418 in 1985 for $1M/3M; in 1986, $1099) but they are concerned about the rapid increases in other states and the possible effects on NC. Ms. Long suggested that if arbitration is used, CRNAs should be on the panels; more data should be collected by the Insurance Commissioner; attorney fee schedules should not be regulated; and professional organizations should conduct peer review; a PR funds should be established to educate the public about their rights and to lower expectations about perfect medical results. CRNA expert witnesses who meet certain criteria are available on a list maintained by the NCANA, a closed claim study of anesthesia is being conducted by the national organization in cooperation with St. Paul, and the state association is surveying members about stress, substance abuse and professional competence, as related to malpractice.

Ms. Long responded to questions about duplication of insurance coverage (saying that some hospitals require CRNAs to carry separate insurance, but hospitals in the NC Hospital Trust Fund and many employer physician groups provide CRNAs with coverage under their policies), certification (all nurse anesthetists in NC are CRNAs), competence (if substance abuse or other problem, the NC Board of Nursing can revoke nurse's license, adding that in 1984, 45 nurses lost their licenses, including 4 CRNAs, of which 2 were for substance abuse).

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

REVISED AGENDA FOR COMMISSION MEETING

Thursday, April 10, 1986
AREA HEALTH EDUCATION CENTER
at Charlotte Memorial Hospital and Medical Center
1000 Blythe Blvd., Charlotte, NC

10:00	Coffee & Donuts	
10:15	Call to Order Committee business Staff report	Rep. Quinn Senator Taft Mr. Warren
10:30	Who speaks for the patient?	Mac Turnage, Assoc. Mini Covenant Presby. Church
10:45	Mecklenburg County Health Care Cost Management Council	Robert Schroeder Council Pres. & Ret. Chm., Celanese
	Task Force on Med. Malpractice	George Stiles, Exec. Dir
11:15	Mecklenburg County Medical Society	Robert E. Miller, M.D. President
11:30	Mecklenburg County Bar Association	R.C. Carmichael, Pres.
11:45	Problems in Denying Staff Privileges and Conducting Disciplinary Procedures	John Foust, M.D. Former Chief of Staff Presbyterian Hospital
12:00	Joint Board & Med. Staff Committee on Liability, Charlotte Memorial Hospital	Frank Martin Board Member
12:15	Discussion	
12:30	Lunch	
1:30	"Liability Insurance Issues in State Legislatures" (Videotape)	Nat'l Conference of State Legislatures
2:00	Relevance of the Insurance Co. Report Prescribed by NC Gen. Stat. 58-21.1	James Wilson, Comm'n Actuarial Consultant
2:15	Report on North Carolina operations of Medical Protective Insurance Co.	David Murray Vice President
2:30	Report on North Carolina operations of St. Paul Insurance Company	Ralph Jones, Gen. Mgr. Charlotte office Steve Belden, Vice Pres. Sally Frans, Sr. Gov't Affairs Manager
4:25	Commentary on small hospital problems	James L. Muse, Admr. Montgomery Mem. Hosp.
4:35	Commentary on insurance market and the NC civil justice system	Jan Ramquist, Govt'l Affairs Coordinator, NC Academy of Trial Lawyers
4:45	Adjourn	

ROOM 2111 STATE LEGISLATIVE BUILDING, RALEIGH, NC 27611 (919) 733-3460

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

Agenda for
Commission Meeting
May 8, 1986
9:00 a.m. - 4:00 p.m.
Room 1027, State Legislative Building

9:00	Reports from: N. C. Medical Society N. C. Hospital Association N. C. Bar Association on recommendations and proposals
10:00	WORKING MEETING OF THE COMMISSION TO CONSIDER RECOMMENDATIONS AND PROPOSALS AS PREPARED BY STAFF
	Break
4:00	Adjourn

ROOM 2111 STATE LEGISLATIVE BUILDING, RALEIGH, NC 27611 (919) 733-3460

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

MINUTES

Thursday, September 11, 1986 - 2:00 p.m.

Room 1027, State Legislative Building

EXECUTIVE SUMMARY (Complete minutes are on file)

Members Attending:

Senator Taft, Representatives Ballance, Cromer and Nye; Insurance Commissioner Jim long; Public Members Bruton, Fuller and Ritchotte.

Co-chairman Taft called the meeting to order and Mr. Warren introduced Professor Clark Havighurst from Duke Law School, a recognized legal scholar on medical issues and health policy.

Professor Havighurst commended the Legislature for enacting the no-fault compensation bill for vaccine-related injuries. He suggested that another innovative approach the Commission might pursue for some of the concerns about medical liability would be to foster private agreements to change tort laws, such as: the forum (e.g., substituting arbitration, private courts, screening panels in place of litigation in state courts), amount and kinds of damages (e.g., setting limits on non-economic damages, changing the collateral source rule), standard of care (e.g., agreeing not to sue for less than gross negligence) and compensation arrangements (e.g., automatic payments for designated compensable events, or for types of medical injuries, even without fault being shown). These private agreements could be built into health care plans and HMO contract options which are made available to employee groups, or other specific groups, such as women seeking prenatal and obstetrical services.

He further suggested that any particular legislative proposals be measured against the goal of effective deterrence of medical malpractice. He commented on numerous proposals, finding net advantages only in substituting proportional liability for joint and several liability, placing some limit on non-economic damages and fee-shifting in frivolous actions. He recommended against certain other proposals, such as limiting contingent fees, eliminating collateral sources, reducing statutes of limitations, and protecting peer review from antitrust laws.

He added that providing compensation through the tort system is only a means to the end goal of prevention; no-fault plans should pay for injuries.

Commission questions included concern about the legality and implementation of his ideas for patient waiver of rights. Several Commission members expressed interest in pursuing some novel way to address the special problems of liability in obstetrics.

Next, Commissioner Long introduced Deputy Commissioner William S. Hale who explained the new regulatory powers established by Chapter 1027 (SB 873) over the medical liability insurance industry in the areas of market conduct and rate making. He stated that no additional powers were needed at the present time. Department Counsel Ann Spragens presented the draft survey forms intended to be used in a forthcoming plan by the Department to collect and analyze detailed data from insurers in a closed claims study on medical liability cases.

Finally, Senator Taft conducted a discussion about the remaining agenda for the Commission. Conclusions included (a) leaving any further proposals for tort reform to be dealt with by the Insurance Liability Study Commission, (b) monitoring and assessing the continuing extent and characteristics of the medical liability crisis, (c) continued support of the earlier proposals to strengthen the powers of the medical licensure board for monitoring medical competency and performance, (d) reviewing potential for peer review and risk management, and (d) pursuing alternative mechanisms for dispute resolution.

Observations were made by Commissioner Long and Mr. Fuller about the favorable position of North Carolina compared to other states, as to low insurance premium rates for medical liability. The Commissioner added that three companies had made recent inquiries about entering the North Carolina market.

The next meeting is scheduled for Friday, October 3, at 9:00 a.m. in Raleigh.

(Minutes prepared by Mr. Warren)

MINUTES OF COMMISSION MEETING

OCTOBER 22, 1986

ROOM 1027, STATE LEGISLATIVE BUILDING

ATTENDING: Taft and Quinn, Cromer, Nye, Fuller, Royall, Richotte, Bruton, Munson, Long (and Spragens)

Senator Taft opened the meeting at 9:00 and introduced Dr. John Foust, a Charlotte physician and President of the NC Medical Society.

Dr. Foust said he represented the 7,000 members of the NC Medical Society in saying that their hope was to see changes which would allow deserving plaintiffs to receive awards more quickly and equitably. Specifically, the Society's legislative goals are (1) changes in the civil justice system, (2) strengthen medical disciplinary procedures, (3) improve the peer review process, and (4) thoroughly examine alternative dispute resolution proposals. He said there is still a need for tort reform, since insurance rates are still rising and doctors are restricting their practices. Also, he noted that the Society commissioned Hamilton & Associates from Washington, DC, to conduct an opinion survey in fall 1986 for the purposes of measuring the awareness level of NC citizens, test support of various tort reforms, assess the attitudes of professionals and determine the attitudes about health care. The findings indicated that two-thirds favor tort reform.

Dr. Foust stated there was a need for legal protections in the peer review process, noting that he had earlier been sued as chief of staff of a Charlotte hospital for $1 billion for delay in granting privileges to a disgruntled doctor. While the suit was dismissed, he was unnecessarily subjected to 10 days of trial as well as considerable anguish.

Dr. Foust urged that improvements were needed in the legal system to give adequate compensation to worthy patients without delay and excessive system costs. He said that new ideas should be explored (such as Prof. O'Connell's "tender and recovery" plan, designated compensable event plans, publicly funded no-fault system) and adjustments should be made in the fault-based system to recognize private contractual arrangements, patient's ages and injury severity, replacing punitive damages with criminal fines, recognition of cost containment pressures on physicians, providing for speedy arbitration in some types of cases, and overcoming the "conspiracy of silence" problems (saying MDs will serve on screening panels if the system is seen as being equitable).

In response to questions, Dr. Foust said that the Society could furnish the Commission some parts of the opinion survey findings, the Society would support some type of forum to address future medicolegal problems, and that a national clearinghouse of physician disciplinary actions is being developed.

Sen. Royall commented that if the next legislative session does not do more than the last one did to address the liability problem, there will be a need for another study commission.

Sen. Taft introduced John Beard, a Raleigh attorney and President of the NC Bar Association. Mr. Beard announced that the Association's Tort Study Committee, composed of both plaintiff and defendant attorneys, has been meeting monthly and will have its recommendations ready to present to the Legislature and the Commission in January. He also reported that the Association's Task Force on Alternative Dispute Resolution has been made a permanent committee.

Sen. Taft commented that the Commission is looking forward to the Tort Study Committee report, since its chairman had told the Commission to delay in making recommendations to the short session of the Legislature while the Association completed its own tort study.

Ms. Spragens asked if ADR tends to increase the frequency of claims. Mr. Beard answered that there were no statistics.

Presentations from members of the NC Bar Association were made on mediation services, arbitration, summary jury trials, and mini trials.

Miriam Dorsey, Director of Mediation Services of Wake County, described mediation services are intended to help alleviate the clogged court system. There are 10 mediation centers in NC and 150 across the country. They take the form of "peoples courts" and deal with both common criminal and civil matters. They depend on a corps of volunteer mediators who are trained listeners, attempting to promote a compromise to be reached by the parties so that the matter will not be taken to court. Funding for the centers is from the Administrative Office of the Courts and includes both state funds and private donations.

Sen. Taft asked if there had been any experience with small medical malpractice claims. Dorsey said that Wake had not but that some others have.

Carmon Stuart, Chairman of the NCBA Committee on ADR and manager of the federal Middle District arbitration program, said that the 1985 General Assembly had authorized the NC Supreme Court to develop a pilot program for mandatory, non-binding arbitration for civil disputes in three judicial districts. Rules for this program were approved by the Court in August 1986 to go into effect in January 1987. While the federal program has been in effect for 21 months and applies to matters under $150,000 in dispute, the state program applies to claims under $15,000. The judge appoints an arbitrator who must be a lawyer with at least 5 years experience, depositions must be obtained and a conference

must be held within 90 days after the appointment of the arbitrator, the conference lasts about an hour, rules of evidence are only a guide, and the arbitrator makes a decision which can be rejected by either party. A disincentive for going back to court is that if the outcome is not improved for the party, the party pays the cost of arbitration (about $100).

Dr. Bruton asked if the dollar limit could be raised to permit larger claims and Mr. Stuart replied there was no reason for a particular cap. Mr. Beard added that arbitration is possible for medical malpractice cases. Mr. Blount said that arbitration has possibilities but there are problems with it.

Sen. Taft suggested that most civil actions are settled anyway. Mr. Stuart noted that in the federal Middle District experience, 200 cases were referred, 30 actually went to an arbitration hearing, half of those asked for a trial de novo but nearly all of those were settled before the scheduled trial date. He felt that the arbitration process actually encouraged more settlements.

Summary jury trials were described by Catherine Arrowood from Raleigh. She said their purpose was to encourage settlement by following pre-trial discovery with the presentation of distilled evidence and arguments to a jury (which is not told their decision will be non-binding). All relevant persons

are required to attend the deliberations and hear how the mock jury decides. Nearly 90% of these cases are then settled without going on to a full jury trial (compared to the usual 70-80% which ordinarily are settled). She felt that medical peer review cases and medical malpractice claims would be good candidates for the summary jury process, noting that one of her two cases in Raleigh involved an accounting malpractice claim.

Dr. Dameron inquired about the methods used and whether the parties are prepared. Ms. Arrowood replied that only facts and an exchange of contentions (supported by depositions, affidavits, etc.) are permitted. At the pretrial conference with the judge, both sides must present their list of witnesses.

Sen. Taft raised the issue of application of summary jury trials to medical malpractice cases. Mr. Blount replied there were two problems: credibility of witnesses' statements in affidavits and depositions, and second, the psychology of going to trial creates an unwillingness by either party to settle since the defendant wants to be exonerated and the plaintiff wants to increase the possible award. As to credibility of witnesses, Ms. Arrowood said that opinions of experts could be shown on video. As to satisfaction with the process, clients would feel they had their day in court, even with a mock jury. She said that a pre-verdict agreement can be used by the parties to include a high-low clause, whereby the defendant agrees to pay an

agreed minimum (even if the jury gives no award) and the plaintiff agrees to accept an agreed maximum amount (leven if the jury gives a higher amount).

Mini-jury trials were described by Sydnor Thompson of Charlotte, a member of the NCBA ADR Committee and an arbitrator for the American Arbitration Association. Based on his attendance at an ABA seminar on mini-trials, he said that mini-trials were not actually a trial but a mechanism for reaching a settlement. They can be used at any time: before filing, after filing or even (by contract) in lieu of litigation. The parties agree to the following steps: (a) exchange of briefs, (b) attendance of all persons who have authority to make settlements (i.e., the corporation CEO but not the employee-wrongdoer), (c) a neutral advisor to hear the evidence presented and to ask questions (but not to decide the case, although he may give his opinion as to the probable outcome in court), (d) expert witnesses who can be cross-examined, and (e) confidentiality of the proceedings. After the evidence is presented, the lawyers and neutral advisor leave; the parties meet together to try settle. Mr. Thompson said that the process has reportedly been used in 28 cases, mostly involving patent infringements and federal Defense Department contracts. He added that it should be useful in medical malpractice actions, since they may involve large dollar claims but that the method works best when the parties are relatively equal.

Frank Laney, Dispute Resolution Coordinator for NCBA, recommended study of the 1985 NCBA report on Alternative Dispute Resolution (ADR). He noted there is no law and no court rulings on most of the forms of ADR. He added that NCBA offers technical assistance to persons wishing to try ADR. He suggested that ADR should be used very early in a dispute, before parties become entrenched.

Sen. Taft introduced Mr. Benjamin Foster, Executive Director of the Duke Private Adjudication Center (PAC), a non-profit affiliate of Duke University Law School. PAC has served as the administrator of the federal Middle District court annexed arbitration project for the past three years. Mr. Foster described PAC's services as an option for those who are not satisfied with litigation. Among other forms of adjudication that PAC offers is a private court, whereby a "neutral" judge hears the case on terms agreed to by the parties. The advantages are in certainty of trial date, savings in trial preparation, savings in trial time and increased flexibility. The private court costs are $800 for half day.

In response to questions Mr. Foster said that the private court option can be utilized before or after a case is filed and that parties can agree that the outcome will be either binding or non-binding. He added that a high and low limits on awards could be part of the agreements.

Sen. Taft introduced Professor Tom Metzloff of Duke University Law School and a specialist in professional liability.

Professor Metzloff presented the rationale and outline of a proposal that Duke University Law School is planning to submit to the Robert Wood Johnson Foundation in the Foundation's competition for medical malpractice research and demonstration projects. He discussed the background of screening panels, noting that 30 states had tried them after the 1975 medical malpractice crisis but that many had failed for numerous reasons. He suggested that any form of ADR must be "party neutral" to be successful. The Duke proposal would design and test a procedure to be offered as an alternative in North Carolina for settling medical malpractice disputes. During the first year, cases presently in litigation would be monitored, data and views about resolution of different types of cases would be gathered, a proposed procedure would be designed and a slate of neutral experts would be developed. During the second year, referrals would be invited for trying the model procedure and its effectiveness will be measured. Professor Metzloff asked the Commission its advice about the project and for its endorsement, saying that enabling legislation and seed money would also be welcome.

In response to questions, Professor Metzloff described some of the procedures that are currently being used in the federal court-annexed arbitration project and how some of

them could be modified for the malpractice project. He pointed out that options about appeals, high-low awards, availability of neutral experts for later trials, etc., can be a matter of private contract. Dr. Bruton suggested that physician defendants might have problems aggreeing to a minimum award if they are found not liable. Mr. Blount said that he has greater confidence in the jury system.

Sen. Taft said that the Commission should seriously be looking at ADR proposals for medical malpractice cases. Dr. Foust said that the research possibilities of an ADR project would be exciting for the medical community.

Dr. Bruton moved that the Commission go on record as vigorously in support of the Duke PAC proposal for the ADR project. Rep. Nye seconded. Mr. Blount questioned whether the motion fits within the charge of the Commission and Sen. Taft ruled that it did and that a quorum was present. The motion passed 7 - 1.

Sen. Taft opened a general discussion, noting that ADR ideas are consistent with the work of the NC Bar Association. Dr. Dameron supported alternatives, including the proposals to be described by Professor O'Connell at the next Commission meeting. Rep. Nye noted that in the absence of an ADR procedure, bad cases are sometimes filed in court. Dr. Bruton talked about the lack of positive response by the manufacturers to the vaccine injury legislation recently

enacted and wanted a report at the next meeting. Mr. Fuller noted that the Mecklenburg Council on Health Costs (George Stiles, Director) is also planning to submit a proposal (relating to risk management aspects of medical malpractice) to the Robert Wood Johnson Foundation and suggested that the Commission also endorse that proposal. Mr. David Executive Director of the NC Academy of Trial Lawyers, asked that details of the Medical Society's recent public opinion poll be released to the Commission and Dr. Bruton replied that relevant portions are already available. Ms. Spragens questioned the effect of ADR on frequency and severity and Mr. Fuller replied that ADR is too new, thus there is no data yet. Sen. Taft suggested that a summary of the experience of other states be made available to the Commission.

Sen. Taft adjourned the meeting at 12:45, announcing the next meeting for Nov. 21.

MINUTES PREPARED BY

DAVID G. WARREN
EXECUTIVE DIRECTOR

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

MINUTES OF COMMISSION MEETING

NOVEMBER 21, 1986

ROOM 1236, STATE LEGISLATIVE BUILDING

ATTENDING: Taft, Cromer, Nye, Fuller, Munson, Long (and Spragens), Dameron, Bruton, Blount

Senator Taft opened the meeting at 1:30 and welcomed guests.

Mr. Warren presented information about the recent enactment of the federal Health Care Quality Improvement Act of 1986. Two of its provisions affect the work of the Commission: first, a federal vaccine injury compensation program was authorized but will not go into effect until it is funded; at that time it will preempt state law provisions shielding manufacturers from suit but will not affect physicians; second, medical peer review activities are protected from antitrust challenges.

Dr. David Tayloe from Goldsboro requested to be heard. He presented a statement (on file) which addressed the new NC vaccine injury compensation program. He said that the NC

Pediatric Society saw no positive effects from the law in that vaccine prices had not been reduced. Therefore, private practitioneras are concerned about the overuse of health departments and the resulting loss of well-baby care by private physicians.

Mr. Munson commented that many private physicians are not participating in Medicaid, resulting in Medicaid patients overusing hospital facilities.

Rep. Nye suggested that NC should consider either manufacturing vaccine within state laboratories and reselling it to physicians or buying it directly from manufacturers at low bid prices and reselling it to physicians, both ways resulting in lower prices for physicians.

Sen. Taft introduced Professor Jeffrey O'Connell from the University of Virginia School of Law for a presentation on alternatives to traditional medical malpractice litigation.

Prof. O'Connell noted that the Commission had been presented with many descriptions of the problem and numerous proposed solutions, causing "swirling variables" for the Commission to consider. He suggested that the Commission should focus on eliminating only two variables: (a) fault as the basis for compensation and (b) payment of compensation for pain and suffering. He noted that all other forms of insurance pay only the face amount of the policy and that the workers

compensation system has successfully eliminated fault in providing scheduled benefits. He said that merely putting a cap on pain and suffering payments is insufficient to minimize litigation, although it might diminish volatility in insurance rates. A no-fault system would be difficult to administer due to problems in defining the "insured event." Prof. O'Connell therefore offered a new proposal to the Commission which he calls an "early compensation program" based on the concept of a potential defendant promptly tendering an offer to pay all the net economic losses of the potential plaintiff in return for not being sued. He would require the defendant also to pay reasonable attorney fees. He would allow other potential defendants to be joined, and to divide the costs later perhaps by arbitration. If the physician or hospital does not make the tender promptly, say within a time period of 180 days, then the plaintiff is free to bring a traditional lawsuit. His proposal is aimed at keeping medical malpractice disputes out of the courts and providing reasonable compensation to injured patients with a minimum of transaction costs. He said that the concept has been embodied in the Moore-Gephart bill pending in Congress and in a bill introduced in the Massachusetts legislature to apply only to OBGYN injuries.

Sen. Taft inquired about how the scheme would deal with a case where there was low economic loss but a very bad result, such as a woman becoming sterile during minor surgery or a boy who loses an eye.

Prof. O'Connell replied that in such cases, the plaintiff might be allowed to reject the tender and to take a chance to sue in court, allowing recovery only if a jury awards a much higher amount (e.g., by a factor of 10) but otherwise paying the penalty of reimbursing defense costs.

Sen. Taft raised the issue of constitutionality of such a statutory program being applied only to obstetrics cases.

Prof. O'Connell said that the legislature should do what is sensible despite some skeptical lawyers and judges seeing possible constitutional problems. He added that he believed the scheme would eventually survive, like workers compensation laws did and also no-fault automobile insurance plans did.

Mr. Munson asked for details about the Massachusetts bill.

Prof. O'Connell said that it was amended to apply to surgeons as well as obstetricians but did not pass last session; the Governor intends to have it considered again, and perhaps have it apply to municipalities as well as physicians. He added that Virginia may be considering it for obstetrics.

Mr. Fuller suggested that the scheme may involve even larger aggregate insurance payouts and invite more claims and there will be litigation over true net economic loss.

Prof. O'Connell replied that it should not change the insurers' present position since insurance companies can still turn away marginal claims. The worry about net economic losses would be solved by paying losses periodically as they accrue. Reasonable medical costs could be paid as for major medical and disability insurance plans. Reasonable wages could be tied to average state wage for simplicity.

In reply to other questions Prof. O'Connell said that other tort law changes, such as caps and shortened statutes of limitations, would have only a marginal effect.

Commissioner Long questioned the effectiveness of no-fault automobile insurance plans in the 14 states that now have it (two have repealed it). O'Connell replied that a DOT study in New York indicates that no fault coverage seems to lower premiums but that in states with both no-fault and tort systems the premiums were higher.

Prof. O'Connell added that "if premiums go up due to my proposal, some physicians may be willing to pay it anyway, since it goes to compensate patients."

Sen. Taft introduced Dr. Robert Deyton, a Greenville physician and chairman of the OBGYN Committee on Medical Malpractice, who presented a statement (on file). Dr. Deyton noted that there have been 243 claims against OBGYN in NC

since 1975, including 103 in 1986 of which 43 involved complications during deliveries. He oited the rising premiums and withdrawal of OBGYN services and procedures.

In reply to Mr. Fuller's question about whether dealing with the OB problem will decrease the crisis, Dr. Bruton said that more data would be necessary and Dr. Dameron said that basic tort concepts need to be addressed, not just stop-gap partial proposals.

In reply to Commissioner Long's question about why OB claims are increasing, Dr. Deyton replied that obstetricians are "victims of technology," not incompetence.

In reply to Rep. Nye's question about how OBGYNs handle increase premiums, Dr. Deyton said it is difficult to afford and some are leaving the practice.

Sen. Taft asked Ms. Spragens to report on the status of the Department of Insurance closed claim study. She said that the Commission has been given copies of the responses to the Department's survey of those with an interest in the study. She recommended that the Commission consider possible legislation which would make the details of the insurer's reports confidential, except perhaps for use by the Board of Medical Examiners.

Commissioner Long added that cooperation might be improved by

confidentiality, but that he could do the project as a market conduct study which would compel compliance anyway.

Sen. Taft noted there were no objections from the members and requested that proposed legislation on confidentiality of these insurance reports be prepared by the staff.

Sen. Taft requested all interested groups to send to the Commission by December 1 any suggestions for proposed legislation to be considered by the Commission at later meetings.

Sen. Taft announced that the next meeting of the Commission would be 9:00 a.m., Friday, Dec. 12, 1986.

MINUTES OF COMMISSION MEETING

DECEMBER 12, 1986

STATE LEGISLATIVE BUILDING

ATTENDING: Taft and Quinn, Ballance, Condor, Cromer, Nye, Miller, Pulley, Munson, Bruton, Fuller, Richotte, Long (and Spragens)

Senator Taft opened the meeting at 9:00 and introduced Mr. Grover McCain, a member of the NC Bar Association's Special Committee of the Tort Liability System.

Mr. McCain said the Committee was meeting this morning and hoped to develop recommendations relating to punitive damages, collateral source rule, and joint and several liability.

Sen. Taft introduced Dr. Ronald H. Levine, NC State Health Director who read prepared remarks (on file) relating to the Vaccine Injury Compensation Act. He reported that the goal of the legislation to substantially lower vaccine prices has not yet been realized. He also reported that the other goal of providing compensation to injured children is being addressed by assigning responsibility to the regional Developmental Evaluation Centers. To his knowledge no claims have yet been filed with Industrial Commission. Dr. Levine noted four problems that need to be addressed by

modifications to the law: (1) manufacturers' reluctance to lower prices, (2) continuing inappropriate vulnerability of health care providers, (3) impact of the newly enacted federal vaccine compensation act, and (4) avoiding double payments under state and federal programs. He made proposals for each of these areas.

Mr. McCain addressed Dr. Levine's proposal to require that all claims for injuries which occurred prior to Oct. 1, 1986, be filed with the Industrial Commission unless an action is filed in court prior to Oct. 1, 1987. He stated that there can be no retroactive application to pending litigation but that the Legislature can provide a reasonable grace period for filing all other claims, citing Judge Exum's opinion in Flippin v. Jarrell.

