PUBLIC HEARING

before

SENATE JUDICIARY COMMITTEE

on

Medical Malpractice

October 31, 1985
Room 400
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator John A. Lynch, Chairman
Senator John F. Russo
Senator Edward T. O'Connor, Jr.
Senator Donald T. DiFrancesco
Senator William L. Gormley

ALSO PRESENT:

John J. Tumulty
Office of Legislative Services
Aide, Senate Judiciary Committee

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SENATOR JOHN A. LYNCH, CHAIRMAN: This is the second in a series of hearings. The first one occurred on June 20, 1985, when we heard from Howard Weiss, Tom Vesper, Dr. Reiter, and Dr. Ben-Asher.

Today we are going to start with the Commissioner of the Department of Insurance, Commissioner Gluck, if she will please come forward. I am sorry for the delay, Hazel, but we were waiting for one Republican to show up. (laughter) They are all out on the trail having too much fun these days.

COMMISSIONER HAZEL FRANK GLUCK: Oh, is that it? Do you mean even Bill Gormley is not here?

SENATOR LYNCH: Some of us are here. We wondered this morning whether or not John Tumulty has a diseased mind, holding a medical malpractice hearing on Halloween, in the middle of a full moon, just a couple of days before the election.

COMMISSIONER GLUCK: The full moon most of all.

SENATOR LYNCH: Why don't you give us your report? I know we have had some reports issued in the interim time between the time of our last hearing and today.

COMMISSIONER GLUCK: I think what I would like to do, Senator, is, since the Malpractice Task Force -- which was set up by Ken Merin -- made their final report, which I think we sent to the Committee, plus their summary.

What I would really like to do is, for the sake of the record, go over some things that were in the summary. In particular, just to refresh everybody's memory, the 70s was the decade of the medical malpractice availability crisis. The 80s could well be the decade of the malpractice affordability crisis.

While medical malpractice is--

SENATOR LYNCH: You are not limiting that to malpractice either, are you?

COMMISSIONER GLUCK: No.

SENATOR LYNCH: Insurance affordability?

COMMISSIONER GLUCK: Right, any liability -- commercial liability.

While medical malpractice insurance is available today to New Jersey physicians and dentists, that insurance is getting increasingly more expensive. While rates have not yet reached a crisis point in New Jersey, this Task Force was charged with investigating whether the impending crisis could be cut off in advance.

The Task Force studied four general areas: The Judicial system, the attorneys, the physicians, and the insurers. By examining each of these four areas it was able to produce a comprehensive report whose package of recommendations would deal with the problem of rising malpractice premiums through preventive efforts by continuing education requirement for physicians, cost avoidance measures such as increasing expert witness qualifications, and strengthening professionalism through measures such as the Certified Malpractice Attorney Program.

The total package of recommendations was seen as the best attempt to both slow the rising rate of malpractice insurance and, yet, guarantee the rights of patients who may have just cause to collect damages.

On the surface, the problem appears to be rising premiums. The Task Force Report points out that Malpractice premiums for about 7000 physicians insured by companies, working under the auspices of the Medical Society of New Jersey, have increased about 19% a year from 1984 to 1985.

The Princeton Insurance Company, which insures about 5000 physicians in New Jersey, has increased its average premiums by 50% in just three years, from $6000 in '82 to $9000 in 1985. It must be pointed out that not all specialties were affected to the same extent. High-risk specialties, such as OB-GYN, have seen their malpractice premiums increase the most. At the same time, ophthalmologists' rates, insured by one company, have decreased.

However, on closer examination, the Task Force found two related phenomenona: More law suits are being filed, and jury awards are higher.

Let me just say this: With regard to medical malpractice premiums, we know that fortunately we do not approach what has happened in New York. I understand that not too long ago there was also a march

on Annapolis by the obstetricians and gynecologists, and recently the physicians in Connecticut have formed a union. So, while it is sort of all around us, I would say at this particular juncture we are not in crisis. Nobody is marching.

Although we have fortunately not approached that point in New Jersey, it is all around us. I am sure we would not like to see something like that happen in New Jersey.

I would like to say to the Committee this morning that I really think what is happening here is a mirror image of what you can expect in your own profession as well. We happen to be talking about medical malpractice this morning, but I know for a fact, for instance, that the State Bar has approached the Department about setting up an Insurance Exchange, because malpractice is spreading to your professional liability and to other areas of professional liability as well. So, I guess what we are talking about really spreads across the board to dentists, attorneys, physicians, or whatever.

By a conservative estimate which took into account only suits which were closed with payments, the number of suits per 100 physicians rose from 9.2 in 1970 to 21.7 in 1982. As for jury awards, between 1964 and 1978, State juries awarded a million dollars in verdicts to seven plaintiffs, spread amongst several kinds of liability actions. Between 1980 and 1983 there were five $1 million verdicts in medical malpractice alone.

Now, consumers are obviously not immune to rising malpractice rates. The rates tend to translate directly into increased doctor bills. I believe the dentists in this State have experienced a 400% increase in their malpractice premiums. Nationwide, the increase was only 300% -- high enough.

A 1983 study done by the American College of Obstetrics and Gynecology found that more than half its members had increased fees, two or more times in the last two years, to their consumers. The major factor cited for these increases was malpractice insurance.

There is also a second impact. It is called "defensive medicine." Doctors order additional diagnostic testing, offered out of fear of potential lawsuits. Some doctors call this good medicine;

others say the additional testing accelerates the overall growth in health care costs. A 1983 study done by the American Medical Association found that 40% of the respondents said they often ordered additional diagnostic tests, while 27% said they prescribed additional treatment to guard against malpractice suits. Now, whether that is good, bad, or indifferent, that is a fact.

So, this Task Force came up with a recommendation. There are really 14 specific items. It was a very difficult assignment. The Task Force was made up of physicians, attorneys, and insurance companies. There was a nurse-attorney on the Task Force, the Public Advocate, and the Department of Insurance. We had a broad spectrum of people, including dentists and chiropractors, and I think what they did was quite remarkable. The fact is, they came up with these 14 points that they could agree on. There were also some points they could not agree on, so these points did not become part of the Task Force recommendation.

Let me just go over the Task Force recommendations briefly. I am not going to go into detail because I know you have a copy. The Task Force recommendations were as follows:

1) Amend the Collateral Source Rule so that plaintiffs can not recover losses that have already been paid by some other source, such as no-fault auto insurance or workers' compensation; abolishment of hospitals' charitable immunity status, under which claim payments against hospitals are limited to $10,000, and are linked to a requirement that only hospitals rather than their individual employees can be sued. This change would reduce defense costs because the insurer would not have to provide an attorney for employees, and it would increase pressure on hospitals to pursue aggressive risk management.

2) Revision of the statute of limitations for adults by an absolute four-year limitation on suits instead of the current two-year statute of limitations from date of discovery of the alleged malpractice.

3) Alteration of the discovery rule for children, to give them the right to sue up to the age of 11 for incidents occurring before the age of eight, instead of two years from age 18.

SENATOR LYNCH: Say that again, please?

COMMISSIONER GLUCK: I'm sorry. Alteration of the discovery rule for children, to give them the right to sue up to the age of 11 for incidents occurring before age eight, instead of two years from age 18.

4) Mandatory, non-binding arbitration for cases worth $50,000 or less.

Then the Task Force got into Certified Malpractice Attorneys, educational requirements for physicians of 150 hours. If you belong to the New Jersey Medical Society you have to take 150 hours of continuing education. But, as I understand it, about 40% of the physicians do not belong to the New Jersey Medical Society, so we have a number of physicians out there who are licensed and who do not take the 150 hours of continuing education over a three year period. The Task Force suggested that that become a part of the licensing process insofar as physicians are concerned.

Other things that you have before you translate into what we feel could benefit peer review for attorneys, and could benefit some of the insurance costs.

Now, what the Task Force did not agree on was, specifically, a cap, and what lay people call "structured settlements," but what the legal profession calls "periodic payments." Those things were not agreed upon.

I know, for instance, that there have been two recent cases settled out of court that deal with periodic payments. We have some information on that but that is not something -- that or capping -- the Task Force agreed on.

Because you have the recommendations in front of you, rather than go into them at any length, I thought there may be some questions you might want to ask.

I really feel-- You know, all of us are often accused of not acting until a crisis happens. These people really hammered this out -- and they hammered on each other -- to get this Task Force Report out. The fourteen recommendations represent a consensus, and I think it is incumbent upon us to take a look at this over the next couple of

months to see if this is something we can put in place. Whether it be strengthening the Board of Medical Examiners; whether it be requiring physicians to do the 150 hours over three years; whether it be something we do to amend legislation; or whatever, if we can put some things in place that we all agree on, perhaps it will assist in stemming what I see as the beginning of a tide which is going to run over all the professions with regard to professional liability insurance.

SENATOR LYNCH: Do you think the problem here is different than other areas of general liability insurance problems we are having, whether they be with dram shops, or local government, or school boards, or engineers, or architects, or lawyers? Does the Task Force believe that as a result of some tightening up, the premiums will stabilize?

COMMISSIONER GLUCK: Yes. The Task Force didn't consider the other lines of insurance, but I think the Task Force felt very strongly that if they could have these 14 things enacted, it would go a long way towards stabilizing the cost of professional liability, in particular medical liability.

SENATOR LYNCH: Well, you have a market here. At least you have a market.

COMMISSIONER GLUCK: That's right, at least we have a market.

SENATOR LYNCH: They can buy insurance?

COMMISSIONER GLUCK: That's right.

SENATOR LYNCH: That's better than some areas.

COMMISSIONER GLUCK: We have a medical malpractice. For instance, The Reinsurance Association has a debt. The figures are from $42 million to $68 million, and we are getting an independent consultant in to verify that these figures do exist. So, Senator, some of the mechanisms that we have set up in the past have obviously not worked.

SENATOR LYNCH: What did the Task Force think with regard to the tightening up? What would it do? What is the projection insofar as the premiums are concerned? We don't have a problem with the market here because we have one.

COMMISSIONER GLUCK: That's correct.

SENATOR LYNCH: We have a problem with the escalating costs?

COMMISSIONER GLUCK: That's correct. The insurance companies that sat on this were the Princeton Insurance Company and the Medical Insurance Exchange.

SENATOR LYNCH: What do they think this will do?

COMMISSIONER GLUCK: Well, they are going to be here to testify, but it is my understanding that they felt it would, at best, stabilize prices. However, the other side of the coin is, if we don't do this, and they see a rapid increase, both of them are going to be coming to the Department of Insurance, I guess within the next six months, for increases in medical malpractice insurance.

So, if we can just get some of these things under control to the point where any potential increase would be 5% instead of 25% or 30%, it would be worth the effort.

SENATOR LYNCH: What we do here— If there were a legislative reaction or response to the crisis that exists, and if some of the bills we have under study now were addressed — which I will refer to in a minute -- where would we go with regard to the other areas where there are problems? Do those bills, and the passage of those bills -- or the adoption of this Report in the form of legislation — impact the other areas of insurance problems? Can we treat medical malpractice totally and independently? Can we treat the dram shop problem totally and independently? Can we treat general liability for municipalities totally and independently? Can we treat engineers independently? Might not what we do here affect what we do elsewhere?

COMMISSIONER GLUCK: There are some pieces of legislation, and there are some things you could do here. If the Legislature ever entertained the concept of a cap, as they have done in California -- that is, by the U.S. Supreme Court not hearing it recently, the cap is in place in California — it would apply to all liability; it would not just apply to medical malpractice liability.

Now, the cap bill that is in — forgive me, I forget whose bill it is -- is for something like $100,000.

SENATOR LYNCH: It is Senator Hurley's bill.

COMMISSIONER GLUCK: Okay. In my opinion, if you are going to have a cap, that is way too low. But, if you did something like that, you would cut across a lot of lines of insurance. It would affect a lot of different areas. The Collateral Source Rule, for instance, might affect automobile insurance more than it would affect medical malpractice, although it will have some effect. You can understand, it is collecting -- supposedly or allegedly -- from two different sources.

SENATOR LYNCH: I am just thinking out loud. To tell you the truth, I am not thinking very well at all today, but it seems to me that whatever we do in this arena is going to have some effect on the thinking regarding other areas of concern in today's insurance marketplace.

COMMISSIONER GLUCK: It should.

SENATOR LYNCH: I am not sure that we can treat any of these independently. When we get down to the reforms that have to be made in order to resolve the problems we have today, don't we have to look at the entire puzzle to see how each one relates to the other? If we are taking action -- and I am not suggesting that we stop holding these hearings, don't get me wrong — to address the existing crisis in the medical malpractice area, won't some of those actions be used as a benchmark for other areas of concern?

COMMISSIONER GLUCK: Yes. I don't think there is any question about that. I think it would be less than candid of me to say no. I think it will be a benchmark, and I think that when the Legislature and the Department looks at this, it will cut across certain lines. If there are certain things--

SENATOR LYNCH: That's the problem. I don't think that the Legislature-- I am concerned that if the Legislature looks at one little area of the problem — and we have a big, big, big problem that is growing -- and it sets benchmarks, they will be used in the other areas of concern we have, which, truly, are much more significant in terms of total cost to the citizens of the State of New Jersey. That is not to say that this is not a significant issue, but if we are going to do things here that are going to impact on other areas,

shouldn't somebody -- certainly not me -- be looking at this total picture as a composite, and not in a piecemeal fashion?

COMMISSIONER GLUCK: The answer to that is probably yes. All right? But there are certain things specific to malpractice that may impact on other professional liabilities, and they won't necessarily have anything to do with pollution problems, vis-a-vis insurance for municipalities.

SENATOR LYNCH: It doesn't matter what industry we talk about today. I mean, if one walks down the street he has four barkeepers on his back who want to know how they can possibly get a policy -- or an engineer, or an architect, or a lawyer.

COMMISSIONER GLUCK: That's right. If we are going to do something like that, Senator -- and your point is well taken -- what we have to do is to do it as quickly as we possibly can because we have people out there, such as tavern owners, who do not have insurance.

SENATOR LYNCH: How about cities?

COMMISSIONER GLUCK: There are very few towns that are "bare."

SENATOR LYNCH: Bare?

COMMISSIONER GLUCK: Yes, that have no insurance at all.

SENATOR LYNCH: No, they are self-insured.

COMMISSIONER GLUCK: Okay. They are either self-insured, or they have no insurance.

SENATOR LYNCH: (continuing) With some reinsurance.

COMMISSIONER GLUCK: Pardon me?

SENATOR LYNCH: And we haven't hit January yet. Wait until January.

COMMISSIONER GLUCK: I know. That is why there is an emergency regulation. I understand that, but--

SENATOR LYNCH: I am not suggesting that it is your problem or your fault. It is your problem because you happen to be working--

COMMISSIONER GLUCK: No, I understand that. But, the fact of the matter is that we can't resolve this alone.

SENATOR LYNCH: Why did you ever want to leave the Lottery? (laughter)

COMMISSIONER GLUCK: Who said I did?

SENATOR LYNCH: Senator Russo, do you have any questions?

SENATOR RUSSO: Hazel, which report are you reading from?

COMMISSIONER GLUCK: You have the Report and Recommendation of the Commissioner's Task Force on Medical Malpractice, dated September 4th.

SENATOR RUSSO: Could you bring that up here for a second?

(At which time Commissioner submits report to Senator Russo)

Hazel, let me preface my remarks by saying that although I am a lawyer, I have never handled a malpractice case in my life. I don't know if I could start now. I think I am too old for it, assuming I ever go back into practice. I want to make it clear that I have some views which may not be in agreement with some of these things. Of course, whenever someone who has a law degree says these things they are immediately accused of reflecting a concern regarding their pocketbook. But, I do not do this kind of work.

The first thing I want to ask you about is, you mentioned a number of verdicts amounting to over $1 million. Has there been a determination made by your Department -- and I know this might be a difficult question -- that these verdicts were unjustified or improper?

COMMISSIONER GLUCK: No, not at all.

SENATOR RUSSO: I think there are some fine recommendations in this report, but the thing that always puzzled me was the Collateral Source Role. When an insurance agent comes to me as a consumer and offers me different kinds of insurance, I am always concerned because I do not want myself or my children saddled with a huge bill that they or I cannot pay, or that may be tremendously harmful.

Therefore, I exercise a choice: I hand him some money and he gives me some coverage for that. The thing that puzzles me is that we have two people who are victims of, let's say in this case, medical malpractice, automobile or whatever. Let's say you and I -- God forbid -- are the two victims. Say I have chosen to pay a premium for 20 years to give me a return, just as I can choose to have 10 life insurance policies and collect on all of them if I want to pay for them.

Now, you choose not to have this coverage, and we have this same incident occur. In effect, the suggestion here is that I cannot collect on the policy that I paid dollars for -- maybe large dollars over many years, including the year of the incident -- I can only collect from the malpractice award, if I get one, and so can you, even though I paid for 20 years worth of premiums and you paid for none. That is what has always puzzled me about the Collateral Source Rule. This approach seems to penalize those who are willing to pay for insurance. Policyholders are not always necessarily wealthy, they may be people who struggle to make the payment because they do not want to be caught short. So, one makes the payment, the same as he would if he bought an extra $100 thousand in life insurance, or an extra $1 million, or what have you. That's what puzzles me about that collateral rule. What would you say about that?

COMMISSIONER GLUCK: Senator, do you really think that when people pay their insurance premium they know that if they get into a situation such as that, they could possibly collect twice?

SENATOR RUSSO: I do.

COMMISSIONER GLUCK: You do, and I do.

SENATOR RUSSO: You see, I pay for it not because I want to collect twice, but primarily so that I can collect once if whatever happens to me is, let's say, not the fault of someone else. So, I pay a premium.

However, the policy says that if, in fact, I have hospital bills, for a premium dollar they will pay me for those hospital bills. I can actually have two, three, or four of those policies, I think, can't I? I can collect my hospital bills two, three, or four times if I want to pay the insurance company two, three, or four premiums, can I not?

COMMISSIONER GLUCK: I'm not sure that is true. I think the way it stands now is, if you pay a premium you can get all of your bills paid -- your hospitalization and all of your medical bills -- and then if you should go to court, you would get all of them paid for again.

SENATOR RUSSO: Yes.

COMMISSIONER GLUCK: The question is, should we as consumers expect to get that? I am not talking about pain and suffering now; I am talking about the medical aspect of it, the bills that are paid. Should we expect to get the bills or the treatment paid for twice?

SENATOR RUSSO: Well, you know maybe I am way off base, but isn't that analogous to— If I want to buy a life insurance policy for $1 million, and now I want to buy another one for another $1 million, I want to pay the premiums. You know, I am being paid—

COMMISSIONER GLUCK: Yes, but the fact of the matter is, I think, Senator, that maybe if we want to be able to do that twice, we ought to pay for it. I don't think--

SENATOR RUSSO: Right.

COMMISSIONER GLUCK: Okay, but I don't think the way it is structured now, we are paying for the ability to collect twice.

SENATOR RUSSO: Well, we may be collecting four times, but if the insurance industry is willing to sell me a policy -- not for nothing; they want money for this -- and they come to me and say, "Look, we will sell you a policy that will pay your hospital bills," and I say to them, "Well, gee, why do I need that? If I am hurt because of malpractice or because of an automobile accident, and it is going to be paid anyway." The fellow then says to me, "Well, there are two reasons, one is if you are not covered by some other kind of coverage -- automobile or malpractice -- you are going to collect on these bills. Then I say to him, "Well, what if I am," and he says, "It doesn't matter; we pay you anyway, and so does insurance company "B," "C," and "D." If I want to pay those premiums, they are going to pay me for those hospital bills two, three, or four times, and I am buying something. I am playing the lottery. I am, in effect, gambling -- hoping I lose, but I am gambling that I am going to get hurt.

COMMISSIONER GLUCK: That's the difference though. With the lottery you are a winner if you hit.

SENATOR RUSSO: Do you see what I mean? This collateral rule proposal has always puzzled me. It seems to penalize those who go out and buy protection. They are not getting it for nothing if they collect four times and the other person only collects once, because they paid four times more in premiums.

COMMISSIONER GLUCK: What you are suggesting is, if we have a Collateral Source Rule, maybe the company should charge to cover that, and maybe those who have malpractice insurance should know they are going to have to pay for the ability of people to do that. I think that is the decision here.

In other words, what we are saying is: Are we going to pay for that kind of coverage to the extent that we as consumers are not paying for it now, and is the profession going to be paying for it vis-a-vis malpractice insurance rates?

I think the reason for this recommendation was that this would be a means by which malpractice insurance rates -- at least one part of 14 ways -- within this packet would achieve stability. As I said, I think this might have a greater effect on automobile insurance than malpractice rates, to tell you the truth.

SENATOR RUSSO: I don't want to belabor the point, but with that change in the rule -- if we do it -- aren't we penalizing the prudent citizen who goes out and buys the coverage? Because the fellow who doesn't have it, doesn't have any Collateral Source Rule. That's what bothers me and always has, for years.

COMMISSIONER GLUCK: I don't know whether it is penalizing them or not, Senator. It never occurred to me that with that kind of a given situation, if you had asked me this question five years ago, I would never have known that I could have collected twice. It would never have occurred to me that I was covered to collect twice, and I might have said, "why?"

SENATOR RUSSO: But that is because you were uninformed.

COMMISSIONER GLUCK: That's correct.

SENATOR RUSSO: Being in the profession -- if you remember I used to do a lot of that kind of work -- I always knew that. I knew it when I bought my coverages, as do other people. I agree with you, not everyone knows that.

But it seems as though-- I don't know that we are going to see any reduction in premiums for these kinds of collateral source benefits. I am sure we are not, because the insurance company will never know whether they are going to have to pay or not, since they

don't know whether we are going to have a malpractice award, or an automobile award, or not. But, it seems as though through this change you may well discourage people from buying this protection which is available to them. I don't know.

COMMISSIONER GLUCK: I don't think that we would discourage them from buying it for one simple reason. I don't think, for instance, that they know they are buying coverage which gives them the right to collect twice, and if they did and they had a choice, I don't know if they would opt to do it. If they did opt to do it, maybe they should have to pay more for it. I don't know.

SENATOR RUSSO: You see, I can recall that recently an insurance agent came to me to sell me trip insurance and baggage insurance, and I said, "Well, gee, if I lose my bags on, say, an airline, the airline is going to pay for it." And, the insurance agent's pitch was, "This coverage is there, regardless." One can collect twice in effect if he wants to pay the coverage. I mean, he is not getting it for nothing.

I think the thing we have to remember here is that nobody collects twice for nothing. They collect twice because they bought and paid for a policy that gives them this protection, regardless of whether someone else pays for it also.

COMMISSIONER GLUCK: I understand the point you are making. I think that what you have to understand about this Task Force Report -- which I am sure you do -- is that now, a single one of these things alone will make a difference. It is a package, whether it be this package or another package. I hope it will be this package of 14 items which the Task Force felt strongly would, in combination, have an effect.

I think if we just said, "Well, let's strengthen the Board of Medical Examiners," and you didn't do anything else, what good is that?

SENATOR RUSSO: Let me ask you this: Is there a difference between someone who, let's say, loses his life as a result of medical malpractice, automobile accident, or whatever? If he recovers the value of his life by settlement, or by jury, won't the next logical step be, "Well, wait a minute. If he happened to have a $5 million

life insurance policy, then why should he collect twice"? Let's say his life was worth $1 million, or it was so determined in the settlement, or verdict, but he has collected $2 million from the life insurance company. Isn't that the same principle? Maybe he shouldn't be able to collect it, but he bought and paid for that coverage and today he collects it. In effect, his family -- I said "he," but he is dead -- collects twice for his life. Doesn't the same logical argument apply -- maybe it should -- "Why should he collect twice"?

What is the difference between medical bills and life insurance? Medical insurance pays for the medical bills, and so does the malpractice carrier. But, it you are dead, life insurance, if you bought it, is paying for your life, and so is the malpractice carrier if the doctor was at fault. Isn't there a logical extension to that? Why should you collect twice? Do you see?

This is something that has been-- You know, this issue was raised long before my lifetime. There were articles written on it. I used to read them when I was in law school. That was the argument in favor of the Collateral Source Rule, and not barring it because if you want to pay for it, you have a right to do so. I mean, the jury may think my life is only worth $1 million, but I may think it is worth $10 million, so I go out and buy $10 million worth of life insurance. If I die, I can collect from both sources: The bus that hit me in the rear; the doctor whose negligence caused my death; and, the life insurance carrier. Isn't there a logical extension to that argument?

COMMISSIONER GLUCK: I understand your argument. I am probably not the one -- if there is a refutation -- that is knowledgeable enough to refute it. I would assume that maybe one of the insurance carriers who are sitting here can tell you why they think that is not a logical extension. I mean, you are buying two different coverages. Here, in one coverage -- as I see it -- you are actually getting two different bites of the apple, while you are talking about two different coverages. But, I see the logic of what you are saying.

SENATOR RUSSO: Let's leave that subject. I think without having discussed nor gone into the extent of it, the argument about suing the hospital but not its employees might have some merit. I have not heard that until recently.

Now, the other thing under the statute of limitations -- I don't know how many cases -- as I said, I do not do this work -- arise where someone finds out beyond four years that the doctor's negligence caused their injury or their death.

COMMISSIONER GLUCK: It is my understanding that most of the cases filed are filed within the first three years.

SENATOR RUSSO: The first three years?

COMMISSIONER GLUCK: Yes.

SENATOR RUSSO: Those statistics would be interesting, and I would like to have them because--

COMMISSIONER GLUCK: I am sure somebody here who is going to testify will have them for you, Senator.

SENATOR RUSSO: I would like to pursue that further because if, in fact, that is correct, then I think we would have no problem with a four-year statute.

COMMISSIONER GLUCK: Part of the problem with this is the 18 plus two. This has created a problem in the sense that a child born 20 years ago-- State-of-the-art at that time is not considered state-of-the-art today, obviously. In some cases, obstetricians and gynecologists that have found themselves sued 19-1/2 years after the birth of the child.

SENATOR RUSSO: Right.

COMMISSIONER GLUCK: That has caused havoc, especially in that specialty. It seems to me -- and I think the Task Force felt this also, and I concur with them -- that between their own physicians and the kinds of things that happen in the school system today, with children who are getting evaluated by teams, etc., that this would be picked up well before the age of 20. That kind of exposure -- when someone decides at age 19-1/2 they are going to sue the obstetrician -- is the kind of exposure that is beyond reason.

SENATOR RUSSO: I don't know whether the logic for the minority plus two rule is based upon constitutional things -- until you are an adult -- or whether it is based upon the concern that maybe we do have some parents that do not pay attention to their children until the child is old enough to make his own judgment. I am not sure of that.

COMMISSIONER GLUCK: I am not either. I don't think this would limit suits. That's the thing that was important in this. What it would do would be, if there was a legitimate reason to file suit, that suit would be filed and there would be some accuracy with which these rates could be predicted.

SENATOR RUSSO: Right.

COMMISSIONER GLUCK: That's very important because there doesn't seem to be any accuracy due to the fact that the tail extends for such a long period of time.

SENATOR RUSSO: Yes. I may not have a problem with that proposal, depending on what we find in the statistics.

COMMISSIONER GLUCK: Well, I am sure there are plenty of statistics that can be given to you by the companies on all of this.

SENATOR RUSSO: Let me ask you this: First of all, Senator Lynch touched on the cap.

COMMISSIONER GLUCK: Yes.

SENATOR RUSSO: You mentioned that you felt the $100 thousand cap was too low. What puzzles me, even though it was not one of the recommendations-- I have always had difficulty dealing with a cap. One hundred thousand dollars may be too high in case "A," and $2 million may be too low in case "B." Do we arbitrarily set a limit which then applies to the person who is totally innocent -- I mean, being brutalized in malpractice or an automobile accident case -- where it may cost, as we know happens, $2 million, $3 million, $4 million, or $5 million just to maintain the person? There is nothing in his pocket for pain and suffering, this is just to maintain him. How do we say to that person, "Well, tough luck. Maintain yourself because we have a cap, even though you were totally innocent," and this is what it is going to cost to keep him for the rest of his life?

COMMISSIONER GLUCK: I think that the cap in California-- I have the information. I haven't been able to read it; it is on my desk. I think the cap in California went to noneconomic. That cap did not have to do with medical expenses.

SENATOR RUSSO: It went only with something like pain and suffering?

COMMISSIONER GLUCK: Yes, not economic losses. But, let me just say this to you: If these 14 recommendations, or close to it, got into the stream, whether by legislation, by educational requirements, or whatever it is, I would much rather try this first, to be very candid with you, before we went to a cap, because if we can control the situation for just the reasons you are stating — if we can find a way to handle that -- to me, a cap would be a further step for consideration if something like this didn't work.

There were members of the Task Force who obviously wanted a cap, and there were members who did not. I do not have to tell you which did and which didn't; it is fairly obvious. It broke down along professional lines. But, the fact of the matter is, if there were other ways for us to be able to predict the cost of malpractice insurance and get some stability into it, that would not be something I would necessarily opt for as my first choice. Okay? I would like to see a run at something like this put into effect first.

SENATOR RUSSO: Well, the problem you have there is, if it didn't work — if it didn't reduce premiums -- we are not going to--

COMMISSIONER GLUCK: I don't know if it is going to reduce them, John.

SENATOR RUSSO: We are not going to even stabilize them?

COMMISSIONER GLUCK: Yes. You know, reduction is something that I don't think anybody would be willing to promise, nor should they because the reverse of that is they just keep going up. I think a lot of people would be happy if they just stabilized, or came close to stabilizing.

SENATOR RUSSO: Let me ask you this on the overall picture. I know you have read Ralph Nader's testimony given to the Congress just recently. I think if I correctly summarize it, Nader basically said that we have a conspiracy on the part of the insurance industry in this country to limit awards, suits, statutes of limitation, and so forth, by using a campaign of terror -- dramatic increases in rates and saying to that profession, "Okay, go to your legislators." I think right now there is a bill in Congress.

Nader basically said that the consumer in this country is about to be had if this works, and he points out a lot of things. I would like to throw in another analogy that I talked to you about. For example, the legal malpractice in my firm was something like $6 thousand a year, and we had no claims. I am not aware of any huge claims or verdicts against lawyers so far, but suddenly the premium went up to, I think, $34 thousand in one year, and everyone else's did too. Have you considered whether this is a campaign on the part of the industry to, in effect, get those people who have to pay this? This is, of course, the same with doctors. They did it with engineers and surveyors, and all the way across the board, to say: "Get legislation through; put a limit on; get caps on," and so forth.

COMMISSIONER GLUCK: Do I think it is part and parcel of a campaign? Yes, I do. But, do I think that campaign extends to the medical insurance exchange which insures physicians in this State, or the Princeton Insurance Company -- we are talking about two vehicles here. Can I put them in the same category as you are talking about? No, I can't. All right? I think if the legal profession has their own legal insurance exchange, I would not be able to put them in that category either.

The reality is, for medical malpractice -- and particularly with the two companies that deal with the profession in this State -- the same thing is not happening with regard to the rest of the country.

Do I think there is a campaign on to reform the tort system? You bet I do. The Chairman of Lloyds of London has said, "We will not reinsure any more," -- and I don't think that is going to be true -- "We will not reinsure any more until the American tort system is reformed." Now, I know England has been around a long time, but I doubt that they can hang in there long enough to see something like that happen, and I am not even sure that all they are asking for, or talking about, is necessary.

The perception you are talking about hangs very heavily over this whole problem, but I think medical malpractice-- Legal malpractice may be different right now because you are insured by a lot

of different companies; maybe that is part of what the other commercial liability problem is. However, this is different, Senator. Medical malpractice is different. If you form your own Exchange, you will also be looking at increases in prices year after year, after year, because of certain things.

So, to me this is a mirror of what can happen to the legal profession in this State if they form their own exchange. I think that the Medical Insurance Exchange is coming in -- I know it is -- and I am sure they are going to tell you about a sizeable increase. That is the company that was put together to insure doctors. It has physicians on its Board. It has insurance people, etc. The same thing applies to Princeton.

So, you are right in one sense, but I am not sure it applies here, is what I am saying.

SENATOR RUSSO: In the broad sense, when these companies came in and they want increased rates, do you remember there was a big controversy on the part of one of your predecessors, Sheeran, who insisted that they produce the income they made from the investment of the premiums, and they did not want to do that. What is the policy now? Do you get that information?

COMMISSIONER GLUCK: Yes, we get the investment income information. That is the first thing.

The second thing is, I hope in the near future to be able to hire a financial analyst. Being very candid with you, I don't think the Department of Insurance in the State of New Jersey has the kind of sophistication needed to deal with what we are talking about here. What we are talking about is financial institutions that are into insurance and, you know, "one stop shopping."

So, what we need to do is to raise the level of some of the sophistication in the Department, which we are going to do. Yes, we can find out about their investment practices. Can we stop the swings we have seen, from selling insurance "way down here," and then premium shock -- you know, jamming it to everybody by 50% or 1,000%? We were just talking about that before the hearing began. We are going to try and make an attempt to somehow get those swings into some kind of

balance without really monkeying around too much with the marketplace, which is something we don't want to do either. However, they are unconscionable, in my opinion.

There are some large insurance companies that have come to me and said, "Look, we don't believe in this cash flow underwriting. We don't want to continue it. We want to maybe help you set up some standards. So, we are going to be looking at that; we can't do it alone in New Jersey. We know it has to go across the country. I mean, we are only one State, flailing our arms at some of these problems.

SENATOR RUSSO: Okay. That's all I had. Are there any other questions from the Committee? (no questions) Thank you, Hazel.

COMMISSIONER GLUCK: Okay. Thank you very much.

SENATOR RUSSO: Senator Lynch had to go to a meeting, so we will continue.

Dr. John Durst? May I ask for the moment that you chair the meeting, Senator O'Connor, while I make one call?

We will begin with Dr. Durst. Doctor, who are you connected with, if anyone, or are you just a medical doctor?

DR. JOHN DURST: I am just a medical doctor.

SENATOR RUSSO: I didn't mean to say "just" a medical doctor.

DR. DURST: I was on the Task Force.

SENATOR RUSSO: You were on the Task Force? Okay.

SENATOR O'CONNOR: Go ahead, Doctor.

DR. DURST: Senators, ladies and gentlemen, thank you for the privilege of addressing you today. I am reminded that George Steinbrenner's opening to his managers is, "I will not keep you long." and I will attempt to follow that philosophy.

My name is John Durst. I am a physician. I graduated from Georgetown Medical School in 1965. I interned and served one year of medical residency at Mercy Hospital in Buffalo, New York. I finished my medical residency in Newark, New Jersey, in St. Michael's. I then served part-time as Director of Medical Education at St. Michael's, and at the same time started practice in internal medicine in Freehold in 1971.

I am past president of the Monmouth County Medical Society. I have been a delegate to the State Medical Society House of Delegates for the past 12 years, and I served on Commissioner Gluck's Task Force on Medical Malpractice.

I am also proud to be a veteran of Vietnam, where I served in the Air Force in 1967-'68. From that experience I have also become familiar with crisis and disaster.

While I don't represent New Jersey physicians in any official capacity, I might be said to be somewhat representative of physicians in general.

My reputation in the medical community is that of a "good doctor." I am careful, persistent, and hard working. I care for and about the well-being of my patients. I am satisfactorily knowledgeable in medicine, and continue to study and expand my knowledge in medicine. I am not, and never have been, careless in medicine.

I wish to emphasize that these are not unusual traits for a physician. I am truly average, not to be self-deprecating or self-demeaning, allowing that I have some strong points which have gained the respect of my peers, and -- most important to me -- the respect of my patients.

Herein lies one of the problems which confronts medicine in the midst of the malpractice crisis -- and I disagree with some of the statements that have been made. Please, rest assured that there is a crisis. To deny that, or to rephrase it, is ludicrous. The crisis extends past medicine, law, architecture, manufacturing football helmets, vaccines which can potentially save children's lives, small hotels, restaurants, many other business, and, in fact, every aspect of life.

Let me just clarify with an example what I mean by crisis. Hurricane Gloria swept the East Coast. It struck Long Island and some New Jersey counties very hard. In those areas people experienced a disaster. Those of us fortunate enough to have kept our lives and our homes undamaged experienced a crisis, and we know it. We lived in fear, and only in retrospect does that fear diminish.

New York, to my way of thinking has a malpractice disaster. New Jersey has a crisis, and, hopefully, may prevent a disaster.

Let me suggest to you that I experienced a disaster. In February of 1984 a jury found me negligent. It also found the plaintiff negligent, and then awarded the plaintiff $2 million. I think that is a record of some sort.

At that time I had what was available and considered to be sensible, safe liability coverage, $1 million. It also happened to be all I could afford. I will not try my case again here or anywhere else, except in my mind, the details are there. The entire matter has dominated most of my free time for the past three years, from the onset, through the courts, and thereafter. I will tell you that it has destroyed my desire to continue in medicine. It has devastated my family, and it has undermined and threatened my family's and my economic stability and security which I have worked 80 to 90 hours a week for 14 years to build.

In my quixotic efforts to study the malpractice issue, I concluded a number of things: Juries give non-economic awards for pain and suffering without rhyme or reason; that expert witnesses, both plaintiff and defendant, are generally inconsistent and ill prepared; that disregard for co-payment stems from laws that antedated even the founding of hospitalization insurance.

Nonstructured payments can destroy insurance companies and defendants alike and are difficult to comprehend by economists, not to mention juries, in explanations from judges.

Finally -- and most important to me -- the object of oratory is persuasion not truth. Today you have to judge the truth, or the validity or value of what I say, as opposed to a rebuttal or denial of someone else's opinion. I might not succeed in persuading you, but the most I have to lose is just that I haven't persuaded you; I can still continue to strive to prevent another disaster like mine and my family's, as well as one that could potentially occur to my fellow physicians and their families.

There are other aspects of the malpractice crisis to consider. I mentioned before I am sort of a medical "everyman," an average physician. When my case became general knowledge to my fellow physicians, they were frightened. They and I were running frightened

anyway. It was as though these men and women said to themselves, "What hope, me next?" because I am really average; I represent them. No one knows what follows the subpoena, despite shallow assurances that "good doctors don't lose cases." Doctors deal in truth and judgment, not oratory.

Why do more doctors -- more so than ever before -- order tests and get more consults? From the medical point of view, because judgment -- the same as with attorneys -- the single most important tool and quality of a physician is an art, and it is being sued out of medicine. With that prevailing atmosphere in mind, there may be 50% or more of physicians who are investigating, in depth, alternatives to medical careers.

I for one could not, in conscience, subject my family to my same real or even potential threat. I happen to still be excited and enthralled with the practice of medicine. Many are not, and some of them are your doctors. You don't want your doctor to be taking care of you while he is pondering the legality of what he does, as opposed to the medical value of it, nor to be bitter about his prices, or ponder being trapped in his profession because he could be at peace in some other field. Not to be mundane, because this is an important subject to me, but you really don't want your doctor to be buying lottery tickets as a way out.

You may not be privy to the private concerns and cares of physicians, attorneys, or others, because a lot of people discuss those matters only amongst themselves and their so called peers. Rest assured, discontent is there. The problem is growing economically and personally to a crisis point and beyond.

I have nothing else. I am going to leave you with a request: Please consider this problem to be a crisis. Thank you.

SENATOR O'CONNOR: Thank you, Doctor. Are there any questions? (no questions) Thank you.

The next witness we will hear from is Senator Wayne Dumont.

SENATOR WAYNE DUMONT: Mr. Chairman and members of the Committee, I simply want to spend a couple of minutes on this bill I introduced in January, 1984, near the beginning of this two-year session, which would

place a three-year time limit as to when an action could be brought against a health care provider -- and they are defined in the bill rather broadly -- three years after the date of the act, or omission, which constitutes the alleged professional liability. Now, there would be some exceptions to that in the case of fraud or intentional concealment on the part of the health care provider, or in the event of the presence of a foreign body which has not been discovered -- or reasonably discoverable -- by the person.

In addition to that, it would allow three years in the case of a minor. Where the minor is under eight years of age, the action could be brought up until the 11th birthday of that minor, providing that the cause of action accrued prior to the eighth birthday of the minor.

It is not intended to be a substitute for the present statute, which is 28:14-2, but, rather, to supplement it, and to appear to be fair.

The problem we are having today with so many of these personal injury actions -- and this is not the only type, by any means, we are having a problem with -- is that court decisions are doing away, substantially, with the two-year limitation. As a result of that, some malpractice claims are not brought until 10 or even 20 years after the treatment, or other incident involved. Now, that contributes tremendously to the high cost of malpractice insurance.

I did not hear all the testimony because I just arrived a few minutes ago, but I gather from what the gentleman prior to me was testifying about, this is practically putting him out of business, insofar as the high cost of insurance is concerned.

We find many competent physicians today who have a great deal of experience -- therefore, are well qualified to take care of patients -- who are finding that the cost of malpractice insurance is so great they can't afford to go on.

Besides this one, I have another bill which is not being heard this morning. It has to do with these long-tailed actions which come against Boards of Education. What I think we have to do is to cut back to some degree on the time within actions may be brought, not to

be unfair to people, but certainly not to continue to be unfair to physicians -- who are trying to practice medicine, and who are necessary to the public because of the good work they can do, and have done in the past -- who are being subjected to the high cost of malpractice insurance.

Everywhere I go one of the major complaints of my constituents -- and I am sure it is the same with you, Senator O'Connor. -- is this cost of insurance, whether they be automobile drivers, tavern owners, or doctors. Everybody is complaining today. We live in what is easily described as an "action happy" society, where many people want to resort to court actions to resolve their problems rather than try to work them out across the table, which, frankly, I think is the way most problems can be easily worked out to a solution. Even if it is hard to work out a solution, at least it can be done that way. The court should be a place of last resort, not a place of first resort.

The way this is working today may be good for attorneys, but it is not good for anybody else. It is certainly not good for the people of this State. I think we have to do what we can through reasonable legislation to try to keep doctors in business; we need them. Certainly, I don't know what I would have done without them during the course of my lifetime.

I think this legislation will help to accomplish this goal, and that is why I am here to speak in its behalf.