In response to questions, Dr. Levine said that a contract with the State of Michigan for their laboratories to furnish vaccine to NC is a possibility and that there have been communications with Michigan officials. He said that another possibility is for the State to purchase vaccine under the federal contract (through CDC with Connaught, Inc.) at very low current prices ($40 per vial) and then distribute it to NC physicians for free, but that would cost approximately $1.3 million in 1987. At present the State-purchased vaccine is distributed only for use of indigent children. Dr. Levine replied to Sen. Taft that the new NC compensation act has made us "better off" but that the problem of vaccine prices still remains.

Sen. Taft introduced Mr. Ronald J. Greene, an attorney with Wilmer, Cutler & Pickering in Washington, DC, and counsel for Lederle Laboratories. Mr. Greene read prepared remarks (on file) noting that Lederle supported the enactment of vaccine compensation legislation similar to that ultimately enacted in NC, except for some provisions. He said that the company has 190 lawsuits pending and that the new federal legislation is not satisfactory to the company because it provides generous compensation to claimants but little protection for manufacturers. Mr. Greene pointed out four "defects" in the NC law: (1) lack of a definition for "defective products," (2) lack of penalties for resale outside the state of vaccines purchased directly from the manufacturer by NC providers, (3) the 3-year sunset provision, and (4) failure to narrow the application only to claims for injuries caused by vaccines admininistered within the state, regardless of where action is brought or injury occurred. He said there were also problems with preemption by the federal legislation and suggested two remedies: either attempt to have federal law amended to exempt NC or amend the NC law to attempt to prevent the federal law from coming into effect.

In response to questions, Mr. Greene said that Lederle's current national price ($171 per vial, which includes $120 for a liability reserve) invites black market resale if NC is given a reduced price. Replying to Rep. Cromer, he said that

the company could not have anticipated problems he cited in his paper. Replying to Sen. Ballance, he said that the $120 is in a "reserve account" on the company's books and it may or may not be a sufficient self-insurance fund to pay future liability claims.

Ms. Ann Christian, legislative counsel for NC Bar Association, asked Mr. McCain to present the Association's "Position Paper on Proposals Concerning Modifications of the Immunization and Compensation Bill (sic)". He pointed out that the paper (on file) supports full and adequate funding of the program, favors the present sunset clause and wants more time to study other proposed changes and the implications of the federal bill. Mr. McCain suggested that if there were to be a grace period for retroactive application of the program, that perhaps a public guardian could be appointed to bring claims on behalf of affected children.

Dr. Levine noted that manufacturers' bids next April on the federal contract for vaccine purchases by state health departments will reflect the industry's response to the new federal vaccine compensation act.

Rep. Cromer questioned the effect of removing manufacturers from the NC law. Mr. McCain opined that there would be no strong equal protection problem since the rational basis test would be used by courts in reviewing its constitutionality.

Dr. David Tayloe, a Goldsboro pediatrician, stated that if the State were to purchase vaccine and redistribute it at no cost, the NC Academy of Pediatricians at this time would be in favor of this and would give it for free to all children.

Sen. Taft opened the floor for general discussion on the vaccine injury compensation program. Dr. Bruton thought the NC law was good, supported the Lederle proposals, advised that the federal law should be ignored for now, and suggested that $1.3 million to allow the State to buy all the vaccine for NC vaccinations is reasonable. Rep. Cromer favored repealing the manufacturers' protection and appropriating money for the State to buy all vaccines. Mr. Robert Scott, a Lederle representative, pointed out that the company had submitted a bid to the State which cut the liability portion of the price by 50%; he added that if the diversion concerns were resolved, the company would lower prices still further and also give a break to private physicians. Commissioner Long wondered if Lederle may be over-reserving. After considerable discussion about the definition of "defective product," possible application of "strict liability" and possible substitution of "negligence," Sen. Taft announced that he would confer with Rep. Alex Hall (sponsor of the vaccine bill in the House) to develop proposed language for modification of the law. He noted that there seemed to be no objection to elimination of the sunset clause, preventing the diversion concerns, and attempting to avoid application in NC of the federal law, but there were problems with authorizing the

Secretary of Human Resources to contract with Michigan if it would require waiving the right to sue. Sen. Condor objected to the State competing with private enterprise.

Sen. Taft introduced Mr. Julian D. Bobbitt, Jr., Legal Counsel for the NC Medical Society, who presented the recommendations of the Society (on file). Mr. Bobbitt reminded the Commission that the Society had earlier presented a comprehensive package of specific proposals to make changes in the civil justice system and to strengthen physician policing and disciplining programs. In addition he suggested that the peer review process be further protected and that the life of the Commission be extended to address longer term considerations about the definition of "true negligence," as well as exploration of private contracts, the O'Connell proposal, various no-fault proposals and alternatives to full civil litigation (private adjudication, screening panels, arbitration, expedited trials).

In reply to Sen. Taft's query about whether the Medical Society wants the Commission to give further consideration to tort reform, Dr. Bruton replied that the Commission should consider tort reforms which would apply to all groups. Sen. Taft said that the Commission can only focus on medical malpractice, not general tort reform. Mr. Glenn Jernigan of the Medical Society said that tort reform should be coordinated between the two study commissions dealing with it. After Commissioner Long raised the question about

whether the Commission had decided in September to take no action on tort reform, Dr. Bruton replied that his impression was that tort reform was only "set aside" while addressing ADR.

Sen. Taft directed Mr. Warren to prepare and send out draft bills to cover the issues raised by the Medical Society as well as the revised version of the Commission's proposals made to the Short Session and today's proposed modifications to the vaccine injury compensation program.

Sen. Taft invited Rep. Miller to present his proposals for modifications in trial procedure for medical malpractice cases. Rep. Miller distributed copies of his proposals (on file) which covered these points: (1) improved case management by close supervision and procedures to expedite their disposition, including designation of expert witnesses, (2) require court approval of a prevailing plaintiff's attorney fees (as presently is the case with minors, incompetents, probate and estate matters), and (3) require claimant in a medical malpractice action to notify the defendant of the claim within a reasonable time or be barred (as presently is provided in the UCC and applied in the Kresge case) but permitting judge to decide that failure to give notice was not prejudicial.

In discussion, Rep. Pulley stated that expediting cases may well have merit, expert witnesses should be identified for

both plaintiffs and defendants, the UCC philosophy applies only to buyers and sellers, and attorneys' fees are increased by the "wearing out" tactics of defense counsel. Sen. Taft suggested that attorneys fees should be approved by the court for both plaintiffs and defendants.

Sen. Taft introduced Dr. Richard Nugent, consultant with the NC Division of Health Services. Dr. Nugent read a prepared statement (on file) about the results of two surveys (March 1986 and Nov. 1986) of physician participation in local health department prenatal clinics and some factors in accessibility and availability of those clinics. He pointed out that the March survey revealed that 49 obstetricians and 31 family physicians had withdrawn from participation, leaving about 180 to 201 participating physicians. The Nov. survey revealed that an additional 16 obstetricians and 20 family physicians withdrew in the seven month period. In March, 22 counties reported that obstetricians and 18 counties reported that family physicians had withdrawn in the previous twelve month period. In Nov. the numbers were 12 and 13, respectively. In addition 35 counties responded that the problem was "important" or "very important." At present, 12 counties have no subsidized prenatal clinics, 18 counties report a waiting peariod for the first prenatal clinic visit of 3 or more weeks, and 76 counties report a lack of transportation as an "important" or "very important" problem. In summary, Dr. Nugent stated that "these data reflect continuing trends toward reductions in the

availability and accessibility of our prenatal clinics,and that physician withdrawal has played a key role in these trends."

Mr. Warren presented his written summary (on file) of the proposal presented to the Commission by Professor O'Connell in November relating to early compensation of infants for prenatal and obstetrical injuries. The provisions include a declaration of policy stating the need for legislative action. Under the proposal, these elements encourage the early compensation for birth-related injuries: (1) a physician who is potentially liable under NC laws may make a tender of compensation offer within 180 days of the event, (2) the offer must be in writing and will be up to the amount of liability insurance coverage, (3) the physician must carry at least $1M coverage, (4) the injured party to whom the offer is made is thereby by law foreclosed from bringing suit (or, rather than completely foreclosing a plaintiff, a legislative policy option might instead provide disincentives for going to court, such as payment of defendant's cost if plaintiff loses, or limiting plaintiff's recovery of non-economic damages to $250,000), (5) hospitals and other possible defendants may join in the offer, (6) the compensation to be paid will amount only to attorney fees plus all "net economic losses," (including expenses for medical care, lost earnings, rehabilitation past and future, not otherwise compensated by a third party, (7) no pain and suffering nor punitive damages are recoverable, and (8) the

compensation will be paid in periodic payments, as expenses accrue. The provisions of this proposal are modeled after Moore-Gephardt "Medical Offer and Recovery Act" bill pending in Congress.

Mr. Warren pointed out that there was no data as yet to suggest that insurance companies would lower premiums if this scheme were enacted. Also, there should be some provision to assure the physician that his insurer would join in the offer and be bound by to make payments. One other problem he noted was the settling of disputes about the amount of "net economic losses"; he suggested that disputes could be either put to arbitration or could be decided by court action. He observed that the proposal as set forth in the 1986 Massachusetts bill was not appropriate for NC legislative style and would have to be drafted to fit our situation.

Commissioner Long announced that (a) he was distributing a special issue of the Orlando Sentinel which recapitulates the medical malpractice news stories in Florida, (b) state insurance commissioners at a recent national meeting he attended related little effects from tort reforms in their states, and (c) the Insurance Service Office (ISO) was conducting a closed claims study and a study of state reforms and the results should be available in the spring.

Sen. Taft adjourned the meeting at 1:00, announcing that the next meeting will be scheduled sometime in January to consider the draft proposals prepared by the Commission staff.

MINUTES PREPARED BY

DAVID G. WARREN

EXECUTIVE DIRECTOR

MINUTES OF COMMISSION MEETING

JANUARY 23, 1987

ROOM 1425 STATE LEGISLATIVE BUILDING

ATTENDING: Taft; Ballance, Blount, Bruton, Conder, Cromer, Long, Miller, Munson

Senator Taft opened the meeting at 9:25 and said that the Commission would consider proposals which were prepared by Mr. Warren and the Legislative Drafting Service, as presented on the Agenda (attached).

1. Increase Insurance Department monitoring of insurers by authorizing the Commissioner to require closed claims reports, with protection of information which identifies persons. (SB 858, Third Edition Engrossed 7/2/86)

Approved with these changes (consensus):

(a) p.1, line 17 - change "shall also file with the Commissioner a report" to "shall also file, upon request of the Commissioner, a report"

(b) p.2, lines 2,3,4 - strike the words "similar to the National Association of Insurance Commissioners (NAIC) Medical Professional Liability Insurance Uniform Claims Report, as revised, or"

2. Strengthening of medical licensing board by providing various new procedural powers and duties. (SB 858, Third

Edition Engrossed 7/2/86)

Approved with these changes (consensus):

(a) p.4, lines 8,9 - strike the words "Upon request by the health care provider,"

3. Promote peer review agreements (including joint programs for impaired providers) between health care provider licensing boards and their respective occupational and professional voluntary associations. (SB 858, Third Edition Engrossed 7/2/86)

Approved with these changes (consensus):

(a) p.8, line 7 - insert after the words "Peer review activities conducted" the words "in good faith"

4. Protect hospital governing boards when reviewing medical staff credentials and granting privileges. (SB 858, Third Edition Engrossed 7/2/86)

Approved with these changes (consensus):

(a) p.8, line 16 - add at the end the words "Nothing in this section is intended to affect the application of antitrust laws as they may apply to hospital governing bodies."

5. Report details of hospital privilege actions to the respective health care provider occupational licensing boards. (SB 858, Third Edition Engrossed 7/2/86)

Approved (consensus).

6. Require risk management programs in hospitals as a condition of licensure. (SB 858, Third Edition Engrossed 7/2/86)

Approved (consensus).

7. Provide criminal penalties (Class J felony) for furnishing false information to patients or altering patients' medical records. (SB 858, Third Edition Engrossed)

Approved (voice vote).

8. Mandatory hospital compliance with requirements for using medical review committees. (Draft 87N-LF-133)

Approved subject to drafting changes by Staff (consensus).

9. Close court supervision over medical malpractice claims and expedite their disposition. (Draft 87-LC-9)

Approved with these changes (voice vote):

(a) plaintiff shall identify all expert witnesses within 60 days after discovery conference and defendant shall identify all expert witesses within 60 days after that event, with court permitted to extend periods for good cause.

(b) require all discovery to be completed within 120 days

10. Require court approval of a prevailing plaintiff's attorney fees. (Draft 87-LC-13)

Displaced (consensus) and not considered.

11. Require court approval of fees to be paid to the attorneys for both plaintiff and defendant. (Draft 87-LC-18)

Approved (7 - 1 vote, Chairman not voting).

12. Require claimant to notify the defendant of the discovery of a claim within a reasonable time. (Draft 87-LC-14)

Approved with these changes (5 - 3 vote, Chairman not voting):

(a) redraft to put in Gen. Stats. Chap. 1 rather than Chap. 90

13. No punitive damages permitted in medical malpractice actions. (Draft 87-LC-15)

Postponed to make these changes (voice vote):

(a) consider the proposals contained in the NC Bar Association Report from Special Committee on the Tort Liability System (Jan. 1987)

(b) draft provisions for criminal penalties for some types of medical malpractice

14. Limitation on qualification of expert witnesses based on same speciality and 75% of time devoted to clinical practice. (Draft 87-LC-16)

Substitute motion to approve with changes in wording (in (b)(3) the words "professional time" changed to "clinical time" and "same speciality" changed to "same area of medicine") failed (4 - 4 vote, Chairman not voting). Original motion to approve with no changes in wording failed (4 - 4 vote, Chairman not voting).

15. Shorten the statute of limitations for minors from 19th birthday to 8th birthday for birth injuries and other claims discovered by 5th birthday. (Draft 87-LC-17)

Motion to approve failed (4 - 4, one abstention, Chairman voting).

16. Early compensation for obstetric injuries based on promoting offers by defendant to pay for all net economic losses (proposal from Professor O'Connell). (Draft 87-LF-12)

Discussion about binding insurers and the need to review letters received from insurers relative to the proposal and the concerns about triggering state action on excess funds or pooling arrangement.

Postponed for later consideration (voice vote).

17. Vaccine program changes I (proposed by manufacturer). (Draft 87-LF-10b)

Discussion about definition of "defective product" and penalties provisions. Comments from Representative Alex Hall about the need for manufacturers to respond to NC legislation with reduced prices for DTP vaccines. Postponed for later consideration (consensus).

18. Vaccine program changes II (proposed by State Health Director). (Draft 87-LF-11)

Postponed for later consideration (consensus).

19. Vaccine at reasonable cost. (proposed by State Health Director). (Draft 87-LF-rule)

Postponed for later consideration (consensus).

Staff was directed to confer with interested parties about drafting a consolidated bill to deal with changes in the vaccine-injury compensation program.

Sen. Taft adjourned the meeting at 1:35. He noted that the legislation creating the Commission requires it to make its report at the start of the 1987 General Assembly "or as soon thereafter as practicable" and he announced that the next meeting of the Commission will be held sometime after the first week in February.

MINUTES PREPARED BY DAVID G. WARREN

C

BACKGROUND PAPER: RECENT DEVELOPMENTS

IN GOVERNMENTAL RESPONSES TO MEDICAL MALPRACTICE

David G. Warren, J.D.
Professor, Duke University, Durham, North Carolina
&
Executive Director, North Carolina Medical Malpractice Study Comission

January 14, 1987

I. INTRODUCTION

During the past year numerous studies and proposals at both the federal and state levels have addressed new ways of dealing with civil liability for personal injuries. The impetus has arisen from concern about rising premium rates for commercial insurance policies for product liability, municipal liability for government services, and most noticeably, insurance for the injuries caused to patients in the course of the practice of medicine. Many have associated these problems in the insurance market with the need for changes in the laws of civil liability.

While most of the recent legislative activity has been stirred by medical interests, coalitions of private and public groups have been formed to promote public attention to general tort reform in the various states as well as nationally. The result has been a considerable amount of pressure on both levels of government to respond.

At the federal level the Congress, Executive Agencies, the Office of the President and the Supreme Court have all addressed various aspects of the multiple issues affecting the field of medical malpractice. More importantly, however, state legislatures and legislative study commissions have been deliberating numerous specific proposals for changing state laws governing the litigation of medical malpractice cases, regulation of the liability insurance industry, and the control of the practice of medicine.

Parallel to these governmental efforts has been a series of studies undertaken by the private sector to analyze the medical malpractice problem and to make recommendations for dealing with it. Business coalitions have become involved since the costs of medical malpractice insurance affect the cost of employee benefit programs and also because the liability insurance crisis has struck business and industry in general.

Most of these public and private developments have been followed by the news media and reported to the public. Both the print media and electronic media nationally have devoted considerable attention to this topic, perhaps because it appears to pit lawyers against doctors and both against the insurance industry. Local media have addressed the topic because the

dramatic increases in insurance premiums have forced many physicians to limit their practices, withdraw from certain services (especially obstetrics) or announce early retirement.

While the initiating force for all these actions was the medical community's alarm about rapidly rising premium rates for liability insurance coverage, the agenda has become much more far-ranging. Included in the discussions are many of the matters that have some effect on the issues of medical practice accountability, legal procedures for settling disputes both in and out of court, insurance company regulation and patient advocacy. Some seemingly related issues, such as control of medical technology and cost of health care services, are not yet part of the debates on medical malpractice, but are being addressed in other forums.

The end results are not yet known, since much of the activity is currently in various stages of development. The work of many of the study commissions is still in progress and it will be several months before some of the state legislatures are convened for considering the legislative proposals. Even in those states which have recently taken definitive steps by enacting special legislation or issuing new regulations there will be both ongoing assessment of the impact of those steps as well as continuing consideration of other proposals being put forward.

II. STATES ARE FOCI OF LEGISLATIVE AND JUDICIAL ACTIVITY

During 1986 thirty eight states enacted some form of legislation designed to address concerns about personal injury liability. Most of these were tort reforms intended to lower insurance rates. Traditionally in the US, both tort law and regulation of the professions have been primarily a state matter. Accordingly, it is not surprising that states have been the battleground.

III. POLITICAL, ECONOMIC AND LEGAL FACTORS

Complicating any analysis of the medical malpractice situation is the fast-developing public and political concern about the availability and affordability of general liability insurance for businesses and community organizations of all types. The resulting pressure from an odd amalgamation of municipalities, day care centers, ski resorts, sports equipment manufacturers and small businesses seeking to force both federal and state legislatures to solve their insurance problems has supplemented the interest in the professional liability insurance dilemmas, rather than diverting it. A particularly acute and surprising aspect is the question of protecting board members of both businesses and non-profit, charitable organizations, due to the scarcity of reasonably priced Directors and Officers (D&O) insurance.

It can be anticipated that a settlement of the situation

will not come about for an extended period due to several major factors. First, any new legislation enacted by state government is subject to constitituional challenge and is likely to be mired in litigation by those who disagree with it or, conversely, those who want to assure its validity through a court test. Second, many of the legislative changes in the rules of civil liability will take some period of time to implement and even longer to assess as to their impact, requiring later adjustment and modification to achieve both workability and acceptability. Third, there are market forces at work in the insurance industry which take time to develop and be acted upon. These forces are to some extent beyond the power of state legislatures to affect.

For example, negotiations on the terms of reinsurance treaties are conducted on an international basis and hinge upon many factors external to state legislation. The impact of those decisions on the setting of medical malpractice insurance premiums is greater than the individual power of any state insurance commissioner, no matter what new regulatory authority the legislature may delegate to that official. Even in states like Massachusetts where the state operates a joint underwriting authority (JUA) it must prescribe rates which reflect the costs of reinsurance.

Underscoring this frustration felt by state legislatures and commissioners of insurance not to be able to have an immediate impact on the problem of high and rising insurance premiums and the sequelae of adverse impact on the health care system, the New York senate is considering a bill (S. 6770, introduced Dec. 5, 1985) which recognizes the problem as follows:

> The legislature hereby finds and declares that although reforms have been enacted to restrain increases in medical and dental malpractice premiums and related costs and to prevent medical and dental malpractice, the complete effect of some of these reforms cannot be fully measured for some time, due to the considerable delay currently between the medical and dental malpractice event and its final determination.

One final overall consideration in evaluating the recent developments in this field in the USA is the inherent and continuing tension about the constitutional jurisdiction of federal and state governments in the field of health matters, coupled with historic competition for political leadership between and among all levels of government in matters affecting health and welfare. Complicating these traditional factors is the new policy of the Reagan Administration to foster private sector responsibility for health care and health services, in effect promoting competitive, "free market" development of appropriate policies and solutions. This political stance has a trickle down effect on promoting both state and private initiatives to address the medical malpractice issue.

IV. FEDERAL ATTEMPTS TO PROVIDE LEADERSHIP IN SEEKING SOLUTIONS

At the federal level several key persons and organizations have emerged and become significant exponents of one approach or another. In Congress Representative John Porter (Republican - Illinois) has assumed a leadership role in attempting to define federal responsibilities in this field. He requested the U.S.General Accounting Office (GAO) to conduct a large scale national study of the medical malpractice problem and has assisted in promulgating the results of the GAO study through press conferences and interagency seminars in Washington. Dr. Nelle Temple on his staff has been monitoring the developments in this area, both in Congress and outside.

House Resolution 386 introduced by Representative Porter and nine others on March 3 is an attempt to foster multiple solutions and promote state initiatives. It cites the increased costs of medical malpractice claims and insurance, gives recognition to the primary jurisdiction of states but notes the federal government interest inasmuch as it pays 30% of the total health care costs in the nation and has the power to "require States that do not undertake necessary reforms...to pay the Social Security taxes which they collect on behalf of their employees in a more timely fashion." Specifically, the resolution states

> That, in order to improve the availability of medical care, to limit the incidence of medical malpractice, to control the direct and indirect costs of malpractice insurance and their impact on the Medicare Trust Funds, to validate alternative procedures for quickly resolving malpractice claims, and to strengthen the regulation of insurance, the States should adopt the following measures:
>
> (1) REFORMING STATE TORT LAW.
>
> (A) Caps should be placed on the recovery of noneconomic losses in medical malpractice suits.
>
> (B) The financial liability of parties bearing less than half the fault in a medical malpractice action should be proportionate to their degree of fault.
>
> (C) The use of structured payouts should be required in cases involving large settlements or judgments.
>
> (D) Duplicate payments from tort recoveries and collateral sources should be eliminated.
>
> (E) Statutes of limitation and allowable discovery periods should be short in order to balance the need to protect the victims of latent injuries and the need to reduce the high costs of insuring

against uncertain risks far into the future.

(2) REFORMING THE MONITORING AND REGULATION OF UNPROFESSIONAL AND NEGLIGENT CONDUCT BY HEALTH CARE PROFESSIONALS.

(A) State agencies which license, certify, and discipline health care professionals should be strengthened by having access to information on malpractice actions for the purpose of identifying practitioners with aberrant practice patterns and by other means.

(B) Risk management programs acceptable to these State agencies should be implemented.

(C) Relevant State authorities should be granted access to insurance settlement information, with proper protection for individual patient confidentiality.

(D) State medical societies should be suthorized to review malpractice complaints and actions, to take such responsible action as they deem appropriate in light of such review, and to report on such actions to State authorities.

(E) State medical societies should be allowed to perform the actions described in subparagraph (D) in confidence and should be exempted from antitrust prosecution for those actions.

(F) Hospital staffs should be authorized to review malpractice settlements and awards involving staff physicians and required to make a report of recommended action to the State medical board.

(G) Hospitals should be required to confirm the professional credentials and work history of physicians seeking staff privileges and should be granted immunity from antitrust and antidiscrimination suits should they deny staff privileges on the basis of unacceptable malpractice records.

(3) REFORMING STATE CONTRACT LAW - Contractual agreements entered into knowingly and willingly between health care providers and their patients to forego malpractice litigation in favor of alternative dispute resolution and claims settlement procedures should be enforceable and presumed valid under State law.

(4) REGULATING INSURANCE - Insurance regulation should be strengthened by the States to protect consumers

through assuring continued availability of commercial, pooled, or self-insured coverage at the fair price consistent with solid underwriting practices.

More direct approaches are visible in the bills introduced by various Congressmen during the past several months.

In October Senator Orrin Hatch (Republican - Utah) introduced S.1804 (identical to HR 3865 in the House), the Federal Incentives for State Health Care Professional Liability Reform Act of 1985, which embodies the recommendations of the American Medical Association. It would provide financial incentives (totalling $222,875,000 over the next 6 years) to states to take legislative steps to adopt specified tort reforms ($250,000 cap on non-economic damages, periodic payments for future damages in excess of $100,000, elimination of collateral source rule, sliding scale restrictions on contingent fees, with a proviso that fees may be increased for good cause), medical disciplinary procedures (including investigatory responsibilities by local medical societies), and insurance reporting requirements (information about awards). The bill also requires providers to have approved risk management programs and to participate in insurer-sponsored risk management education programs every 3 years. Further, the bill states that any peer review activities undertaken by professional societies shall not be subject to state or federal antitrust law enforcement. The provisions of this bill have received considerable attention through support from the medical community.

Last summer and again on January 6 Representative Henson Moore (Republican - Louisiana) and Richard Gephardt (Democrat - Missouri) introduced HR 3084, the Medical Offer and Recovery Act, a novel mechanism for alternative dispute resolution which promotes rapid settlement of economic damages and avoids payment of non-economic damages to an injured party. This bill, which gathers more interest and support when it is explained as an additional alternative to the traditional tort system, is designed to serve as a model act for state legislatures. While there are no financial incentives and no direct penalties attached for non-adoption, the bill would apply to all beneficiaries of federal health care programs in states which do not enact similar provisions. The mechanics of the scheme include the following major points:

(1) A health care provider would, within 180 days of an occurrence, have the option of making a commitment to pay the patient's economic loss. Payments from collateral sources such as private health insurance and workers' compensation would offset the amount.
(2) The provider's offer to pay would foreclose the patient's right to sue, except for cases where the provider intentionally caused the injury or a wrongful death occurred.

(3) The payment would be for all economic losses but not non-economic losses, and would be paid periodically as the patient's loss occurred.
(4) The provider may join other third parties; any disagreement between the joined parties as to responsibilites for injury will be settled by arbitration.
(5) Patients may sue for enforcement of the commitment, if necessary. Physicians are required to carry insurance or to post bond to participate.
(6) If a patient's demand for compensation for economic loss is denied by the provider, the patient may sue in traditional tort or may request arbitration, which forecloses the patient's right to sue.

On March 12 Representative Ron Wyden (Democrat - Oregon) introduced HR 4390, the "Health Care Quality Improvement Act of 1986," which encourages state medical licensing agencies to establish special review committees to validate the actions taken by individual hospitals which deny or limit medical staff privileges for physicians. If the review committee judges that the hospital's decision was a good faith process, the hospital is immune under federal liability laws. Second, the bill establishes a national data bank to collect and collate settlement and judgment information from insurers and licensure actions from state license boards. This information about individual physicians is to be made available only to hospitals and state licensure boards.

Numerous other bills have been introduced to address the problem in various ways. Among them are bills which would facilitate self-insurance by physicians (S.1357, HR 2261, HR 3761), permit patients to sue military physicians (HR 3174), provide financial incentives for states to establish screening panels and to conduct studies (S.175 and HR 2659), and apply tort law reforms to federal courts, preempting state laws inconsistent with those reforms (S.2046).

It can be expected that bills will continue to be generated in the Congress, since constituency pressure for relief from increasing insurance rates seems to be mounting, according to news media releases.

Last year the Attorney General of the US created an interagency study group to make recommendations for federal action. This group issued its report in February 1986 with primary contributions from the Department of Justice, Department of Commerce and Small Business Administration. The principal reforms recommended are these:

(1) Return to a fault-based standard for liability
(2) Base causation findings on credible scientific and medical evidence and opinions
(3) Eliminate joint and several liability in cases where defendents have not acted in concert

(4) Limit non-economic damages (such as pain and suffering, mental anguish, or punitive damages) to a fair and reasonable maximum dollar amount
(5) Provide for periodic (instead of lump-sum) payments of damages for future medical care or lost income
(6) Reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery
(7) Limit attorneys' contingency fees to reasonable amounts on a "sliding scale"
(8) Encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

The report details reasons why government insurance or indemnification would be undesirable. "Such a federal...program would not only be extremely expensive, but also could exacerbate the problems of tort law by making the "deep pocket" of the taxpayer available in many cases. In addition, such a program could undermine public health and safety, require more extensive government regulation of private sector activities, involve the government in substantial litigation, lead to increased federal involvement in state insurance regulation and inhibit the ability of the private sector to adapt insurance services to changing economic and social conditions."

The report was promptly acted upon by the President's Domestic Council which announced in March that it was preparing legislation for Congress to modify tort law as it affects suits against the federal government.

Some of the concern about medical liability of the federal government stems from an audit by the Inspector General of the Veterans Administration which revealed that the Veterans Administration medical system paid out neary $35 million in claims in fiscal years 1983 and 1984 (as reported in Hospital Risk Management, Feb. 1986).

Another concern at the federal level was whether Medicare should include in its reimbursement of hospital costs an amount for the expense of purchasing hospital liability insurance. A 1979 regulation from the Health Care Finance Agency limited reimbursement to the national loss ratio for liability claims paid to Medicare patients (about 5% then, now 13%), or higher if an institution could show a different loss ratio for its Medicare patients. That "apportionment rule" was challenged repeatedly in the federal courts and found to be invalid in eight separate appellate judgments across the country. Unless the federal government adopts a different rule, hospitals will be entitled to more than $400 million in back payments during the period of the flawed regulation. The Agency is now in fact in the process of promulgating a new regulation as a compromise, hoping that hospitals will not bring further court challenges. Under it the backpayments would total only $200 million. The new rule divides liability insurance costs into two components: an "administrative component" and a "risk component." The former

is based on the assumption that overhead costs, commissions and taxes are used proportionately by Medicare and non-Medicare patients. The latter uses the national Medicare loss ratio and scales the individual hospital's Medicare utilization rate to it. This seemingly technical controversy, ranging over the past seven years, manifests the tension between the hospital industry and the federal Medicare agency and also reflects hospitals' fears about absorbing the fast-rising costs of insurance.

The U.S. General Accounting Office (GAO) has embarked on a year-long study of the medical malpractice issue at the request of Senator John Heinz and Representative John Porter. Their first report was issued in February 1986, entitled "Medical Malpractice: No Agreement on the Problems or Solutions." It presents the opinions and perceptions of nationally based organizations representing medical, legal, insurance and consumer interests concerning (a) the medical malpractice situation, (2) the effectiveness of various mid-1970s state tort reforms, (3) the impact of the threat of suits on the health care system, (4) alternatives for resolving claims, and (5) an appropriate federal role, if any, in the medical malpractice area. In addition it includes a comprehensive review and discussion of studies assessing the impact of tort reforms as well as literature describing alternative approaches for resolving disputes. Future GAO reports will provide information on the costs of medical malpractice insurance, the current malpractice situation in six selected states (CA, NY, FL, NC, IN, AR), and the characteristics of malpractice claims closed in 1984.

On April 25 it was announced that the GAO is also studying the issue of whether to increase the federal role in regulating the insurance industry, which would require repeal of the McCarren-Ferguson Act of 1945. That historic legislation exempts the business of insurance from antitrust regulation and permits states to regulate insurance. GAO teams are currently visiting three states (Delaware, North Carolina and Ohio) to gather information and perspectives.

V. ORGANIZATIONAL CONFRONTATION IN THE PRIVATE SECTOR

Private organizations at the national level which have recently addressed the medical malpractice issue are the ones which have the greatest stake in any changes that may be made which affect medicine, law or insurance.

The American Bar Association in December 1984 released a 1000-page report entitled, "Towards a Jurisprudence of Injury: The Continuing Creation of a System of Substantive Justice in American Tort Law." Resulting from a five year study, the report concludes that the tort liability system is generally effective in its present form, although state and federal courts should "experiment vigorously" with procedures for more effective alternative dispute resolution, litigation efficiency should be improved, frivolous suits should be penalized, and special

procedures should be devised to deal with catastrophic occurrences. It allows that while the tort system is not a perfect way of dealing with medical malpractice cases, there is "no evidence that alternative general approaches would be superior," either as a matter of economics or justice.

The American Medical Association responded with a series of three reports in 1985, entitled "Professional Liability in the '80s," which described the problem, including compilations of supporting data and opinions, and put forward a series of proposed modifications affecting primarily tort reform, and also changes in medical disciplinary mechanisms.

The American Bar Association countered with the adoption in February 1986 of a report from the Special Committee on Medical Professional Liability which carried these 12 recommendations:

(1) Medical malpractice regulation is a state matter, not federal.
(2) Frivolous suits and defenses should be penalized.
(3) Medical licensure and hospital risk management should be strengthened.
(4) Medical malpractice actions should not be exempted from punitive damage awards.
(5) Disclosure of the financial worth of the defendant should generally not be required.
(6) Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary.
(7) No special rule is justified for allowing malicious prosecution.
(8) Trial courts should scrutinize qualifications of expert witnesses.
(9) Collateral source rule should be retained; third parties should be permitted to seek reimbursement from the recovery.
(10) Contingent fees should have no special restrictions.
(11) Structured settlements are encouraged.
(12) Data should be collected on the cost and causes of professional liability claims and studies should be undertaken; loss prevention programs should be developed.

The National Insurance Consumers Organization, headed by former federal insurance administrator Robert Hunter, has maintained repeatedly over the last several months that the insurance industry has not been examined closely enough to verify whether rates and conditions of coverage are fair to the public; it has urged state insurance commissioners to be more aggressive in regulating the industry.

The American Trial Lawyers Association and state chapters have been active in defending the current civil justice system both publicly and at legislative hearings across the country, countering the lobbying efforts of the AMA and state medical societies. The trial lawyers have blamed the problem on the

insurance industry, attacking in particular the poor investment decisions made by the companies in the early 1980s and new signs of profitability.

Supplying some credence to the lawyers' charges was a report published in "Review and Preview," January 1986 by A. M. Best Co., an independent insurance analyst in New York, which states, "Despite higher underwriting loss, the insurance industry seems to be well into its first phase of recovery." It reported a $71 billion year-end surplus in 1985, a $7 billion gain over 1984 for liability and casualty insurers.

VI. RECENT STATE LEGISLATIVE RESPONSES

Several state legislatures have recently received attention for enacting medical malpractice "packages." Notably the $350,000 cap on non-economic damages in Missouri (in February) and in Maryland (in April) received national headlines. During the past year New York and Florida have been actively and openly wrestling with numerous legislative enactments, then faced court rulings on those legislative actions and now are entertaining new proposals. The New York assembly reconvened in December and the Florida legislature is meeting again in April.

Several states have study commissions still working on developing recommendations for legislative sessions which will convene later this year. Maryland's study commission issued its report was largely adopted in the April enactments, while Virginia's legislature adjourned in February after taking only minor action on recommendations that had been discussed in a year-long study commission report. In North Carolina a study commission is currently preparing recommendations for some changes in medical malpractice liability, insurance reporting, medical discipline and risk management, and protecting the state's immunization program. A separate study commission will likely make more extensive recommendations for tort reforms in general, to address the general property and casualty liability insurance problem.

VII. INSURANCE INDUSTRY RESPONSE

The principal actors in the insurance industry are St. Paul Insurance Company (the largest commercial carrier) and the 33 physician-owned mutual insurance companies. St. Paul has increased the pressure on state legislatures to take some sort of action; in January the company declared a nationwide moratorium. Company officials stated it was not taking any new medical malpractice business, although promising to service existing policyholders and to cover new members of medical groups already holding policies. Their announced rationale was to take time to analyze the market. The result has been increased focus on the physician mutual companies to absorb the new applications. A somewhat surprising additional result has been the entry into the market in some states of a few new companies. Medical Protective Insurance Co. of Ft. Wayne, Indiana, has decided to expand its

market into some other states, including North Carolina, on a selective basis. At this time no existing companies have left the market entirely and none have gone bankrupt, although there are some reports that several of the physician mutual companies are under-reserved and unstable.

VIII. PROPOSALS PUT FORWARD IN STATE LEGISLATURES

The following listing of proposals in state legislature are grouped by tort reforms (alternatively termed "civil justice reforms," or "changes in civil liability laws"), insurance regulation, medical practice regulation, and alternative dispute resolution. This is a comprehensive listing, but not necessarily complete since new proposals are continuously being made.

A. Changes in civil liability laws

In most of these areas there had been proposals developed and legislation enacted during the earlier "malpractice crisis" in 1975-77. Currently, many of the same or similar proposals are being considered and those earlier enactments are being reviewed. Thus, proposals are being made for both new laws and modifications of existing laws. An important additional consideration is that some of these proposals are being made to apply only to medical malpractice litigation while others are changes to all civil liability litigation.

1. Attorneys' fees

Numerous proposals have been designed to modify the current practice of plaintiffs' attorneys using the contingent fee system. Under this type of arrangement (in use all across the US but only in a few other countries, or parts of countries) the attorney accepts a case on the basis of his or her fee being paid from the proceeds of an award or settlement. If there is none, then no fee is paid or expected. If the case is won or settled, the attorney is paid an agreed percentage of that amount. That percentage varies from 25% to perhaps 50%, depending on area, type of case, and the attorney-client relationship.

General practice is difficult to document, since the arrangement is considered in most states a private contractual matter between the lawyer and the client. It is often stated that the percentage in medical malpractice cases is usually 40% for jury verdicts and 33-1/3% for pre-verdict settlements.

Practice varies too on how much of the expenses of case preparation are paid by the client. Generally clients are expected to pay out-of-pocket costs of medical record copying and professional review (this upfront cost may range from $500 to $3000 or more). The costs of other consultants, deposing witnesses and expert witnesses, copying other documents, performing tests, and other investigatory and pretrial expenses are usually borne by the client at the time of the service, unless

billing for them is deferred by the persons performing the services. Attorneys are not ethically allowed to advance clients any funds for expenses. Payment on either an hourly basis or a contingent basis is considered ethical in all 50 jurisdictions.

No serious proposals have been made to eliminate the contingent fee system for medical malpractice cases, only to restrict it. Two arguments are commonly put forth for continuing it: social and political. The social argument is that the present system provides a measure of access by citizens to legal services and to the courts and promotes vigorous representation of deserving clients. The political argument is that the system has served justice well for many years and change may bring forth unknown inequities; additionally, it is recognized that plaintiffs' lawyers are well organized and politically difficult to counter. Nevertheless, the arguments against the contingent fee system cite the very high fees that some attorneys fortuitously receive in high verdict cases which are based more on sympathy for the client's misfortune than a measure of the amount or value of work effort by the attorney. Also, it has been suggested that potential clients with deserving cases but injuries which are minor (perhaps under $10,000-20,000) are turned away by plaintiff's attorneys, since the contingent fee might be minor as well, compared to the possible difficulty of preparing even a small suit.

Proposals fall into two categories: (a) establishing a variable schedule for maximum fees that can be paid on a contingent basis, using a sliding scale of percentages compared to the size of the award or settlement, and (b) limiting the maximum percentage. At least 23 states received proposed legislation limiting attorneys fees during 1985-86.

Here are examples of types of enacted legislation:

(a) California' sliding scale
(Cal.Bus.& Code sec.6146)

Up to	$50,000	40%
"	$100,000	33-1/3%
"	$200,000	25%
Over	$200,000	10%

(b) Indiana - 15% above $100,000
(Ind.Code Ann. sec.16-9.5-5-1 par.2-611.1)

(c) Hawaii - "reasonable amount as approved by a court of competent jurisdiction"
(Hawaii Rev.Stat. sec. 671-2)

Proposals affecting attorneys' fees seem to be among the most controversial. There has been, however, more interest in pressing for contingent fee schedules in the wake of the U.S. Supreme Court decision in Roa v. Lodi Medical Group, __U.S.__ (1985), which let stand the Calilfornia Supreme Court approval of a statutory sliding fee schedule. The state court decision found

the statute was not unconstitutional as a denial of due process, violation of equal protection or violation of separation of powers doctrine and was reported in 211 Cal.Rptr. 77 (1985).

2. Awards

Enacting legislation which limits the amount of the award that a court may permit in verdicts and settlements has been a common proposal. There are many variations on the concept. The two basic categories are (a) limits on economic and non-economic awards, (b) limits on non-economic awards, and (c) limits or modifications on punitive damage awards.

Non-economic damages include those for pain and suffering, loss of consortium, disfigurement, mental anguish, inconvenience, lessened quality of life and other factors which are not deemed compensation for out-of-pocket losses by the plaintiff.

Several states have enacted statutory limitations, or caps, on total recovery. Some like Indiana have a cap which is coupled with state-administered compensation fund. In Indiana the physician must have commercial insurance for the first $100,000 and the state fund pays the next $400,000, with a total cap of $500,000. It has been observed that such an arrangement is more constitutionally defensible than a total cap without a compensation fund. Virginia last year raised its total cap from $750,000 to $1,000,000, but has no compensation fund. Proposals range from $500,000 in South Dakota to $3,300,000 in Wisconsin. Variations include $3,000,000 each case, $6,000,000 annually for each provider (Kansas); $1,000,000 individual, $5,000,000 group (Nebraska); $500,000 limit exclusive of future medical care costs (Louisiana); limit exclusive of punitive damages (Florida); judicial review of damages which are either inadequate or excessive and judicial authority to order additur or remittitur (Georgia, Florida).

During the past few months Missouri and Maryland enacted limitations of $350,000 on non-economic awards. The proposal of the Governor's study commission in New York recommended a $250,000 cap on non-economic damages, but it has been reported that while Governor Cuomo favors the remainder of the commission's recommendations, he is not supporting the cap. Pending in numerous other states are recommendations for limitations, ranging from $250,000 (the figure suggested by the AMA through the state medical societies) to $500,000.

The array of proposal affecting the award of punitive damages is even wider. Some states have proposals before them to eliminate punitive damages in medical malpractice cases (New Hampshire, Illinois), others to limit it to 25% of the annual gross income of the guilty party (Kansas), others to direct any amount over $100,000 to be paid to the state treasury (North Carolina), some to limit them to 3 times actual damages (Mississippi) or 2 times (Pennsylvania). In North Carolina, unlike most states, punitive damages are insurable.

Like the contingent fee schedule, a cap on awards has stirred considerable controversy but increased interest has been recently stimulated by judicial approval of the California statute. The California Supreme Court in Fein v. Permanente Medical Group, 211 Cal.Rptr. 368 (1985), upheld the constitutionality of the California statute which imposed a $250,000 limit on non-economic damages in medical malpractice cases. The U.S. Supreme Court on October 15, 1985, dismissed an appeal for want of a federal question, as reported in 106 S.Ct. 214 (1985). Indiana had previously upheld the constitutionality of medical malpractice damage awards in Johnson v. St.Vincent Hospital, Inc., 404 N.E.2d 585 (1980). Nebraska also upheld a limitation. Four other states have invalidated state statutory damage limitations on federal constitutional grounds:

New Hampshire - Carston v. Maurera, 424 A.2d 825, 120 N.H. 925 (1980) ($250,000 limit on non-economic damages)
North Dakota - Arneson v. Olsen, 270 N.W.2d 125 (N.D. 1978) ($300,000 limit on total damages)
Ohio - Simon v. St. Elizabeth Medical Center, 355 N.E.2d 903, 3 Ohio Ops 3d 164 (Com.Pl. 1976) ($200,000 limit on "general" damages); see also, Duren v. Suburban Community Hospital, 482 N.E.2d 1358 (1985).
Texas - Baptist Hospital of Southeast Texas v. Barber, 672 S.W.2d 296 (Tex.App. 1984) ($500,000 limit on damages other than medical expenses); but, see also Hoffman v. U.S. (No. 84-5572, Aug. 9, 1985, 54 U.S.L.W. 2116) (Ninth Circuit upheld $250,000 limit on non-economic damages)

In addition, two other states have reviewed damage caps on state constitutional grounds:

Illinois - Wright v. Central DuPage Hospital Association, 347 N.E.2d 763, 63 Ill.2d 313 (1976) (stuck down limit on award for both economic and non-economic damages)
Idaho - Jones v. State Board of Medicine, 555 P.2d 399,97 Idaho 859 (1976), cert.denied 431 U.S. 914 (remanded for factual determination on whether medical malpractice crisis actually existed to justify measure)

3. Burden of proof

There have been various proposals to change the burden of proof from a "preponderance of the evidence" to "clear and convincing evidence" (New York, Wisconsin, Pennsylvania, South Dakota). Some proposals suggest elimination of the res ipsa loquitor doctrine, or severely limiting it to certain surgical procedures (e.g., sponges left in abdominal cavity).

4. Collateral Source Rule

The collateral source rule is a traditional rule of

evidence which makes inadmissable any evidence of collateral sources of payment. It in effect prevents a set off against the plaintiff's award of other amounts from health and diability insurance which the plaintiff may be entitled to receive for his or her injuries. While the intent is to not permit the defendant to escape the full consequences of the negligent act, the effect is sometimes to produce a windfall for the plaintiff through multiple payments.

Proposed reforms take the form of eliminating the collateral source rule by declaring that evidence of payment from collateral sources is admissable and that either (a) the jury should consider such evidence in its determination of damages, or (b) the collateral source payments directly reduce the amount the damages. Variations include allowing plaintiff full or partial credit for any insurance premiums paid to obtain the benefits, exempting governmental payments and preserving the subrogation rights for payors of collateral benefits.

5. Expert witnesses

Proposals in this area are designed to address the concern about expert medical witnesses who devote a considerable portion of their practice to making appearances in medical malpractice litigation. These persons are considered by many to be "hired guns," or professional witnesses who may not be promoting the best interests of the medical profession. Trial lawyers claim that they resort to this type of witness, usually from out of state and charging high witness fees, because of the unavailability or unwillingness of local physicians to serve as expert witnesses. The most common proposal, backed by state medical societies (e.g., in North Carolina), is to limit expert witnesses to the field of specialty of the defendant physician, but not limit the expert geographically. A variation imposes a further limitation that the witness shall not devote more than 20% or 25% of his or her time to serving as an expert witness; in Kansas, 50% of time must be in clinical practice.

6. Frivolous suits

A central element of the debate between the medical and legal communities is the prevalance and significance of suits brought without sufficient grounds. Trial attorneys maintain that there are very few frivolous suits, while some physicians believe that every case in which a plaintiff is unsuccessful constitutes a manifest groundless suit which should be penalized. In fact, both sides agree in principle that frivolous suits should be discouraged, regardless of any agreement on their definition or prevalance. Therefore, several proposals have been made to address this matter. While some states already have given courts the authority to award costs and attorney fees to the prevailing party if the other party brings a groundless suit (e.g., NC Gen. Stats. 6-21.5 [1984] provides for awarding attorney's fees if "the court finds that there was a complete absence of a justiciable issue of either law or fact raised by

the losing party in any pleading.") Proposals include court costs and attorney's fees to be awarded in any frivolous action (NY, IN, MI, WY), requirement for attorney to present certification from a similar health care professional that the suit is meritorious (FL, MD), posting of bond by plaintiff (FL). Already enacted in Florida are provisions for mandatory pretrial court hearings, 90 day notice of plaintiff's intent to file a claim, and possible penalties for refusing an offer or demand for judgment, in the Comprehensive Medical Malpractice Act of 1985. These are designed to restrict unfounded tactics by attorneys on both sides.

7. Funds

At least four states operate special compensation funds for medical malpractice claims: Hawaii, Indiana (claims over $100,000 up to $500,000), Kansas (claims over $200,000) and Louisiana. At least one other state (NC) has authorized but not funded such a fund. Proposals for various types of funds have been made in NY, MI, WI.

8. Joint and Several Rule

In most states a plaintiff who has successfully sued two or more defendants may require any of them to pay the full amount of the award. The paying defendant may have a right of contribution from the co-defendants but they may be insolvent or uninsured. In some cases a defendant who is only slightly involved in the case may end up with the whole liability. This is sometimes called the "deep pocket" phenonemon and often is a disadvantage for hospitals. Even in jurisdictions where the contributory negligence rule has been replaced with the more equitable comparative negligence rule, the joint and several rule is often still in effect. (As of 1985, six states and the District of Columbia still retained the doctrine of contributory negligence: AL, DE, KY, MD, NC, VA.)

Six states have abolished the joint and several rule by statute (KA, LA, NH, OH, PA, VT) and some states (e.g., Oklahoma) have created a modified several rule. At least 12 states are considering proposals for elimination or modification of the rule.

9. Limits on liability; immunity provisions

While most states in the 1960s enacted various types of good samaritan legislation for emergency medical care and in the 1970s many adopted special immunity provisions for blood transfusions, there are now several proposals for extending those statutes or providing immunity or statutory defenses in other situations: AR (drawing blood to determine alcohol or substance abuse), ND (free care for amateur athletes), VA (drug administration in patient's home), NY (good faith failure to order supplemental tests), FL (administering prenatal care in health departments).

10. Statute of limitations

Most states modified their statutes of limitations in various ways during the 1975-77 reform period. Now there are proposals to shorten the periods from 3 to 2 years in several states (e.g., AZ, IN, NY [2-1/2]) and reduce the maximum period for minors.

11. Structured awards and periodic payments

Traditionally judgment and settlement awards have been distributed in lump sum amounts, even when a large part of the award is intended to compensate the plaintiff for uncertain costs of medical expenses or lost wages anticipated to be incurred in the future. Some state statutes now allow a court to structure awards attributable to future losses by instructing that arrangements be made for payment at regular intervals of costs actually incurred or a set amount as agreed. Upon the death of the plaintiff, payments or a portion thereof will cease, thus precluding a windfall to heirs and an unnecessary expense for the payors.

Some versions of periodic payments have been found unconstitutional (NH and an early version in FL). California upheld its statute which requires the trial court in cases of $50,000 or more in future damages to enter judgment for periodic payment at the request of either party. American Bank and Trust Co. v. Community Hospital of Los Gatos, 683 P.2d 670 (1984).

Structured awards anticipate the purchase of an annuity, bank trust or other secured form of payment mechanism. Such a purchase costs less than payment of a lump sum because of investment and actuarial factors.

At least 17 states currently provide for structured awards. A frequent proposal by state medical societies would require periodic payments for future damages in excess of $100,000. Proposals include provisions for paying attorney fees in a lump sum, continuation of payments for lost wages past the time of death, and various threshold amounts ranging from $50,000 (WA) to $500,000 (FL).

12. Itemized verdicts

Sometimes specifically required in proposals for structured awards, itemized verdicts are expected to force the jury to produce a designated dollar amount for specified categories of damages: general and special, or in more detail, each type of economic damage (medical expenses, lost earnings, other out of pocket expenses), each type of non-economic damage (pain and suffering, lessened quality of life, inconvenience, mental anguish, disfigurement, etc.), and punitive damages.

IX. CHANGES IN LAWS GOVERNING MEDICAL PRACTICE

A variety of changes in state laws governing licensure, review and discipline of physicians and other health care professionals and new licensure requirements for hospitals have been proposed, including these:

1. Adding lay members to licensure boards (KA)
2. Require insurers and providers to report to the licensure boards any suspected acts of physician incompetence, with fines levied for non-compliance ($5,000 to $10,000 in KA)
3. Requiring hospitals to implement approved risk management programs (FL; in KA, must institute peer review within 30 days of suspected physician negligence)
4. Increase license renewal fees to improve capacity of licensure board (NC, NY)
5. Guidelines, criteria, and protocols for credentialing of physicians by hospitals (NY, MD, FL)
6. Licensure criteria: revocation or suspension in another state considered grounds for revocation or suspension (NY), cooperation with peer review is condition of licensure (FL), proof of financial responsibility to pay claims (FL), failure to pass examination 3 times will require 1 year of postgraduate training before sitting, uniform penalties for practicing without a license (CT)
7. Misconduct: commissioner of health authorized to conduct demonstration programs on monitoring and probation (NY), misconduct hearing panels with 2 MDs and 1 layman (NY), board review allegations of negligence in treatment (WI), copies of hospital credentialing committees be sent to state board (WA), "repeated negligence" is defined as misconduct (FL), state notify all health facilities about license disciplinary actions (CT)
8. Required continuing medical education (60 hours in 3 years, plus 5 hours risk management education, FL)
9. Board meet minimum of 12 times per year (WI)
10. Risk management requirements: variations include exceptions for some facilities, guidelines established by state, reports required to be sent to state for studies
11. Expanded immunity from civil and criminal liability for members of medical peer review committees.

X. NEW REQUIREMENTS FOR INSURANCE REGULATION

Insurance regulations vary widely among the states and many minor, technical proposals for modifications have been made. Some of them are described here.