As I understand it, this is a public hearing today. It is not necessarily a time when you are going to release bills from Committee. But I would hope that this progresses to the point where it will get out of Committee sometime in this two-year session, because if it doesn't, I will put it in again in January. I will work on it in the next two-year session to try and get it moving. We at least want to do what we can in this two-year session in order to lay the groundwork for bills to be passed in the next session, even if we can't necessarily get them through the two houses by noon on January 14, 1986, which is when this two-year session expires.

That is really all I have to say. I would be glad to answer any questions if there are any, if I can, since I am no expert in this type of legislation. I believe that this is fair, reasonable, and necessary legislation.

SENATOR O'CONNOR: Are there any questions? (no questions) Thank you very much, Senator.

SENATOR DUMONT: Thank you. I appreciate it.

SENATOR O'CONNOR: Is Dr. Joseph Riggs present? (affirmative response)

DR. JOSEPH A. RIGGS: Senator Lynch and other Senators of the Judiciary Committee, and ladies and gentlemen, I thank you for allowing me the opportunity to speak before you today.

I am Joseph A. Riggs from Haddonfield, New Jersey, in Camden County, southern New Jersey.

I am here as the President of the Camden County Medical Society, representing 550 physicians from Camden County. I am also here as the Vice Chairman of District III of the American College of Obstetricians and Gynecologists, representing 2221 obstetricians in the States of Pennsylvania, Delaware, and New Jersey, and I am on their Medical Malpractice Task Force also.

I am here also as a delegate of the Medical Society of New Jersey, which represents 7500 physicians from New Jersey. And, I am here as an alternate delegate of the American Medical Association, representing 502,000 physicians in the United States.

Most important of all, I am here as an active physician member of the Insurance Commissioner's Task Force on Medical Malpractice.

Personally, I am here as an individual -- as a gynecologist who is affected and concerned. But, I think the most real reason that I am here is because I am a representative of the people of the State of New Jersey, who are the real losers in this whole situation.

Every statistic available shows that the American people are

Every statistic available shows that the American people are getting more and better care by better trained physicians than they have ever had in the history of the United States. Yet, in spite of that fact, the number of malpractice claims, the amount of awards, and the amount of malpractice premiums have soared! For example, in 1956, one claim was made per 65 physicians, and the highest medical malpractice award was $230,000. In 1983, there was one claim per five physicians, and the highest awards were into the millions of dollars. However, it is not just "bad doctors" or "hungry lawyers" that are creating the problem.

The main problem is a growing trend, not only in New Jersey, but country-wide, towards suits in every phase of life, not just medical malpractice. Doctors are no more negligent than carpenters, or engineers, or architects, or accountants, or barroom owners, or lawyers, as has been previously mentioned this morning. If that is so, then why should they pay so much more for their alleged misconduct?

There are probably a lot of reasons for that. The practice of medicine is a high-risk liability profession.

Damages are not as easily correctable on a patient as they are on a building, car, or a bank account.

Physicians supposedly make more money than others, and they have higher coverage than others, which may make them more vulnerable.

Most important of all is that excellent technological advances have been made in medicine in the past decade, to the point where the public expects, indeed even demands, perfection from their encounter with a physician. However, no matter how much training a physician has, how many continuing medical education courses he is required to take or takes on his own, or how much technology is used, untoward and unexpected results are going to occur, and mostly in the absence of negligence.

However, there is one sad fact about this whole situation that disturbs me the most, and that is that the real victims of this whole medical malpractice crisis are the patients -- the people of the State of New Jersey. They are the real losers, and I will point out to you why they are the real losers, and maybe cover some things that weren't necessarily covered by the prior speakers.

1) Indeed, we are going to talk about finances. There will be fee increases. It is estimated that last year, because of malpractice increases around the United States, there was in excess of $2 billion a year passed on to the patient just for medical malpractice premium reasons.

Let's talk about New York, our neighbor to the north. Medical malpractice premiums were raised 52% this year. Office visits, very shortly thereafter were increased $20 per visit. Minor surgery was increased by $500 per operation. Major surgery was increased over $1000 per operation, and obstetrical fees went from $1800 to $2500.

Let's compare New Jersey with New York. Let's compare obstetricians, because that is what I am most familiar with. An obstetrician in New Jersey pays $22,000 in malpractice premiums; in New York he pays $82,000. In New Jersey an obstetrician charges about $1000 per delivery; in New York he charges $2500 a delivery. In New Jersey an obstetrician does an hysterectomy for $1500; in New York patients pay $3600. And, it goes on and on.

So, I think there is no question in anyone's mind that fees do get increased when medical malpractice premiums are increased.

2) The second thing that is also very important in addition to fees, is deprivation of care. This is happening right before our eyes, especially in the obstetrical field. Some doctors are simply retiring early. But one of the sad things is that the most competent and most capable doctors are giving up high-risk care. The ones that really should be taking care of that high-risk -- that difficult -- patient, the ones that had the most training and most experience are giving it up. And who suffers for it? The patient.

In Florida, for example, when they had a 43% increase in medical malpractice premiums last year, 25% of the obstetricians gave up OB. They had another increase this year, and it is expected by the end of 1985, 30% more will give up OB. That is one state where 55% of the obstetricians are giving up OB, mostly because of the increases in malpractice premiums.

3) Patients and people are losers also, because the physicians are being forced into practicing what we call "defensive

medicine." I don't like the terminology, but that is what it is called. They are ordering more tests, more X-rays, they are ordering ultrasounds, and CAT scans. They are ordering everything they can to protect themselves in case something comes up. Five years ago they didn't think about ordering half of those tests, and ten years ago they even ordered less.

It is estimated by James Davis, the Speaker of the House of the AMA, that during the year of 1984 there was approximately $15 billion to $30 billion spent in the United States on the practice of defensive medicine. Who is paying for it? The people are.

4) Why are the people losing? This is something that Dr. Durst touched on a bit, but I think you should know more about. There is a crippling of the doctor/patient relationship, and a lot of it has to do with medical malpractice. Lost in all the talk about finances, money, and time lost is the most important factor of all, the emotional cost to the physician who is sued. It does no good to say after a trial, or after a settlement, "We won. We are vindicated." The damage is already done. The emotional damage to the physician and his family is the unwritten factor that no one seems to want to take into consideration.

This, ultimately, has effects. It leads to a deleterious effect in the everyday practice of that physician, and the patients that he is caring for. I refer you to a very excellent study done in Cook County, Illinois is 1984, where there were 152 physicians who were sued, and then surveyed in detail. It was so important to those physicians that 143 of the 152 did reply, and here is what they replied:

Eighty-four said they ordered more diagnostic tests.

Fifty-six stopped seeing high-risk patients.

Thirty-seven refused to do high-risk surgery.

Forty-seven suffered severe depression.

Twenty-nine had repeated anger and resentment irritability.

And eleven reported out of practice because of physical impairment, such as peptic ulcers, colitis, and three of those eleven suffered a heart attack.

What would we do if I were to extirpate some of those figures from that study into the State of New Jersey? And bear with me a moment so I can do that.

1) We have about 112,000 active practicing physicians in New Jersey. One in five physicians are sued. That means we have about 2400 physicians in New Jersey that are sued each year at the present rate. Taking those percentages from that study and putting them into New Jersey, that would mean that we have 1320 physicians out of the 2400 who were depressed each year, and still practicing and still taking care of patients. We have 480 physicians who go to the operating room and delivery room and their offices angry and irritable. Don't think that doesn't have some kind of effect on patient/doctor relationships and the care that the patient receives. And, out of those 2400, we have 120 who no longer practice. They don't practice because they have an ulcer, or they have colitis, and 26 out of the 120 will probably end up with a coronary.

Now, we have 1920 physicians, according to that kind of a syllogism who are affected by a malpractice situation, and they are affecting thousands and thousands of patients in the State. That is a serious problem; the people are the losers.

Therefore, this ever present malpractice spectre is anathema to the rendering of the best treatment and care to patients. It would appear self-evident -- at least to this Committee -- that some limitations to the Statewide expansion of medical malpractice lawsuits is essential to restore the confidence that is necessary to provide quality medical care in the best interests of the patients being served.

If we are really serious about curtailing the medical malpractice "pre-crisis" conditions in New Jersey, and truly want to prevent the people from becoming the unmerciful victims of the "super-crisis" conditions in New York, then, I think, something has to be done and it has to be done now. Certainly more has to be done than has been done in the last two years. There have been some bills before this Committee and this Senate that have not been acted upon since January of 1984. At the same time -- from that period of time

until now -- medical malpractice premiums went up 24% this year and are expected to go up 28% next year. I think a little more activity is necessary.

The Governor realizes it, the Insurance Commissioner realizes it, and a Medical Malpractice Task Force was formed in October of 1984. I think, for the first time in the history of New Jersey the expression of collegiality was practiced. What I mean by collegiality is that there was a sharing of responsibility and energy at every level by all affected parties. That means that the task force was wisely made up of physicians, trial lawyers, insurance professionals, and governmental agencies. Indeed, they had a unique opportunity during this past year, and they took that opportunity and met almost ten times in the year. And, these were long sessions; they met together; they worked together; and they thought together. But, indeed, they came up with some very excellent recommendations, 14 of which we have sent to you. I am sure you have them, I believe you are familiar with them, and I am not going to go into them. Commissioner Gluck has already done some of that, and I believe some of the other speakers will do some of that. My plea to you today is to give serious consideration to those 14 recommendations, and to give it now, not 1987 or 1989, when we have a situation like New York, because that is the way it is going to be.

I would like to conclude by saying that medical malpractice is not going to be solved by tort reform, but certainly there can be an interim containment of the serious measure that is before us. I believe that of all the literature reviewed it is noted that there are 19 states in the United States that are considering or have already implemented serious medical malpractice tort reform in 1984. I hope that by 1985, New Jersey will be the 20th State to do so.

Let's not wait until we get to the crisis and panic stages like New York and Florida, and then in emergency last hour sessions make legislative measures that may not be in the best interest of our people. We still have an opportunity in the State of New Jersey to carry out some recognized reform, but it must begin early -- I mean, now!

Unless true, meaningful reform is carried out, the solution probably will not be solved by the medical profession, or by the bar, or by task forces, or maybe even by the Senators. I think it is going to be solved by the people. They are the ones, after all, who pay the bills. It is going to be solved by the health care providers; they are the ones paying the bills.

The goal of reform is not, necessarily, physicians' pocketbooks. That gets the most attention, but that is not the goal. the goal is reform to stop this incredible drain on the entire system that exists to this day. When patients begin to realize it is them and their pocketbooks that are being affected, I think that is when something will have to be done. Let's do it before it gets to that stage.

Thank you very much.

SENATOR O'CONNOR: Doctor, on the point that you made about New York's increases in medical malpractice premiums, and the fact that those costs were passed along to the patients, do you have any figures there showing what percentage the two bore to each other? How much of the increase in the medical malpractice premiums was passed along to patients in the form of higher fees?

DR. RIGGS: I told you that if you were a patient in New York before the 52% increase you had a certain office visit fee. After that you had $20 extra added onto that. I think it goes along directly -- there is no written rule -- but I believe in the State of New Jersey, if we do get a 28% increase starting February of 1986, fees will go up. I think the people will be the ones paying for this kind of action. I feel that there are certain people who are gaining monetarily by winning an award in a particular medical malpractice trial, but they are doing it at the expense of all the other people in the State.

SENATOR O'CONNOR: How many of the dollars of a typical physician's practice go to pay for medical malpractice premiums?

DR. RIGGS: I am a gynecologist and obstetrician, and I estimate that at least eight percent to ten percent of my expenses are medical malpractice. I am paying $22,000 a year, and if the 28%

increase occurs, I'll be paying $28,000 a year. That's double my rent, Senator.

SENATOR O'CONNOR: Would you repeat that?

SENATOR DiFRANCESCO: Eight percent of your gross is--

DR. RIGGS: Eight to ten percent. It differs in different specialties. I believe family practitioners pay less medical malpractice, and perhaps their percentage is less.

SENATOR O'CONNOR: Senator Russo?

SENATOR RUSSO: You know, you referred to people who win the awards as gaining at the expense of the rest of the patients, and you use winning and gaining. Do you feel that these people who have recovered didn't deserve the recoveries?

DR. RIGGS: No, of course I think that doctors are human beings; they make mistakes. When they make mistakes people suffer, and when they suffer they certainly should be compensated. I have no argument against that at all. But I don't believe that there are 2400 claims that are necessary in the State of New Jersey. I don't believe that much medical malpractice is being done in this State by the physicians of our State. If that is so, then we have a lot of cases -- in fact most of them -- which are unnecessary cases. And they cost money because discovery and everything else that goes along with the legal fees, and that has to be paid by somebody.

SENATOR RUSSO: Sure. What I gather you are saying is -- if this is what you are saying, I absolutely agree with you -- we've got to root out the unjustified claims. We don't want to penalize those who have a legitimate claim and have been severely hurt or destroyed or whatever as a result of malpractice. We don't want to penalize them, do we?

DR. RIGGS: I agree 100% with what you are saying.

SENATOR RUSSO: But we have to get at the ones -- or the lawyers, if they are at fault -- who are making claims that are unjustified and unfair to the doctors. That has to be our focal point.

DR. RIGGS: I think a lot of that is covered in our 14 recommendations. Also, something we didn't include in our recommendations is that some states have instituted a system whereby if

someone files a claim, and it is thought to be frivolous and is dropped, then all the expenses are paid by that person. This is something that eliminated people from filing unnecesary claims.

SENATOR RUSSO: Wouldn't that also eliminate people from filing claims that wouldn't be well justified, because they can't take that chance?

DR. RIGGS: It may, but I don't think so.

SENATOR RUSSO: Why?

DR. RIGGS: Because if they are really hurting and are really sick and suffering, with good reason, I think they would take it.

SENATOR RUSSO: Well, if they are really, hurt and sick and suffering, when the doctor says, "Hey, it wasn't my fault." And the patient says, "Well, I don't know whose fault it was, because I was fine before, and I think it is your fault." And then when the patient goes to a lawyer the lawyer says, "I think that is fine and you have a good case, but I want to tell you right now, Mr. Smith, if you lose, you are going to have to pay all the doctor's claims--"

DR. RIGGS: That's where a panel comes in. If a claim is made and is heard before a panel comprised of a judge, a lawyer, and a physician, and they say there is certainly justification, go on with no problem. But if they say no, and still that patient goes on, then you have the problem.

SENATOR RUSSO: Oh, I see what you are saying, you wouldn't just have them file a suit that is peril. If the panel said it wasn't justified, and then he still took his chances, then he would run the risk— Which is a little less harsh than what I thought you were saying. Basically, the thrust of what you are saying is you have to weed out the unjustified claims because of the tremendous costs that are involved in those, too. For example, the argument we so often see used, is the emotional argument. Why should people get $5 million? Well, most people say that's right, because they find they are healthy and not the guy sitting in his bed the rest of his life, and in that case, $5 million may be far too little for what happened to him. I think that is the thrust that so many insurance carriers are using to try to get us to cap or limit awards by talking about these

multi-million dollar awards, all of which were given by juries after a court trial under rules that are adopted.

I am glad to hear that your thrust at this is not that, because if it is justified it doesn't matter how much it is, as long as it is fair and justified. But rather the fraudulent or phony claims are what you are trying to do away with. That makes sense.

SENATOR O'CONNOR: Senator DiFrancesco, do you have a question?

SENATOR DiFRANCESCO: Did you start out by saying that you are a member of the Task Force? Is anyone else going to testify from the Task Force, that you know of?

DR. RIGGS: Yes. I believe later on today there is.

SENATOR DiFRANCESCO: In the summary of this report, the first paragraph mainly talks about two charges. One is to recommend an equitable method of funding a $42 million deficit.

DR. RIGGS: That is a different subject altogether.

SENATOR DiFRANCESCO: Is it?

DR. RIGGS: Yes. I don't think we are addressing that issue at all today. That is the New Jersey Reinsurance Authority, in which--

SENATOR DiFRANCESCO: The second was to recommend the measures that would reduce the incidence of malpractice, as well as stabilize the costs, right? The crisis you talked about before you were suggesting is a crisis of cost. The affordability of malpractice premiums -- am I understanding you correctly? Mostly, you have addressed affordability in what you have said.

DR. RIGGS: Cost is certainly one factor. I also said there is a crisis in care that the people are getting, because competent physicians are dropping out of practice, and people are being cared for by younger physicians who may not be experienced, perhaps. I also said there was a crisis in not only the pocketbook and care, but in the fact that the people are being cared for by doctors who are under a great deal of stress, from not only hard work, but from the pressures of legal actions.

SENATOR DiFRANCESCO: You are suggesting that a lot of doctors have dropped out of practice because of medical malpractice insurance premiums?

DR. RIGGS: Yes, I can assure you that many obstetricians have given up obstetrics because of that. I read some statistics from Florida about that. Twenty-five percent in California, twenty-six percent in New York, and maybe fifty-five percent in Florida, and I am not sure of the percentage in New Jersey, but we are working on that right now.

SENATOR DiFRANCESCO: The $22,000 you spoke of personally--

DR. RIGGS: Yes?

SENATOR DiFRANCESCO: Is this just your personal premium?

DR. RIGGS: Yes.

SENATOR DiFRANCESCO: Your one person practice?

DR. RIGGS: Yes, one person.

SENATOR DiFRANCESCO: Okay, thank you.

SENATOR O'CONNOR: Thank you doctor.

DR. RIGGS: Thank you very much.

SENATOR O'CONNOR: Doctor Louis Fares?

DR. LOUIS G. FARES: Good morning. I am Dr. Louis G. Fares. I am from Trenton, Mercer County. Basically, I am here as a concerned citizen, but also as an ex-member of the Governor's Task Force. I would like to digress for a moment and thank the Governor for his foresight. I should also thank former Commissioner Merin for starting the task force, also Commissioner Gluck for seeing it through, and the Attorney General and his staff who listened and gave us a lot of input, and staff members, Laura Saunders and Leonard Karper, who were of real help.

The Task Force had to make a lot of compromises. As politicians, you know much more about that than I do. There are two points I have to disagree with, and I am sure I will be questioned on one of them. The first is the cap on pain and suffering. When I am questioned, I will answer, but believe me, for a doctor who has been in practice almost 40 years, I have seen miracles that would put Lourdes to shame, when somebody gets a payment check how quickly they get better. That is a type of a cap I am referring to, instead of having no limit. I also disagreed with the ruling to drop Supreme Court Panel 421. Other states are now reinventing the wheel by coming up with this same type of panel. The objections to the panel were from

the attorneys' point of view, and I could see that. But I have to object to it from the point of view of the patient. Please don't get me wrong. For someone who has been in actual practice for almost 40 years, I feel any patient that has had malpractice committed against him should be reimbursed. Let's start right off the bat with that premise. I honestly, sincerely believe this.

It is not a question of the patient that has been wronged. The question is of those who are looking for a lottery because of a bad result. There is a big difference between malpractice and a bad result. There is no control a doctor has on how thick a scar a person is going to get or how wide a scar, or what may happen to it. That is what my objection is to.

I was born in New Jersey, and I am proud to be in this State. The report was published a couple of months ago. It said there is not a crisis now -- the Task Force was to prevent a crisis -- but we are heading into a crisis. You say, "He's a doctor, he has a vested interest." I do have a vested interest. My vested interest is in you Senators, the staff, and the consumers. It has been mentioned that in the long run, it is the consumer who pays for the high premiums that are now being imposed on us. About a year ago the premiums went up for my specialty -- general surgery -- roughly 21%. Come February it is going to be 27% or 28% more. That is almost a 50% increase in the cost.

Because I happen to have a group with four or five surgeons and a couple of nurses handling patients, I have to pay over $120,000 in malpractice premiums. Incidentally, we haven't had one against us in general surgery that we have lost. We had one thrown out, but none have been found against us. But, I still have to put out that money. That is almost $2000 a week before I can pay my gas, electric, rent, phone bill, or buy a cup of coffee or glass of soda for one of my personnel. Needless to say, that cost is being passed on.

Other costs will be coming up because of people being entrepreneurs and finding new angles. The State is going to be coming in now and paying more because the prisoners are starting to sue for anything that comes along. I can speak in that field as an authority

because our group does most of the surgery for the State Prison system. All a prisoner has to do is get one of the library books, file a claim, go to a judge and say, "I am indigent," there is no filing fee, and you are tied up for a few days filling out forms and interrogatories, and then depositions, and then it is thrown out anyway. It is time wasted; time costs money to a doctor, and all we can do is give people our time, really, and that loss is passed on.

The doctors voluntarily froze their fees a year ago. Now, when this second increase comes in in February, I can't for the love of me keep my fees the same with a 50% increase in a couple of years. They are going to go up. Our group is very busy -- probably the busiest general surgeons' group in this entire area -- because we are reasonable. I am going to have to pass it on.

I feel the Task Force recommendations are excellent, but I also feel they should be expanded in your good judgement. I am open to questions, but I don't want to tie you up any longer than I have to. I have a lot of other opinions and I will gladly answer them if you choose to ask.

SENATOR O'CONNOR: Senator, do you have any questions?

SENATOR RUSSO: Just one question. Doctor, what percentage -- and this is a question we have asked before -- of your gross does that malpractice premium represent?

DR. FARES: Off the top of my head, probably 10%. We're just going through our year-end figures, so I would say it is a good 10% of our gross per year.

SENATOR DiFRANCESCO: That's $100,000?

DR. FARES: Yes. It is a large group. We do a lot of our--

SENATOR DiFRANCESCO: And it is only $100,000?

DR. FARES: Oh, I'm sorry, no. I'm a surgeon, I'm not a mathematician, I'm sorry. Do you mean of our gross per year?

SENATOR DiFRANCESCO: Well, you have a large group of physicians.

DR. FARES: Yes.

SENATOR DiFRANCESCO: Do you pay one medical malpractice premium for the whole group?

DR. FARES: They are individual.

SENATOR DiFRANCESCO: You have individual policies?

DR. FARES: Yes. And then we have a policy for the two nurses that handle patients, plus a policy covering our professional corporation. No wait a minute-- The figure of $100,000-- Our malpractice is over $100,000.

SENATOR DiFRANCESCO: You keep saying "our." Is it yours? Is it everybody's?

DR. FARES: The Fares Surgical Associates is a group that I founded. When I say ours, I mean our professional association, not mine personally. The group's. I can't break mine down.

SENATOR DiFRANCESCO: How many in the group?

DR. FARES: Five.

SENATOR DiFRANCESCO: So, $125,000?

DR. FARES: Roughly. In that area.

SENATOR DiFRANCESCO: Okay. That represents 10% of your gross?

DR. FARES: A little less than 10%; in that area. There are others in the group. There are 13 workers besides the doctors.

SENATOR O'CONNOR: Thank you very much, doctor.

DR. FARES: Thank you.

SENATOR O'CONNOR: Is Mr. Myron Kronisch here?

MYRON KRONISCH: Senator O'Connor.

SENATOR O'CONNOR: Good morning.

MR. KRONISCH: Members of the Committee, my name is Myron Kronisch, and I am a past President of the New Jersey Affiliate of the Association of Trial Lawyers of America. I speak to you today in opposition to the four bills now before the Senate Judiciary Committee concerning medical malpractice suits. I will limit my discussion to, essentially, the cap on damages under S-1112 and the statute of limitations bill, S-1079.

If I might add a parenthetical note, however, apropo of some of the comments of some of the physicians who testified earlier today, I, as a professional attorney, do not know of any attorney who has been practicing for more than a few years who occasionally has not been careless or negligent. I don't know of any physicians, other than Dr. Durst, who has ever said that he has never been negligent.

I think one of the problems with physicians when they approach the question of medical negligence is that they consider that medical negligence is the equivalent of being a bad doctor, and, of course, sometimes juries think that way too, but judges and plaintiffs' lawyers try to disabuse them, and point out that medical negligence is something that is committed by perfectly good doctors. In most of the medical negligence work that I have done in the last 30 years -- and I and the five other attorneys in my firm do practically nothing but medical malpractice -- I rarely have had the occasion to sue a bad doctor. Most of the doctors I sue are good doctors who, in moments of taking on too much work, or being too tired, or not having enough associates, not having properly trained their office nurses, get into trouble.

About the number of cases, Dr. Riggs pointed to the question that he can't believe there is that much negligence. It is pretty well established, starting with the Secretary of Health, Education, and Welfare Report of about eight years ago, and I think every plaintiff's attorney throughout the country can confirm the fact that, at most, only 10% of the negligent doctors and nurses are brought to the claims stage. Ninety percent of the cases of negligence in my office are turned down for economic reasons. Between 75% and 92% of the cases that come in from year to year are turned down because the injury isn't serious enough. The typical turndown would be, "I'm sorry, you say your husband almost died. He was in a coma for two days, but he has recovered. There is no real permanent injury. It almost doesn't count. We cannot justify bringing a malpractice case."

According to the Federal Government's study on malpractice, 90% of the cases of malpractice are never brought to the claims stage. Of those cases that are brought-- I noted my brother at the bar, Mr. Dughi, will be testifying in a few minutes and I think he will confirm this. The overwhelming number of claims-- Some of them are brought out at the last minute before the attorney can properly investigate them. That is a problem, and occasionally we get a case into the system that doesn't belong there. But those that do not belong are weeded out because there will be no doctor to testify in support of the claim.

In our experience, 85% to 90% of the cases we take are settled. Clearly, the overwhelming majority of the cases we take, and most plaintiff personal injury lawyers take, result in settlement, indicating that the insurance company, the doctor, and the plaintiff's attorney all agree the cases have merit. That does not mean there is still no problem with the non-meritorious case coming along once in a while.

Let me address myself briefly to the two bills I wanted to talk about, and then, of course, I will answer any questions from the Committee.

Notwithstanding what Dr. Rigg's said, there is no crisis in New Jersey now. Last Sunday I attended a meeting -- Sunday afternoon -- and I parked my car in Midtown Manhattan. It cost $26 for three hours, and I was shocked; however, I found that garages in that area are charging that rate. Today, I hope to get out of here for less than $7 or $8. What goes on in New York is quite different from what is going on in New Jersey. I don't think we have a crisis here, and I think one of the reasons why we don't have a very serious crisis is because we have, primarily, two rather well managed companies that are handling most of the medical malpractice business.

Now, for the first several years they were doing very well, and they turned back $5 million to their physician members. Of course, that probably reflected the fact that in the first few years there was no backlog of cases in the courts. I understand they haven't had anything like that type of payback recently, and don't anticipate one. As a matter of fact, rates will now probably go up, as they have been in the last two or three years. But that is far from saying there is a crisis.

S-1079 attempts to limit the time within which a patient may institute a cause of action. We are unalterably opposed to any limitation. The present one, insofar as adults are concerned, is based on a case lawyers recognize as Lopez vs. Dwyer. Mrs. Lopez had been treated by several doctors. She knew that the condition she had had gotten worse, notwithstanding the treatment she thought was the best the doctors could render to her. It was not until about seven or eight

years after the negligence had occurred that she happened to be at Columbia University and the radiologist came out of the room she was in, went into the next room, and told the doctors assembled there, "Well, gentlemen, now you see what happens when the radiologist turns on the x-ray machine and goes out for a smoke." When she heard that, she realized for the first time that she had been the victim of malpractice and that her horrendous injuries had been caused by malpractice.

The Supreme Court developed-- Now throughout the country we have the Discovery Rule. It is basically unfair, and I believe unsound -- and perhaps unconstitutional -- to take away a cause of action from a person before they know they have it.

SENATOR DiFRANCESCO: Can I stop the witness here?

SENATOR O'CONNOR: Just one second.

SENATOR DiFRANCESCO: Can I ask him a question?

SENATOR O'CONNOR: Sure.

SENATOR DiFRANCESCO: Myron, can I stop you?

MR. KRONISCH: Sure.

SENATOR DiFRANCESCO: Because this is obviously a very important part of this package, wherein they recommend restricting the statute of limitations for adults to four years, according to this piece of paper I am looking at.

Just now you mentioned "across the country." Would you give me some kind of sketchy description of what other states do?

MR. KRONISCH: I would venture to say that one of the few states that doesn't have the Discovery Rule is New York. There, people -- such as the DES victims -- as I understand it, still are unable to recover if it was held that they were injured at the time their mother took the DES while they were in utero; therefore, the statute expired two and one-half years after they were born, or two and one-half years after exposure.

Now, I can't give you the statistics regarding the entire country, but I would say that the majority -- I would say somewhere around 30 or 35 -- of the states have, and almost always, judicially, recognize the Discovery Rule; that is, the statute doesn't begin to run

until the patient knows, or should reasonably have known, that malpractice was committed.

Now, it so happens that the Discovery Rule is a little more stringent and is slightly different from medical malpractice in other areas. In other areas we don't need experts to tell a man who was exposed to fumes at work that he may have been hurt by the fumes. I think that is the Byrd case.

But, in medical malpractice areas, our Supreme Court for 15 years or so has said there is a fiduciary relationship, not just between people and their attorneys, but also between people and their doctors, and when a doctor has done something wrong and he knows it but the patient doesn't, and that patient continues to be treated by the doctor, certainly it would be unfair to suggest in New Jersey, "You patients have to start thinking about whether or not what the doctor is doing is negligent." So, as a matter of policy our Supreme Court said, "Lopez vs. Dwyer will be the rule because we don't want patients thinking in terms of suing doctors." We all know how important the patient-physician relationship is, the laying on hands, and the mystique -- something we didn't even understand until endorphin was discovered about eight years ago. When the doctor comes in the house, you and I feel better, whether we are the patient or the father, "The doctor is here, thank goodness." There is that trusting relationship. So, it is a special rule.

The Discovery Rule applies throughout New Jersey tort cases, but it is applied especially in malpractice cases because the Supreme Court has said, "We don't want to interfere with that physician-patient relationship, and have the patient unduly suspicious."

Now, the other portion, the $100 thousand cap for the non-economic losses: Again, we see no demonstrated need for this type of legislation. I believe Senator Russo brought out earlier in the colloquy with one of the doctors how unfair it is to say that the person who suffers a minor injury -- a comparatively minor injury, perhaps an amputation -- will have medical bills or other bills and he will get $100 thousand for pain and suffering, but the person who is in a wheelchair is going to have chopped off of that recovery whatever the

jury thinks he is entitled to for pain and suffering. The idea of taking the non-economic amount that the jury has awarded -- and the Appellate Division has the power to set aside if it thinks it is excessive -- and don't set it aside but, take that amount and say, "You can't collect it because the doctors can't afford it," is unfair, unreasonable, unsound, and ludicrous. The doctors happen to be a very successful portion of our society in terms of income.

Now, it is true that the two people who testified here today, representing the medical profession, are paying very high rates. Now that is a problem for the insurance companies and the doctors to work out. I know that all lawyers pay the same rates. Generally speaking -- there may be some exceptions -- I pay the same rate as my brother who is in general practice.

It seems to me that perhaps it is advantageous. If you are going to have a campaign and try to develop legislative and public opinion in favor of doing something about a crisis, if you charge a very small section of the medical profession outrageous rates, or rates which are very high, it makes good headlines. If the three or four high-risk groups were not paying those rates -- and, certainly, I am not going to redesign it -- and if they just looked at what the insurance industry was doing to lawyers and architects-- An architect, whether he is doing a $50 thousand house or a $10 million building, is probably paying the same rate.

So, I think the problem can be solved, and it can be solved just as quickly as the doctors, through their medical society, and the insurance companies can get together and say, "This is silly." The alternative is to get to the point where it is so high-- Sure, we have a shortage of obstetricians and gynecologists. We don't have it yet. There are a lot of good men who are retiring early or are cutting down on their practice, but that could be eliminated if they would just look again at the rating system.

Eventually, if they don't do that we do lose all the good obstetricians and gynecologists, and something will have to be done. Then the loss will suddenly be taken from the doctors and the insurance companies and it will be dumped on the victim. Well, through the

taxpaying system, maybe the taxpayer will pick it up. But, there is a better system somewhere between the present one, where you are taking the high-risk group and saying, "Only those in the high-risk group, not the the entire medical profession, not the entire health care profession, but just this little, narrow, high-risk group, you are going to pay it—" I think perhaps something should be done there. I think it should be done, not necessarily by legislation but by the insurance company representatives and the doctors who are here thinking about it.

SENATOR O'CONNOR: I am just curious. You are speaking today as a representative of the American Trial Lawyers Association?

MR. KRONISCH: That is correct.

SENATOR O'CONNOR: I see from the report of the Task Force that your President was a member of that Task Force.

MR. KRONISCH: As a matter of fact, Alan Medvin, our President, and Gerry O'Connor, both distinguished members of the Plaintiff Trial Bar, were on that Task Force. However, I can assure you, Senator O'Connor, they were not there as representatives of ALTA. I believe Mr. O'Connor was President of the Trial Attorneys of New Jersey, and I understand he was not representing the trial attorneys of New Jersey. They were there as individual attorneys, expressing their individual views.

I think Commissioner Gluck mentioned the proposals are by no means unanimous. As one of the doctors pointed out, he disagreed with some. I am sure the attorneys disagreed with some. It was a work that came out with some proposals, many of which we think are good, but not all of them.

SENATOR O'CONNOR: So is it the American Trial Lawyers position that you support the recommendations of the Task Force, except for the two that you carved out this morning?

MR. KRONISCH: No, there are others. I believe that Mr. Duffy, who is going to be testifying later on behalf of the New Jersey State Bar Association, will be criticizing and commenting on two other portions -- or maybe more. I can tell you that his testimony is one which the Association of Trial Lawyers of America, New Jersey branch, endorses.

SENATOR O'CONNOR: All right. Senator, do you have any questions? (no questions) Thank you very much.

MR. KRONISCH: I might add just one other thing, if I may. Dr. Durst's story is indeed a tragic one. Perhaps I can make a suggestion to other doctors who may hear this message some day by pointing out that many plaintiff attorneys, such as myself, although we represent plaintiffs in medical malpractice cases, occasionally we and other attorneys -- some defense attorneys -- represent the doctor individually.

Every insurance company in New Jersey -- I believe -- when they get a letter, or a demand, from a plaintiff's attorney which exceeds the policy limits, sends to the doctor saying, "Doctor, you have been sued, and it goes beyond the amount of your coverage." I am shocked to find after the fact how many of them do not take the suggestion that the insurance company goes on to say in the next paragraph: "You have the right to, and are invited to, have personal counsel."

I submit that it sounds to me as if Dr. Durst either did not have personal counsel, or he was so overcome by the fact that he was not a bad doctor, that he forgot good doctors can make mistakes. In any event, my suggestion is, if that insurance company was told by Dr. Durst, "Don't settle," then, of course, they couldn't settle under the terms of his policy. It sounds as if Dr. Durst was convinced that he was right, and perhaps overrode the recommendations of his insurance company.

If he had personal counsel who could explain to him some of the things regarding what happens in a courtroom, perhaps he would have said to his insurance company, "Please get this case settled. Even though I think I am innocent of any wrongdoing, I want this case settled." And if he has said so, then that insurance company probably would have gotten the case settled, and if they didn't, under the Rover Farms Doctrine in New Jersey, the doctor would not have had one dollar of liability. The doctors of New Jersey should know that. They should know how important it is that the insurance company is not out there to hurt them. The insurance company is out there to protect them and

help them, and when the insurance company says, "Maybe you better get personal counsel," they should always follow that advice. Thank you very much.

SENATOR O'CONNOR: Thank you. Peter Sweetland?

MR. SWEETLAND: May I ask that Mr. Dughi be allow to testify? He is expected in court.

SENATOR O'CONNOR: Very well.

LOUIS JOHN DUGHI, JR.: My name is John Dughi. I am member of the Firm of Dughi and Hewit in Westfield and Cherry Hill. For the last 13 years, as a member of that firm and an associate with Shanley and Fisher, I have been defending medical malpractice cases. That is virtually 100% of my practice.

I know all of the plaintiffs' lawyers who are here today very well. I have had many, many cases with Mr. Kronish, who just spoke to you, and certainly Mr. Medvin and Mr. O'Connor are close associates.

Let me give you my point of view, because I am here basically representing myself, certainly not the Defense Bar; no one has asked me to be here. I think perhaps I represent the Plaintiffs' Bar as well. My focus is slightly different from what you have heard thus far today.

Justice Schreiber's report on the problems we have with the courts noted that the complex cases, which are about 10% of all the cases filed, eat up about 60% to 70% of court time, and the complex cases are clogging the system and stopping the judiciary from handling our flow of litigation. Malpractice makes up a large component of those complex cases.

My little firm -- we have about 10 lawyers overall, and about seven who are doing malpractice -- had five judges tied up in one northern county last fall for about three weeks on malpractice cases, and there were two other malpractice cases pending. Parenthetically, only one of those cases went to a plaintiff's verdict.

Malpractice is not the doctor's problem; it is the lawyer's problem. We created it, not the doctors. Now, I am not going to sit here and tell you that there isn't malpractice out there. There is, and I will talk about that a little bit more. I do not -- repeat, do not -- agree with Mr. Kronisch in any way at all when he suggests that

I would agree with him that 90% of the malpractice committed by doctors never gets to the attention of even the claims stage. That is absolutely not my opinion, and I doubt very much that it is true. I will say more about that in a moment.

Bar success ratio -- and now I am speaking for the Defense Malpractice Bar -- is in the range of 80% to 90%. My firm runs between 85% and 90%. That is to say, of the cases we try, we win virtually all of them.

Now, Mr. Kronisch, Mr. Medvin, and Mr. O'Connor, who were mentioned -- in fact, all of the plaintiff's lawyers who sit behind me -- belong to a very distinguished and elite club. I have never tried a case against any of them in all the years I have been trying malpractice cases, and there is a very good reason for that. They evaluate their cases carefully, and more often than not, if the case has merit it is settled. More often than not, if the case has no merit, they dismiss it.

The problem with malpractice, and a major component of the crisis Senator Russo mentioned before, is the meritless case that grinds on and on in the system.

There is malpractice, but it is not just malpractice just of doctors, it is malpractice of lawyers, both on the Plaintiffs' and the Defense Bar, and, frankly, it is malpractice of the court system. I hesitate to say judges; I have to be in front of one of them in about 15 minutes.

Plaintiff's lawyers who know what they are doing in this field -- and I assure you, all the ones who will speak to this Committee in opposition to these bills know what they are doing -- are not the problem. The problem is the case that goes through the hands of a professional malpractice attorney -- maybe two or three of them -- and then finally some lawyer brings the case. Judges are hesitant to visit malpractice or the incompetence of plaintiff's attorney upon the client. They will not pitch the case from court and dismiss it because plaintiff has not gone out and gotten an expert. They will give him more time. They are afraid -- maybe justifiably -- that if a very fine lawyer had the case, "Would he develop the theory; would he find an

competent expert; would he be able to proceed?" and he will give him another three months. They don't remove the offending attorney from the case; they permit the case to go on for yet another 90 days, and yet another, until maybe an expert will be found, and it grinds on, and on, and on.

Now, let's talk about the malpractice that is out there. Where there is medical malpractice, and of course there is, those cases are usually settled. I am not that great a trial lawyer, although my ego compels me to feel that I am, that I win 80% to 85% of my cases just because I am brilliant. I win them because I have the facts, and where I don't have the facts, by and large, those cases are settled.

Put aside the malpractice problem with doctors, let's address the malpractice problem with lawyers. If we approach some of the root problems that fuel this system, perhaps we can start to contain the meritless litigation that goes on, and on, and on. And, I am glad Senator Russo has returned because I think this is an area he has some interest in. Medical malpractice cases have to be supported by an expert witness in order to set the standard of care for the trier of the fact, the jury. It is imperative that the plaintiff's attorney be forced to evaluate his case early, and the only way that can be done is either to have a plaintiff's attorney, such as those who are sitting behind me, who are very good at that and who have experts available to them to help them, or to force the novice plaintiff's attorney, the person who may be very, very good in general liability but who doesn't know malpractice, to go out and get a real expert -- not someone supplied by a third-party agency but an expert in that field -- to give him a report that there is malpractice. I think the Medical Certificate bill is very important in that regard.

The other problem -- and I think it is part of the root cause of all of this -- is that this is a system fueled on greed, whether it be the greed of the litigant for a windfall recovery, or the greed of the plaintiff's counsel for a large fee. Greed is a major component.

Senator Russo got into a discussion with the Commissioner of Insurance about the Collateral Source Rule. I am very much opposed to the continuation of the Collateral Source Rule. We try meritless case

after meritless case, and I am about to go down to Burlington County right now to continue one, because there are tremendous medical specials. We have $93 thousand of medical bills going before a jury in a couple of days in a case that everyone, including plaintiff's attorney, will candidly admit has virtually no liability. Because of this high number of specials, he is going to roll the dice and see what happens. About $10 of that amount was not picked up by insurance.

Now the original theory behind the Collateral Source Rule was elucidated by Senator Russo, and he is absolutely accurate; that is the precise reason why the Collateral Source Rule was first introduced many, many years ago. As one of the witnesses testified earlier, the passage of that Rule nationwide in all the states that have it -- and virtually all the states do -- antidates third-party pay in most medical situations. Almost all of the Blue Shield-Blue Cross type coverage is provided by employers as a prerequisite of employment. And while you can certainly get into an argument that that is a part of the compensation that it is money out of the person's pocket, the simple fact is, the money is not paid by the claimants' before the jury, and if they recover in that case, that is a windfall, and fuels the idea of the attorney who has not carefully evaluated, or doesn't have the competence to evaluate the case to bring this meritless -- and by that I mean no or low liability -- case before the court.

SENATOR RUSSO: What are you going to do about the one who isn't covered by his employer? Are you going to have a different rule for him?

MR. DUGHI: No, sir. Life is not entirely 100% fair, and you cannot cover every particular point. You have to address the problem we are facing here today, and the problem is a crisis. When Mr. Kronisch says there is no crisis, I suggest that he look at little more closely at the situation we are facing.

SENATOR RUSSO: Tell me, if you change the Collateral Source Rule, is that going to solve the problem?

MR. DUGHI: No, sir, but it is going to help tremendously.

SENATOR RUSSO: It will?

MR. DUGHI: Yes, sir.

SENATOR RUSSO: How do you define tremendously? How much of the medical malpractice awards, or settlements that are paid out, represent a duplication of medical bills that were paid under the Collateral Source Rule?