1. Premiums: delays in effective date of increases, advance notice to policyholders and insurance commissioner about increases, insurance commissioner set rates for mandatory excess coverage
2. Claims made policies: transferability when insurer is

liquidated, required tail coverage by claims made insurer
3. JUA: new authorization (MT, ID, NY)
4. Non-renewal or cancellation notices: extended to 60 days (FL), 90 days (NC, ND); notify professional licensure boards (FL)
5. Insurance exchange: study feassibility (MD)
6. Experience rating: for physicians (FL), to set surcharges on premiums (KA), merit rating (NY)
7. Proof of insurance required for licensure (KA)
8. Insurance company reporting: claims and actions (AZ, WA, WI), financial information (premiums, income, losses) (WA, VA, OH, WI), more frequent reporting (FL), reports open to public (CA)
9. Insurers required to cover arbitration awards (NY)
10. Insurer can offer settlement without approval of insured (FL)

XI. OTHER MISCELLANEOUS PROPOSALS

1. Arbitration: prescribes or modifies panel composition (full-time salaried chairman with other two chosen by parties, NY), mandatory arbitration for claims under $15,000 (ME), under $50,000 (NJ), guidelines (FL), modification of procedures, such as mutual waiver, depositions of MDs admissible, hospital records admissible, minimum of 2 experts in a designated specialty per party, procedures for selection of alternate arbitrators (MD)

2. Pre-trial activities: mandatory pre-calendar conference (NY), mandatory settlement conference 3-weeks before trial (FL), cooling off period (60 days, PA: 90 days, CA, FL), mandatory filing within 60 days after issues are joined (NY), claimant must notify provider of pending action by registered or certified mail (FL)

3. Validation of private contractual arrangements for arbitraton. No special validation has yet been proposed in legislative forums for private contracts which would place limits on damages, lower the standard of care, change the statute of limitations or other tort rules, etc., as has been proposed by Professor Havighurst of Duke and Professor Danzon of Wharton.

While this does not exhaust the variety or nuances of proposals which have been made (or which will inevitably be proferred), it is a realistic listing of ideas which have been or will become the agenda for the political, as well as the academic, discussions of the next several months in the various States of America.

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THE NORTH CAROLINA ACADEMY OF TRIAL LAWYERS

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TESTIMONY TO THE MEDICAL MALPRACTICE STUDY COMMISSION
February 13, 1986

My name is Walt Baker. I am President of the North Carolina Academy of Trial Lawyers and practice law in High Point. I appreciate the opportunity to describe the medical malpractice issue from the perspective of representing the rights of victims.

First, we all need to understand the standard of medical care required in North Carolina. Negligence is a lack of "ordinary" care--care that a reasonable, prudent doctor would use under similar circumstances. There can be no recovery in North Carolina unless this standard has been breached. In the medical field, a health care provider is given additional protection before a negligence standard can be imposed. Before a health care provider can be found negligent, the plaintiff, or injured party, must show that (1) he, she, or it failed to exercise his or her or its best judgment; (2) failed to use reasonable care and diligence; or (3) to act in accordance with the standards of practice used by other health care providers with similar training and experience from the same, or similar, communities. The care is judged by the standards at the time the health care service was rendered. These points must be proven by the greater weight of the evidence to both a jury and the judge presiding. If this process establishes negligence then, it must be established that the negligence caused the injury.

Medical malpractice suits are perhaps the most difficult kinds of cases to prepare, to try, and to win. No lawyer would undertake lightly the bringing of a medical malpractice case.

This difficulty is caused by two related factors. First, as a general rule, a medical malpractice case will not reach a jury without competent expert testimony that there was negligence--a violation of the standards of practice--and that the negligence caused the plaintiff's injuries. This testimony is very difficult to obtain, for plaintiffs and their attorneys must rely upon the same health care professions whose members feel attacked by filing a lawsuit. Second, to prevail, plaintiffs and their attorneys must not only show that the negligence of the defendants caused some injury to the plaintiff, but they must also overcome that natural and necessary desire we all have, including jurors, to trust our doctors, nurses and hospitals and our resulting reluctance to find that these authority figures have made a mistake.

The Academy feels that we must protect conscientious physicians willing to report negligent and incompetent behavior from slander. The Academy has repeatedly offered to meet with physicians' groups to tackle these issues together. We again make that offer to the medical associations.

The Academy is also concerned about frivolous suits.

The Academy supports legislation to deter frivolous suits and encourage discipline of attorneys who file no-meritous cases. With the same desire for justice, we also propose legislation to address the problem of frivolous defenses.

The Academy would like to work with this commission to draft legislation to provide civil immunity to health care providers who report alleged cases of negligence or improper conduct by other health care providers.

The issue of medical negligence must be addressed. Although we do not have the North Carolina data, it is clear in other states that a small percentage of bad doctors creates a large percentage of malpractice. Yet these doctors are not removed and for the most part are not disciplined. Equally important, they do not pay a higher rate. It would be as if someone was responsible for a half dozen car collisions and was allowed to pay the same rate as a safe driver who had never had a ticket or wreck.

A small number of doctors accounts for most of the medical negligence claims. Physicians who had been subject to disciplinary review were 10 times more likely to have negligence claims filed against them. (Quality Care v. Medical Malpractice, Washington State Medical Association/Aetna Partnership Program for Risk Management).

A four-year California study demonstrated that 0.6% of 8,000 Los Angelos physicians accounted for 10% of all claims and 30% of all payments. (Ferber, S., Sheridan, B., "Six Cherished Malpractice Myths Put to Rest 52 Medical Economics 150, 1975).

This has not changed. A study in Pennsylvania revealed that 1% of the doctors were responsible for more than 24% of the payments in 1976. Florida's closed claim study of 1975-1982 revealed that 0.7% of the doctors in Florida were responsible for 24% of the claims in which indemnity payments were made. One

physician, Dr. Gross, was responsible for 31 claims paid. Dr. Gross is still practicing medicine in Florida. (Florida Insurance Commissioner Gunter, Closed Claims Study of Medical Malpractice Insurance, 1975-82). In automobile insurance, we have provisions for "high risk" drivers. Health care providers who continually find themselves subjected to justified claims should have to pay more than those many health care providers who will go through their entire career with no claim ever being made.

The cause of negligence litigation is medical negligence. Only one in every 15 severe injuries resulting from medical negligence lead to negligence claims. (Pocincki, L.S. et al, "The Incidence of Iatrogenic Injuries," Appendix, Report of the Secretary's Commission on Medical Malpractice, Washington, D.C., 1973).

"By finding fault and assessing damages against that negligent provider, the system sends all providers a signal that discourages future carelessness and reduces future damages." (Schwartz, William B., M.D., and Komesar, Neil K., J.D., Ph.D., "Doctors, Damages and Deterrence," New England Journal of Medicine, June 8, 1978).

The Academy suggests that one of the most effective means of reducing claims and insurance losses is to reduce negligence. If manufacturers are more careful in their design of products, then product liability lawsuits will be reduced. If professionals regulate themselves and commit fewer incidences of malpractice, the malpractice lawsuits will be reduced. Several states are improving professional discipline policies and the Academy is most

willing to work with the medical associations and this commission to decrease the necessity of litigation.

Insurance companies should also provide incentives to risk management practices that improve care. Good practices should be rewarded.

The Academy of Trial Lawyers as well as everyone in this room recognizes that insurance premiums are being raised at staggering rates. Attorneys as well as doctors pay liability insurance. However, we think the substantial cause and solution lie not with the legal system. The facts indicate the cause is the internal management and a function of the free market cycles of the insurance industry. Even casual reading of insurance industry journals indicate that even though the profits have been less in the last couple of years, the insurance industry is on a rebound. It is possible that the intense pressure by the insurance industry in the form of high premiums and lack of availability is occurring at this time for a reason. It will likely become clearly evident to the public by 1988 or as early as 1987 that insurance is profitable for the companies and investors. The Academy is not suggesting inaction but the direction of the legislation should be to stabilize the insurance industry not limit victims' rights.

Although it is difficult to obtain information from the insurance industry, pieces of information support the Academy's contention that better reporting by the insurance industry will reveal adequate profits and funds to pay claims.

To hear industry spokesmen tell it, the wolf is at the door. During 1984, according to the industry-maintained Insurance

Information Institute, the nation's property and casualty insurance companies reported a pre-tax deficit. That sounds pretty grim. And it would be...if it were true. But it's not.

According to Best Company's Aggregates & Averages for 1,733 property/casualty companies in 1984: When actual losses and underwriting expenses are subtracted from premiums written, and investment income, and tax credits, the bottom line is a profit of $8.6 billion.

That's the balance sheet for what industry analysts are calling the worst year in insurance since 1906, the year of the San Francisco earthquake.

For the decade ending in 1983, the General Accounting Office of the United States Congress found that property and casualty insurance companies enjoyed net gains totaling $72 billion--while receiving $63 million in federal tax credits. The GAO is begging Congress to change the tax policy relating to insurance companies.

*By the end of 1984 total assets for the leading property/casualty insurers had grown to $228.3 billion.

*According to Best's Review (Dec. 1985) property/casualty insurance stocks had soared to record highs, 49.8% according to Best's Stock Index and 44% on Dow Jones Index.

Recent business articles view insurance as a good investment.

*On January 13, 1986, Business Insurance said the insurance index rose 1.4% during the latest period and outperformed the three major market indicators.

*On Janury 14, 1986, USA Today said that insurance industries profits are expected to shine, property/casualty insurers profits are up 881% from a year earlier. The industry has recuperated from losses in 1984.

*On January 20, 1986 in Business Insurance the President of the Insurance Service Office said the property/casualty insurance industry "under reasonable assumptions" can expect to generate operating income of $5 billion this year, $8 billion in 1987, and $11 billion in 1988.

*On January 21, 1986, the Wall Street Journal said that in spite of heavy hurricane damage, "the industry expects to post a net income of $1.7 billion.

These articles were easily found within a one week period.

The premium increases are completely out of proportion to the actual claims paid out on their policies. For example, many day care centers in North Carolina are finding it hard to obtain liability insurance coverage and yet there has not been a single jury verdict in North Carolina against a day care center for professional negligence.

It is a small wonder that the increases have produced something like a "nationwide panic". Insurance companies pay out less money in North Carolina than in other states, according to the Insurance Service Office, a national industry information organization. In North Carolina from 1980 to 1983 for $1.00 earned premiums, insurance companies paid out in losses the following average:

$0.50 for day nurseries

$0.53 for dram shop

$0.36 for municipalities

$0.53 for public schools

$0.74 for streets and roads

$0.20 for governmental subdivisions

In addition, the insurance industry earns money from the interest on insurance premiums. These figures refute the insurance companies claim that there are high risk groups. These figures instead indicate profits not justification to cancel these lines of insurance. However, rather than to address their own problems the insurance industry had chosen to attack the legal system.

In fact the litigation rate in North Carolina had declined in the last four years. According to records released by Franklin Freeman Director of the North Carolina Administrative Office of Courts, suits filed per thousand population has decreased from 2.5 to 2.2 in recent years. The facts refute the insurance industry's claims that litigation is increasing. The insurance industry is using this myth in an assault on the rights of North Carolina citizens.

The percentage of cases involving liability insurance is very small. During the 1984-85 reporting period, two-thirds of total cases filed were criminal cases. The lowest percentage of cases, less than one percent (0.73%) were negligence cases. These figures counter the claim by insurance companies that litigation rates are the reason for exorbitant insurance premium rates being charged to North Carolina businesses and customers.

The same is true of medical malpractice claims. The number of claims filed per 100 has remained the same for the last three years. According to St. Paul Fire and Marine Insurance Company, the largest medical malpractice insurer in North Carolina, claims filed have remained nine per 100 doctors since 1982. Fewer than half of these claims result in lawsuits. These admissions demonstrate that the insurance companies have needlessly scared doctors into believing that they are likely to be sued. This scare tactic is part of their campaign to shift the focus away from the insurance industry's practices and profits.

In 1984, Medical Mutual of North Carolina paid 76 claims or 1.9 per 100 doctors. There were 128 suits filed, or 3.3 per 100 doctors. Many experts view this crisis (like the so-called crisis of the early 70's) as a combination of bad management and incorrect prediction of market results.

In October, 1985, in testimony to the N.C. Product and Liability Insurance Study Committee, Glenn J. Douden of Nationwide Insurance admitted, that under the cash flow underwriting approach, "insurance company underwriters began to increase the cash flow without regard to intelligent pricing and sound underwriting principles. Companies simply wanted more cash flow from new accounts so they could increase the funds available for investment purposes. As a result this led to extreme levels of price competition in the early 1980's."

This happens in a free market. Just like people, corporations are allowed to have bad years and when that occurs there is usually a decline in profits, salaries, expenses, and

dividends. However, the insurance industry wants "utility-like protection" guaranteeing a large profit, but for which it does not make the same disclosure as the utilities about profits, salaries, bonuses, expenses, reserve formulas, and the like.

There is one proposal of the insurance industry that should be put in perspective. Some of the proposals that we have seen call for a cap on the limit that can be awarded for "pain and suffering" of an injured party in civil litigation. The limits that have been proposed range from $100,000 to $500,000 on most proposals we have viewed. This payment would represent a once-only, lifetime payment. The irony of this proposal is that a number of insurance executives behind this proposal earn annual incomes in excess of $400,000 per year. They receive a salary four times per year greater than they propose an injured party receive for his/her injuries for a lifetime.

The Academy maintains that better insurance reporting is necessary before the General Assembly can make an informed decision about major changes in the justice system.

-There should be complete financial disclosure by insurance companies.

-Experience rating should be required for the establishment of premium rates. Thus, our day care centers and physicians should not be subject to skyrocketing premiums when no liability had been established in this State.

-Funding to the North Carolina Department of Insurance should be increased to hire actuaries, accountants, and lawyers necessary to improve the state regulation of the insurance industry.

-Rate incentives should be established for risk management programs.

-Companies should be allowed to deduct as business expenses reasonable reserves for self-insurance.

TESTIMONY

of

NORTH CAROLINA NURSES ASSOCIATION

PRESENTED TO THE

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

March 13, 1986

Presented by Davy Crockett, R.N., M.P.A.
Vice-President
NCNA

THANK YOU, MR. CHAIRMAN, FOR THE OPPORTUNITY TO BRING TO THIS STUDY COMMISSION THE CONCERNS OF NURSES ABOUT THE IMPACT OF THE MALPRACTICE LIABILITY INSURANCE ISSUE ON NURSING PRACTICE AND THE HEALTH CARE SYSTEM.

I AM DAVY CROCKETT, VICE-PRESIDENT OF THE NORTH CAROLINA NURSES ASSOCIATION, THE VOLUNTEER MEMBERSHIP ORGANIZATION FOR REGISTERED NURSES IN THIS STATE. I AM CLINICAL DIRECTOR OF SURGICAL SERVICES AT MOSES CONE HOSPITAL IN GREENSBORO.

INDIVIDUAL MALPRACTICE LIABILITY INSURANCE PREMIUMS FOR RNs HAVE DOUBLED IN THE PAST FEW YEARS. WITH THE DRAMATIC ADVANCES IN TECHNOLOGY AND IN HEALTH CARE DELIVERY SETTINGS, NURSES ARE PRACTICING MORE AUTONOMOUSLY AND AT HIGHER LEVELS OF SKILL THAN EVER BEFORE. MOST NURSES CARRY INDIVIDUAL COVERAGE, REGARDLESS OF WHAT KIND OF UMBRELLA INSTITUTIONAL COVERAGE IS PROVIDED.

WHILE DOUBLING OF PREMIUMS OVER THE PAST FEW YEARS IS NOT AS DRAMATIC AS THE INCREASES IN PREMIUMS EXPERIENCED BY SOME OTHER HEALTH CARE PROVIDERS, NURSES' SALARIES ARE MODEST, AND THEIR INDIVIDUAL PREMIUM GENERALLY CANNOT BE ABSORBED BY THE PROFITS OF A BUSINESS OR PASSED ON TO ANYBODY ELSE IN THE FORM OF HIGHER PATIENT FEES.

THERE ARE GROUPS OF NURSE SPECIALISTS WHO ARE ESPECIALLY ADVERSELY AFFECTED BY THE PRESENT "CRISIS." IN THE PAST YEAR, MALPRACTICE LIABILITY INSURANCE FOR CERTIFIED NURSE MIDWIFES HAS VANISHED FROM THE MARKETPLACE. CERTIFIED NURSE MIDWIVES CANNOT BUY INDIVIDUAL MALPRACTICE INSURANCE. IN THIS STATE THEIR INSURANCE PROTECTION IS ONLY AVAILABLE IF THEY ARE <u>EMPLOYED</u> BY A PHYSICIAN ALREADY COVERED.

THUS THE MIDWIVES ARE GEOGRAPHICALLY LIMITED TO THE PHYSICIAN'S PRACTICE AREA. BECAUSE OF THIS LACK OF AVAILABLE MALPRACTICE INSURANCE COVERAGE, FOUR NURSE MIDWIVES HAVE HAD TO CEASE CERTIFIED NURSE MIDWIFERY PRACTICE -- TWO WHO WERE WORKING IN HEALTH DEPARTMENTS SERVING INDIGENT PATIENTS.

NONE OF THE NURSE MIDWIVES IN OUR STATE ARE NOW DOING HOME DELIVERIES. AT ONE OF THE BIRTHING CENTERS, DELIVERIES ARE PERFORMED IN THE CENTER AS WELL AS IN A HOSPITAL. THE LIABILITY INSURANCE PREMIUM HAS RISEN FROM $850 TO $4,000 PER MIDWIFE, AND IT IS NO LONGER AVAILABLE TO THEM AS INDIVIDUALS. IT IS ONLY AVAILABLE THROUGH A BACK-UP PHYSICIAN.

ANOTHER BIRTHING CENTER IN OUR STATE IS A NURSE MIDWIFE - OWNED PRACTICE. THE NURSES CONTRACT WITH A PHYSICIAN FOR BACK-UP. THESE MIDWIVES HAVE PRACTICED WITHOUT ANY MALPRACTICE INSURANCE SINCE THEIR INSURER CHOSE NOT TO RENEW THEIR POLICY IN JUNE 1985. THEIR BUSINESS IS GROWING, ALTHOUGH THEIR CLIENTS ARE INFORMED THAT THERE IS NO MALPRACTICE INSURANCE COVERAGE FOR THE MIDWIVES.

SINCE CERTIFIED NURSE MIDWIVES ARE SMALL IN NUMBER IN OUR STATE, THEY WERE ABLE RECENTLY TO SURVEY THEIR GROUP REGARDING CLAIMS EXPERIENCE. THEY RESPONDED THAT THEY HAD PAID A TOTAL OF $80,000 IN MALPRACTICE INSURANCE PREMIUMS IN THE PAST 10 YEARS BUT THAT TO THEIR KNOWLEDGE ONLY $2,500 HAD BEEN PAID OUT IN CLAIMS INVOLVING MIDWIVES. THAT CLAIM WAS AGAINST A <u>PRACTICE</u>, AND THE MIDWIFE WAS NOT NAMED IN THE SUIT. NATIONALLY, ONLY 6% OF CNMs HAVE EVER BEEN INVOLVED IN A MALPRACTICE CLAIM. IF THERE

IS ANY RISK DATA TO SUPPORT TERMINATION OF MALPRACTICE COVERAGE FOR THESE NURSES, WE ARE NOT AWARE OF IT.

WE HAVE A GRAVE CONCERN THAT WHAT HAS HAPPENED TO CERTIFIED NURSE MIDWIVES COULD SPREAD TO OTHER GROUPS OF NURSES - SUCH AS NURSE PRACTITIONERS. THESE ARE REGISTERED NURSES WITH ADVANCED EDUCATION WHO PROVIDE PRIMARY HEALTH CARE SERVICES - DIAGNOSIS AND MONITORING OF COMMON AILMENTS; HEALTH MAINTENANCE SERVICES INCLUDING ROUTINE PHYSICAL EXAMINATIONS AND WELL-CHILD CARE; COUNSELING, TEACHING AND SUPPORTING INDIVIDUALS IN ALL ASPECTS OF THEIR HEALTH CARE. FURTHER, THE CURRENT COSTLY RATES ARE SUBJECT TO SPREADING TO CERTIFIED REGISTERED NURSE ANESTHETISTS AND OTHER NURSE SPECIALISTS.

THE LACK OF INDIVIDUAL MALPRACTICE INSURANCE COVERAGE RESTRICTS PRACTICE ARRANGEMENTS AVAILABLE TO NURSES -- SUCH AS NURSE-OWNED SERVICES, JOINT PRACTICE, OR PRIVATE PRACTICE. IT INTERFERES WITH HOW NURSES CAN PRACTICE, AND IT LIMITS CONSUMER CHOICE OF THE SERVICE AND THE PROVIDER.

WE FIND THE AVAILABILITY AND PRICE OF MALPRACTICE INSURANCE IN TODAY'S MARKET A DETERRENT TO QUALITY CARE IN THE HEALTH CARE SYSTEM IN OUR STATE, THE PARAMETERS OF PRACTICE OF THE PROVIDER, THEIR ACCESSIBILITY TO INDIGENT POPULATIONS AND THEIR GEOGRAPHIC ACCESSIBILITY. THE BUSINESS ASPECT OF HEALTH CARE PRACTICE IS BEING AFFECTED BY THE ISSUE OF AVAILABILITY OF MALPRACTICE INSURANCE. THE HEALTH CARE SYSTEM IS BETTER SERVED WHEN THE DELIVERY OF CARE IS SHAPED BY THE NEEDS OF THE CLIENT, MATCHED WITH APPROPRIATE CARE GIVERS AND MADE ACCESSIBLE BY CREATIVE DELIVERY SYSTEMS.

THE NORTH CAROLINA NURSES ASSOCIATION'S POSITION IS THAT THERE IS A SERIOUS PROBLEM, THAT REFORM IS NEEDED. WE WOULD LIKE TO PARTICIPATE IN DESIGN OF REMEDIAL MEASURES.

North Carolina Medical Society

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GEORGE E. MOORE
Executive Director

REMARKS BY GEORGE E. MOORE, EXECUTIVE DIRECTOR

TO THE

MEDICAL MALPRACTICE AND MEDICAL LIABILITY

STUDY COMMISSION

MARCH 13, 1986

Good morning. I am George Moore, Executive Director of the North Carolina Medical Society. Thank you for the opportunity to meet with you again.

My purpose today is to speak on behalf of the physicians of the state and recommend some solutions to the medical liability problem. Let me say at the outset that there are no easy solutions. You and I know, and the citizens of the state should know, that this is a terribly complex issue. No single profession or industry group is responsible for its problems. Let us not point an accusing finger. In my judgment, there is already far too much heat and smoke and too little light on the issue. We should avoid the acrimony which has characterized efforts like ours in other states. The real issue, amid all the smoke, is that the system for resolving medical liability claims eventually touches every citizen of the state. When it works well, it is a major social asset; when it works poorly, its failings eventually harm everyone. Given the present environment, we believe that it is a flawed system. The creation of this Commission gives the citizens of the state an opportunity to study the system as an integrated whole and to improve its imperfections. We hope that

the suggestions we share with you will lead to informed and dispassionate debate as you consider the best possible means for dealing with the issue of medical liability in our state. Let me offer some recommendations.

Improved policing and self-discipline of physicians.

It is not accidental that this is first among our suggestions. Before citing specific legislative remedies, let me assure you that the vast majority of members of the North Carolina Medical Society do not want incompetent colleagues protected under a "conspiracy of silence". The marginal practitioner is an unwelcome member of the profession. He is a very small minority of the profession but he gives an undeserved black eye to the overwhelming majority who are highly skilled men and women concerned first and foremost with the well-being of their patients.

When I spoke with you before, I stressed the Medical Society's intention to ferret out those few bad apples. Our current President, Kenneth E. Cosgrove, M.D., has been responsible for a number of initiatives that will help us better identify and affect positively those members who overutilize the available health care resources, who overcharge, who practice substandard medicine, who are impaired, etc.

Let me emphasize, however, that the malpractice case involving the marginal practitioner is the exception. Most malpractice cases involve physicians who are fully qualified. Often it is the best ones who are accused of malpractice. But let it be said clearly: we recognize that malpractice exists. We acknowledge that some patients are injured as a result of physician error. We believe that the patient should be compensated in a fair and timely manner. We

need legislative action that will give physicians and appropriate agencies greater ability to prevent maloccurrences, and we need greater immunity from civil action when they participate in peer review and disciplinary activities. But we are hindered at every turn in this by restrictive and confusing laws that allow self-discipline on the one hand but create severe liability exposure on the other. In recent months, immunity and confidentiality were upheld in one state for physicians participating in a review of their colleagues, but in another state the reviewing physician was convicted of antitrust violations and ordered to pay over $1,000,000 to the plaintiff physician. Peer review is a long, difficult, and uncomfortable process but one we are committed to doing.

We have presented a proposal to a major national foundation for a four-year grant that would give us generous financial support to develop studies and models that just might make North Carolina a leader for other states in achieving understandings and modifications of physician behavior through peer intervention. We have outlined another program that would be a joint effort with a state agency. We have a serious commitment to this goal of more effective self-policing of the medical profession.

We believe that the following five specific legislative actions would be extremely useful:

1. Each company which provides health care insurance in the state shall (a) make information available to state licensing boards about awards for damages against the professionals under their jurisdiction, (b) establish programs for risk management for their insureds, and (c) require each insured as a condition of maintaining insurance to participate in such programs at least once every three years.

2. Each state board shall enter into agreements with state or county professional societies to permit the societies to review information concerning practice patterns of health care professionals. Such agreements shall provide that the review occur expeditiously, that the society report its findings to the state agency, that it take such other action as it considers appropriate, and that the review and reporting preserve confidentiality of medical information and the review process. All such activity shall be immune from state civil or criminal liability, including antitrust. Patient information shall not be subject to discovery or subpoena, and review shall not be a breach of patient records confidentiality.
3. Licensing boards shall have appropriate disciplinary prerogatives, investigatory power, and immunity for the entity and its members.
4. Hospital medical staff peer review and policing shall be encouraged by providing such activity adequate immunities and protections and establishing appropriate communications with the North Carolina Board of Medical Examiners.
5. We believe that punitive damages are intended as compensation for willful and malicious harm. If a physician's conduct is so outrageously malicious and harmful to a patient, the physician ought to be tried in criminal court on a felony charge rather than in a civil court as part of a malpractice proceeding. If convicted, the physician would be subject not only to the penalties prescribed by law but also to appropriate disciplinary action by the Board of Medical Examiners and professional associations, up to and including loss of license to practice medicine.

We cannot talk for long about solutions without talking about the tort system, that complex web of rules, institutions, and insurance mechanisms which has evolved for the purpose of deciding which injuries should be compensated, who should do the compensating, and how much compensation is enough. The legal rules governing this system have their roots in a Common Law tradition that began in Britain in the ninth century and have evolved through case-by-case decisions in British and American courts for more than a thousand years. Over the centuries, the tort system has taken an irregular course because it always has to respond to changing social demands.

It is immensely difficult to determine which modifications to current law hold the greatest promise of equity to all involved. The issues are so complex that any change requires a balance of pluses and minuses. In weighing the many options, the North Carolina Medical Society has rejected all but a handful because their implications are so uncertain that they present more risk than promise. This is a serious business, and we believe that the recommended steps that follow will significantly improve the ability of the tort system to accomplish its purpose. We obviously have our own interests, but we offer these adjustments to keep the tort system as a dynamic and changing force that mirrors the needs of the times.

Recommended Tort Reform #1: Mandatory periodic payments for awards of future damages exceeding $100,000.00.

Periodic payments of awards, known as "structured awards" or "structured settlements," are in general use in many states and foreign countries. Payments are guaranteed through the establishment of a trust fund or the purchase of an

annuity. Structured settlements are reasonable in that awards are intended to provide for the support and treatment of the injured person in years to come, not to provide a huge one-time payment. Perhaps more important, a defendant deprived of the periodic payment mechanism may be required to liquidate all of his or her assets immediately and on highly unfavorable terms in order to pay a judgment which could be met with much greater ease and certainty if it were spread over the years to which it is supposed to apply.

Structured settlements could reduce insurance rates because the cash involved in the judgment would be left with the insurer to earn interest which would help to offset the effect of the judgment on the company's assets. The premium rates for an annuity or payment to a trust fund which guarantees support of the injured person total considerably less than one large settlement. The compounded value of money over time results in substantial savings for the insurer.

Predicting life expectancy is an error-prone activity. Making such predictions where the subject has suffered an injury serious enough to justify a large award for future losses is even more difficult. Sadly, it often results in large windfalls to beneficiaries whose financial dependence and emotional linkage to the deceased have been slight or non-existent. Justice and the purposes of the compensation would be better served if specific provisions were made in the award that, in the event of the plaintiff's death, sums would be transferred to a surviving spouse, children, and other dependent heirs, if any, and the remainder would revert to the defendant.

The nationally known accounting firm of Milliman and Robertson has done an exhaustive actuarial analysis of this and three other tort changes we will recommend for your consideration. Copies of the study will be furnished to you

to examine in detail at your leisure. The initial savings estimated to be realized by the four tort reforms are for medical professional liability only. Under the statistical models described, initial premium savings of one billion dollars nationally are estimated. Obviously, the total savings would be astronomically larger if applied to the whole range of liability insurance and to additional reforms. For structured settlements as presented, the estimated savings are 6% of medical liability premiums. Total annual medical liability premiums in North Carolina are estimated at approximately $35,000,000.00. Mandatory structured settlements would save an estimated $2,100,000.00.

Recommended Tort Reform #2: Reduction of awards received by compensation from other sources (elimination of collateral source rule).

The traditional collateral source rule in tort cases forbids evidence that the plaintiff has received compensation from other sources, such as insurance. Thus, a patient may receive compensation from more than one source for a single element of loss, such as medical expenses. Mandatory setoff from payments of such collateral sources will prevent double compensation.

It is difficult to understand why a jury, as it awards damages, should not have before it all the relevant facts. We find it especially troubling that collateral source payments are not admissible even when the injured person did not contribute, by way of premium or otherwise, in obtaining collateral benefits. For example, if an injured person will be paid a monthly sum under a federal or state rehabilitation program for the cost of rehabilitation treatment, it seems unfair to allow an uninformed jury to order a physician to pay the patient a second time for the same treatment. The estimated initial savings are 8% of annual premiums, approximately $2,800.000.00.

Recommended Tort Reform #3: Modification of the statute of limitations (the time period within which civil actions must be commenced).

No claim may be commenced unless filed within three years from the date of the occurrence of the alleged act, except that a minor under the age of five years shall have until his eighth birthday in which to commence a claim.

The statute of limitations shortens the long tail of claims. The shortening of the limitation period applicable to minors will help ensure pertinent evidence when witnesses are available, allow insurers to better estimate awards and claims, and protect defendants against changes in legal doctrine and the risk of being judged on the basis of new knowledge. It protects the defendant from the inflation factor of verdicts increasing over time while the insurance coverage is frozen to the amount in place at the date of the alleged incident.

The members of this Commission have had called to their particular attention the special plight of physicians who practice obstetrics in this state. Adjusting the statute of limitations for minors would be tremendously beneficial in arresting the alarming trends endured by them over the last several years. Let me just say briefly that an ever-growing fear of being sued, coupled with astronomical premium increases, is forcing many obstetricians and family physicians who do obstetrics out of practice. This has ominous consequences for the citizens of our state, especially those who live in non-urban areas. Access to care will be a problem, especially for expectant mothers. There will be shortages of medical care. And there will be a worsening of our present infant mortality rate problem.

Recommended Tort Reform #4: Limitation of awards of non-economic damages.

The amount of any award of damages for non-economic losses should be limited to a certain amount, including losses for pain, suffering, mental anguish, inconvenience, etc.

There are inherent difficulties in placing monetary value on non-economic damages. Since the setting of such damages is so subjective, widely differing awards in similar situations frequently occur. Limits will provide more equity between awards.

Juries are presented with allegations that pain and suffering can be measured out and priced on a dollar basis. Translating emotional damage into dollar equivalents always has been and always will be an arbitrary process. We believe it would be useful, however, to develop standards of comparison from a large body of cases and to form appropriate compensation levels for each injury category. Perhaps a State Commission could be created with a mandate to study and develop sample standards of reasonable awards for non-economic damages which would be used as general but not absolute guidelines with which juries would be acquainted before rendering judgments.

The actuarial estimate of initial savings is 12% of professional liability premiums, approximately $4,200,000.00.

Recommended Tort Reform #5: Limitation of award for mandatory procedures (DPT Vaccine).

Damages for injury resulting from a medical procedure mandated by law, such as giving DPT injections, shall not exceed $250,000.00, unless additional amounts are ordered by the court. Health care providers should be protected

from excessive risks of loss when performing medical procedures mandated by law. The state may choose to develop a compensation fund, which we will discuss in a moment, for injuries resulting from these procedures. The North Carolina Medical Society will work closely with other interested groups in the refinement of this proposal.

Recommended Tort Reform #6: Limitation on awards and development of a Patient Compensation Fund.

Damages for liability by a health care provider may not exceed $500,000.00; further, a health care provider is not liable for an amount in excess of $100,000.00 per occurrence, and any amount over that shall be paid from the Patient Compensation Fund (PCF) which shall be created by the state, funded by an annual surcharge on health care providers in the state, determined upon actuarial principles, and collected on the same basis as premiums by professional liability insurers.

This limitation of awards would reduce costs to benefit all consumers and would guarantee the availability and affordability of health care. With a limitation on payments, a viable patient compensation fund can be established to help ensure solvent sources of insurance for plaintiffs and make it easier for insurers to estimate liability.

The State of Indiana enacted such legislation several years ago. All reports indicate a highly positive experience, and the system has since withstood a challenge to its constitutionality. Even though health care providers fund the Patient Compensation Fund through a surcharge on liability premiums, their total outlays should diminish because the PCF essentially

performs a reinsurance function. Reinsurance these days is an expensive and increasingly scarce commodity. There are no domestic companies willing to write such coverage in North Carolina, and Medical Mutual Insurance Company has to negotiate its reinsurance treaties with Lloyd's of London. Present terms require a deductible of the first $192,500.00 of an award before the reinsurance coverage begins, up from $100,000.00 just a few months ago. Annual increases in the deductible are now part of the treaty agreement.

It is essential that there be a maximum award if a Patient Compensation Fund is created because a few extraordinary awards could deplete its resources. We offer this recommendation in full awareness of its potential impact on the severely injured party. With a structured settlement program of the kind discussed earlier, the $500,000.00 "cap" recommended could purchase an annuity sufficient to compensate the injured person fully for economic losses for the balance of his or her life. For instance, a three-year old male would receive a $51,586.00 cash payment immediately and monthly payments beginning at $1,330.00 that increase annually by 6% to $125,230.00 at the 75th year (his actuarial life expectancy). Total payments over that period, for a $500,000.00 award, would be $25,580,540.00. (These are exact numbers taken from an insurance company's bid on January 28, 1986.) Obviously, each settlement should be structured for the specific needs of the injured person. With appropriate safeguards, all parties can benefit.

Recommended Tort Reform #7: Refinement of qualifications for expert witnesses.

In addition to current requirements, an expert, to qualify to testify, must be qualified as an expert within the specialty of the defendant and be currently in active practice of that specialty.

The battle of the experts is to many people one of the most depressing aspects of the tort system. It often appears that there is no position on any side of an issue on which it is impossible to enlist the support of an expert witness. There is emerging a breed of "professional experts" whose livelihood depends on traveling from court to court to serve the interests of the party paying the bill.

Because "experts" are distinguished in the law primarily because they can testify to opinion as well as to fact, an expert witness must be truly that. The suggested safeguards will protect the system by ensuring that witnesses testifying as experts are intimately familiar with the applicable standard of care in this age of increased specialization of health care disciplines. We are not recommending that experts be restricted along geographic lines.

Recommended Tort Reform #8: Limitation of attorneys' fees.

When a plaintiff receives a settlement or an award for damages, the payment to the individual's attorney shall not exceed a sliding scale percentage amount that reduces as the amount of the total settlement or award increases, unless the court orders additional payment.

The limitations on attorneys' fees will ensure that reasonable amounts go to the injured plaintiff without denying the attorney fair compensation, encourage earlier settlements by removing incentives to pursue large jury verdicts and therefore larger fees, and reduce incentives to take cases that have doubtful merit but hold hope for a huge recovery.

The United States is one of a handful of nations in the world that permits plaintiffs' attorneys to set their fees as percentages of either court awards or settlements. Many responsible authorities, including the entire British Bar and

those of most other countries, argue for abolition of the contingency fee and its replacement by the standard fee-for-service arrangement typical of other areas of law and of professional services in general. We have carefully considered the arguments advanced by people who hold this view, but we remain unconvinced. In our view the contingency fee performs functions which would not be as well performed by other procedures. Principally, it is a powerful discouragement to frivolous or lightly considered suits, and it assures access for the poor to legal services which would not be provided in any other way in the absence of a Legal Aid mechanism many times the size of the one now in existence. Therefore, we do not recommend that the practice of charging contingency fees be made illegal.

However, legitimate questions about proper limits on contingency fees have arisen. Too little goes to the injured party from awards.

A statute should be enacted placing a quantitative limitation on contingency fees. Contingency fees should be calculated after the deduction of plaintiff's non-recoverable costs. The schedule, for example, might limit fees to not more than 33 1/3% of the first $150,000.00 in damages, 25% of the next $150,000.00, and 10% of the balance of any damages awarded. If the case is settled prior to decision, the corresponding percentages might be 25%, 18%, and 6%. The court awarding a judgment should be authorized to increase the permissible fee upon a petition which justifies additional compensation. Initial savings are estimated to be 9% of annual premiums, approximately $3,150,000.00.

Recommended Tort Reform #9: Countersuits to frivolous suits.

The defendant shall have a cause of action against the plaintiff and/or the plaintiff's attorney upon a determination by the court that the suit is frivolous.

Non-meritorious suits are an expensive drain on resources and should be discouraged. Current North Carolina countersuit laws are too weak to be effective deterrents.

There is no direct counterpart in civil law to the "probable cause hearing" employed in criminal proceedings, in which the prosecution is required to demonstrate that there is a solid basis for the action. Thus, even a tort suit with no semblance of merit can exact huge financial and emotional costs on the defendant for years before a determination is made. One liability carrier estimates that just the filing of a claim generates a cost of approximately $20,000.00 in legal fees alone. More than 80% of malpractice claims in North Carolina are closed with no payment, but they take their toll on the defendants in the process. In today's climate there has grown up the notion that a dissatisfied patient is a mistreated one, entitled to his day in court no matter how frivolous his claim. It is a sad fact of life that an adverse outcome can result from the very best care. But the steady advance of medical science, which routinely produces results that would have been considered miracles just a few years ago, has raised patients' expectations to unrealistic levels. Anything less than perfection too often triggers a rush to litigation. The time and facilities of the justice system could be freed for the serious cases if a more effective means of bringing charges against an irresponsible party are provided as a deterrent.

Those are our suggestions. We think they are realistic. We think they are fair. We think they will stand the test of constitutionality. And we know they will reduce health care costs considerably in this state. Except for one or two that address medical situations specifically, these changes are applicable generally to the tort system and do not represent special interests.

Again, we thank you for this opportunity to share our thoughts with you. There is a growing sense of concern in the public at large on these issues. In just a moment, we are going to distribute suggested language for each of these proposals. Let me stress that these are only recommendations which we hope will be helpful to you. We stand ready to work with you and others who can contribute to improving the language and the tort system for the benefit of all.

Thank you. I'll be pleased to try to respond to your questions.

JAMES C. WILSON, F.C.A.S.
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1029 ENGLEWOOD DRIVE
WINSTON-SALEM, NORTH CAROLINA 27106

JAMES C. WILSON
PRESIDENT

(919) 722-1766

April 9, 1986

Mr. David Warren, Executive Director
N.C. Medical Malpractice Study Commission
Room 2111 State Legislature Building
Raleigh, NC 27611

Dear Mr. Warren,

Re: Analysis of data filed with
NC Insurance Dept. by Medical
Malpractice carriers, per GS 58-21.1

When combined with five prior years of information filed with the Insurance Department there are some interesting observations that are squeezed out of the captioned data by massaging it. The calculations are demonstrated in Exhibits I to V that are attached and may be appended to extra copies of this report letter.

EXPLANATION: The analysis and comments that follow are based on limited data only and on calendar year data only. Unique relationships are examined to obtain the most intelligence from the data that has been submitted. Though not conclusive the observations suggest probable development in direction if not in magnitude. The observations may suggest directions for further inquiry.

APPROACH: The approach has been to use the current calendar year's reported frequency and the average payment severity for claims closed in the calendar year as an indication of the ultimately expected frequency and severity. This approach avoids all estimates of unpaid claims that may or may not be paid in the future. There are many deficiencies in the approach. It is only used when no other information is available and a decision needs to be made. Under those circumstances it is the best approach available.

The calendar year approach would be satisfactory for a mature and stable operation with no change in volume between the years; but as used in practical situations, it tends to understate the losses and needed premiums when inflation and volume growth are present. Similarly when inflation or volume growth are reduced or decline, the indicated losses are overstated.

CAVEAT The foregoing explanations and possible adjustments must be considered when interpreting the following observations -

(1) Both St. Paul Insurance Group (St. Paul) and N.C. Medical Mutual Insurance Company (NCMM) have experienced significant annual average increases in number of claims reported for physicians; 15.9% and 18% respectively.

(2) The frequency however when related to the earned premiums (in $100,000's) has shown average annual reductions for the physicians in last five years.

Note: By not having the number of physicians insured, the only measure of frequency that could be made was to the earned premiums. When comparing two or more periods this combines the actual frequency change with the inverse effect of the rate level changes.

The reductions of -4.4% and -13% respectively indicate a change in the number of losses reported, relative to the earned premiums charged by St. Paul and by NCMM. It obviously represents more increase in premiums than any reduction in the number losses.

(3) The average paid severity increase for physicians in the two companies are comparable at 23.4% and 27% annually.

(4) The Frequency & Severity loss ratio index is only significant as a comparison to prior periods. It indicates, by an increase, that both companies have experienced significant deteriorations in the adequacy of the premium level to pay the losses being incurred.

This has developed over the last five years. It says nothing about the rate level at the beginning of 1981. But it does say there has been an average annual deterioration in the adequacy of that 1980 premium level whatever it may have been. If we assume that the 1980 premium was exactly correct, then the indicated losses have increased by an average of 17.3% annually more than the premiums for St. Paul, and by 10% for NCMM.

(5) The average reserve changes, -4.1% for St. Paul and +18% for NCMM when compared to average increase in severity similarly reflect changes from whatever level existed at the end of 1980. Information from the annual statements clearly indicate now that St. Paul was over reserved and that NCMM was under reserved at December 31, 1980. Part of the observed changes are expected corrections of prior conditions.

(6) The Highest Awards Paid show substantial annual average increases of 23.4% for St. Paul and 36% for NCMM.

(7) The trend in the Number of Claims Closed With No Payment show a smaller increase than the number of reported claims, hence it indicates a significant reduction in the percentage of No Payment Claims for St. Paul.

The opposite result is observed for NCMM.

(8) The difference in the No Payment % of Reported Claims between the two companies may be traced to the consideration of a defense payment, versus only an indemnity payment, for assignment of a claim to the no pay category.

(9) The reduction in number of hospital claims for St. Paul probably suggests a reduction in number of hospitals written.

(10) The severe increase trend for average severity and in the highest awards for hospitals could be a part of the reason for the reduction in volume. A reduced volume has probably exaggerated the loss indications for the hospitals.

(11) The credibility of the few claims reported in the other professionals and other facilities is so small as to produce near absurdities in the same analysis that was applied to physicians and hospitals.

The severities are based on only 3 or fewer claims for years prior to 1985. Consequently the severity and other calculations based on it are especially unreliable.

(12) The percent of verdicts paid, related to the number of claims reported for the second prior year ranged between 1/3 of one percent to 1.29% for physicians and for hospitals. This observation does not appear on the Summary. These figures are generally increasing for St. Paul's physicians and hospitals; but declining for NCMM.

Cordially,

James C. Wilson

James C. Wilson, F.C.A.S., M.A.A.A.

JCW:mb

N.C. MEDICAL MALPRACTICE STUDY COMMISSION

SUMMARY OF DATA FILED WITH NORTH CAROLINA INSURANCE DEPARTMENT

BY MEDICAL MALPRACTICE CARRIERS PER GS 58-21.1

	PHYSICIANS ST PAUL CO'S.		PHYSICIANS NC MED. MUTUAL		HOSPITALS ST PAUL CO'S.	
	1985 DATA	FIVE YR ANNUAL TREND %	1985 DATA	FIVE YR ANNUAL TREND %	1985 DATA	FIVE YR ANNUAL TREND %
DIRECT PREMIUMS WRITTEN (000'S)	16736	21.9	19959	36	6188	17.4
NO. CLMS REPORTED	749	15.9	729	18	224	-1.2
FREQUENCY, REPORTED /100 M EP	4.48	-4.4	3.65	-13	36.2	-14.8
SEVERITY = AVG AWARD PAID	87348	23.4	105897	27	101128	53.5
FREQ *SEVERITY = LOSS/EP INDEX	3.91	17.3	3.87	10	3.66	23.8
AVERAGE RESERVE	19126	-4.1	30506	18	53638	22
A) HIGHEST AWARD PAID	87348	23.4	1000000	36	2735000	99.5
NUMBER CLMS, NO PMT.	254	5.5	504	28	164	-6.7
NO PAYMENTS % OF REPORTED		34		69		73

	OTHER PROFESSIONALS ST PAUL CO'S.		OTHER FACILITIES ST PAUL CO'S.	
	1985 DATA	FIVE YR ANNUAL TREND %	1985 DATA	FIVE YR ANNUAL TREND %
DIRECT PREMIUMS WRITTEN	1369	30.4	1035	15
NO. CLMS REPORTED (2+3+4-1)	60	57.8	39	38
FREQUENCY, REPORTED /100 M EP	4.38	19.9	3.77	18
SEVERITY = AVG AWARD PAID	5413	-18.4	4500	23
FREQ *SEVERITY = LOSS/EP INDEX	.24	-2.4	.17	47
AVERAGE RESERVE	21997	-3.3	18977	4.5
A) HIGHEST AWARD PAID	35000	13.7	7500	31.5
NUMBER CLMS, NO PMT.	37	47.4	27	29.1
NO PAYMENTS % OF REPORTED		62		69

4/9/86

N.C. MEDICAL MALPRACTICE STUDY COMMISSION

EXHIBIT I
PHYSICIANS
ST PAUL

DATA FILED WITH N.C. INSURANCE DEPARTMENT PER GS 58-21.1

BY ST. PAUL COMMPANIES FOR PHYSICIANS

DOLLARS IN (000'S), OTHER THAN AWARDS AND AVERAGES

	ROW REFERENCE TO EXH 1 GS 58-21.1	1979	1980	1981	1982	1983	1984	1985	INDICATED ANNUAL TREND FACTORS
NUMBER CLAIMS PENDING EOP	1 &2)	273	298	398	342	408	402	811	E 1.149
NUMBER CLMS SETTLED OR PAID	3)		41	44	81	59	75	86	E 1.153
A) HIGHEST AWARD PAID	3 A)		100000	170311	750000	375000	565000	1150000	E 1.540
B) LOWEST AWARD PAID	3 B)		58	101	100	903	1948	1500	
C) AVERAGE AWARD PAID	3 C)		27775	31655	39349	36763	55611	87348	E 1.234
NUMBER CLMS, NO PMT.	4)		201	178	327	266	242	254	E 1.055
NUMBER CLMS, JUDGEMENT PAID	5)		3	3	2	2	2	5	E 1.039
" SETTLED BEFORE VERDICT	6)		38	41	79	57	73	81	E 1.160
AVERAGE RESERVE	7)		29225	35818	38349	35020	38262	19126	L .9593
PREMIUMS COLLECTED	8)								
A) DIRECT PREM WRITTEN (000)	8 A)		6168	6337	8246	8708	11915	16736	E 1.219
B) " " EARNED (000)	8 B)		4948	6233	7458	8257	10285	13630	
TOTAL EXPENSE, LESS RESERVE	9)		227	740	805	1074	1262	1945	
" " RESERVE ONLY	10)		3307	4147	4181	4193	4116	4842	
TOT EXPENSE INCURRED	(9 +10)		3534	4887	4986	5267	5378	6787	E 1.108
% OF PAYMENTS TO TOTAL	(9/(9+10)		6	15	16	20	23	29	
								5YR TOT.	
UNDERWRITING PROFIT = (UP)	11)								
A) UP + INVESTMENT INCOME	11 A)		-1443	-3464	3566	3458	3023	658	5798
UNDER PROFIT % /EP	(11A/8B)		-29	-56	48	42	29	5	11
B) (A)-INCURRED BUTNOT RPTD	11 B)		-1123	-2951	3333	1947	2068	1214	
C) (A)-ALL CLM RESERVES	11 C)		2191	2595	2321	2992	3161	1344	
ANNALYSIS									
NO. CLMS REPORTED (2+3+4-1)	12)		267	322	352	391	311	749	E 1.159
FREQUENCY;NUMBER REPORTED/ EP	(12/8A*100)		4.33	5.08	4.27	4.49	2.61	4.48	L .9562
SEVERITY = AVG AWARD PAID	(3 C)		27775	31655	39349	36763	55611	87348	E 1.234
FREQ *SEVERITY = LOSS/EP INDEX	(3C*12/8A)		1.20	1.61	1.68	1.65	1.45	3.91	E 1.173
CLOSED, NO PAY %/(12) CY	(4/12)		75	55	93	68	78	34	
NUMBER PAID %/(12) 1ST PY	(3/12)		-	16	25	17	19	28	
NO. VERDICTS PAID %/ 2ND PY	(5/12)		-	-	.75	.62	.57	1.28	
NUMBER PENDING / REPORTED %	(2/12)		112	124	97	104	129	108	
PREMIUM EARNED /CLAIM REPORTED	(8B/12)		18532	19357	21188	21118	33071	18198	E 1.044

TYPES OF ANNUAL TRENDS: E = EXPONENTIAL LEAST SQUARES
L = LINEAR LEAST SQUARES

4/9/86

N.C. MEDICAL MALPRACTICE STUDY COMMISSION

EXHIBIT II
PHYSICIANS
NC MED. MUT.