MR. DUGHI: Well, we are not talking about settlements; we are talking about the attempt to take a case to a verdict. Obviously, if the plaintiff's attorney has large medical specials that he knows will go to the jury, they do affect the amount of the settlement.

SENATOR RUSSO: Well, he is going to have even more inducement to go in if they haven't been paid by somebody else.

MR. DUGHI: Oh, no, sir. You missed the point.

SENATOR RUSSO: I probably did.

MR. DUGHI: It is only when they were paid by third parties that they go to the jury. If they were out-of-pocket expenses to start with, they would be part of a settlement or a verdict, obviously.

SENATOR RUSSO: Let me see if I follow you. You are suggesting that they can't go to a jury if they were paid by another carrier.

MR. DUGHI: That is the Collateral Source Rule, sir.

SENATOR RUSSO: I understand that. I worked with it for a lot of years. I am just trying to get your position clear. You think that will discourage bringing the claim before a jury?

MR. DUGHI: If you would let me finish just two more points, I think I will cover that question.

I don't speak for the cap that is in the bill today, but some rational approach to limiting non-economic damages must be a part of a package. Whether it is set up with some type of sliding scale based on the type of injury, or any other approach, some type of a cap -- floor or ceiling -- must be approached.

If you tie that type of cap, and you have a statute of repose, I don't care if it is three, four, five, or six years -- I don't care what it is, but it must be a firm statute -- you then start to remove some of the greed factor from the litigation. The old saying, "If I have enough damages, I don't worry about liability" that you hear in the courtroom many, many times is the problem we must

address. Meritless, low-liability, or no-liability malpractice cases, will continue if the plaintiff's attorney feels that he can get on the blackboard a large number of specials that will hopefully convince the jury to have tremendous sympathy for the claimant because there is a chance that money actually came out of their pocket.

This is where I believe, Senator Russo, the Collateral Source Rule will assist in reducing the number of cases. There will be no incentive for a plaintiff's counsel to take a case he knows has very little liability if he also knows that because Blue Cross-Blue Shield -- and I just picked those because I happen to know those names -- or some third-party payer has paid those damages, his client has not paid economically out-of-pocket for that, and that case will not be put before a jury.

SENATOR RUSSO: I will have to risk interrupting you before you finish both points. Is that it?

MR. DUGHI: Yes.

SENATOR RUSSO: This puzzles me. Again, as I illustrated to Mrs. Gluck, we have two plaintiffs, one who didn't buy other insurance--

MR. DUGHI: Sir, I heard your point and maybe I can respond to it. I understand precisely what you are saying. You are making a brilliant 18th Century argument that was made to pass those bills, but that argument has no relevance today.

Certainly, you can go out tomorrow morning and find four or five people who may have paid for their own third-party pay, and who may have been hurt. But I suggest to you that virtually all of the third party pay comes from employment today, and that is simply not an argument that is valid in today's economy.

SENATOR RUSSO: I just want you to know that sitting up here I don't take offense to your referring to my argument as out-of-date. The only thing I would point out to you is, perhaps if you weren't doing defense work, and if you were doing plaintiff's work, you might have a little more validity. But, nevertheless, I don't want to go back and forth by characterizing your comments. I will accept the fact that you characterized mine because maybe you are right.

MR. DUGHI: Well, sir, I don't mean to offend you. Perhaps I can come at this from a plaintiff's standpoint. Allow me to point out that my focus -- which, unfortunately, you were not here to hear at the beginning -- is very simple. We are stopping the system. The Plaintiffs' Bar cannot move cases. If we are tying up judge after judge after judge with malpractice cases which all go to a successful conclusion from a defense standpoint -- only 15% are being won by plaintiffs -- are we not stopping plaintiffs from bringing their actions, the valid actions, and getting recoveries for people. That's my concern.

SENATOR RUSSO: It seems to me as though your goal is a good one, and I think we share it. Your means to get there I won't characterize, because then I will be guilty of the same offense I think you are guilty of.

MR. DUGHI: Sir, your point is well taken, but may I suggest -- I am being rude on top of offending you -- my point is very simply that I cannot see how you can justify a windfall recovery, a double recovery, of the medical expenses that have already been paid.

SENATOR RUSSO: Well, as you said, you heard what I said before, and I don't want to bore you with it all over again; you obviously don't agree with it. You know, there is room for two viewpoints in this world, not just your own. I have a different viewpoint, and, as I said, I don't do malpractice. So, none do it where I come from. I don't know whether you are affected by the fact that you do defense work. I am sure you are not. You are here as a good citizen, regardless of the fact that you are a defense lawyer for malpractice. In any event, I am not on either side of that issue.

So, I raise the same points I did before: If I want to go out and buy it and pay for it, it is no windfall. That's sheer nonsense. I paid for it; nobody gave it to me for nothing. Some insurance company said to me, "Do you want to buy this coverage"? and I said, "Well, what happens to me if I have a malpractice case against me?" -- obviously, I wouldn't ask him this because I wouldn't plan on it happening -- he will say to me, "Well, you pay for it, you will recover twice, not because you paid only once but because you chose to buy it."

Leaving that aside, let's talk about a cap. It seems again as though your goal is laudable, but the steps that you talk about are, in my judgment, outrageous.

MR. DUGHI: Well, that may be so from your point of view.

SENATOR RUSSO: You talk about a cap and I raise the same points I raised earlier, a $100 thousand cap may be too high for some of these phony cases that are clogging up our courts -- or some of these fraudulent cases -- and $5 million might be too low. And no one is even suggestion a $5 million cap. I am sure that is not what you have in mind. You are probably talking about a lot less, and I only raise the point that I don't want to have to tell the fellow who sits in bed for the rest of his life that even though he had nothing to do with it and it wasn't his fault, he can't collect.

MR. DUGHI: Let me say this, and then I think we can probably come to a point where we can leave this room agreeing with each other. The cap is not what I am here to talk about. I mentioned this; I feel some form of cap may be needed. Maybe it is $5 million, Senator; I don't know. Certainly, when doctors asked me 12 years ago, "What is enough insurance?" what I told them then is different from what I tell them today.

But let's go back to what I think has become a topic for you, and certainly for me, the Collateral Source Rule, because the Collateral Source Rule is something I see every day, in and out. This is the one big problem we face. It is a very small part of the package, and while I characterized your argument as 18th Century, that was not a denigrating point; it is an 18th Century argument.

SENATOR RUSSO: Funny, I took it that way.

MR. DUGHI: I have no problem with that. It is an 18th Century argument. I happen to feel it no longer has validity today, although it certainly had validity then.

Moving forward from that, I believe with all due respect -- and you know what that means, sir -- that you are confusing apples and oranges when you talk about the cost problem of a person purchasing third-party pay, as opposed to the double recovery problem at the other end. No insurance professional in his right mind is going to

sell you a medical pay policy, a third-party pay policy, and use as part of the sales trap, "If you ever do have a big verdict in malpractice, you get paid twice."

SENATOR RUSSO: Of course not.

MR. DUGHI: Thank you. So, let's look at the goal that you and I are trying to achieve, and that is to cut down, frankly, my income. I get paid by the hour. I'm happy having meritless cases. They go on forever, and I get paid without a chance of looking like a bad lawyer, because I am going to win, but it is clogging up the system. It is slowing down everything.

One of the parts of that -- and it is a small part, but it happens to be one that we see so often that I am upset by it -- is the fact that the plaintiff can put up on the board $90 thousand, $150 thousand of specials where there was no economic detriment to the person because they were paid by someone else. Now sir, this does not affect a situation where there is a lien applied by a State agency to pay the bills; they would go into evidence. This does not affect a situation where someone didn't have the foresight, as your reasonable man would have, to go out and buy insurance, and he had to pay the expenses himself. They will go to evidence.

My point is that I think it is 18th Century to try to make the argument that we shouldn't penalize the foresight of the man who takes the extra effort and the extra penny from his pocketbook -- and it is no penny, as you well know -- to buy that insurance today.

SENATOR RUSSO: And you don't think that is what this would do?

MR. DUGHI: Oh, no, sir.

SENATOR RUSSO: You don't?

MR. DUGHI: Absolutely not.

SENATOR RUSSO: I think you could probably go on forever with the argument. You know, the only thing I can tell you is, every six months or so I sit down and review all my insurance and that of my children, and I say, "Have I got every kind of coverage? If not, how much does it cost?" and I choose to pay it.

MR. DUGHI: Yes, sir.

SENATOR RUSSO: But, if it happened that they were injured, or I was injured, in a malpractice case, I will wish I hadn't done it because it doesn't make any difference.

MR. DUGHI: Well, that is not so.

SENATOR RUSSO: No?

MR. DUGHI: First of all -- and I hope this never happens to you -- in a medical malpractice case there is no guaranteed recovery. Just because you honestly believe -- and maybe you can find three diplomats of a particular specialty to agree with you -- that a malpractice was committed, that doesn't mean you are going to recover any money, let alone a large amount.

SENATOR RUSSO: That's right. How do you answer the life insurance analogy? Was I off-base with that?

MR. DUGHI: I had a lot of trouble with that, and I still do. I think the answer is quite simple. Today, in the 20th Century, your argument would still hold a lot of water because no employers, to my knowledge, offer as a--

SENATOR RUSSO: I'm getting to like you all over again.

MR. DUGHI: Yes, sir; we can get right up there. (laughter)

No employers, to my knowledge -- and certainly not my firm, which I have some say over -- offer all the life insurance that or any of my employees want as a perquisite. However, I do offer all of the medical insurance they are likely to need.

In the 18th Century -- and I would like to turn this around on you if I can -- the only way one got insurance was to buy it himself. It was not a piece of fungible benefits that seemed to move through employment.

I suggest that in 200 years we can come back and fight again, and at that time I can accuse you of having 20th Century thoughts about live insurance.

I think today an extremely good argument to use was the one you used: "What's next, life insurance?" That would be a good scare argument, but I really don't think today, where benefits of employment are so ubiquitous with respect to medical payment that the argument is a direct analogy.

SENATOR RUSSO: Well, of course, life insurance is part of most employment contracts too.

MR. DUGHI: To a small degree.

SENATOR RUSSO: I'll tell you something. I honestly never even thought of that life insurance analogy until we were in the process of discussing this.

MR. DUGHI: It is an excellent analogy, and I think it does point to the fact that this is not a perfect solution. You are going to hurt someone -- and you have picked out the person -- if you do this.

On the other hand, the analogy I have heard and never quite understood which was first told to me as a young boy was about the navy ship that was going along. There were three people in the water who were from another torpedoed ship, and this navy ship goes past them and lets them drown. The reason for this is, if it stopped to pick them up, it would be torpedoed also, putting at risk the 1,000 men on the ship. I still have philosophical problems running that through my mind. How does one know there is a submarine there? How does one know he is going to sink?

The point is, sometimes you have to look at the benefit for the greater number than the detriment to the few.

In the everyday grist -- that I why I am here today and I know many people will disagree with me -- of handling malpractice cases, most of the grist is supplied by cases that ultimately go nowhere vis-a-vis trial.

Now, we settle a lot of cases, and I agree with Mike to the degree that there is a lot of malpractice out there. We have been supporting a firm doing it almost exclusively for seven years. I worked for Shanley for seven years before that, we did a lot of malpractice, and we settled a lot of cases. There is no question about that. I am not for a minute saying it is not there. The point is, most of the trials we try are meritless trials. I have never tried a case against Mike, or Gerry, or John Blume, or a lot of the people who do nothing but this, because they carefully evaluate their cases. They are not going to waste three weeks adding another victory to my record

so I can tell my wife they lost three cases. The point is, we are wasting a lot of time.

I think it would really help if we got rid of the Collateral Source Rule and the trials that we shouldn't try. I thank you.

SENATOR DiFRANCESCO: John, do you mean do not allow into evidence the amount of the medical bills if they are paid?

MR. DUGHI: If they are paid for, they should not go into evidence.

Now, you can approach it in a different way if that shocks your conscience. You can use it as a set-off. But, I prefer that if it was paid, it shouldn't go into evidence.

SENATOR DiFRANCESCO: But the thrust or your testimony is it shouldn't be allowed in evidence.

MR. DUGHI: Absolutely.

SENATOR DiFRANCESCO: And that is going to have an impact on the trial calendar and it is going to curb settlements.

MR. DUGHI: Well, it is not going to curb settlements so much, although it may, but it is going to encourage people not to carry a dead horse because they have great damages even though they have very little liability.

SENATOR DiFRANCESCO: So, in the scenario you just outlined, you said you have to run down to Burlington County. Was $64 thousand the number?

MR. DUGHI: We have 73 specials. Ninety-three are going to go on the board. Everybody in the room admits there is no liability, and the only reason this case has been carried by the plaintiff's counsel is because he got from a third-party agency -- an outfit down in Maryland that supplies doctors -- someone who came in yesterday and did a perfectly terrible job, but who said the magic words. It will go to the jury, and the only thing the jury will have in front of them is a young boy with a leg that is slightly shortened and a $93 thousand bill, and it is laughable.

Now, it is conceivable the jury will come back with a verdict, but that is the type of case that usually goes on to a no-cause. This will tie up a Superior Court judge for two weeks. It

has been in my office for almost two years. I wouldn't tell you what my bill is, but it high, and that is just adding to the problem.

You are not going to solve malpractice by saying, "Okay, Dughi is right, we will pitch Collateral Source," but it is an important part of this package and I hope it is addressed carefully. I was concerned by this morning's comments respecting it. Thank you, sir.

SENATOR O'CONNOR: Thank you, Mr. Dughi, and thank you for the very poignant colloquy with Senator Russo.

MR. DUGHI: I always enjoy Senator Russo.

SENATOR RUSSO: See you in the 21st Century.

SENATOR O'CONNOR: We are going to break for lunch at 1:00. We will now hear from Peter Sweetland, President of the New Jersey Medical Inter-Insurance Exchange.

PETER SWEETLAND: Thank you, Senators. I am Peter Sweetland. I am currently involved with a doctor-owned professional liability insurer in New Jersey. I have been in the insurance business 25 years, and the bulk of that has involved me, in some way or another, with malpractice insurance.

I guess you have heard quite a few back and forth statements as to whether or not there is a crisis. I think I should add my own opinion. Clearly, there is a crisis looming. One can talk about it being affordable, and statements have been made that prices today are acceptable, but in my estimation at the rate of increase that is going on, we are not that far behind New York — unfortunately.

The number of cases presented in New Jersey has doubled. The number of cases per doctor has doubled in the last five years. The average amount paid over the last several years has gone from $46 thousand in 1981, to $63 thousand in 1982, to $70 thousand in 1983, to $78 thousand in 1984. It continues to escalate. These are real numbers. We are not talking about the problem that is exacerbated by a single verdict in Jackson Township. We are talking about a long period of time in New Jersey, where we have specific details of loss experience and what is happening in this State.

I would not agree with Mr. Kronisch that only large-value cases are presented. Actually, the median amount of money we pay is $25 thousand. There are many cases presented at lower values.

SENATOR DiFRANCESCO: The numbers you cited were average numbers of all cases?

MR. SWEETLAND: All settlements and verdicts for those cases in which a payment of indemnity was made.

SENATOR DiFRANCESCO: Settlements and verdicts?

MR. SWEETLAND: Yes. But, this rate of increase of both the number of cases per doctor insured and the value of the cases that are paid are the main ingredients in deciding what the premiums ought to be.

SENATOR DiFRANCESCO: Can I ask you another question?

MR. SWEETLAND: Certainly.

SENATOR DiFRANCESCO: You are the President of the New Jersey Medical Inter-Insurance Exchange?

MR. SWEETLAND: Yes.

SENATOR DiFRANCESCO: When was that formed?

MR. SWEETLAND: In 1976. We first wrote business on February 1, 1977. It succeeded Chubb as the main writer of doctors in the State.

Some questions have been raised as to the average cost of this insurance to a doctor, and 10% has been suggested. There are studies made of the average insurance cost for manufacturers and their products. I will tell you that in the latest study I saw, the latest percentage for any product was 8%.

SENATOR DiFRANCESCO: You haven't said what you think the percentage is.

MR. SWEETLAND: I go by the studies I have seen recently. There were quite a few done in New York in relation to a discussion of similar bills. They estimate that for the average physician 10% is a fair number, and for the higher rated specialties it is higher. In New York, they estimate that obstetricians and gynecologists are paying 19%.

Now, you can assume 10% is a low number, but I don't think any of you, nor myself, would care to think that every other Monday we are going to work to pay for our liability insurance and nothing else; that is where it is now, and it is getting worse.

We could optimistically depress rates and hope that we are wrong in terms of our projections, but I submit that is the reason the Task Force was brought together to begin with. It was mentioned that one of the charges was to find out what to do with the deficit of the Reinsurance Authority. The Reinsurance Authority existed for a period of time at depressed rates, and now there are indications that the deficit in the balance sheet for the Authority ranges around $50 million. I suggest that when Commissioner Gluck's new study is done, the number will be higher.

The projections we have to make for cases still to be presented against all years in which insurance was provided continue to escalate. The causes are complex. Now, it has been mentioned that there certainly are correctable acts of medical negligence and something must be done about it; something must continue to be done about it. We think as insurers we are contributing to the effort to control problems of this sort in medicine, but you are wrong if you believe that the elimination of a handful of physicians who may be significant repeaters is going to have a dramatic impact on this cost.

As Mr. Kronisch ably said, this is a random event for most doctors. Most of the doctors who arrive in court and lose a case, or have a case settled, are good doctors who have had this one instance.

The system needs to change. That is the reason for the bills before you, and I would like to talk primarily about the four of them, with some additional comments.

The Certificate of Merit bill, S-1140, demonstrates what we believe is a strong need to qualify an expert to verify that a case is a case before it is presented. The requirement that an attorney verify that there is a case and that he have an expert within a limited period of time, we believe is essential. We are seeing many cases where, through a liberal interpretation of who is qualified to testify, we are just unnecessarily having to defend groundless cases.

SENATOR DiFRANCESCO: Can I ask you about that? The 60 days seems to me to be a little short.

MR. SWEETLAND: Well, I believe it was mentioned at the earlier hearing that bills are under consideration, and they are certainly not in their final form, I am sure, in the eyes of the Committee. Some limit should be there. If it is not 60 days — and I don't stand or fall on 60 days--

SENATOR DiFRANCESCO: You just want a limitation?

MR. SWEETLAND: It should be a reasonable limit of time to produce an expert.

The statute of limitation bill, 1079, has been discussed several times here. I believe that the majority of the states have passed legislation confining the statute of limitations to a strict period. I am disappointed to hear Mr. Kronisch say that the Trial Bar has now reversed what we thought was a view of the Task Force, which was agreement that some limit on the statute was appropriate.

One of the most significant reasons why I have a need for a strict statute is, in dealing with our reinsurers there are really only two companies in this State writing professional liability for doctors -- they are both represented here today. Both of us are having difficulty with our reinsurers, and reinsurance is indispensable in this business. The main problem is what is perceived by those insurers as an unlimited period of exposure.

It happens that although we started business in 1977, for a period of time we offered a policy which allowed doctors to increase their limits retroactively on prior use, and we were just presented a case under that program last month that was 12 years old. Routinely, we get one or two cases a month presented now, in 1985, against our first year, 1977. The uncertainty created by just how much longer this is going to run expands the reinsurers' estimate of what it is going to cost to provide us reinsurance; if they are willing to do it at all. That is one of the major reasons I see for having a need, from an insurance standpoint, for a limitation.

The other issues has already been raised: After a period of time the information is clouded, the trial gets cold, and it is much

more difficult to do a realistic job of appraising what the problem was.

SENATOR O'CONNOR: Mr. Sweetland, let me interrupt you. I gather that you are going to be a while, and I don't want to short-change you on time. We want to break for a short lunch, and we will resume at 1:30 with your testimony.

MR. SWEETLAND: Thank you very much.

RECESS

AFTER RECESS:

SENATOR O'CONNOR: We are now going to pick up where we left off.

MR. SWEETLAND: Okay. At the point we broke off, we were talking about the statute of limitations. One of the key features insofar as any insurance company's projections of what costs are going to be, is their estimate of what is still unknown about years in which they have provided coverage. An example of that for us is, as a result of this increase in the number of cases, and the average size of that increase in this last year, we have had to augment the reserves we hold by $30 million, just for the cases we anticipate are still to be reported from prior years. This is a feature of professional liability that is a bit distinct from other types of insurance.

Senator Lynch asked if the changes that are proposed are really too confined relative to the overall insurance problem. Actually, of the four bills discussed, two of them are not limited to professional liability. Careful reading will show that they talk about all negligence. The others do deal with aspects of professional liability that really aren't similar in other areas of insurance. So, from my experience, and in answer to his question, I would say that action on these bills is not detrimental, and, in fact, may indeed be a portion of necessary action as far as the overall insurance crisis is

concerned, and there is one -- there is no question about that -- partially brought on by the major companies and their underestimation of what was needed for premiums. I don't think we have that here in New Jersey insofar as professional liability rates are concerned.

We have attempted to be responsible. We have continued to use the same method of calculating anticipated rates that we have used for the last eight years. But, it happens that the method of calculation does forecast as an indicator the 27% increase next year. This piles on top of 24% last year, and the three years' prior 14%. In combination, rates have virtually doubled in the last four years in this State.