DATA FILED WITH N.C. INSURANCE DEPARTMENT PER GS 58-21.1

DOLLARS IN (000'S), OTHER THAN AWARDS AND AVERAGES

	ROW REFERENCE TO EXH 1 GS 58-21.1	1979	1980	1981	1982	1983	1984	1985	INDICATED ANNUAL TREND FACTORS
NUMBER CLAIMS PENDING EOP	1 &2)	346	443	569	844	980	1005	1139	E 1.228
NUMBER CLMS SETTLED OR PAID	3)		32	39	57	57	74	91	E 1.227
A) HIGHEST AWARD PAID	3 A)		250000	500000	389999	535986	1631948	1000000	E 1.361
B) LOWEST AWARD PAID	3 B)		320	41	11	75	132	1000	
C) AVERAGE AWARD PAID	3 C)		32608	52583	36740	69233	92573	105897	E 1.265
NUMBER CLMS, NO PMT.	4)		183	194	150	370	471	504	E 1.280
NUMBER CLMS, JUDGEMENT PAID	5)		0	0	0	2	2	2	E -
" SETTLED BEFORE VERDICT	6)		32	39	57	55	72	89	E 1.219
AVERAGE RESERVE	7)		11667	14562	14018	16106	18953	30506	L 1.177
PREMIUMS COLLECTED	8)								
A) DIRECT PREM WRITTEN (000)	8 A)		4216	5917	7605	9592	14333	19959	E 1.356
B) " " EARNED (000)	8 B)		3850	5033	6884	8511	10374	19558	
TOTAL EXPENSE, LESS RESERVE	9)		384	510	599	688	947	1060	
" " RESERVE ONLY	10)		561	1086	2085	2942	2730	4511	
TOT EXPENSE INCURRED	(9 +10)		945	1596	2684	3630	3677	5571	E 1.396
% OF PAYMENTS TO TOTAL	(9/(9+10)		41	32	22	19	26	19	
								5YR TOT.	
UNDERWRITING PROFIT = (UP)	11)								
A) UP + INVESTMENT INCOME	11 A)		364	120	464	-2629	123	-2751	-4309
UNDER PROFIT % /EP	(11A/8B)		9	2	7	-31	1	-14	-8
B) (A)-INCURRED BUTNOT RPTD	11 B)		-1778	-3528	-4928	-7481	-6936	-12991	
C) (A)-ALL CLM RESERVES	11 C)		1568	-2238	1850	782	2816	1949	
ANNALYSIS									
NO. CLMS REPORTED (2+3+4-1)	12)		312	359	482	563	570	729	E 1.180
FREQUENCY:NUMBER REPORTED/ EP	(12/8A*100)		7.40	6.07	6.34	5.87	3.98	3.65	L .8688
SEVERITY = AVG AWARD PAID	(3 C)		32608	52583	36740	69233	92573	105897	E 1.265
FREQ *SEVERITY = LOSS/EP INDEX	(3C*12/8A)		2.41	3.19	2.33	4.06	3.68	3.87	E 1.100
CLOSED, NO PAY %/(12) CY	(4/12)		59	54	31	66	83	69	
NUMBER PAID %/(12) 1ST PY	(3/12)		-	13	16	12	13	16	
NO. VERDICTS PAID %/ 2ND PY	(5/12)		-	-	0.00	.56	.41	.36	
NUMBER PENDING / REPORTED %	(2/12)		142	158	175	174	176	156	
PREMIUM EARNED /CLAIM REPORTED	(8B/12)		12340	14019	14282	15117	18200	26829	E 1.144

TYPES OF ANNUAL TRENDS: E = EXPONENTIAL LEAST SQUARES
L = LINEAR LEAST SQUARES

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N.C. MEDICAL MALPRACTICE STUDY COMMISSION

EXHIBIT III
HOSPITALS
ST PAUL

DATA FILED WITH N.C. INSURANCE DEPARTMENT PER GS 58-21.1

DOLLARS IN (000'S), OTHER THAN AWARDS AND AVERAGES

	ROW REFERENCE TO EXH 1 GS 58-21.1	1979	1980	1981	1982	1983	1984	1985	INDICATED ANNUAL TREND FACTORS
NUMBER CLAIMS PENDING EOP	1 &2)	134	163	230	175	210	216	231	E 1.078
NUMBER CLMS SETTLED OR PAID	3)		21	32	38	44	23	45	E 1.088
A) HIGHEST AWARD PAID	3 A)		100000	115000	177000	695000	1171000	2375000	E 1.995
B) LOWEST AWARD PAID	3 B)		62	265	100	341	2000	618	
C) AVERAGE AWARD PAID	3 C)		13478	15206	46578	31454	89380	101128	E 1.535
NUMBER CLMS, NO PMT.	4)		101	120	194	154	26	164	E .9338
NUMBER CLMS, JUDGEMENT PAID	5)		0	0	0	2	2	3	E -
" SETTLED BEFORE VERDICT	6)		21	32	38	42	21	42	E 1.068
AVERAGE RESERVE	7)		15811	21221	28841	30590	37792	53638	L 1.220
PREMIUMS COLLECTED	8)								
A) DIRECT PREM WRITTEN (000)	8 A)		2687	2331	2539	2484	3808	6188	E 1.174
B) " " EARNED (000)	8 B)		2390	2215	2322	2340	2899	4535	
TOTAL EXPENSE, LESS RESERVE	9)		100	242	315	401	509	1118	
" " RESERVE ONLY	10)		1159	1864	1725	1876	268	2242	
TOT EXPENSE INCURRED	(9 +10)		1259	2106	2040	2277	777	3360	E 1.060
% OF PAYMENTS TO TOTAL	(9/(9+10)		8	11	15	18	66	33	
								5YR TOT.	
UNDERWRITING PROFIT = (UP)	11)								
A) UP + INVESTMENT INCOME	11 A)		239	-1853	999	-1170	-1605	-6299	-9689
UNDER PROFIT % /EP	(11A/8B)		20	-167	86	-100	-111	-278	-58
B) (A)-INCURRED BUTNOT RPTD	11 B)		403	-1799	1149	-1303	-2267	-6104	
C) (A)-ALL CLM RESERVES	11 C)		1459	505	1315	69	-528	-1877	
ANNALYSIS									
NO. CLMS REPORTED (2+3+4-1)	12)		151	219	177	233	55	224	L .988
FREQUENCY:NUMBER REPORTED/ EP	(12/8A*100)		5.62	9.40	6.97	9.38	1.44	3.62	L .8520
SEVERITY = AVG AWARD PAID	(3 C)		13478	15206	46578	31454	89380	101128	E 1.535
FREQ *SEVERITY = LOSS/EP INDEX	(3C*12/8A)		.76	1.43	3.25	2.95	1.29	3.66	E 1.238
CLOSED, NO PAY %/(12) CY	(4/12)		67	55	110	66	47	73	
NUMBER PAID %/(12) 1ST PY	(3/12)		-	21	17	25	10	82	
NO. VERDICTS PAID %/ 2ND PY	(5/12)		-	-	0.00	.91	1.13	1.29	
NUMBER PENDING / REPORTED %	(2/12)		108	105	99	90	393	103	
PREMIUM EARNED /CLAIM REPORTED	(8B/12)		15828	10114	13119	10043	52709	20246	E 1.184

TYPES OF ANNUAL TRENDS: E = EXPONENTIAL LEAST SQUARES
L = LINEAR LEAST SQUARES

4/9/86

N.C. MEDICAL MALPRACTICE STUDY COMMISSION

EXHIBIT IV
OTHER PROFESSIONALS
ST PAUL

DATA FILED WITH N.C. INSURANCE DEPARTMENT PER GS 58-21.1

DOLLARS IN (000'S), OTHER THAN AWARDS AND AVERAGES

	ROW REFERENCE TO EXH 1 GS 58-21.1	1979	1980	1981	1982	1983	1984	1985	INDICATED ANNUAL TREND FACTORS	
NUMBER CLAIMS PENDING EOP	1 &2)	17	16	16	26	34	46	53	E	1.251
NUMBER CLMS SETTLED OR PAID	3)		1	1	2	3	3	16	E	1.652
A) HIGHEST AWARD PAID	3 A)		7000	45000	60000	29500	17500	35000	E	1.137
B) LOWEST AWARD PAID	3 B)		7000	45000	5000	4330	1000	610		
C) AVERAGE AWARD PAID	3 C)		7000	45000	32500	14610	7333	5413	E	.8065
NUMBER CLMS, NO PMT.	4)		12	9	17	17	127	37	E	1.474
NUMBER CLMS, JUDGEMENT PAID	5)		1	1	0	0	0	0	E	-
" SETTLED BEFORE VERDICT	6)		0	0	2	3	3	16	E	-
AVERAGE RESERVE	7)		19812	25640	13251	15058	14369	21997	L	.9672
PREMIUMS COLLECTED	8)									
A) DIRECT PREM WRITTEN (000)	8 A)		385	500	654	777	1257	1369	E	1.304
B) " " EARNED (000)	8 B)		366	438	561	713	972	1362		
TOTAL EXPENSE, LESS RESERVE	9)		11	22	23	74	52	193		
" " RESERVE ONLY	10)		160	213	145	188	2156	525		
TOT EXPENSE INCURRED	(9 +10)		171	235	168	262	2208	718	E	1.506
% OF PAYMENTS TO TOTAL	(9/(9+10)		6	9	14	28	2	27		
								5YR TOT.		
UNDERWRITING PROFIT = (UP)	11)									
A) UP + INVESTMENT INCOME	11 A)		284	133	374	29	293	-26	1087	
UNDER PROFIT % /EP	(11A/8B)		78	30	67	4	30	-2	25	
B) (A)-INCURRED BUTNOT RPTD	11 B)		251	189	417	205	492	126		
C) (A)-ALL CLM RESERVES	11 C)		267	282	352	373	641	631		
ANNALYSIS										
NO. CLMS REPORTED (2+3+4-1)	12)		12	10	29	28	142	60	E	1.578
FREQUENCY;NUMBER REPORTED/ EP	(12/8A*100)		3.12	2.00	4.43	3.60	11.30	4.38	L	1.199
SEVERITY = AVG AWARD PAID	(3 C)		7000	45000	32500	14610	7333	5413	E	.8065
FREQ *SEVERITY = LOSS/EP INDEX	(3C*12/8A)		.22	.90	1.44	.53	.83	.24	E	.9764
CLOSED, NO PAY %/(12) CY	(4/12)		100	90	59	61	89	62		
NUMBER PAID %/(12) 1ST PY	(3/12)		-	8	20	10	11	11		
NO. VERDICTS PAID %/ 2ND PY	(5/12)		-	-	0.00	0.00	0.00	0.00		
NUMBER PENDING / REPORTED %	(2/12)		133	160	90	121	32	88		
PREMIUM EARNED /CLAIM REPORTED	(8B/12)		30500	43800	19345	25464	6845	22700	E	.8241

TYPES OF ANNUAL TRENDS: E = EXPONENTIAL LEAST SQUARES
L = LINEAR LEAST SQUARES

4/9/86

N.C. MEDICAL MALPRACTICE STUDY COMMISSION

EXHIBIT V
OTHER FACILITIES
ST PAUL CO'S.

DATA FILED WITH N.C. INSURANCE DEPARTMENT PER GS 58-21.1

DOLLARS IN (000'S), OTHER THAN AWARDS AND AVERAGES

	ROW REFERENCE TO EXH 1 GS 58-21.1	1979	1980	1981	1982	1983	1984	1985	INDICATED ANNUAL TREND FACTORS
NUMBER CLAIMS PENDING EOP	1 &2)	7	6	10	4	5	14	24	E 1.183
NUMBER CLMS SETTLED OR PAID	3)		1	0	2	1	0	2	E 1.082
A) HIGHEST AWARD PAID	3 A)		1083	0	17500	16053	0	7500	E 1.315
B) LOWEST AWARD PAID	3 B)		1083	0	15000	0	0	1500	
C) AVERAGE AWARD PAID	3 C)		1083	0	16250	16053	0	4500	E 1.225
NUMBER CLMS, NO PMT.	4)		7	7	13	8	17	27	E 1.291
NUMBER CLMS, JUDGEMENT PAID	5)		0	0	0	0	0	0	E -
" SETTLED BEFORE VERDICT	6)		1	0	2	1	0	2	E -
AVERAGE RESERVE	7)		14583	16700	18750	26000	16785	18977	L 1.045
PREMIUMS COLLECTED	8)								
A) DIRECT PREM WRITTEN (000)	8 A)		477	441	449	459	617	1035	E 1.150
B) " " EARNED (000)	8 B)		383	472	460	470	535	834	
TOTAL EXPENSE, LESS RESERVE	9)		6	9	17	17	35	42	
" " RESERVE ONLY	10)		53	83	28	43	92	184	
TOT EXPENSE INCURRED	(9 +10)		59	92	45	60	127	226	E 1.256
% OF PAYMENTS TO TOTAL	(9/(9+10)		10	10	38	28	28	19	
UNDERWRITING PROFIT = (UP)	11)								5YR TOT.
A) UP + INVESTMENT INCOME	11 A)		282	128	565	294	203	301	1773
UNDER PROFIT % /EP	(11A/8B)		74	27	123	63	38	36	56
B) (A)-INCURRED BUTNOT RPTD	11 B)		285	263	502	339	210	347	
C) (A)-ALL CLM RESERVES	11 C)		321	342	410	355	315	567	
ANNALYSIS									
NO. CLMS REPORTED (2+3+4-1)	12)		7	11	9	10	26	39	E 1.380
FREQUENCY:NUMBER REPORTED/ EP	(12/8A*100)		1.47	2.49	2.00	2.18	4.21	3.77	L 1.179
SEVERITY = AVG AWARD PAID	(3 C)		1083	0	16250	16053	0	4500	E 1.225
FREQ *SEVERITY = LOSS/EP INDEX	(3C*12/8A)		.02	0.00	.33	.35	0.00	.17	E 1.470
CLOSED, NO PAY %/(12) CY	(4/12)		100	64	144	80	65	69	
NUMBER PAID %/(12) 1ST FY	(3/12)		-	0	18	11	0	8	
NO. VERDICTS PAID %/ 2ND PY	(5/12)		-	-	0.00	0.00	0.00	0.00	
NUMBER PENDING / REPORTED %	(2/12)		86	91	44	50	54	62	
PREMIUM EARNED /CLAIM REPORTED	(8B/12)		54714	42909	51111	47000	20577	21385	E .8191

TYPES OF ANNUAL TRENDS: E = EXPONENTIAL LEAST SQUARES
L = LINEAR LEAST SQUARES

4/9/86

JAMES C. WILSON, F.C.A.S.
CASUALTY ACTUARY, LTD.
1029 ENGLEWOOD DRIVE
WINSTON-SALEM, NORTH CAROLINA 27106

JAMES C. WILSON
PRESIDENT

(919) 722-1766

April 11, 1986

Mr. David Warren, Executive Director
N.C. Medical Malpractice Study Commission
Room 2111 State Legislature Building
Raleigh, N.C. 27611

Dear Mr. Warren,

Re: Defense cost per closed claim per GS58-21.1 data

The following information is furnished in response to a question from one of the members at the meeting yesterday in Charlotte.

	Average paid expense cost/closed Claim	Five year annual trend %
Physicians - St. Paul	5,721	33
Physicians NCMM	1,782	-3.6
Hospitals - St. Paul	5,349	55

Like some of the other items, it appears that the companies have responded with their best interpretations of the requested data; but it may not be the same interpretations that other companies have used.

If we assume only that each company was consistent with its own interpretation for each of the five years, then the data reveals that the insurance companies have increased their rates by substantially less than is indicated by the experience they have reported.

It is reasonable to speculate that both the companies and their reinsurers have unwittingly contributed more of the medical malpractice losses in North Carolina, than is currently recognized by either.

Posting Correction in my letter of April 9, 1986; for page 2, item 6 and the summary exhibit: The Highest award paid in 1985 for Physicians by St. Paul is 1,150,000. This is an annual average increase of 54.0% according to exhibit I. It was the average award of only 87,348 that is increasing at only 23.4%.

Cordially,

James C. Wilson/mb

James C. Wilson, F.C.A.S., M.A.A.A.

JCW:mb

F

United States General Accounting Office

GAO

Report to Congressional Requesters

December 1986

MEDICAL MALPRACTICE

Case Study on North Carolina

HRD-87-21[illegible]

Overview

The medical malpractice insurance situation is worsening for health care providers in North Carolina. Since 1980, medical malpractice insurance premiums in the state have increased significantly for both physicians and hospitals. High-risk physicians, such as neurosurgeons and obstetricians, are paying the highest premiums and have experienced the largest premium increases. Also, the frequency of claims and the average paid claim increased between 1981 and 1984 for physicians and between 1980 and 1984 for hospitals, with the greatest increases being in the average paid claim.

In the mid-1970's, major malpractice insurers either withdrew or threatened to withdraw from the malpractice insurance market. This concern stimulated the creation of two insurers—a medical-society-linked, physician-owned company and a hospital association trust fund. The creation of these insurers and the return of the major insurer to the state alleviated concerns regarding the availability of insurance. The state also modified several aspects of its tort laws governing medical malpractice cases. However, the interest groups we surveyed did not believe that these reforms have had a major effect on any aspect of the medical malpractice situation.

Several interest groups identified major current medical malpractice problems regarding the increasing size of malpractice awards/settlements, the equity of awards/settlements for malpractice claims, and legal expenses for malpractice claims. The groups expect these problems to continue and anticipate that the cost of malpractice insurance and the number of claims filed would become major problems in the future. To address malpractice problems, four of the six interest groups we contacted strongly supported use of risk management programs designed to reduce the incidence of malpractice claims by eliminating problems that result in those claims.

The groups surveyed primarily supported state rather than federal actions to address malpractice problems.

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NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

March 27, 1986

Mr. Douglass M. Phillips
Executive Vice-President
Medical Mutual Insurance
Company of North Carolina
Post Office Box 26088
Raleigh, NC 27611

Dear Mr. Phillips:

I want to express my concern about Medical Mutual's decision to amend your rate filing on certain family physicians delivering obstetric care. The information provided to the Commission at its hearing recently by the State Division of Health Services and the NC Academy of Family Physicians tends to indicate that your amendment will do very little to lessen the adverse consequences upon prenatal care that your steep rate increases will create. County health departments and pregnant women in many counties will not be helped by the temporary abeyance of your rate increases, and will affect too few family physicians delivering obstetrics.

I have received the information that the rate increases may be necessary for your financial viability, but I genuinely believe there are other ways to spread this risk so as not to impact so severely and so precipitously the provision of maternal and child health services in North Carolina.

I would also like to point out that your conditioning the abeyance on whether "meaningful tort reform" is presented and adopted by the North Carolina General Assembly at the Short Session fails to demonstrate a full appreciation of the causes and solutions to the overall medical malpractice problem. Civil justice modifications are indeed a part of this solution, but it will be meaningless without steps that affect the regulation of insurance, risk management by physicians and hospitals, peer review and self discipline initiatives. As you know, the Medical Malpractice Study Commission is attempting to conduct its work so as to truly assess real causes and real solutions to this problem and not simply to assist the insurance industry. We would expect that our multifaceted efforts will have a broader impact on the occurrence of medical malpractice as well as the impact of malpractice claims upon insurance companies.

ROOM 2111 STATE LEGISLATIVE BUILDING, RALEIGH, NC 27611 (919) 733-3460

In this spirit and commitment to the broader public interest, we would hope that your company would reconsider its decision to so radically increase premiums on family physicians performing obstetric care.

Thank you for the commitment of your Board of Directors and staff to work with this Commission. A commitment by all of us to a truly objective analysis of the causes and solutions will certainly promote your company's business objectives.

Sincerely yours,

Thomas F. Taft
Co-Chairman

TFT:jyg

cc: The Honorable Jim Long
Dr. Franklin Church
Commission Members

COPY

NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

March 28, 1986

Steve Belden, Vice President
St. Paul Fire & Marine Insurancea Co.
385 Washington Street
St. Paul, MN

Dear Mr. Belden:

We appreciate the willingness you and Robert Trunzo expressed in coming to Charlotte to assist the Commission with its study. Your expertise will enable us better to understand the insurance perspective on this complex problem of medical malpractice.

In order to deal with the data being presented to the Commission by the various insurers, we have engaged a consultant, James C. Wilson who is an independent casualty acutuary. He has helped us prepare a set of guidelines for you to follow in making your presentation to us. If there are any technical questions you have about any of the items on the list, please call him for clarification; he can be reached at his office in Winston Salem, (919) 722-1766. I know this is rather short lead time but Mr. Wilson assures us that St. Paul should have most of this information already prepared.

The agenda for our meeting on April 10 will include morning presentations by various Mecklenburg county groups and then the afternoon will be addressed to insurance. I hope that the 2 hours (2:30 - 4:30) we have allotted for the St. Paul presentations will be adequate. Remember that the Commission members often raise many questions during our meetings.

We are pleased that David Fuller from St. Paul's Charlotte office is on our Commission. He has been an active and valuable member. Your statutory report (enclosed) is also useful.

Thank you again for the cooperation you have always shown us.

Sincerely,

David G. Warren

Encl. (Guidelines, Statutory Report)

ROOM 2111 STATE LEGISLATIVE BUILDING, RALEIGH, NC 27611 (919) 733-3460

GUIDELINES FOR PRESENTION TO NC MEDICAL MALPRACTICE STUDY COMMISSION

GENERAL INFORMATION

1. Frequency
2. Severity
3. Exposure
4. Credibility standards, assumptions and formulae
5. Underwriting selectivity
6. Claims management strategies and changes
7. Reserve development history
8. Investment strategies, changes and yields
9. Loss ratios
10. Acquisition costs

As appropriate, present the above information separately for four groups (physicians, other health care professionals, hospitals, other health care facilities) in North Carolina only and in other comparative territories.

IN SUMMARY FORM

1. Frequency: reported claims in the last five years in NC related to defined exposures

   a. by report lag in years (to tenths), and by incurred indemnity size groups to 25,000, 100,000, 500,000, 1,000,000, and over 1M (or comparable intervals)
   b. by rate and statistical classes

2. Severity: closed paid claims in NC for last five years for indemnity and ALAE (allocated loss adjustment expenses, i.e., total defense costs), separately,

   a. by indemnity paid amount groups (same intervals as in 1.a.)
   b. by report lag time in years (to tenths) by indemnity groups (same intervals as in 1.a.)
   c. by additional disposition lag time from report to disposition (same intervals as 1.a.)
   d. by type groups as follows (same intervals as 1.a.)
      (1) not represented by attorney
      (2) represented but closed before suit filed
      (3) represented but closed after suit filed and before verdict
      (4) verdict amount
      (5) settled after verdict for different amount
      (6) settled after appeal for verdict amount
      (7) settled after appeal for different amount

3. Exposures: identification and definition of separate basis exposures

   a. number of physicians
   b. number of occupied beds
   c. other

4. Underwriting selectivity

   a. ratio of new application acceptance: total applications
   b. ratio of renewal offers: total number of expiring policies
   c. ratio of uprated classification renewal offers: total number expiring policies

SPECIFICS AND DETAIL OF PARTICULAR NC CASES

1. Three largest INDEMNITY closed claims in each of last five years, with the following information

   a. dates (occurred, reported, closed)
   b. city of occurrence
   c. placea of occurrence (hospital, office, other)
   d. class and specialty of policyholder
   e. type of incident
   f. amount paid (special damages, general damages, punitive damages, separately)
   g. ALAE (i.e., total defense costs)

2. Three largest ALAE closed claims in each of last five years, with information similar to above

3. Description of underwriting specifics and considerations during 1985 for the most recent three cases (in each physician rate classification) for each of these situations:

   a. rejected applicants
   b. uprated to higher classification
   c. non-renewed for cause

4. Description of NC agents contracted commissions, contingent commissions and any other compensation to brokers, MGA or procedures

DEPARTMENT OF INSURANCE
State of North Carolina
P. O. BOX 26387
RALEIGH, N. C. 27611

JIM LONG
COMMISSIONER OF INSURANCE

(919) 733-7343

September 5, 1986

Mr. David M. Warren
c/o Senator Thomas Taft
2111 Legislative Building
Raleigh, NC 27611

Re: Medical Malpractice Closed Claim Survey

Dear Mr. Warren:

Enclosed for your information and review is a copy of the proposed survey the Insurance Department plans to use to collect data on medical malpractice claims closed in North Carolina since January 1, 1983. Data will be collected from the major insurers and self-insurers of medical malpractice in North Carolina.

The purpose of this survey is to obtain information about the nature and disposition of claims, and factors that impact the cost of claims. It is not meant to determine other items such as the adequacy of rates or the profitability of insurers, which the Department will pursue through other means.

We would be most interested in any comments or suggestions you have on the proposed survey.

Please send me your responses by October 6, 1986.

Very truly yours,

Jim

Jim Long

JEL/AWS:ja
Enclosure

NORTH CAROLINA MEDICAL PROFESSIONAL LIABILITY INSURANCE UNIFORM CLAIMS REPORT

Report each claim closed on or after January 1, 1983. Submit a report for each defendant covered, including claims without payment. Complete all items on the form using the data base in Lotus 1-2-3, Version 1A or a compatible software product (i.e. reads and writes Lotus 1-2-3, Version 1A files directly). If information is unknown, enter "UN," if not applicable, enter "NA." When there is more than one response to a question, enter each response in the data field separating them with commas. When an item calls for a dollar amount and no amount is involved, enter 0. Record all amounts in whole dollars only. Record all dates as DD-MMM-YY (using the date function and date format), and all ages (at nearest age on date of occurrence) as YY.

1a. Name of insurer 1b. Claim file identification

2a. Date of incident 2b. Date incident reported to insurer

2c. Date claim filed with insurer 2d. Date of closure

3a. Insured's name 3b. Age at Incident

3c. Sex (M/F) 3d. License Number

3e. Address 3f. City 3g. State 3h. Zip

4a. Profession or business (CODE) 4b. Specialty (CODE) 4c. Type of practice (CODE)

5a. Board certification (CODE) 5b. Other Certification specialty

5c. Foreign medical graduate? (yes/no) 5d. Country

6a. Place where injury occurred (CODE) 6b. Address

6c. City 6d. State 6e. Zip

7a. Name of institution (if injury occurred in institution) 7b. Location in institution(CODE)

8a. Injured person's name 8b. Age at Incident 8c. Sex (M/F)

8d. Marital Status (Code) 8e. Total Number of Dependents

8f. Address 8g. City 8h. State 8i. Zip

9a. Total defendants involved in claim 9b. Names of other defendent(s)

9c. License number(s) of other defendant(s) 9d. Derivative claim (CODE)

10a. Was an attorney involved for plaintiff? (yes/no) 10b. Attorney Name

10c. Address 10d. City 10e. State 10f. Zip

11a. Was an outside attorney involved for insurer? (yes/no) 11b. Attorney Name

11c. Address 11d. City 11e. State 11f. Zip

Was a separate attorney involved for insured? (yes/no) 12b. Attorney Name

12c. Address 12d. City 12e. State 12f. Zip

13a. Did plaintiff have an expert witness? (yes/no) 13b. How many expert witness'

13c. Witness Name(s) 13d. Witness License Number(s)

13e. Number who were board certified. 13f. Specialty Code(s) of Board Certification(s)

14. How long in months was plaintiff a patient of the medical care practitioner before the filing of the claim?

15a. Final diagnosis for which treatment was sought or rendered (patient's actual condition)

15b. ICDA Code for 15a.

15c. Describe misdiagnosis made, if any, of patient's actual condition

15d. ICDA Code for 15c.

16a. Operation, diagnostic or treatment procedure causing the injury

16b. ICDA Code for 16a.

17a. Describe principal injury giving rise to the claim 17b. ICDA Code for 17a.

17c. Severity of injury (CODE) 17d. Characteristics of Injury (Code)

18a. Misadventures in procedures (CODE) 18b. Misadventures in diagnosis (CODE)

18c. Cause of Misdiagnosis (CODE)

19a. Others contributing to injury (CODE) 19b. Associated issues (CODE)

19c. Coverage (CODE) 19d. Per Claim Limit of Coverage 19e. Aggregate Limit of Coverage

20. Companion claim file(s) identification

21a. Claim disposition (CODE) 21b. Settlement (CODE)

21c. Court (CODE) 21d. Trial (Code)

21e. Binding arbitration (CODE) 21f. Review panel (CODE)

21g. County where suit filed 21h. County where trial held

22. Amount paid by insurer on behalf of this defendant

23. Amount paid by the insured due to retention or deductible

24. Amount paid by excess insurer due to settlement or award

25.	Amount paid by insured due to settlement or award in excess of policy limits.	
26.	Amount paid by other defendants/contributors and/or their insurers	
27.	Loss adjustment expense paid to defense counsel	
28.	All other allocated loss adjustment expense paid by insurer	
29.	Injured person's medical expenses through date of closing	
30.	Injured person's anticipated future medical expense	
31.	Injured person's wage loss (including employer paid fringe benefits) through date of closing	
32.	Injured person's anticipated future wage loss (including employer paid fringe benefits)	
33.	Injured person's other expenses through date of closing	
34.	Injured person's anticipated future other expenses	
35.	Amount of non-economic compensatory damages	
36a.	Actual amount of prejudgment interest, if any, paid on award	
36b.	Estimated amount of prejudgment interest,if any, reflected in settlement	
37a.	Punitive damages (Code)	37b. Amount requested
37c.	Amount awarded by judgment	37d. Amount included in settlement
37e.	Impact of punitive damages (Code)	37f. Amount paid by insured
38a.	If case was tried to verdict, what percentage of fault was assigned to your insured?	
38b.	If claims was settled, estimate the percentage of fault for your insured	
38c.	What percentage of the final award or settlement was paid for your insured	
39a.	Were collateral sources available to the plaintiff (Code)?	
39b.	What collateral sources were available	
39c.	How much was available (estimate if exact amount not available)	
19d.	How much did the plaintiff pay to secure these sources (estimate if exact amount not available)	

Was a structured settlement used in closing this claim (Yes/No)?

40b. If (40a) yes, did the structured settlement apply to plaintiff attorney's fee (Yes/No)?

40c. If (40a) yes, give the amount of the first payment

40d. If (40a) yes, indicate present value of total future payments (price of annuity if purchased)

40e. If (40a) yes, indicate projected total future payout.

41a. Was injured person employed at the time of injury (Yes/No)?

41b. Injured persons occupation (CODE)

41c. What was the annual gross salary at the time of the incident?

41d. What was the annual value of employer paid fringe benefits at the time of the incident?

---

42. Major source of payment of patient's health care costs (CODE)

---

43. Other relevant remarks regarding claim.

44a. Contact Person

44b. Telephone Number

44c. Address

44d. Person Responsible for Report

NORTH CAROLINA MEDICAL PROFESSIONAL LIABILITY INSURANCE UNIFORM CLAIMS REPORT INSTRUCTIONS

2a. Date of Incident: Enter the date the injury occurred. If the occurrence took place over an extended period of time, give the last date on which treatment was provided.

2b. Date Incident Reported to Insurer: Provide the date the insurer first received notice that an incident took place which may lead to a medical malpractice claim.

2c. Date Claim Filed with Insurer: Provide the date the insurer first received notice from a potential plaintiff that a claim may be filed.

2d. Date of Closure: For some resolved claims, the claim file may still be open, pending payment of an expense item or due to a structured settlement. If so, give the date on which the judgment was rendered or the payment of the indemnity was started to the claimant. In other instance, indicate the date on which the claim file was closed according to the company's normal procedures. Decisions on appeal should not be reported as closed claims until ultimately resolved.

4a. Profession or Business Code: 1) physicians and surgeons, 2) nurses, 3) dentists, 4) other practitioners without M.D.'s (i.e., chiropractors, optometrists, psychologists, etc.), 5) hospitals, 6) convalescent/nursing home, 7) mental institution, 8) outpatient clinic, 9) sanitariums, 10) other medical professionals, 11) other health care facilities. If code 10) or 11), other, please describe.

4b. Specialty Code: (five digits) from ISO Common Statistical Base classifications used in NAIC medical malpractice 1975-1978 closed claim study.

4c. Type of Practice Code: 1) institutional (academic), 2) professional corporation or partnership (group), 3) self-employed, 4) employed physician, 5) employed nurse, 6) all other employees, 7) intern or resident, 8) other. If code 8), other, please describe.

5a. Enter appropriate code if insured physician is Board Certified in 1) specialty coded in 4b, 2) a different specialty, 3) both specialty coded in 4b and another specialty 4) insured physician is not board-certified. If 2 or 3 is entered, also enter the additional specialty code (5 digits) in item 5b.

5b. Other Certification(s): Use this item to enter the other specialty(ies) that the medical provider is certified in.

5c. Indicate yes or no if insured physician is a Foreign Medical Graduate.

5d. Enter Country in which primary medical education was received if other than U.S.

6a. Enter the appropriate code of the Place Where the principal Injury Occurred: 1) hospital inpatient facility, 2) emergency room, 3) hospital outpatient facility, 4) nursing home, 5) physician's office, 6) patient's home, 7) other outpatient facility, 8) other hospital/institutional location, 9) other. Use only one code. If code 9, other, please describe.

7b. Enter appropriate code if Location of Institutional Injury was: 1) patient's room, 2) labor and delivery room, 3) operating suite, 4) recovery room, 5) critical care unit, 6) special procedure room, 7) nursery, 8) radiology, 9) physical therapy department, 10) hallway, 11) bathroom, 12) other. Use only one code. If code 12, other, please describe.

8d. Marital Status Code: 1) Single, 2) Married, 3) Widowed, 4)Divorced, 5) Separated.

9a. Enter the Total Number of Defendants (persons and institutions other than John Does) Involved in Claim.

9b. Enter the appropriate code(s) if a Derivative Claim (on behalf of someone other than the medically injured) was made by: 1) spouse, 2) children, 3) parent, 4) personal representative, 5) other (please describe). The amounts contained herein should be the sum of the amounts for the primary claim and any derivative claim(s) combined.

15a. Use nomenclature and/or descriptions to enter the Final Diagnosis for which Treatment was Sought or Rendered (actual abnormal condition).

15c. Use nomenclature and/or descriptions to enter the Misdiagnosis, if any, of the Patient's Actual Condition.

16a. Use Nomenclature and/or Descriptions of the Procedure used. Include method of anesthesia, or name of drug used for treatment, with detail of administration.

17a. Use Nomenclature and/or Descriptions of the Injury. Include type of adverse effect from drugs where applicable.

17c. Enter one digit code for Severity of Injury from scale provided below. Enter the code for the most serious injury if several are involved.

	Severity of Injury Scale	Examples
	1) Emotional only	Fright, no physical damage.
	2) Insignificant	Lacerations, contusions, minor scars, rash. No delay.
Temporary	3) Minor	Infections, misset fracture, fall in hospital. Recovery delayed.
	4) Major	Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
	5) Minor	Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
	6) Significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung.
Permanent	7) Major	Paraplegia, blindness, loss of two limbs, brain damage.
	8) Grave	Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
	9) Death	

17d. Enter the appropriate Characteristics of Injury Code: 1) occurrence of new abnormal condition induced by treatment or procedure, 2) incomplete cure or removal of original medically abnormal condition, 3) occurrence of new abnormal condition through lack or failure of preventive efforts, 4) performance of unnecessary treatment or procedure without further complications, 5) failure to accomplish intended goal (original condition not medically abnormal), 6) emotional and/or financial consequences of a mis-diagnosis in the absence of an abnormal condition, 7) physical, emotional and/or financial consequences of performing unauthorized acts whether or not such conduct was medically proper, 8) other (please describe).

18a. Enter the appropriate Misadventure Code(s) if the Procedure was: 1) not adequately indicated, 2) contraindicated, 3) there was a more appropriate alternative, 4) delayed, 5) improperly performed, 7) occasioned by misdiagnosis, 8) inadequate assessment, 9) mis-identification of the patient, 10) delay in notifying physician, 11) failure to notice an improper order, 12) failure to obtain a proper order, 13) failure to instruct patient, 14) treatment of wrong body part, 15) defective equipment, 16) patient mishandling, 17) other (please describe).

18b. Enter the appropriate Code if the following Misadventures in Diagnosis caused or aggravated the injury: 1) delay in diagnosis, 2) misdiagnosis of the abnormal condition, 3) misdiagnosis in the absence of an abnormal condition.

18c. Enter the appropriate Code(s) for the Cause of Misdiagnosis: 1) inadequate history, 2) inadequate physical or mental examination, 3) failure to request x-ray, 4) failure to request other diagnostic tests, 5) improper selection of x-rays, 6) improper selection of other diagnostic tests, 7) misinterpretation of x-rays, 8) misinterpretation of other diagnostic tests, 9) misinterpretation of otherwise adequate information acquired by history or physical examination, 10) other (please describe).

19a. Enter the appropriate code(s) if any Other Person(s) caused or Contributed to the Injury: 1) attending physician, 2) house staff, 3) consultant, 4) nurse R.N., 5) nurse L.P.N. or L.V.N., 6) aide, 7) orderly, 8) pharmacist, 9) radiologist, 10) radiology technician, 11) anesthesiologist, 12) anesthetist, 13) pathologist, 14) laboratory technician, 15) physician's assistant, 16) O.R. technician, 17) physical therapist, 18) inhalation therapist, 19) other therapists, 20) other technicians, 21) dietitian, 22) maintenance personnel, 23) engineer, 24) administrator, 25) other personnel, 26) patient, 27) another patient.

19b. Enter the appropriate Code(s) if one or more of the following factors were Associated Issues in the claim: 1) abandonment, 2) premature discharge from institution, 3) false imprisonment, 4) lack or delay of consultation, 5) lack of supervision, 6) breach of confidentiality, 7) failure to prevent an abnormal condition, 8) failure to accomplish intended result, 9) failure to conform with regulation or statutory rule, 10) lack of adequate facilities or equipment, 11) laboratory error, 12) pharmacy error, 13) products liability, 14) failure to timely disclose, 15) failure to provide warning instructions, 16) lack of consent from proper person, 17) inadequate information for informed consent, 18) procedure exceeded consensual understanding, 19) breach of contract, 20) warranty, 21) assault and battery, 22) res ipsa loquitur, 23) emergency equipment, 24) cooling devices, 25) heating devices, 26) cautery equipment, 27) x-ray equipment, 28) radiation therapy equipment, 29) traction equipment, 30) anesthesia equipment, 31) operative equipment, 32) surgical instruments and materials, 33) food preparation equipment, 34) laboratory equipment, 35) laboratory mislabeling, 36) laboratory computation error, 37) inadequate laboratory specimen, 38) lost laboratory specimen, 39) laboratory interpretation, 40) laboratory reporting error, 41) laboratory delay in reporting, 42) sterilization of equipment, 43) skin preparation, 44) aseptic technique, 45) isolation for infection control, 46) records, 47) billing and collection, 48) inter-professional relations, 49) vicarious liability, 50) statute of limitations, 51) punitive damages.

19c. Enter the appropriate Coverage Code for the type of policy covering the claim: 1) policy covers all claims made during the term of the policy (i.e., claims-made), 2) policy covers all claims made during the policy term for events which occurred during a designated previous policy term, (i.e., tail coverage), 3) policy covers all claims whenever presented for events which occur during the policy term (i.e., occurrence policy).

21a. Enter final method of Claim Disposition: 1) settled by parties, 2) disposed of by a court, 3) disposed of by binding arbitration.

21b. If settled by agreement of parties, enter appropriate Settlement Code: 1) before filing suit or demanding hearing, 2) before trial or hearing, 3) during trial or hearing, 4) after trial or hearing, but before judgement or decision (award), 5) after judgement or decision, but before appeal, 6) during appeal, 7) after appeal, 8) claim or suit abandoned, 9) during review panel or non-binding arbitration.

21c. Enter the appropriate Court Code: 1) no court proceedings, 2) directed verdict for plaintiff, 3) directed verdict for defendant, 4) judgement notwithstanding the verdict for the plaintiff, 5) judgement notwithstanding the verdict for the defendant, 6) judgement for the plaintiff, 7) judgement for the defendant, 8) for plaintiff after appeal, 9) for defendant after appeal, 10) all other (please describe).

21d. Enter the appropriate Trial Code: 1) heard by judge and jury, 2) heard by judge alone

21e. Enter appropriate Binding Arbitration Code: 1) claim not subject to arbitration, but previously coded disposition reached in lieu of award, 2) award for plaintiff, 3) award for defendant.

21f. If a Review Panel or Non-binding Arbitration was used in disposition, enter appropriate code: 1) finding for plaintiff, 2) finding for defendant.

22-28 Use the present value as of the date of settlement or award for the amounts requested in these items. If an annuity was obtained to discharge the obligations, use the price of the annuity.

22. Paid by Insurer: Enter all amounts paid under primary policy whether or not insurer recovered some costs from a reinsurer.

24. Paid by Excess Insurer: These are amounts paid under a separate policy issued to defendant to be excess over primary policy issued by insurer. These are not the amounts recovered by the insurer under a reinsurance policy, which should be included in item 24.

25. Excess Payment by Insured: This is the amount paid by the insured above the combined limits of the primary and excess policies.

27. Defense Counsel Fees: Enter fees paid to your defense counsel for this defendant. Do not include those items set forth in item 28.

28. Other Allocated Loss Adjustment Expense: Enter filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc.

29-30. Medical Expenses: This should include all payments made to physicians, hospitals, and other medical care service providers. Payments to providers of long-term care (i.e., nursing homes) and for custodial care in a residence should be included in items 33 & 34.

31-32 Provide the value of the Gross Wage Loss, before reduction for various deductions, plus the value of employer paid fringe benefits forgone (i.e., retirement benefits, workers' compensation, health insurance, life insurance, etc.).

35. Amount of Non-Economic Compensatory Damages: Non-economic compensatory damages include amounts paid for pain and suffering, loss or consortium, inconvenience, physical impairment, disfigurement, etc. Please note that any prejudgment interest or punitive damages should be shown separately in items 36 and 37.

36. Prejudgment interest: Enter the amount payable in accordance with G.S. 24-5(b).

37. Punitive Damages: These amounts are not meant to compensate the plaintiff for either economic or non-economic compensatory damages (which amounts are to be included in items 30-34 and 35 respectively), but to punish the defendant for actions done intentionally, willfully, or with reckless disregard for the plaintiff's welfare.

37a. Enter the appropriate Punitive Damage Code: 1) Asked for in complaint; not granted, 2) Asked for and granted by court or jury, 3) Asked for in settlement; not granted, 4) Asked for in settlement and paid by insurer, 5) Not asked for by claimant

37b. Amount Requested: Enter the amount that was asked for in the court complaint.

37c. Amount Awarded: Enter the amount that was awarded in final judgment after all appeals were exhausted and an actual punitive damage amount was separately awarded.

37d. Settlement Amount: Enter amount asked for in settlement

37e. Enter the appropriate Impact of Punitive Damage Code: 1) Major, 2) Minor, 3) None

39f. Paid by Insured: Enter the amount of the punitive damages paid for by the insured.

39a. Enter the appropriate Collateral Source Code: 1) Yes, 2) No, 3) Unkown

39b. Collateral Sources: Examples of collateral sources are workers' compensation, health insurance, and disability insurance.

40a. Structured Settlement First Payment: Enter the amount of the up-front payment made to the claimant in addition to the structured settlement amount.

40d. Structured Settlement Present Value: Enter either the price of an annuity if purchased or the present value of the projected total future payout if an annuity was not purchased.

40e. Structured Settlement Total Payout: Enter the projected total payout (undiscounted for investment income) the claimant and/or dependants will receive.

41b. Occupation Code: Use the 3-digit 1980 census occupational classification system coding structure.

42. Major Source of Payment Code: 1) Self, 2) Private insurance, 3) HMO, 4) PPO, 5) Medicare, 6) Medicaid, 7) Workers' Compensation, 8) Other (please describe).

43. Remarks: Enter any other relevant facts regarding the case.

NORTH CAROLINA HOSPITAL ASSOCIATION TRUST FUND
P.O. Box 10686 • Raleigh, North Carolina 27605-0686 • (919) 832-9550

September 19, 1986

Mr. David Warren
Box 2111
Legislative Building
Raleigh, North Carolina 27611

Dear Dave:

Enclosed is a copy of the memorandum I sent to Trust Fund participating hospitals in July regarding the increased rates for 1986-1987 effective October 1. The increase to $600.00 per short-term bed was raised from $332.00 per bed, or 80 percent increase. Last year we increased rates from $150.00 per bed to the $332.00 plus adding premium for outpatient surgery and emergency room and outpatient visits, or the equivalent of $415.00 per bed. Last year's increase represented about 177 percent.

Also enclosed is a bulletin recently published by St. Paul Insurance Company. You will note their current rates in each state. The rate is $725.00 per short-term bed in North Carolina plus extra premium for employee coverage, CRNAs and outpatient services. I believe St. Paul's increase this year was about 35 percent.

It would be my view that rates country-wide have about leveled off or we will see a much smaller rate of increase next year. I expect you will see some downward trend beginning in about two years. Any increase in medical malpractice liability insurance rates will likely be much slower coming.

Sincerely yours,

Marion J. Foster
President

MJF:atf

Enclosures

NORTH CAROLINA ASSOCIATION OF NURSE ANESTHETISTS

P. O. Box 535
Apex, North Carolina 27502
January 16, 1987

Mr. David G. Warren
Executive Director Medical Malpractice Study Commission
State Legislative Office Building, Office 2111
Raleigh, North Carolina 27611

Dear Mr. Warren:

The subject of anti-trust exemption for peer review activity has concerned us since the 1986 General Assembly.

First, there is no statutory definition of peer review. The professional definition is "a process by which practitioners of the same rank and profession critically appraise each other's work performance against established standards." Standards are based on statutory scope of practice, required education, code of ethics, professional scope of practice, and the incorporation of these into practice. Therefore, one profession can not properly appraise performance of another because each independently establishes our own previously mentioned standards and are governed by our individual practice acts.

This system of independent professions provides choice and the best health care for our patients. Consider the review of a nurse carrying out physician orders. The physician evaluates based on whether the nurse carried out the orders as written. The nurse evaluating the nurse, evaluates based on were the orders given according to established policy; did she assess whether the orders were proper for that patient; and, if she did not think so, did she question them in a manner established by policy; and, if carried out, did she follow standards. You can see why review by the proper person provides better patient care by application of proper professional standards.

Even if peer review is established with peers only reviewing true peers, it still has the inherent possibility of being anti-competitive. The decrease in dollars spent on medical care has increased competition among like providers for business. The providers in a position to protect their practice will be tempted to do so. Committees, boards and review groups must guard against anti-competitive activity. Governing bodies which control or oversee these activities need incentives to insure these committees are established in a manner which will not allow anti-competitive activity and, in fact, they are not being used in this manner. Anti-trust exemption

removes the incentive to guard against this activity. The advantage versus disadvantages of anti-trust exemption will need careful scrutiny. We believe that in the competitive environment of health care, now, it is not in the best interest of the public and the professions to legislate anti-trust exemption.

I am enclosing a report that shows a trend to more narrowly define anti-trust as it applies to peer review. Maybe this will negate the need for exemption.

In summary, when drafting legislation on peer review, please consider including a definition. Please also consider the competitive environment between professions and providers within individual professions to guard against a system that can be used for anti-competitive activity. We, as professionals, believe that valid, properly conducted peer review will help with malpractice problems. We are working for a system that will solve the problems with peer review, not create more problems. Thank you for your consideration of our concerns.

Respectfully,

Betty C Evans

Betty C. Evans, Chairman
NCANA Governmental Relations

ORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

December 17, 1986

Mr. Douglass M. Phillips
Executive Vice President
Medical Mutual Insurance Company
of North Carolina
222 N. Person Street
Raleigh, North Carolina 27611

Dear Doug:

As you know the Commission has been attempting to find a way to deal with the issue of obstetrical liability. We are told that prenatal and delivery services are becoming limited across the state due to physicians fear of liability or unwillingness to pay increasingly higher insurance rates.

We are interested in stabilizing the claims environment in obstetrics by a mechanism proposed by Professor Jeffrey O'Connell of the University of Virginia and author of the Medical Offer and Recovery Act bill pending in Congress (HR 3084). The plan was introduced last year in the Massachusetts legislature and I have enclosed a copy of a study of its possible implications. Also enclosed is a summary version of the proposal that I presented to the Commission on December 12.

Before we take any action on this proposal, we are seeking the advice of the insurers in North Carolina. Since the cooperation of insurers is essential for implementation, Senator Taft requests that you consider these questions and provide us your comments:

a. Compared to current experience, would this plan increase the number of claims paid?

b. Would it reduce the average period that claims remain open?

c. Would it increase the total amount of claims paid?

d. Would it decrease defense costs?

e. Would it decrease the average claim paid?

f. How would it affect premiums?

g. Would you be willing to participate in a limited trial of this plan?

We know these are difficult questions to answer but any advice you offer before our next meeting in mid-January will be appreciated.

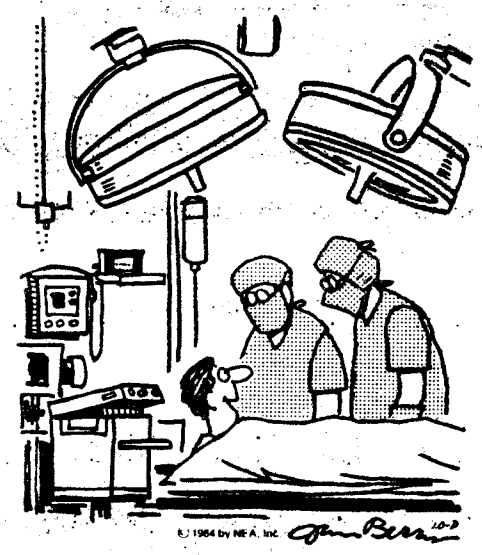
Sincerely,

David

David G. Warren
Executive Director

Enclosures
copy: Commission Members

Berry's World



"What with the malpractice situation, you must be just as nervous as I am about this, eh?"

Statistics misused

Recent statements by the trial bar are but more examples of a self-serving search for a convenient scapegoat in the medical liability crisis.

Over the years, plaintiff attorneys have misused insurance industry statistics to allege excessive profits by medical malpractice insurers and a manufactured crisis designed to restrict the public's access to the courts.

These lawyers have neglected to mention that most medical malpractice insurers are not-for-profit companies owned and operated by health-care providers. Their loss experience is similar and their rates comparable to those of St. Paul Fire and Marine, a publicly-held corporation. It defies reason to allege that non-profit companies owned or sponsored by doctors would seek to exploit their own members.

And if medical malpractice is so profitable, why has insurer after insurer left the market? Fewer than 2 percent of the companies that sell property and liability insurance are now in the medical malpractice marketplace. Losses in medical malpractice have been staggering.

No crisis is being fabricated. In 1985 St. Paul's average claim payment against North Carolina physicians was $76,900. That figure does not include defense costs or other expenses. And it's more than a 200 percent increase from five years ago. In that same time period, the number of claims per 100 doctors has increased 50 percent. This combination of more and bigger claims has an obvious result: larger and larger malpractice premiums.

Still, N.C. physicians' loss experience is better than the national average, and that is reflected in their rates. N.C. doctors pay a fraction of what doctors in high-risk states pay. They do not bear the burden of losses in other states, as the trial bar has alleged.

These self-serving attempts by the trial bar to disguise the real issues offend the intelligence of all those who are genuinely seeking to restore stability to the system.

RALPH JONES
General Manager
Charlotte Service Center
St. Paul Fire and Marine Insurance Co.
Charlotte

Raleigh: News & Observer

Will Doctors Testify Against Each Other?

A lot of frivolous medical malpractice lawsuits get filed against doctors. Somebody's health goes bad and they decide to get rich on the local doctor. Most of these suits get thrown right out of court.

But doctors and their insurance companies would like to avoid having to appear in court at all. There's a great deal of time, heartache and expense involved in getting a case ready for a judge to throw out. They'd like some kind of pre-screening procedure conducted by an impartial board of doctors and others.

As the legislature's Medical Malpractice Study Committee looks for ways to ease the medical insurance crisis, pre-screening is one option sure to be discussed. But before pre-screening would ever be accepted by the legislature, the medical community will have to clean up its public and political image. Doctors don't rat on doctors, the sentiment goes, and so they wouldn't give people suing for medical malpractice the fair hearing the court system is designed to provide.

Dr. Frank Greiss of Winston-Salem, president of the N. C. Obstetricians and Gynecologists Association, told the study committee of the incredible insurance premium increases practicioners of his specialty have encountered. Some rates are up 517 percent in five years, he said. Greiss asked the legislature to develop a system of physician pre-screening of malpractice suits.

That brought the lawyers on the committee out of the woodwork.

Sen. Tom Taft, D-Pitt, committee co-chairman, noted that "often a plaintiff's attorney (the person suing the doctor) finds it difficult to find a physician where a clear case of malpractice occurs who is willing to testify" against the defendant doctor.

Greiss had conceded earlier that he once testified for a plaintiff and felt tremendous peer disapproval. Rep. Paul Pulley, D-Durham, noted that Greiss's concession of "intense pressure" in that case had just "underlined the problem." Doctors won't come to the aid of an injured plaintiff, Pulley said. Those plaintiffs must often go outside of the state to get expert witnesses. Plaintiffs with few resources get shut out.

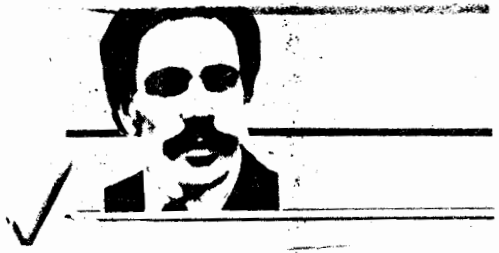
Rep. George Miller, D-Durham, said there is an "element of distrust when a profession itself is the final arbuter on an action of malpractice" against one of its own. All three lawyers noted that lawyers aren't any more likely to testify against their own than are doctors.

Greiss said that doctors are now ready to take a step forward to arrest public distrust of such pre-screening. He noted that the state Medical Society is working on a plan.

Miller noted that there are a number of steps which could be taken to reduce public distrust. Any screening panel should be only an interim step, he said. "You can't have no recourse" after an unfavorable ruling from the screening board, he said. But maybe a plaintiff whose suit was ruled frivolous by a screening board would bear extra consequences if that case was appealed and lost in the courts, he suggested.

Miller said public confidence in such a pre-screening process could be enhanced if, when the board found reason for a suit, the doctors on the board then became available as witnesses for the plaintiff.

The malpractice issue is like a New York city street at noon. It's gridlocked. No one can move and everyone expects someone else to move first. On this issue, doctors will hear that they first have to move away from their practice of protecting one another if they expect the legislature to give them the kind of pre-screening procedure they want.



by Paul O'Connor

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Malpractice insurance often cheaper in N.C.

State in lower half on premiums, report says

By VAN DENTON
Staff Writer

Although medical malpractice insurance costs doubled in North Carolina between 1983 and 1985, doctors here still enjoy lower premiums than in many other states.

A recent General Accounting Office report on medical malpractice insurance costs showed that North Carolina consistently ranked in the lower half of premium costs when compared with other states. The GAO is the investigative arm of Congress.

The report, released last week, found that between 1983 and 1985 malpractice insurance costs nationwide rose from $2.5 billion to $4.7 billion. It also concluded that while the cost of such insurance was increasing rapidly, it still represented only a small part of the cost of operating hospitals and doctors' offices.

In a look at how malpractice insurance rates have affected doctors, the report found that premium costs varied widely from state to state, depending on the doctor's speciality. Despite the fluctuation, North Carolina's malpractice insurance rates were considered some of the lowest in the nation.

For instance, family doctors in North Carolina paid $2,760 for $1 million in insurance coverage in 1985, compared with $12,156 in Florida. Neurosurgeons, considered the highest risk by insurers, paid $18,595 in North Carolina for $1 million in coverage; in Florida, the same type of policy cost $64,696.

The report, based on premiums charged by each state's largest insurers of doctors in July 1985, found that malpractice insurance costs for physicians nationwide rose from $1.7 billion in 1983 to $3.4 billion in 1985. The North Carolina figures were provided by Medical Mutual Insurance Co., a doctor-owned company.

Insurance Commissioner James E. Long said malpractice insurance costs for doctors and hospitals in North Carolina also doubled during the same two-year period, rising from $24 million to $48 million.

But Long said North Carolina doctors enjoyed lower rates than their counterparts in other states because fewer claims were being filed here and court judgments were not as high.

"I think the basic reason you don't see the higher

See MALPRACTICE, page 39A

Malpractice insurance often is cheaper in N.C.

Continued from page 37A

rates," Long said, "is our juries are very conservative in their awards. We don't have as many suits or claims being filed, and the tort system is more conservative."