Moving on to the other two bills, which do apply to all negligence, not just professional liability, there is one feature of S-1135, the Dalton bill, which did get the support of the Task Force, and that is the Collateral Source. Perhaps I should reserve my comments until Senator Russo returns, but I do have some comments about Collateral Source that supplement what has been said so far.

As Mr. Dughi pointed out, other health insurance is predominantly purchased by employers, not by the individuals. My estimate is 80% of the Collateral Sources that would be involved are not purchased by the individuals.

Another point I would perhaps like to make is, conceivably the bill could be fashioned to include some form of reimbursement for the premium portion of past payments of this other insurance. But, the main objective should be to remove duplicate payment from the system. Duplicate and excessive payment is really what is driving this engine and forcing prices to where they are in professional liability premiums.

Senator Russo made an analogy, for example, about life insurance. There is a distinction. I can guarantee I am going to die. The price for insuring one's life is something that can be set, based on expected mortality, being fairly accurate in establishing just what has to be collected to eventually pay the face value of that policy. If one buys another policy for more money it is appropriate; the price is set. We are talking about an uncertainty when we start

talking about the consumption of health care -- the need to consume health care -- and the cost of it. Contrary to what Senator Russo said, it is my understanding that most health policies provide that there should not be duplicate payment between health policies. One cannot go out and buy two or three hospitalization policies and collect under all of them. They have provisions in them that say they will either pay over and above other valid and collectible insurance, or they will share on an equal basis.

The duplicate cost that is characterized in the Collateral Source issue is significant. It was asked what we thought the value of removal of the Collateral Source Rule would be. I participate in a group of companies. We have an association of doctors and companies, and at this point we are examining what we think the dollar value of a variety of these proposals would be. The Collateral Source Rule change, as we see it in different states, is somewhere between 2% and 10% of premium. The reason for the range is, the removal of Collateral Source occurs in a varying way in different places. To simply permit the information as evidence, an evidentiary change, seems to have a limited impact. But, a mandatory offset of the verdict -- the amount of Collateral Sources -- would certainly have a dollar impact, and that is actually what is in the bill before you, which we support in that version.

Now, the other aspect of 1135, referred to as "periodic payments" is something which seems to have engendered quite a bit of confusion. Fundamentally, what we are saying is, let's take the future damages in an award and pay them when they are needed. By virtue of doing that, we can do a better job of estimating what they really are. We can take advantage of real income stream, if that money is invested while we are waiting to pay it, and in the end the overall cost will be lessened. One of the ways in which the cost is lessened is, the income stream on a lump sum award, once paid and subsequently invested, is taxable. If an award is made in periodic payments, each one of those payments can be construed as an individual claim, and the internal interest buildup is then shielded from tax.

This is really one recommendation which has benefits, both ways. The plaintiff can maximize recovery while the cost of the system is lessened. The concept has been fought by the Trial Bar, one part of it being if the patient ultimately dies and the payments suspend, that would be a windfall for the insurance company. Well, it is not a windfall for us because we usually take care of this through the purchase of an annuity. We would start up-front with an evaluation, or an identification of the payments that need to be paid, go to an annuity writer and purchase a contract which will make those payments at a reduced price. The writer of that annuity is the one who takes the risk regarding how long the person is going to live.

The real underpinning of this idea is that it only takes out of the system those payments that really aren't called for. We are talking about properly compensating for just damages, but not going beyond that if we don't have to.

Of course, the fourth bill, the cap on non-economic, 1112, loss has had quite a bit of discussion. We strongly support -- despite the comments made here today -- the idea of limiting non-economic loss. That is not removing compensation for any specific loss that is identifiable. It is not eliminating recovery for true financial loss. But, the non-economic portion of an award appears to be that area where the jury takes the most license; where the jury decides to be punitive, if they feel justified to do so, without realizing that the cost is not borne by that individual physician. We are not punishing the individual physician with a boxcar award; we are punishing the purchasers of health care, because that cost has to be spread. Isn't it about time we set some limit on the impact of any of these cases on the cost of health care?

I have an example. It is a fresh example. There was a verdict rendered last Friday for $1,200,000 against our company. It happens there were two $1,200,000 verdicts last Friday. We had one of them, and I won't go into the details of liability, although we contested the liability issues, and would do so again. But mainly, the case dealt with a relatively young wage earner who went to the hospital with complaints that could be characterized as flu or a variety of

thing, but with some stiffness in his chest. He was seen by a doctor and sent back home with some treatment, but, as the plaintiff's side pointed out, he was not given an electrocardiogram. Now, it was also maintained that an electrocardiogram is not normally done under these circumstances, but be that as it may, if, indeed, there was a mistake made by not ordering that additional test, the question for the jury was, "Would this man have lived even if this problem had been spotted"? He died. He had -- and this was in some dispute -- a cardiovascular accident, or some sort of a heart problem.

The question is, if it had been discovered and if he had lived, would he live for a normal life expectancy? Well, the jury said yes. For that, they awarded $1,200,000, and now I am getting to my point. That amount of money, invested at 10%, with the expected life of the widow will give her $122,000 a year. This man made $40 thousand a year. Had the award been in the form of a structure which would have paid adequate compensation over her expected lifetime, increasing for inflation, plus lump sums in five-year periods, we probably could have purchased it for less than $300 thousand.

Now, I have to conclude that the portion over the $300 thousand is non-economic damages awarded by that jury. Is it fair for society, in effect, to bear the $900 thousand additional cost? Now, I haven't even talked about pre-judgment interest, which is thrown in as well; it will be an even larger amount. But, there are numerous example such as this.

The number of cases awarded in excess of $1 million is escalating. This is a key ingredient of why the rates are going up and why our reinsurers are getting more and more nervous. Something has to be done to the system.

The proposals that have been made, in our view, do not eliminate the access to the courts, nor do they attempt to eliminate any justifiable financial loss. We are just talking about the amount over and above that. What should society have to bear in compensating an unfortunate individual? There is no question the individual appears unfortunate. He or she usually has a lifetime of different circumstances before he was involved with treatment. But, if we are

indeed going to have some income pass-through to take care of those less fortunate, perhaps we should have a better understanding of what it is costing all of us.

That is my testimony, Senator. Are there any questions?

SENATOR O'CONNOR: What comments do you have regarding Mr. Kronisch's recommendation that perhaps the premiums that are charged to medical practitioners ought to be similar to those charged to other professionals? In other words, instead of having different rates for different specialties, the risk should be spread over the entire profession.

MR. SWEETLAND: Well, I am glad you brought that up. The rates charged to doctors probably range in a multiple of 10, from the lowest to the highest. They are consistent with the kinds of payments and awards that are being made by specialty. When we set rates, we look at each individual specialty's experience and we examine the relativity of losses. It happens that the specialties we have identified as higher rated -- neurosurgery, for example, is our highest rated; they will be paying $38 thousand a year next year -- have the largest value cases assessed against them. They are targets as far as the Plaintiffs' Bar is concerned, and as far as we can see.

Now, to charge everyone an average number -- and our average number for next year would be about $11 thousand per doctor -- would be okay in a vacuum, but we are in a competitive business. My competitors are in the room today. They would be delighted if I charged every doctor I have $11 thousand. They would immediately skim off every lower-hazard physician at an appropriate rate for that specialty, and I would be left with an adverse business.

SENATOR O'CONNOR: I don't think Mr. Kronisch was suggesting that particular companies do that. I think he was suggesting that an industry approach to it that might be similar to what is applied in other professional industries.

MR. SWEETLAND: Well, actually he is not correct. There are differences in lawyers rates. Lawyers involved in tax and real estate work, as I understand it, have higher charges.

There are certainly differences by territory in the country as to what these rates are. It really gets down to insurance fundamentals. In a vacuum, if we were the only company around and it was fair to charge everybody the same amount of money, we would be willing to do it. I am not too sure I can get past that fair barrier. That really means that the general practitioner who does no surgery and who has relatively little involvement in professional liability cases must share the cost of all the other physicians in the higher hazard specials.

SENATOR O'CONNOR: Aren't you talking about-- How many, by percentage, are what you would call general practitioners? Aren't most physicians now specialized in one area or another?

MR. SWEETLAND: Well, our largest group is internal medicine. They still do not do surgery, and they are slightly below that average dollar amount I mentioned.

We have a typical spread of specialties, but we have more primary care physicians than any other kind.

SENATOR O'CONNOR: Okay, thank you very much.

Is Robin Glazer here? (no response) George Duffy?

GEORGE DUFFY: Good afternoon, gentlemen. I am George Duffy. I am appearing today representing the New Jersey State Bar Association. On their behalf we appreciate the opportunity to present to you the views of the New Jersey State Bar Association on this pending legislation because we see the effects. We live and work in the court system -- in the adversary system -- and we see the effects of the implementation of the existing principles and try to anticipate what these changes will bring about. We are in there; we see the effect on the public; we have a knowledge of the reasoning behind the development of the law as it is today; and, today we will try to impart that information -- or present that information -- to this Committee so that you can be informed for your considerations.

There will be a position paper presented on behalf of the State Bar, and for the purposes of efficiency and time, I will try and concentrate my remarks on S-1135, which does apply to all personal injury, negligence, and death accidents.

The Collateral Source Rule was the subject of some discussion before I got here in the middle of this morning's session. I had my annual physical this morning and I did tell my doctor that I had to leave early, but I did not tell him where I was going nor what I was going to be doing.

The New Jersey State Bar does oppose S-1135. The Collateral Source Rule has been supported in the cases in New Jersey for over 100 years. It is based on an economic principle of "what is bought and paid for should be yours," if we can put it it colloquial terms. But I think there is an additional significance to be found in the reflection that it has been in our law for over 100 years, during which time it has been reexamined by the judiciary and fact-finders in numerous situations, numerous reported cases, and at no time has this doctrine been found wanting.

SENATOR RUSSO: George, if I may interrupt.

MR. DUFFY: Yes, sir.

SENATOR RUSSO: I think the fact that it has been reexamined over 100 years and so forth, is aside from the point, if I may suggest that. Let's reexamine it again. I think you were here through the hearing this morning and you heard what my views are, but maybe they are influenced by the fact that I have studied that rule and I have worked with it over the years.

Let's see if we can talk about the arguments made against it today. In other words, let's give it another reexamination, and maybe another one next year, and in 50 years, and 100 years from now.

MR. DUFFY: Sure.

SENATOR RUSSO: Okay? Let's see whether in fact it deserves to be kept. We have thrown out doctrines before that have existed for hundreds of years. Maybe we should throw this one out. Why not?

MR. DUFFY: Okay, number one, in reducing a tort-feasor's liability, it reduces the deterrent effect of his legal obligation, which is accountability. This goes right to the heart of the matter in malpractice, because we have seen where a concerted attack on accountability with the anesthesiologists can improve the overall picture. If you take that financial incentive/penalty away and reduce that responsibility, you are going to dilute the accountability.

Number one, the proposed legislation is in direct conflict with the lien provisions under the New Jersey Workers Compensation Act. Section 1540 provides that where there is a tort-feasor, the comp carrier is entitled to get it back. Now, that subrogation under workers compensation has been thoroughly legislated as recently as 1980, and it is a subject that covers a lot of economic interest in this State. The whole workers compensation -- and it is an integral part of that entire workers compensation situation -- is a Collateral Source effect that this would have on that specifically.

Now, you want to reexamine from a very broad philosophical point of view, as members of the Legislature, your concern with making sure that laws are established fairly between parties -- private rights. If a doctor is exempted from payment because the injured individual has had the foresight to go out and buy private insurance, there is an element of unfairness, in our point of view, in taking away that remedy from the injured person.

Look at it from a larger point of view, and that is the public sector. What goes uncompensated in the private sector falls on the public sector. In other words, we bought and paid for our Social Security. We bought and paid for other benefits, such as Medicare, and if those things can't be kept in the private sector, the public budget is affected. We all know from recent political history that more and more of the public budget in this country is coming back to the state capitols. So, this infringes. This gives them a benefit at the potential expense of public expenditures. That is a cogent reason today, in a reexamination, why Collateral Source shouldn't be played around with.

SENATOR RUSSO: I for one-- That argument doesn't impress me, George. The thing I have trouble with--

MR. DUFFY: I have lost cases too, Senator.

SENATOR RUSSO: The thing I have difficulty with, as I expressed earlier -- and I expressed it not in the sense that I have a closed mind on it, but because I was trying to ask the other speakers to tell me where it is wrong -- you have touched upon. I don't care if it is public or private, if I buy that coverage or my employer does, it doesn't make--

MR. DUFFY: Which you earn. I mean, the employer buys it, but you earn it.

SENATOR RUSSO: I understand. I don't think it matters who buys it. Whether the employer is buying it instead of giving me that extra few bucks, or whether he gives me the few bucks and I go out and buy it myself is irrelevant. The thing I have trouble with is, if, in fact, I do buy it -- in whatever manner -- why should I not be able to collect on it if I paid for it? That is the argument which, basically, I think you agree with.

MR. DUFFY: That is the primary economic argument behind the reasoning that established the Collateral Source Rule in the first place.

SENATOR RUSSO: Yes, I understand that.

MR. DUFFY: I don't think it is any different today than it was originally.

SENATOR RUSSO: Well, that is, of course, the question. You heard me accused of being in the 19th Century and not the 20th -- the 19th, kicking and screaming. I was referred to as adopting an outmoded 18th Century idea.

MR. DUFFY: I think it is a false premise to say that because an individual is supplied these benefits through his employment he doesn't pay for them. They are part of his earnings.

SENATOR RUSSO: Yes. I don't care who pays for it because under the proposed bill, it would not matter who pays for it.

MR. DUFFY: That's right.

SENATOR RUSSO: If I go out and purchase that insurance, and then I get an illness through no one else's fault, I am compensated for that because I paid for the coverage. But if instead of that, a truck hits me in the rear at a red light, I am not compensated for what I paid for because he is going to pay for it. If I am compensated, it would be double recovery. That is the argument.

MR. DUFFY: Yes.

SENATOR RUSSO: Which led me to raise the question about life insurance, which I thought was an analogous situation. If I buy a $1 million policy, and then I buy a second and third one, if I want to pay

my premiums, even though my life is worth, say, $1 million, I can collect $3 million. I paid for it. I think that is the argument you ought to be focusing on, not this public sector thing -- I think that is nonsense -- and not the fact that it has been reexamined for 200 years because maybe it should be reexamined again.

In reexamining it, it seems as though I ought to be able to buy whatever protection I want, as long as I am willing to pay for it, and it if results in a windfall because my life is worth $1 million but I collect $10 because I paid for $10 million worth of life insurance, that is my business. The same thing applies to the medical part of this. If I want to go out and buy two, three, or four policies, under the present system, unless we change the law that says you can only recover once, you can't recover twice even if you are willing to pay for it-- If you want to change that, that is a different thing. But, if I want to go out and pay for it, it seems as though I should be entitled to recover what I paid for, and not have recovery depend on chance, depending on whether someone else caused my injury or not.

That is what I think ought to be the argument. That's the one that appeals to me until someone shows me where I am wrong.

MR. DUFFY: It goes back to the deterrent effect on the--

SENATOR RUSSO: Oh, that doesn't-- I will tell you, George, in all due respect, that to me is the weakest argument you can make, that we ought to make them pay twice because it will have a deterrent effect.

MR. DUFFY: Well, they get their premiums on the risk. That is why. There is a premium paid for the malpractice, and the premium is for your private health insurance.

SENATOR RUSSO: No. You see, to tell me that some doctor is going to be deterred depending on whether or not the patient can collect from him for his medical bills or not, no. No doctor deliberately commits malpractice, and he is not going to be less likely to commit it because he is going to have to pay the medical bills as well as pain, suffering, and so forth.

MR. DUFFY: He is going to be less likely to commit it if it is going to affect his premium cost. Currently, a prefect example of

that is the anesthesiologist. They have done a job on themselves because they were faced with high cost.

SENATOR RUSSO: What you are suggesting is that if we keep their premiums high, we will make better doctors out of them.

MR. DUFFY: It is all part of accountability.

SENATOR RUSSO: I am not comfortable with that argument at all; I really am not.

MR. DUFFY: Well, it is unfortunate, but it is a fact of life. You have to keep them on their toes.

I don't stand here as a public benefactor saying that we have to make them clean up their act or anything like that. I don't mean to sound that way. But the fact of the matter is, if they know their premiums are going to go up unless they are careful, then they will be careful, and everyone benefits from that because nobody makes money in malpractice. I mean, lawyers and insurance companies make a living from it, but the injured don't make money on malpractice.

SENATOR RUSSO: I'd rather approach it from the viewpoint of a person's responsiblility for the effects of their negligence.

MR. DUFFY: Yes.

SENATOR RUSSO: Whatever that negligence may be. It is a fairness argument, rather than saying, in effect, "Hey, if their premiums are high they are going to be more careful." I don't know, that is just one viewpoint.

MR. DUFFY: I am not discarding the fairness argument. I am trying to--

SENATOR RUSSO: I understand. Let's leave the Collateral Source Rule and go on to the next point.

MR. DUFFY: The next item is the portion of the bill that relates to future payments. That concept is in direct conflict with the court rules governing pre-judgment interests which were enacted in 1972, 4:42-11, Subsection (b), which established pre-judgment interest. Pre-judgment interest was a child of the court's management, of its own calendar: Defendants could not use the time spent on litigation to earn money on premiums. Insofar as deferred payments conflict with that economic principle, it is-- We have the prior

experience that this has been in effect for 13 years in the court for a specific reason, to keep things moving. There are no attorney's fees allowed on that pre-judgment interest for the same reason. So, there is no economic incentive, except the early disposition of disputes.

Now, the bill as drafted, as I read it, appears to me to be done in a primitive fashion. I don't want to use that as a biased word, but it is an elementary approach. It is a primitive approach because when structures first came around some carriers were working on the basis of, "Well, we won't pay you dollars now, but we will give you all this money 'here,'" and when you first started asking, "Well, yes, but what is this worth?" they would say, "Well, that's for us to determine." The question is, do you want it in this form?

Before the court rule was enacted requiring the cost factor to be disclosed so that the contingent fee could be established, I, as a matter of logic, couldn't rationally inform a client as to what his settlement was worth unless I knew the actual cost value of what the structure was, because who is to get the benefit of the income during the interim period? And this bill, as designed, is not clear. Does the jury fix a figure, and then does the judge lay it out? The common practice today is rather advanced. Everyone goes around and they are shopped out with annuities -- with annuity companies.

This bill could force the property and casualty carriers, or enable the property and casualty carriers to go into the annuity payment system, and whether that is a good thing is hard to say -- whether they have the mechanics to do it. They themselves now go to the annuity carriers to take care of those situations where large sums of money are involved and it is better to-- There is a mutual agreement that the pay-out be extended over an extended period. But, everyone knows where the money is. There is no tax effect, because the ownership of the policy is left with the annuity carrier. The income on those earnings over the years is taxed through the annuity carrier. They pay the taxes on it, not the individual beneficiary. This is why Internal Revenue is satisfied. They are shopped around. There are special situations, all of which is much more mature than the presentation here, which would create problems.

SENATOR RUSSO: You then prefer the present system and you oppose the compulsory annuity system. I think that is basically what you are saying.

MR. DUFFY: Yes, sir.

SENATOR RUSSO: Okay. Let's go on to the next point. I have to kind of try and move this along, George, because as you can see, staff thought that scheduling this hearing just before the elections would turn out a large number of Committee members and it just hasn't worked out that way, so we have to move through as much as we can today.

MR. DUFFY: I won't go on much further because I am basically limiting myself to those two things. The State Bar does oppose all four bills. Their reasons will be presented. I think at this point, unless you have a specific area you wish me to cover, we are trying to respect the Committee's time.

SENATOR RUSSO: Okay, and we thank you for that, George. Thank's a lot.

Dr. Ralph Fioretti, New Jersey Medical Society? Do you have a prepared statement?

DR. RALPH FIORETTI: Yes.

SENATOR RUSSO: Has it been submitted?

DR. FIORETTI: I don't know whether it has or not. Just one minute and I will get it.

SENATOR RUSSO: Okay.

DR. FIORETTI: I will read this. It should take me less than five minutes.

Mr. Chairman, I am Ralph Fioretti, President of the Medical Society of New Jersey.

There are 9,400 physician members of the Medical Society licensed to practice in New Jersey. We have all suffered the economic, emotional, and professional trauma of the medical malpractice crisis.

I am a family physician in Rochelle Park, New Jersey. By February of next year, my professional liability rates will have increased 80% since 1982. That, however, is only one aspect of the problem.

I practice defensive medicine. That costs everyone. Every doctor I know does the same. I order more tests than are clinically necessary because I fear being sued. I don't want to be criticized three years later for not having ordered a CAT scan, an x-ray, a laboratory test, and so forth. My philosophy and approach to my patients has changed. Twenty years ago, I viewed them as ill and injured human beings reaching out to me for the assistance I could provide. They trusted me, and I them. Today, I approach each patient as if they are a potential adversary. I do the best I can for them, but at the same time I view each with a cautious regard for their potential to sue me.

I do not believe that they are any different than any other group of people. They have come to expect and demand a great deal. If what they receive does not quite please them, they are likely to seek redress in the courts whether they were injured by negligence or not.

The entire field of personal injury and liability insurance needs revisions. The crisis we face is not at all restricted to medical malpractice; it cuts a much wider and deeper path. Municipalities are faced with large increases in their liability insurance if they can find anyone willing to write it. Products liability insurance is virtually unavailable at anything except exhorbitant rates. Architects, accountants, dentists, and podiatrists are confronted by huge increases. My lawyer friends tell me their rates increased between 200 and 300 percent this year. Our auto rates continue to rise.

You have got to help us. You are our last resort. We have done, and continue to do, all we can to promote sound educational and risk prevention controls. We have relentlessly pursued quality assurance, patient safety, and peer review. You control the single factor that can restore balance and sanity to the laws regarding liability. We are asking you to act in a clear, reasonable, and effective fashion.

The package of bills before you has our support.

Regarding the Commissioner's Task Force on Medical Malpractice, I can state that we support most of what they have

recommended, but believe they did not address several critical areas. I have written to the Commissioner in that regard. A copy of that letter is attached to the statement I am delivering today, and I would ask you to incorporate it into the record and into your deliberations. Thank you.

SENATOR RUSSO: Thank you. I have just one question. I wonder if you have considered this: Basically, when you talked about the entire field of personal and liability insurance you mentioned psychiatrists, engineers, lawyers, and so forth; rates are going up, so, therefore, we have to do something; we have to pass this package of bills. Have you considered the possibility that this is a ploy on the part of of the insurance industry, and that this is an effort on the part of the insurance industry to jack up the rates and force people like you, me, engineers, and so forth, to say, "Hey, let's change the system"?

DR. FIORETTI: I don't think that is the case; I really don't. I think rates are based on what they are getting out and what they project on the line.

SENATOR RUSSO: Is that what you think? There is a different viewpoint, incidentally.

DR. FIORETTI: I am willing to listen to you.

SENATOR RUSSO: Yes. What I ought to do is ask staff to send you a copy -- which I think really summarizes it -- of the testimony of Ralph Nader -- I forget the other person -- before the Congressional Committee on this subject. I don't know, is Nader a lawyer? I don't think-- Someone just shook his head yes. I am not sure whether he is or not. I know basically he is, of course, a consumer advocate, not that as a lawyer he wouldn't be. But he outlines what I've felt has been the case for some time.

For example, legal malpractice. There haven't been any big legal awards; yet, the rates went up not 300% but 1,000% in some law firms.

DR. FIORETTI: Because you fellows were very low to start with.

SENATOR RUSSO: We were very low? I don't know. I don't get involved with it much anymore, but as I remember a six-member firm was $6,000 and it went up to $34,000.

DR. FIORETTI: That's a lot of money.

SENATOR RUSSO: Yes, it sure is. I immediately called Mrs. Gluck and said, "Hey, what has happened here"? I just throw this out for your consideration, and some people suggest that the tort system hasn't changed in hundreds and hundreds of years, then all of a sudden--

DR. FIORETTI: The only thing is, Senator -- let me just say this to you -- in 1975 one out of 10 physicians were sued. Last year it was one out of three.

SENATOR RUSSO: I think you make a good point.

DR. FIORETTI: You know, I don't know if there are any machinations on the part of the insurance companies; I really don't think that is the case at all. At least with our insurance company, we are very aware of what is coming down the pike and we are frightened. We don't want to be in the same position of real true crisis that they have in New York State.

SENATOR RUSSO: That's why I think, Doctor -- and I suggested this to one of the other witnesses -- we have to attack the question of frivolous, or unfounded, lawsuits rather than limiting claims, even for those most entitled. You know, the just claim ought not to be limited or hamstrung in any way. Rather, what we ought to be aiming our efforts at is how to stop -- if, in fact it is so -- the number of unfounded claims. I think if we focus our efforts on that, we are liable to get somewhere.

With all due respect, when we come in and say, "Well, the insurance company has raised my rates; therefore, I want you to change the tort system that has been here for 300 years, and put caps on and statutes of limitations," and so forth, I think maybe we are going after the problem in the wrong way. We are going to hurt innocent people that way.

DR. FIORETTI: No, that isn't the purpose. The 14 points put out by the Commissioner of Insurance--

SENATOR RUSSO: Many good ones.

DR. FIORETTI: (continues) --address many facets of this. It is not a one-single deal. I think you have an opportunity now on this Committee -- and you, as a Senator -- to address the whole business here.

SENATOR RUSSO: Right.

DR. FIORETTI: It is a different ball game. You know, there is as much malpractice in Europe as there is in America, probably more. I would like to compare the rates between what we pay here and what is paid in Europe, which is a similar society.

SENATOR RUSSO: I don't know about Europe, but you see--

DR. FIORETTI: I am trying to say to you that I think you have to look at all of it. I can't answer; I am not an expert on insurance. All I know is, my rates are going up.

SENATOR RUSSO: Mine too.

DR. FIORETTI: I have nothing to do with. I just get a bill, and if one does not pay it, he can't sleep at night.

SENATOR RUSSO: Me too. But, you see, what concerns me is, that Task Force—

DR. FIORETTI: Let me just say that the medical community is not asking you to give us a special break. We are asking you to address the entire problem. It has many facets to it, and I think the Task Force was a beginning. I think we are going to have a good dialogue. I just want you to hear us, and not just look at us as though we are looking at it-- We are looking at it from the patient's viewpoint also.

SENATOR RUSSO: The only thing that concerns me is, for example -- that Task Force made a good beginning, and I think a lot of it makes sense -- in your statement you want to adopt all the bills that are part of this package. That's a lot further than the Task Force went. It seems as though it is almost a reaction of -- and you sort of say it here -- "My God, I have a crisis, do something. Anybody who wants to put in a bill that will cut down on premiums, good or bad, pass it." That's what concerns me.

The Task Force has made a good beginning, and there is much in there that I agree with.

DR. FIORETTI: We are asking you to address the problem. You know we have a problem.

SENATOR RUSSO: Right.

DR. FIORETTI: I think you have to look at it. I want to tell you that if this continues to go up, next year 27%, and then the next year 24%, how long do you think the doctors are going to take this kind of nonsense? They can't afford it. We are going to have the same sort of thing that went on in New York State, where the doctors said, "Well, we are not going to see anybody for a week or two." We don't want that to happen. We are looking down the end of the tunnel and saying, "Wait a minute. We haven't arrived there yet, but we are getting there. At 27% per year, let's address it and let's look at it."

If there is something in those bills that is not right, okay, let's talk about. However, I do not think you can throw the whole thing out.

SENATOR RUSSO: Oh, I agree with you.

DR. FIORETTI: This is very serious, and I think you have to look at it.

SENATOR RUSSO: I agree with you. Are there any questions? (no questions) Doctor, thank you very much.

DR. FIORETTI: Thank you.

SENATOR RUSSO: Doctor Cohen? Good afternoon, Doctor.

DR. JEROME B. COHEN: How have you been?

SENATOR RUSSO: Okay. How are you today?

DR. COHEN: Fine, thank you.

My name is Dr. Jerome B. Cohen. I am President of the New Jersey Association of Osteopathic Physicians and Surgeons and represent over 2500 physicians in the State of New Jersey. Seventy-five to 80% are general practitioners, rendering quality health care to the consumer.

I myself am coming from a different point of view than the other men. I will try to be brief and not redundant because the men before me handled much of my statement.

On behalf of the new Jersey Association of Osteopathic Physicians, we would like to support the report from the Insurance Commissioner's Task Force on Medical Malpractice. We are fully appreciative of the effort, time, and thought that went into the preparation of the report. We do support the 14 recommendations made by the Task Force, fully understanding that many of them are a result of compromise.

We have some statements to make. We take exception to item number eight. We feel that the State Board has many duties now, and to impose additional duties on it would be bad. You are giving further support to a regulatory body which is really not supported.

Number nine should be amended with a higher figure and preferably even eliminate transferring of any claims to the Board of Medical Examiners.

We feel that a major consideration would be the addition of a cap on damages, as was expressed previously; utilization of periodic payments of settlements; and we would also like to ask you to restrict punitive damages. This is also entering into the concept of malpractice and it is causing early and sometimes unnecessary settlements of claims.

The main point we feel strongly about -- personally now -- is not the financial aspect but the lack of good medical care to the community by forcing physicians out of practice, and preventing other men from coming into highly sensitive specialty areas, so this crisis is being imposed upon the patients.

Many physicians who have great expertise are no longer available, and they are unwilling to be available because of this exposure.

It was previously mentioned that there is an adversarial feeling among physicians which is being fostered by this particular problem.

I think other men have made our other points. We are very happy to be here, and if there are any questions I can answer from viewpoint as family practitioner and as the President of the Osteopathic Society, I would be glad to do so.

SENATOR RUSSO: Okay, thank you, Doctor. Your statement will be made a part of the transcript, and we appreciate it.

DR. COHEN: Thank you.

SENATOR RUSSO: Arthur Taub? Is it Mr. Taub?

ARTHUR TAUB: Yes.

SENATOR RUSSO: You have given us a prepared statement which will be made part of the record. I wonder if you would consider highlighting any points you may want to, or adding to it rather than going through the whole statement?

MR. TAUB: I can make one point that you referred to before regarding the possibility of some type of conspiracy. If you look at our testimony, you will note that our people are being denied insurance at the moment. We are unable to replace policies that have run out. New members and new practitioners cannot buy insurance.

We are also privy to some facts. The amount of moneys that are being paid as a result of claims are almost zero for the last three years, with respect to employed pharmacists' liability. That certainly is strange that where there are no losses, or insignificant losses, on 30 or 45 days' notice, people are being denied insurance. I think that might set it off.

SENATOR RUSSO: Let me see if I understand what you are saying. It sounds similar to my own illustration regarding legal malpractice insurance. You say that there have been virtually no claims against people in your category?

MR. TAUB: That's our information; yes, sir.

SENATOR RUSSO: Yet, you have received notices that they won't renew policies?

MR. TAUB: The only reason that insurance is in force now is because the government saw to it that liability policies at least be extended. That courtesy has been made, I do have to admit that. But, there has been no assurance that new policies will be issued at the end of this interim period.

SENATOR RUSSO: So, perhaps the suggestion that I advanced, and the one pushed by Mr. Nader before Congress, is not exactly totally inaccurate.

MR. TAUB: Absolutely not.

SENATOR RUSSO: I will raise the question: I wonder if they would be looking for your premiums if the investment market was still 18%, as it was a couple of years ago?

MR. TAUB: That's a good point.

SENATOR RUSSO: Frankly, this is what concerns me. I think the Task Force Report has some good suggestions in it, but I think the public pressure that is being brought about may be little more than a conspiracy by the insurance industry. I don't know.

MR. TAUB: I have to say that the panic is here, and we would hope that this is resolved sooner rather than later.

SENATOR RUSSO: Is there anything else?

MR. TAUB: That's it.

SENATOR RUSSO: Thank you, sir. Joseph Sturtz?

JOSEPH STURTZ: I have a prepared statement; however, I do not have copies. Would it be all right for me to read it?

SENATOR RUSSO: How long is it, sir?

MR. STURTZ: Four pages.

SENATOR RUSSO: I'll tell you what, suppose you highlight it and we will make copies for the members of the Committee and make it part of the transcript?

MR. STURTZ: That will be fine.

SENATOR RUSSO: Okay. Are you connected with any organization?

MR. STURTZ: No, I am not. I am a -- excuse my nervousness.

SENATOR RUSSO: That's all right.

MR. STURTZ: I have two interests in medical malpractice. One is, prior to my present employment I was a surgical orderly and, number two, I have filed suit against a doctor in another state.

In studying the situation of medical malpractice, and in doing some definite research, I have come across some very interesting facts. In 1972, the Department of Health, Education, and Welfare had a Malpractice Commission, and this Commission made a study of two hospitals that were deemed average standard of care, based on the nation as a whole. It was determined by that study that more than seven of every 100 people -- 7.6 to be exact -- who were admitted to a hospital are injured by the treatment they receive.

In 1975, there were 35 million hospital admissions. Consequently, that would be 2.6 million treatment related injuries. In 1975, only 20 thousand medical malpractice claims were filed. The only crisis I could see at this time was that not enough patients were filing suits against their malpractitioners. This 2.6 million figures is also relatively conservative.

SENATOR RUSSO: Let me interrupt you if I may.

MR. STURTZ: Sure.

SENATOR RUSSO: We are dealing with a packet of bills and a Task Force Report. I would ask you if you can to address any comments you have to the particular bills that are before us.

MR. STURTZ: Okay. I noticed in the Asbury Park Press a letter that pertains to just the legislation that is being proposed right now. I would like to read it to you verbatim. The title of it is, "Why Shouldn't Physicians Pay for Mistakes Like the Rest of Us?" and it is written by Russell Kussman of Glendale, California who holds a medical degree and also practices law.

SENATOR RUSSO: Would you summarize the points of the letter, since it is part of your statement?

MR. STURTZ: The points of the letter are, number one, people who are injured don't ask to be injured, and when you are malpracticed against, you are entitled to a remedy. Okay? By limiting the amount of awards people should be due because of their injuries, you are taking away one of the most important ways to put a damper on careless physicians practicing.

He goes on to say-- There is a very important paragraph here that I would like to read verbatim. He says, "Suddenly, the potential defendant -- the alleged wrongdoer -- was dictating the rules of the game. The insurance companies had stood the problem on its head. They turned the victim into the wrongdoer, blaming medical malpractice suits on plaintiffs rather than the negligent health care providers."

I would like to summarize by saying that the only reason for medical malpractice is medical malpractice itself. The suits are-- People don't want to turn around and sue somebody. I do not like suing people. It is more aggravation than I want. I would rather be made

whole. But, by suing somebody you try to attain equality. You can never be made whole. No amount of money can every make you whole. People who have been injured by careless operations, such as operating on the wrong eye as happened to the girl from India who was operated on. I believe she was in India. She had an ulcerated eye and the wrong eye was removed.

I mean, people are entitled to be made whole, but that will never, ever be. I would like to suggest that before the Committee makes any kinds of decisions on these proposed bills, I feel there are two things they should read, both the Medical Malpractice Report of 1973 by the Department of Health, Education, and Welfare, and I believe another very objective source of information concerning medical malpractice is a book written by John Guinther, who goes into detail about the problems between insurance carriers, excessive fees, excessive insurance premiums, and the injured parties as well. I found it was an extremely objective piece of work, and I recommend that you read this before you make your decision. I think it is a definite eyeopener. That is about it, Senators.

SENATOR RUSSO: Okay, thank you very much, Mr. Sturtz.

That concludes the list of witnesses, and it concludes the hearing for today. It will be determined by Senator Lynch, as Chairman, whether there will be any further hearings or whether the Committee will go into the bills without further public hearings. I am sure that will be announced.

Unless there is anything else to come before the Committee, the hearing is adjourned.

(Hearing Adjourned)

APPENDIX

Report and Recommendations of the Commissioner's Task Force on Medical Malpractice

September 4, 1985

IX (a)

MEMBERS

Jesse E. Benton Jr., executive director, N.J. Medical Malpractice Reinsurance Association.

Stanley David, D.P.M., former president, N.J. Podiatry Society.

Michael J. Doyle, M.D., chairman, board of directors, N.J. Academy of Family Physicians; chairman, Insurance Committee, Medical Society of New Jersey.

John Durst, M.D., former president, Monmouth County Medical Society; 11-year member, House of Delegates, N.J. Medical Society.

Louis G. Fares, M.D., director of surgery, St. Francis Medical Center; member, board of trustees, N.J. Blue Shield.

Lars Hyberg, Esq., Valore, McAllister, Westmoreland, Gould Vesper & Schwartz.

Sanford M. Lewis, M.D., member, Board of Medical Examiners; former chairman, Health Care Administration Board of New Jersey.

Robert S. Maurer, D.O., past president, N.J. Association of Osteopathic Physicians & Surgeons; member, board of trustees, Medical Inter-Insurance Exchange.

Alan Y. Medvin, Esq., Medvin & Elberg; president, New Jersey affiliate, Association of Trial Lawyers of America.

Gerald B. O'Connor, Esq., O'Connor and Rhatican; member, N.J. Supreme Court Committee on Model Jury Charges; former president, Trial Attorneys of New Jersey.

Joseph A. Riggs, M.D., chief of gynecology, Our Lady of Lourdes; former member, Board of Medical Examiners.

Jill S. Slattery, Esq. & R.N., private practice and lecturer in the area of nursing law.

Donald E. Smith, vice president, underwriting, Health Care Exchange/Princeton Insurance Company.

Peter Sweetland, president, Medical Inter-Insurance Exchange.

Carl J. Valore, Esq., Valore, McAllister, Westmoreland, Gould Vesper & Schwartz; general counsel, Burdette Tomlin Memorial Hospital; associate editor, N.J. Law Journal.

Herbert Dolinsky, D.D.S., advisory member.

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Executive Summary

The Commissioner's Task Force on Medical Malpractice was created in October, 1984 by Insurance Commissioner Kenneth Merin. The panel was comprised of physicians, insurers, attorneys and a nurse. A representative from the Dental Association also served as an advisory member. Don Bunda and Peter Manzo of the State Office of the Public Advocate served as non-voting members. The panel was charged with two tasks. The first was to recommend an equitable method of funding the projected $42 million deficit in the N.J. Medical Malpractice Reinsurance Association. Those findings were the subject of a separate report. Second, it was to recommend measures that might reduce the incidence of medical malpractice as well as stabilize the cost of medical malpractice insurance, which is the focus of the attached report. While the task force was still working, Hazel Frank Gluck was named Commissioner of the Insurance Department and she guided the panel through its deliberations.

The medical malpractice market is not yet in crisis in New Jersey. But it is experiencing difficulties that could push it into crisis if nothing is changed.

First, there remains the problem of the New Jersey Medical Malpractice Association, which insured or reinsured approximately 3,500 physicians for five years (1977-1982). The Reinsurance Association incurred a projected deficit of approximately $42.1 million, which someone (be it the Reinsurance Association physicians, all physicians, all insurance policyholders or the state's taxpayers), will eventually have to pay. (See Task Force Report I, "Funding the Deficit in the New Jersey Medical Malpractice Association.")

Second, after a period of slow and undramatic increases, malpractice insurance rates statewide have jumped up 38 percent in just two years. Some fields have been particularly hard hit by increases. Dentists, for instance, have seen their rates increase 300 percent in the past year.

Equally important, the trend points to continued increases:

+Claim costs are climbing. The state's largest physician insurer, the Medical Inter-Insurance Exchange, reports that average payments on claims rose from $66,360 in 1977 to $82,790 in 1980.

+The number of million dollar awards is increasing. Between 1964 and 1978, state juries awarded $1 million verdicts to 7 plaintiffs, spread among several kinds of liability actions. Between 1980 and 1983, there were 5 $1 million verdicts in medical malpractice alone.

+The frequency of suits is also up. The most conservative counts indicate that although fewer than 1 in 10 New Jersey physicians was sued in 1970, 1 in 5 had been by 1982.

+Between mid-1978 and 1982, medical malpractice actions increased by 45 percent, while all civil cases increased only 32 percent.

+Two thirds of the cases filed end without payment to the plaintiff.

+There is a significant difference in the rate of success between attorneys specializing in malpractice and those involved in only a case or two.

+Although there are a few physicians with a large number of claims inst them, suits are not concentrated against a small group of "bad tors." Instead, many physicians having been sued once or twice.

+Obstetrics/gynecology leads all other fields in losses.

+There is no continuing education licensure requirement for sicians, general dentists, podiatrists or attorneys, although the fessional societies encourage ongoing education. Nor do the state's ical or dental schools require students to take special coursework in clinico-legal issues surrounding medical malpractice.

+The application of the discovery rule has created an unlimited tute of limitations which makes it difficult to estimate future losses price policies realistically. As a consequence, reinsurance is oming difficult to obtain, and the survival of the current policies, h insure against incidents from a given year for the lifetime of the sician, are being threatened.

After debating more than two dozen ideas, the task force has adopted roposals, many of them unanimously. Some, such as the suggested change he collateral source rule, are pure cost containment measures. Others, the continuing education requirement for physicians, attempt to avert t suits by reducing the incidence of malpractice. Still others, such he creation of a special certified malpractice attorney program, are nded to reduce the numbers of suits by increasing professionalism. The owing are the task force's recommendations:

1) Amend the collateral source rule, so that plaintiffs are not paid a nd time for losses already covered by other insurance sources.

2) Restrict the statute of limitations for adults to four years. ts now have either two years from the date of incident or two years the date of discovery of the injury to file. The new rule would give ts four years to file, no matter when the injury was discovered ept in cases where there was fraud or a foreign object was left inside rgical patient.), This change would give insurance company projections stability.

3) Amend the statute of limitations for minors. Children now have l 2 years after they turn 18 to file, no matter when the injury. The force recommends that children have until age 11 to file for injuries h occurred when they were 8 or younger. This should aid etricians/gynecologists by spurring parents to file earlier, making it ible to price ob/gyn insurance with some accurancy.

4) Limit the proliferation of multi-defendant suits by abolishing the rule which limits awards against hospitals to $10,000 and allow suits over hospital-based incidents to be filed only against non-employee physicians and the hospital.

5) Require plaintiffs to file an affidavit of reasonable cause signed by a physician within 60 days of filing suit. This should help to eliminate the weakest cases early.