Susan D. Kladiva, the GAO project manager for the report, agreed.

"Ultimately those rates are reflective of the number of malpractice claims that are filed and the size of awards associated with those claims," Ms. Kladiva said in a telephone interview from Washington.

David R. Fuller, manager of the Medical Services Department of St. Paul Fire & Marine Insurance Co. of Charlotte, the state's other major medical malpractice insurer, said that the company recently increased its medical malpractice premiums in the state by an average of 20.2 percent but that North Carolina had the second-lowest premiums of its customers nationwide. The company insured more than 55,000 physicians in 44 states in 1985.

"Even though the (North Carolina) climate is not as conservative as it once was, maybe it is still more conservative than in the neighboring states," Fuller said by telephone.

The report also found that premiums ranked fourth of the five major expenses for doctors, behind office payroll, office expenses and medical supplies. Only medical equipment costs were less.

But insurance costs were increasing at a much quicker rate, about 45 percent, than other physicians' expenses, faster than the 8 percent increase in the consumer price index or the 13 percent increase in the medical care index over the same period.

David G. Warren, a professor in health law at the Duke University Medical Center and executive director of the N.C. Medical Malpractice Study Commission, said North Carolina doctors were concerned that the low rates may soon be a thing of the past.

"There is a feeling that we may not for much longer enjoy our low premiums," Warren said. "There is also the sense that we can still do something about it ... because of the fact that things aren't out of hand yet. There's still time to come up with long-range solutions."

Reasons for the more conservative climate here, Warren said, could include a more dispersed population, more public confidence in doctors, the less litigious nature of state residents and a higher quality of medical care.

Robert Hunter Jr., president of National Insurance Consumer Organization, a Washington-based consumer group, agreed that North Carolina residents were less litigious and adopted "a neighborhood approach" to their disputes. But he said it was further evidence that the civil justice system here was working.

"I don't think the justice system needs any tinkering in North Carolina," Hunter said by telephone. "It may in other places, but not in North Carolina."

The N.C. Department of Insurance is conducting a three-year claims study in an attempt to find out just what the insurance climate in the state is, including why claims or lawsuits are filed, the number and the amount of awards. It will also look into what effect changes in civil justice laws would actually have on insurance costs.

Malpractice support group being formed

RALEIGH — The N.C. Medical Society will form a malpractice support group for N.C. physicians.

John W. Foust, M.D., president of the organization which represents the state's licensed medical doctors, said the support group is needed because of the increasing number of suits filed against practicing physicians.

"There is nothing more devastating to a physician and his or her family than a lawsuit," Foust said.

"We need a support system for physicians and their families when they are facing such a terrible experience."

A malpractice survey recently released by Medical Mutual Insurance Co. of North Carolina showed that 666 claims were reported in 1985, up from 570 in 1984.

Although almost six out of seven claims resulted in no payment to the plaintiff, the claims still require an investigation and preparation of defense to properly defend the physician.

"We hope that our support group will be able to help them through a very tough time," Foust said.

Physicians in this state, represented by the N.C. Medical Society, have sought legislation to reduce the number of unfounded malpractice cases while helping to insure proper compensation for anyone actually injured through a physician's actions.

Rocky Mount Telegram
1 11/28/86

News & Observer 12/15/86

Crisis in malpractice

The editorial, "Faults with no-fault," correctly suggests that changing the legal rights of persons injured by medical negligence is not the answer to the medical malpractice problem. Obstetrical malpractice, however, is not simple cause-and-effect negligence.

Bad outcomes continue to occur despite increasing numbers of excellently trained obstetricians and increasing technology applied to the birth process. Often the actual malpractice is an arguable omission by a caring obstetrician. Then experts on both sides differ markedly on whether there was any negligence.

Moreover, the causal relationship between the malpractice and the outcome is becoming increasingly suspect in recent studies. The penalty paid by the obstetrician under such circumstances far exceeds the degree of culpability.

In 1985 the Medical Mutual Insurance Company of North Carolina paid three $1 million claims in obstetrics. In 1986 the company has already received more than 50 percent of all the ob-gyn claims it has ever received. More than 25 percent of obstetrical fees are consumed by malpractice premiums.

The geometric rise in premiums to meet the alarming rise in claims seemingly has no end as births increase, the number of plaintiff's attorneys increases, and the public becomes more aware that a bad outcome has a good chance of compensation. The cost of caring for a handicapped child is overwhelming and must be obtained from some source.

An obstetrical compensation system, like workers' compensation, funded by a small fee paid from the 90,000 deliveries annually in this state, would meet the needs of injured patients. The deterrent effect of the tort system could be fulfilled by effective peer review boards armed with disciplinary power.

Obstetricians cannot continue to be effective care-givers in an adversary system, the antithesis of the doctor-patient relationship.

H. ALEXANDER EASLEY III
Greenville Obstetrics and Gynecology
Greenville

"I want a liability policy with reasonable rates."

Long seeks exemption for some insurance reports

Insurance Commissioner James E. Long asked legislators Friday to exempt some insurance reports from the state's public records law to overcome insurance industry resistance to a survey of trends in malpractice claims.

Long said the exemption would was needed to overcome insurers' objections to revealing the identity of patients and doctors involved in malpractice claims.

"The insurers are extremely reluctant to provide any data that would risk confidentiality," Long told members of the N.C. Medical Malpractice Study Commission. "We need immunity to be exempt from the public records law."

Long is conducting a three-year claims study to define trends in the frequency and amount of malpractice claims in North Carolina. The survey would obtain detailed information from insurance companies about all malpractice claims and lawsuits filed in the state since 1983 to determine if there has been an increase in their number and amount of payment.

Long said he has met with resistance from insurers in recent meetings on what form the survey reporting requirements would take. Under the plan he proposed to the study commission Friday, the insurance department would keep confidential the individual reporting forms filed by the insurance companies on each malpractice claim. But the insurance department would make public a summary and analysis of all of the claims reported.

Long said he hoped to win the insurance industry's cooperation in the survey, but he would go forward with it even without the cooperation. State law gives him the authority to send inspectors to examine insurance company records if the company refuses to volunteer the information.

"We don't think we'll have to do that," he said.

The study commission's chairman, Sen. Thomas Taft, D-Pitt, asked the commission staff to draw up a proposal for the public records law exemption.

— DONNA ALVARADO

Insurance plan OK'd for N.C. midwives

Professional midwives practicing in North Carolina may soon find it easier to obtain liability insurance coverage.

State Insurance Commissioner James E. Long announced Thursday that he had approved a proposal by the American Casualty Company of Pennsylvania to offer liability coverage for professional nurse midwives.

The company, which can begin writing claims Dec. 26, will be the only one in the state offering such liability coverage.

The coverage would be provided to certified nurse midwives who are members of the American College of Nurse Midwives. Coverage will range from $250,000 per claim to up to $1 million.

How It Feels To Be Sued For Malpractice

CHARLOTTE PHYSICIAN

By WILLIAM G. PORTER
Special To The Observer

This is about medical malpractice. Every doctor worries about it, today more than ever.

We worry because so many malpractice suits are being filed, because juries routinely award settlements of several million dollars, driving up our malpractice insurance premiums and tempting others to sue. We worry because people have unrealistic expectations of medicine. Publicity about our triumphs, such as heart transplantations, has convinced many people that every case should have a successful outcome. If it does not, they reason, then someone must have done something wrong. We worry because we go to work every morning in a country where two-thirds of the world's lawyers live and where 95% of all lawsuits are filed.

Porter

Until recently I worried about malpractice in the same vague, generic way I worried about burglars or auto accidents. I reasoned that if I did my best to practice skillful, up-to-date, compassionate medicine and to communicate fully and honestly with my patients and their families, I would not be sued. I was wrong.

Not long ago a patient for whom I *had* done my best and with whom I *had* communicated fully and honestly sued me, alleging "willful and wanton negligence." Now, several months later, the suit has been dropped, and I have "won" the case. Here is the language of the order to dismiss: "Now comes the Plaintiff by and through her undersigned attorney who moves the Court for an Order dismissing this action with each party to bear its own costs and attorneys' fees."

> **"I reasoned that if I did my best to practice skillful, up-to-date, compassionate medicine and to communicate fully and honestly with my patients and their families, I would not be sued. I was wrong."**
>
> *— Dr. William G. Porter*

Let me tell you about some of this party's "own costs." Last year my insurance company spent $1.8 million defending North Carolina doctors against "nonmeritorious" claims — that is, claims that never came to trial because there was no substantial evidence of malpractice. But I'm not talking about monetary costs, significant as they are. I'm talking about being stunned into angry disbelief when I learned I had been sued, about nights spent in confidence-eroding, sleepless scrutiny of my professional competence, about a fear of being sued again which has freighted every subsequent patient encounter. I'm talking about hours of conferences with my attorney, hours of being questioned by the plaintiff's attorney, and hundreds of hours of anxiety about the potential impact of the suit on my colleagues, my family and myself. Finally, I'm talking about my decision to quit practicing medicine — a decision significantly influenced by a malpractice suit which I "won."

I do not know how to end the malpractice crisis. Malpractice *does* occur, and there must be a legal remedy for it. Incompetent and impaired physicians must be identified and dealt with. Limiting the size of awards for pain and suffering, and the size of contingency fees to attorneys, would help also, as would a more realistic public perception of the nature and limitations of modern medicine.

My object in these paragraphs is simply to point out that insufficient attention is being paid to the impact which the *threat* of malpractice is having on the everyday professional lives of competent, unimpaired, caring physicians, and hence on the quality and cost of medical care. That threat distorts what should be a trusting relationship between physician and patient, causing doctors to think of patients not just as people who need help, but also as potential legal adversaries. To protect ourselves we order too many tests and too many consultations, driving up costs. We are less likely to attempt potentially helpful, but risky, procedures for fear of being sued for an unsatisfactory outcome.

We go anxiously through our daily rounds knowing that a malpractice suit, like a terrorist attack, can come, suddenly and capriciously, at any moment, however conscientiously we try to prevent it. We feel like the targets of big game hunters, who are stalking another trophy.

In this hostile environment, more and more of us are saying "to hell with it" and taking other jobs. The rest are increasingly angry, defensive and frightened.

There is indeed a malpractice "crisis" in this country, and much more than money is involved. It is a crisis that deserves the urgent attention of the public and the lawmakers before it further erodes the quality and availability of medical care.

William Porter is a physician in private practice who will be joining the internal medicine faculty at Charlotte Memorial Hospital and Medical Center as a full-time medical educator.

CHARLOTTE OBSERVER #- 4-27-86

Many doctors face insurance rate hike

By VAN DENTON
Staff Writer

Medical malpractice insurance rates would jump an average of 27 percent for about half of North Carolina's doctors under a rate increase filed by Medical Mutual Insurance Co. of North Carolina.

The doctor-owned insurance company, one of three companies providing malpractice insurance in the state, also is proposing that a discount be granted to groups of doctors who are willing to insure themselves for part of their coverage and that high-risk doctors pay extra for insurance.

The rate increase, submitted Friday to the N.C. Department of Insurance and scheduled to go into effect April 1, represents the 10th increase in 10 years for the company. In March, it increased its rates an average of 44.6 percent but raised those for family doctors delivering babies by 357 percent.

The latest increase is expected to spark more debate about the need for changes in the state's civil justice laws to hold down premiums. Doctors have been among those calling for such changes, which were rejected in 1986 by the General Assembly.

The increase would range from 25 percent to 30 percent, depending on a doctor's experience,

See MANY, page 2C

Medical Mutual malpractice premium increases

Premium increases for a medical malpractice policy with a maximum coverage of $1 million per claim or $1 million per year, written by Medical Mutual Insurance Co. of North Carolina.

Date	% increase
Oct. 1, 1979	20.2
Sept. 1, 1980	29.9
July 1, 1981	24.0
June 1, 1982	12.5
May 1, 1983	20.0
Feb. 1, 1984	15.0
July 15, 1984	32.2
July 1, 1985	16.9
March 1, 1986	44.6
April 1, 1987*	26.8

* Proposed

Source: Medical Mutual Insurance Co. of N.C.

Continued from page 1C

specialty and the type of coverage. The company provides insurance for about 3,900 doctors, or roughly half the doctors in the state and 80 percent of those in private practice.

For instance, a physician in the lowest risk group, such as one with five years of experience who does not practice surgery, would see his premium for $1 million in coverage increase from $2,573 to $3,332, or 29.5 percent. A neurosurgeon, who is in the highest risk class, would see the premium increase from $24,339 to $30,544, or 25.5 percent.

Douglass M. Phillips, executive vice president of the not-for-profit company, said Monday that the increase in premiums was needed to cover an increase in claims being filed against doctors and the higher costs of paying those claims.

"The number of claims has continued to rise, and the severity has continued to rise at even a faster pace," Phillips said in a telephone interview. "For one reason or another, more people are filing claims against medical practitioners, and larger awards are being given by juries, and then the settlements are higher because of the expectations."

However, Phillips said he did not have data showing an increase in the number and cost of claims.

Though the number of civil suits filed in North Carolina has increased in the past two years, the rate of suits filed — two per every 1,000 residents — has remained virtually unchanged since 1975, according to the state Administrative Office of the Courts. There have been 15 verdicts of $1 million or more in the history of the state's court system, and 10 of those verdicts were overturned or settled for lesser amounts, according to the N.C. Bar Association.

Final 1986 data on claims and settlements is not yet in, Phillips said, but the company is projecting a $1 million shortfall. That would result from $16 million in losses, $11 million in premiums earnings and $4 million in investment income.

The new rates are under review by state Insurance Commissioner James E. Long, who can require more data and a hearing if he finds them unjustified. But the industry can put the rates into effect without Long's approval. He could require a rollback in rates, but only after they had been in effect for a year. Long declined to comment on whether the rate hike was justified.

The discount on premiums for groups of doctors who agreed to insure themselves for the first $100,000 each would be 22.5 percent, Phillips said. That will provide an incentive for doctors who believe they can reduce losses, he said.

"We've got several major groups who feel they have effective loss-prevention plans, and they are looking at ways to effectively reduce their premium costs," Phillips said.

The premium surcharges for high-risk doctors would vary. Those who are responsible for more than $25,000 in claims payments would face a 20 percent surcharge for each $25,000 claim; those disciplined by a medical board, 20 percent; and surgeons still practicing at age 70, 50 percent.

Long said the surcharges and discounts were innovative proposals.

"That's an encouraging thing because they are recognizing the fact that there are different levels of exposure for different physicians," Long said. "I think that the company needs to be looking at the risk they are taking on with Doctor A vs. Doctor B."

Long said that even though the increase was a significant one, North Carolina doctors would still have lower premiums than their counterparts in many other states.

Mount Airy News
New Bern: Sun-Journal
Newton: Observer N-E
Raleigh: News & Observer

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Draft – For discussion only – Not for distribution

OUTLINE OF PROPOSALS TO MODIFY RULES OF CIVIL LIABILITY IN MEDICAL MALPRACTICE CASES

Prepared for NC Medical Malpractice Study Commission
by Sally Marshall, April 6, 1986

1. ARBITRATION

a. decision may be binding or nonbinding

b. may be mandatory, by prior written agreement of parties, or by current agreement of the parties

c. may be mandatory for all cases under $? amount

d. arbitrator may be single member (usually approved by American Arbitration Assoc>,or panel (e.g., physician, lawyer, lay person; or one person selected by each party and those two select the 3rd)

e. discovery mechanisms available

f. usually financed by the parties

g. hearings not open to public

h. appeal available as agreed or specified in statute (e.g., on basis of biased arbitrators)

i. may be governed by Uniform Arbitration Act (NC Gen.Stats. 1-567.1 et.seq.) or special act

Proponents: speedier claims resolution, less procedural costs, more objective decisions, less formality, more confidentiality, greater access for small claims, usually smaller awards, reduced likelihood of appeal

Opponents: panel may be biased in favor of defendants, may not adequately compensate injured party, agreements to arbitrate may not be fair or deemed to be legal, informality may violate due process rights, may allow plaintiff to use both arbitration and courts if multiple defendants, removes bad actors from public review, plaintiff forfeits right to jury and normal appeal processes

2. PENALIZING FRIVOLOUS ACTIONS

a. all or some costs can be awarded to the winning party (e.g., reasonable attorney fees, witness fees, documents and photographs, court costs, etc.) in discretion of court on specified conditions (e.g., lack of reasonable

grounds for suit, malicious intent, bad faith) (Note: current NC law is costs, when justice requires it)

b. attorney fees can be awarded when lack of justiciable issue in allegations, motions, etc. (Note: current NC law)

c. expand basis for countersuits based on abuse of process or some specified basis

d. require posting of bond prior to filing action

e. require 90 day notice prior to filing action

Proponents: discourages frivolous claims, harrassment, fishing for settlements

Opponents: discourages pursuit of some valid claims

3. CONTROL ATTORNEY'S FEES

a. sliding statutory scale limiting percentage of contingent fees for plaintiff's lawyers, based on size of award, stage of proceedings (settlement, verdict, appeal)

b. authorize court discretion in setting reasonable attorney fees (1) for plaintiff only, (2) for both plaintiff and defense attorneys

Proponents:

Opponents:

4. Collateral Source Rule

a. permit evidence of compensation plaintiff receives from other sources (e.g., health insurance, employer benefits)

b. offset award by some or all payments received from collateral sources (option: if not derived from premiums paid by or on behalf of plaintiff)

Proponents:

Opponents:

5. Expert witness qualifications

a. expert must actively practice in defendant's speciality

b. expert must be familiar with standard of care in defendant's community

c. plaintiff must provide expert testimony or expert treatise in order to get to jury

d. medical society furnish panel of experts to plaintiff upon certification of necessity by court

Proponents:

Opponents:

6. Limits on liability

a. place statutory maximum (increase with inflation?) on amount of non-economic damages (e.g., pain and suffering, disfigurement, change in quality of life, loss of consortium) (Note: Calif - $250,000; Mo and Md - $350,000)

b. place statutory maximum on total award (Note: Va - $1M)

c. place statutory maximum on awards in specified types of actions (e.g., medical procedures required by state law, such as vaccinations, tests for TB and other communicable diseases)

7. Punitive damages
   a. limit to maximum amount
   b. prevent insurability
   c. prohibit
   d. direct all or portion go to a designated state fund

8. Periodic payments

9. Pretrial screening panels

10. Res ipsa loquitur

11. Statute of limitations

12. Statute of limitations for minors

13. Fund the existing patient compensation fund

14. Change evidentiary standard to clear and convincing instead of greater weight of the evidence

15. Itemize jury verdicts for each element of special damages (medical expenses, lost wages, etc.) and general damages (pain & suffering, etc.)

16. Affidavits for noninvolvement (allow defendant to file denial of connecton to negligent act and require plaintiff to show cause for naming that defendant

17. Limit recovery for physician's failure to perform diagnostic tests deemed unnecessary if second physician concurs in writing

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NORTH CAROLINA MEDICAL MALPRACTICE STUDY COMMISSION

June 5, 1986

The Honorable Robert B. Jordan III
President of the Senate

The Honorable Liston B. Ramsey
Speaker of the House of Representatives

Dear Lieutenant Governor Jordan and Speaker Ramsey:

On behalf of the members of the Commission we are pleased to present to you and the North Carolina General Assembly this interim report recommending two bills for consideration, as authorized by Chapter 6 of the 1986 Extra Session.

The Commission was charged by Chapter 792 of the 1985 Session Laws to "make a thorough and comprehensive study on any and all laws affecting medical malpractice liability and insurance" and to report to the 1987 General Assembly. The Commission was organized in December 1985 and has diligently pursued its mission, soliciting information and advice from numerous organizations and individuals in this State and obtaining data through staff research on developments here and in other states and the federal government. Five public hearings and three Commission working sessions were held which have produced the basis for our recommendations, although not every Member concurs in all of them.

Abundant but sometimes conflicting testimony and evidence received by the Commission point to problems in both the affordability and availability of professional liability insurance for health care providers. In particular, the services of physicians, especially family physicians who do obstetrics in health departments and rural counties, have been limited in numerous ways by current pressures and future uncertainties. The true financial condition of insurance companies is not clear and their claims experience in North Carolina is difficult to analyze. Nevertheless, predictability in civil liability outcomes would benefit their operation and perhaps their rate structures.

While all the causes of the medical malpractice problem remain undertermined, it appears that part of the dilemma for injured patients and their legal advocates, as well as for insurers, is attributable to a percentage of the medical profession which is not as competent as modern medicine requires.

To the credit of all parties who make suggestions to the Commission, there is willingness by insurers to furnish more information to the State, by health care providers to more actively pursue self-discipline, and by the legal profession to discourage frivolous legal maneuvers.

Therefore, we are recommending a bill which will improve the capacity of the State to monitor the claims experience of liability insurers and create a data base for policy analysis and decision making; to assist the health care professions in peer review, risk management and self-disciplinary efforts; and to limit liability awards against health care providers for noneconomic and punitive damages.

We also note a serious development which affects the State-mandated childhood vaccination program. Nationwide, vaccine manufacturers are raising prices precipitously due to liability insurance costs and North Carolina pediatricians and family doctors are wary of liability in vaccine-related injury cases. Therefore, we are proposing a second bill which addresses those concerns.

The Commission's work is not finished and after adjournment we will be continuing our study of this complex problem. We plan to be able to make a full report and recommendations in December 1986.

For the Session of the General Assembly which convenes on June 5, we recommend these two bills be considered. Attached also are a separate letter and proposal from Commissioner Long and a dissenting letter from Members Pulley, Soles, Ballance and Cromer.

Sincerely,

Senator Tom Taft
Co-Chairman

Representative Dwight W. Quinn
Co-Chairman

Enclosures: Draft bill to implement the recommendations of the Medical Malpractice Study Commission (Omitted)

Draft bill to establish the NC childhood vaccine-injury compensation program (Omitted)

Letter from Commissioner Long with proposed bill (Bill Omitted)

Letter from Members Pulley, Soles, Ballance and Cromer

June 3, 1986

The Honorable Robert B. Jordan, II
President of the Senate

The Honorable Liston B. Ramsey
Speaker of the House of Representatives

Re: Minority Report

Dear Lieutenant Governor Jordan and Speaker Ramsey:

It should be made clear the report was made based upon a sharply divided Commission which did not reach a consensus.

The letter from the chairmen states that the evidence "points to problems in both the affordability and availability of professional liability insurance...." A representative of St. Paul Insurance Company who is a member of the Commission stated in at least two meetings that there is no problem in North Carolina with regard to availability or affordability of insurance for medical malpractice. Medical Economics, November 11, 1985 reported that physicians pay only 2.7% of their gross income for medical malpractice insurance.

Major changes are being proposed to tort law which was developed over 300 years in the face of repeated statements from the industry that they don't know if it will have any impact on rates.

The increase in premiums is caused by a reduction in investment earnings, not problems with tort law. A United States General Accounting Office Report, April 28, 1986, said that insurance, like all business, is subject to profitability cycles and that the underwriting cycles have turned. The Journal of Commerce, March 24, 1986 supports this statement by showing that the property and casualty industry made $2 billion nationwide in net-after-tax income in 1985. They have already made $2.3 billion in net after tax income in the first quarter of 1986.

The insurance industry and proponents of this legislation resisted the Insurance Commissioner's request for some supervision over rates and their position was adopted by the Commission although its charge was to deal with rates. Almost every proposal to secure more information was met with resistance by the industry which complained "too burdensome," "not on computer," or "you don't really need that."

An example of the extreme position recommended by the Commission and the attached bill is the issue of punitive damages. There has never been but one verdict against a physician for punitive damages in the history of North Carolina and that was an

extremely flagrant case. Mazza v. Medical Mutual Insurance Company of North Carolina, 311 N.C. 621, 319 S.E.2d 217 (1984). Insurers may exempt punitive damages and one carrier insures this risk at no charge. And yet the Commission has recommended abolition of punitive damages.

Another proposal of the majority is for a cap on non-economic damages in the amount of $250,000. This is proposed with uncontradicted knowledge that North Carolina is not a high verdict state. Also actuaries have testified, without contradiction, that frequency, not high verdicts, has more impact on rates of premiums. It should be pointed out that the centerpiece of the Medical Society's argument is a $6.5 million verdict in Eastern North Carolina which got much publicity but was set aside by the court, meaning there was no verdict.

Medical Mutual which increased the rates so greatly for Family Practitioners has paid a net redemption of guaranty capital certification to its investors every year until the current year.

The undersigned do not believe the system is perfect and do not out of hand object to any change. We do believe there should be some logical basis to change a well developed system of justice which, although imperfect, is the envy of many governments.

In conclusion the undersigned dissent from the report and the proposals concerning punitive damages, Section 17 and a cap of $250,000 on non-economic damages, Section 18. Close attention is invited to the other proposals which were not studied in depth by the Commission.

Respectfully submitted,

Rep. W. Paul Pulley, Jr.
Sen. R. C. Soles, Jr.
Rep. Frank W. Ballance, Jr.
Rep. Charles L. Cromer

WPPjr/teh

DEPARTMENT OF INSURANCE

State of North Carolina

P. O. BOX 26387

RALEIGH, N. C. 27611

JAMES E. LONG
COMMISSIONER OF INSURANCE

(919) 733-7343

June 3, 1986

The Honorable Thomas Taft
Co-Chairman, Medical Malpractice Study Commission

The Honorable Dwight W. Quinn
Co-Chairman, Medical Malpractice Study Commission

Dear Senator Taft and Representative Quinn:

The Medical Malpractice Study Commission was charged by Chapter 792 of the 1985 Session Laws to "make a thorough and comprehensive study on any and all laws affecting medical malpractice liability and insurance". Proposals presented to the Commission included those calling for restrictions on the North Carolina civil justice system. However, evidence and opinions offered to the Commission during the course of its study were highly conflicting concerning whether changes in the civil justice system would have any salutory effect on insurance rates, i.e., reduce premiums.

Restricting the legal rights and remedies of our citizens is a grave undertaking especially when lower insurance rates are not guaranteed. Therefore, I present the attached bill to provide for a roll-back of insurance rates, to assure the health care providers who have to pay these premiums that any and all benefits emerging from reform legislation otherwise enacted, shall be fully reflected in their medical malpractice insurance rates. The bill is a modification of a New York statute recently used by the New York Superintendent of Insurance to force a retroactive 15% reduction in medical malpractice insurance rates. I regret our Medical Malpractice Study Commission did not see fit to adopt my recommendation of May 22 to provide such authority to the Insurance Department of this State.

For the Session of the General Assembly which convenes on June 5, I therefore recommend this bill be considered.

Very truly yours,

Jim Long

JEL:AWS/ja
Enclosure
cc: David G. Warren
Executive Director
N.C. Medical Malpractice Study Commission
Room 2111 State Legislative Building
Raleigh, NC 27611