6) Decrease costs by instituting mandatory arbitration for malpractice cases with claims of $50,000 or less. The system should be modeled on the one in use for automobile liability.

7) Improve the quality of justice by seeking voluntary cooperation of the medical and dental societies in making better expertise available to the court system.

8) Strengthen the Board of Medical Examiners with increased staff and computerization, so that it can become a stronger watchdog on the physician community.

9) Amend the legislation requiring all claims of $25,000 or more to be transferred to the Board of Medical Examiners. A better screen would consider both claim frequency and size. The Task Force suggests claims be transferred whenever the payment is $100,000 or more, or whenever a physician has had three or more claims in five years.

10) Educate physicians before they start practice by requiring students to take a course focused on ethics, risk management and the clinico-legal issues related to medical malpractice.

11) Improve the quality of physician practice by mandating that physicians take 150 hours of continuing education every three years as a requirement for licensure.

12) Emphasize as part of the student and professional curriculum, the importance of educating patients so that they understand all the ramifications of a procedure before it is performed.

13) Improve the efficiency of case handling and screening by creating a special certified malpractice attorney program modeled on the certified trial lawyer program.

14) Increase the efficiency with which attorneys practice by instituting an attorney peer review program similar to the physician peer review now utilized in hospitals.

REPORT AND RECOMMENDATIONS OF THE COMMISSIONER'S TASK FORCE ON MEDICAL MALPRACTICE

RISING PRICES

A decade after the so-called "malpractice crisis" of the mid-1970s, New Jersey again faces trying times in the field of medical malpractice liability insurance. In 1975, the problem was availability; in 1985, it's affordability.

By any measure, frequency -- the number of suits filed per 100 doctors -- is rising. And that increase is pushing up expenses, premiums and doctor bills.

The projected $42.1 million deficit in the New Jersey Medical Malpractice Reinsurance Association, the collapse of Florida's physician-owned insurance company and the 52 percent increase in New York State's malpractice rates may be the most spectacular examples of the difficulties in the market. But rates are rising at other companies as well.

For physicians, New Jersey has only two major medical malpractice insurers -- the Medical Inter-Insurance Exchange, with about 7,000 physicians, and the Health Care Insurance Exchange/Princeton Insurance Company, with about 5,000 doctors and podiatrists. The American Dental Association Protective Plan insures a majority of the state's dentists.

In New Jersey, insurance companies working under the auspices of the Medical Society of New Jersey traditionally have held the largest single market share. Between 1974 and 1976, the Medical Society's carrier was Federal Insurance Company, a subsidiary of The Chubb Group of Companies. In 1977, the Society helped to form the Medical Inter-Insurance Exchange.

Overall rates for physicians covered by the Society's programs increased 296 percent between Jan. 1, 1975 and Jan. 1, 1985. By comparison, the New York-New Jersey consumer price index rose an average 95.8 percent between 1974 and 1984, and the region's medical care index increased 137 percent, according to the U.S. Bureau of Labor Statistics.

The increases are impressive on their own, but the underlying patterns are more revealing. The first 87 percent of that increase occurred between 1975 and 1977, the peak of the malpractice crisis in New Jersey. The second surge appeared in 1984 and 1985, when rates rose an average of 19 percent a year.

Princeton, which opened its doors in 1982, held the line on rates in 1983. But in the three years of its existence, its overall average premium has gone from $6,000 in 1982 to $9,000 in 1985, an increase of 50 percent.

In general, however, all physicians have not been impacted equally by price increases. MIX's current opthamologist rates, for instance, are down $640 from 1977 levels.

better than other groups. Their price for a standard policy from MIX has risen 34.8 percent since 1977. This compares to a 73 percent increase for high-risk specialties and general practitioners who perform minor surgery. MIX's highest-rated specialty, neurosurgery, now commands $30,122 a year for a standard policy.

The situation is even more serious for dentists and podiatrists. This year, general dentists covered through the ADA plan, saw their premiums increase 316 percent, from $872 to $3,625. Rates for some oral surgeons went from $8,522 to $30,896. National Fire, another major writer of dentists' coverage, was charging North Jersey dentists $3,989, an increase of 290 percent from last year, and oral surgeons, $31,184, up 266 percent over 1984. (Both companies offer lower rates in South Jersey.)

Rates for podiatrists have risen more than 180 percent since 1978.

In addition, both physicians and podiatrists face the prospect of a new surcharge to cover the projected $42.1 million loss in the N.J. Medical Malpractice Reinsurance Association. If a surcharge is placed on all doctors, it would come to about $870 a year. If it is levied exclusively on Reinsurance Association doctors it could range from $460 a year for retired physicians to $11,120 for orthopedic surgeons, neurosurgeons and obstetricians.

But beyond rising prices for individual specialties, there is a second trouble sign -- the rising level of minimum coverage.

In 1979, the first year for which the Medical Inter-Insurance Exchange has statistics available, 14 percent of its doctors purchased what was considered a basic policy of $100,000 per incident, $300,000 maximum a year. About 26 percent bought coverage for $500,000/$1.5 million, and 60 percent had coverage of $1 million/$3 million, which was the largest policy MIX sold.

These days, $1 million/$3 million is the standard policy, and many physicians consider even that to be inadequate. At MIX, 21 percent of policyholders opted for coverage ranging up to $5 million/$5 million, MIX's new maximum. Princeton sells a still larger policy of $6 million/$8 million.

Neither company continues to offer the old standard $100,000/$300,000 policy to physicians.[1] In fact, 1985 is the last year MIX will sell $200,000/$600,000 coverage (purchased this year by only 4 percent of its policyholders). The smallest policy available to physicians from Princeton has limits of $500,000 per incident and $1 million maximum per year. About 20 percent of its customers continue to buy the minimum policy.

It is difficult to say just how much rising malpractice premiums affect bills to patients or total health care costs.

Data from the AMA's continuing Socioeconomic Monitoring systems indicates that in 1983, premiums accounted for about 3.69 percent of average gross income for physicians nationwide.[2] (Nationally, the average premium was $7,100 and average gross income, $192,200. In New Jersey, the average premium for a physician insured by the Medical Inter-Insurance Exchange in 1985 was $9,000. The average premium for a surgeon was $21,000.)

In general, the AMA's national data shows that premiums as percentage of gross income rose in the mid-'70s (from about 2.35 ercent in 1973 to 4.40 percent in 1976), then fell slowly until bout 1981, when they reached 2.99 percent. In 1982 and 1983, they egan edging up, and physicians and insurers argue that when 1984 nd 1985 figures are available, they will show steep increases.[3]

Moreover, broad national figures tend to mask problems mong specific specialties. In 1983, for instance, only 7.6 percent f physicians nationwide paid more than $20,000 a year for alpractice insurance. But 23.6 percent of obstetricians did.[4]

Premiums also have varying impacts on physicians of ifferent ages. A $20,000 premium that poses no problem to a hysician with a well-established practice may be a serious barrier o a young doctor with debts to pay or an older physician who needs r wants to cut back on hours.

Patricia Danzon, an associate professor of economics at uke University and an expert on malpractice, has said her studies ndicate premium costs represent 1 to 2 percent of all health care osts and that even the highest premiums represented about 8 percent f doctors' gross incomes.

When do premium costs become significant? That is a matter f opinion. In Florida, where the average malpractice premium is elieved to represent about 2.6 percent of physician gross income, he Academy of Florida Trial Lawyers characterized the 2.6 percent s "a relatively insignificant cost of a doctor's business."[5]

On the other hand, 4 percent is the portion of premiums lue Cross of New Jersey spends on administrative costs.

As for overall health care costs, malpractice litigation nd the fear of it may contribute to both the size of physician fees nd the number of procedures ordered.

Certainly, there is anecdotal evidence that physicians ttempt to raise fees to cover premiums. A 1983 study by the merican College of Obstetricians and Gynecologists found that more han half its members had increased fees two or more times in the ast two years, with the major factor cited being malpractice nsurance. A fifth of the obstetricians surveyed reported that they assed along 75 percent of every increase in premium charges to atients.[6]

The usual cost for delivering a baby on Long Island, where b/gyn premiums are $82,500, is about $2,500. In New Jersey, where remiums range from $20,028 to $20,304 (with an additional 5 percent er physician for corporate liability), the cost of a delivery is bout $1,000.

The American Medical Association believes that fear of itigation also leads to what it calls "defensive medicine," dditional care or testing ordered primarily as a guard against otential lawsuits.

When the AMA surveyed its members in 1983, 40 percent eported that they often ordered additional diagnostic tests, and 27 ercent prescribed additional treatments they might not have ordered xcept for fear of suit.

The AMA's Committee on Professional Liability estimated nat "positive defensive medicine constitutes 25 percent to 50 ercent of the cost of treatment," or about $15.1 billion nnually.[7]

But physicians are under growing pressure to stop passing through costs and to reduce utilization of medical services. Last year, many physicians agreed to a voluntary across-the-board freeze on fee increases to Medicare patients. The Reagan administration is seeking to extend that freeze into the next year. For physicians who agree, any increase in malpractice premiums will either reduce cash flow or cause fee shifting to other patients.

Other health insurers, among them Blue Cross and Blue Shield, are trying to hold the line on their own costs by increasing their use of utilization review panels, which monitor physician decision-making for unnecessary use of resources.

So the physician is squeezed between two forces -- the need for health care cost containment and fear of malpractice litigation.

The AMA questions whether the ordering of the additional procedures is desirable. But others might argue that the tests, which were designed to weed out the rare but catastrophic illness from the mass of routine ailments, are eminently desirable and even, in the long run, cost effective.

As the chairman of the AMA Committee on Professional Liability noted, "Defensive Medicine is also defensible medicine. Nevertheless, we must recognize that it is costly...."[8].

And there's the rub. What is reasonable? What is negligent? Where does prudence end and waste begin?

The simplest definition of malpractice is deviation from "customary standards of medical practice." It is a medical standard which leaves decision-making in the hands of the medical community. If most doctors order expensive tests, then their colleagues must follow suit or face the courts if something goes wrong.

But in a time of rapidly changing technology, the standard is not so simple. Recently, for instance, the New England Journal of Medicine published a study in which researchers examined 491 admissions to a California veterans hospital with a high prevalence of cardiopulmonary disease. 294 of the patients were administered a $50 chest x-ray as a routine part of admission.

The x-rays produced new findings in 20 cases. Although care was changed in 12 of the 20, in only one case would appropriate treatment have probably been omitted in the absence of the film, which revealed lung cancer. But even that patient's outcome was not improved by the treatment instituted.[9]

The finding was similar to that of previous studies which led the American College of Radiology to suggest hospitals discontinue routine use of chest x-rays, a practice with an estimated cost of $1.5 billion a year.

Five years ago, failure to administer an x-ray might have resulted in an expensive malpractice suit. Now, presumably, the rationale is gone. It is even conceivable, given the research on the long-term effects of radiation, that a doctor who goes on administering routine chest x-rays may someday face suits from patients who believe, rightly or wrongly, that the x-rays caused their lung cancers.

Doctors say it is the element of uncertainty that makes malpractice so anguishing. One physician involved in a court case said it affected him in ways a tour of duty in Vietnam never had.

A survey of physicians from Cook County, Ill. who had been ed between 1977 and 1981 found that the suits took a toll on the tors. 56 percent experienced a bout of major depression, and other 20 percent reported anger, irritability, insomnia, fatigue, trointestinal symptoms or headaches. Three physicians suffered art attacks, and 10 saw existing illnesses (angina, ulcers, astic colon and hypertension) worsen significantly.[10]

Physicians also raise the specter of reduced care if rent trends continue. In Florida, about half of the tetricians/gynecologists who responded to a survey reported that ey had decreased the amount of high-risk work they did, and nearly percent had given up obstetrics altogether.

A survey of California physicians during the 1975 practice crisis in that state found that the biggest changes were de by family physicians who reduced their practice of surgery and tetrics. Those decisions had the heaviest impact on rural areas, ich relied more heavily on family physicians for all kinds of re.[11]

GHER PAYMENTS, MORE SUITS

The pricing of malpractice policies is as much good esswork as it is good mathematics. The true cost of providing the verage for any particular group of physicians does not become ear until all the claims for that year have been filed and tled. In a state like New Jersey, where minors may file up until e 20 for birth injuries and adults can file within two years of scovering their injury, a company's bottom line depends on its ility to guess how many claims will occur, what interest will be rned on the initial premiums, how much it will cost to pay the aimants, and how much administrative and legal expenses will run a 20-year plus period.

That long period between the opening and closing of the oks is one reason discussions about malpractice insurance become heated. One person's prudent reserve against future loss is other person's padded account for hidden profits.

It is also the reason that insurance companies spend so ch time poring over data for trends. Two of the standard measures ed are frequency -- the number of claims per 100 doctors -- and verity -- the size of payments to successful plaintiffs.

verity

Some states have experienced alarming increases in the size payments made to claimants. The Illinois State Medical ter-Insurance Exchange reports, for instance, that its average ard skyrocketed from about $15,600 in 1977 to $132,700 in 83.[12]

New Jersey does not appear to be suffering a problem of ual magnitude. Average awards are lower than those in Illinois, though insurers see a worrisome trend toward higher verdicts.

There are several ways to monitor the average cost of claims. The most common measure counts all suits which required defense fees or injury payments. (Since suits that end with no payment may have legal and administrative costs, this measure tends to produce lower averages than those related solely to cases that ended in payments to plaintiffs.)

By that measure, average claim costs in New Jersey marched steadily upward from $9,572 in 1972 to $26,031 in 1977. Then, based on data from the Medical Inter-Insurance Exchange, the average began to rise and fall, hitting peaks in 1978 ($29,174) and 1980 ($32,607), the last year for which fully reliable data is available. (See Chart I on following page.)[13].

The insurance companies suggest the roller-coaster pattern indicates that, "(T)his average has become cyclical and probably a function of specific patterns of very high awards."[14].

A slightly different indicator limited to cases involving actual payments also shows an upswing followed by a decline. The Medical Inter-Insurance Exchange reports that its average payments rose steadily from from $66,360 in 1977 to $82,790 in 1980.[15]. (See Chart II on following page.)

The Reinsurance Association reports that its average payments went from $46,416 in 1982 to $28,873 in 1983 to $74,675 in 1984.[16].

Similarly, the American Dental Association reports that average payments for dental claims soared, from below $800 for year 1976 to more than $4,000 in 1979, dropping back to about $2,600 for year 1980. (See chart III)

The data on average awards suggests that the rest of the nation has been playing an unhappy game of catch-up. Average payments nationally in 1977 were much lower than those in New Jersey, but by 1983, the national average was as high or higher than New Jersey's.

AMACO, the American Medical Assurance Company, which last year surveyed Medical Society-related insurance companies nationwide, reports that between 1979 and 1983, its clients saw average paid claims increase from $20,396 to $72,243 -- or 254.2 percent.

By comparison, the increase in the northeast (which included New Jersey) was a relatively moderate 142.6 percent, from $28,194 in 1979 to $68,409 in 1983.

A third indicator is a simple year-by-year tally of all payments combined. There, MIX's trend line goes straight up. In 1982, the average was $50,086. In early 1984, $57,410, and in 1985, $64,475. (See Chart IV on following page)

Tracking for the Reinsurance Association shows a similar trend. In 1983, Princeton's average payment for the Reinsurance Association was $21,832; in 1984, $68,567.

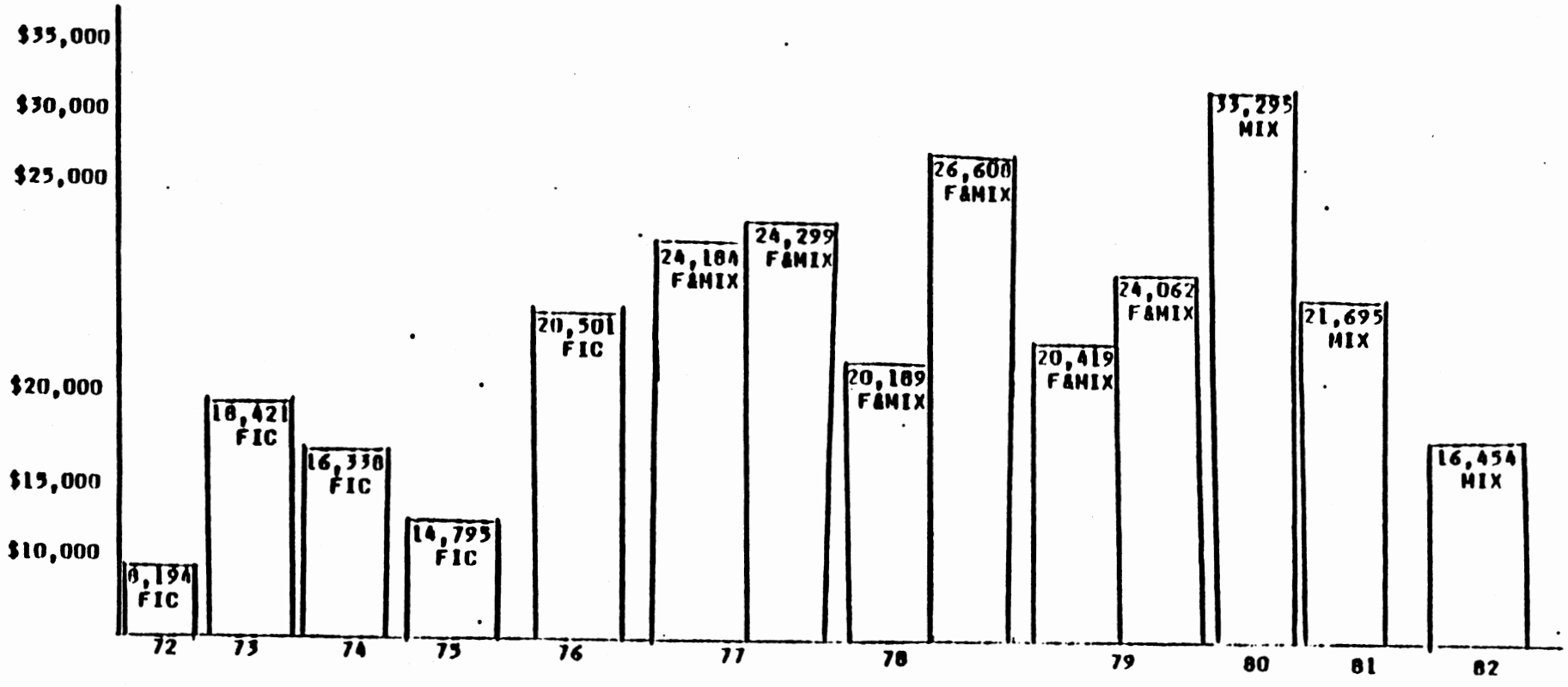
But beyond the question of average awards, there has been an upswing in the number of awards of more than $1 million, a phenomenon which does not bode well for the future.

Nationally, there were three $1 million medical malpractice awards made by juries in 1975. In 1983, there were more than 254.[17].

Chart I
NEW JERSEY PHYSICIANS' AND SURGEONS' PROFESSIONAL LIABILITY

Severity History

Average Indemnity Payment for Claims Closed
With Payment of Indemnity or Expense
(Total Limits) (as of 12/31/83)



Years 1972-1976 - Data from Federal Insurance Company
Years 1977-1979 - Data from Federal & Medical Inter-Insurance Exchange
Years 1980-1982 - Data from Medical Inter-Insurance Exchange

12 X

Chart II
Average Payment to Plaintiffs
Medical Inter-Insurance Exchange

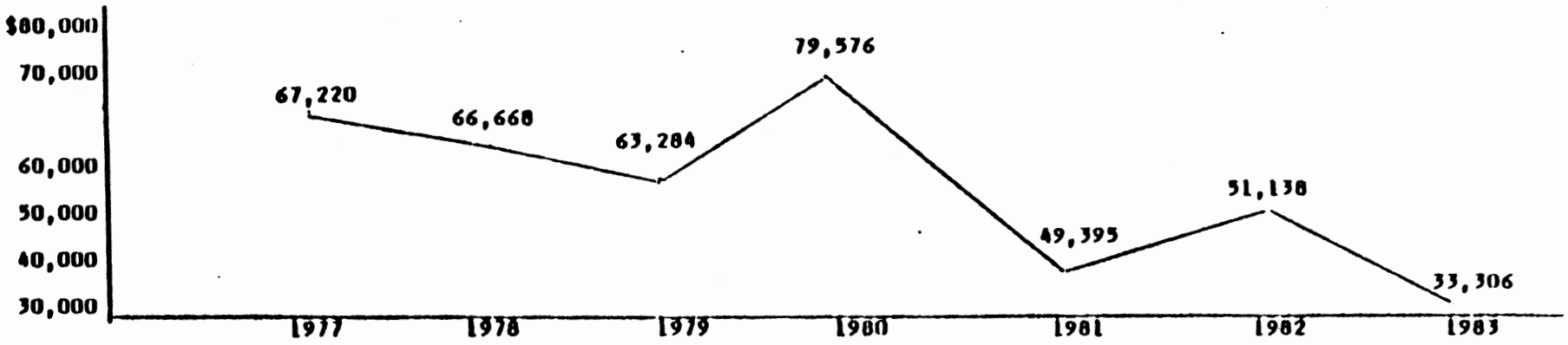
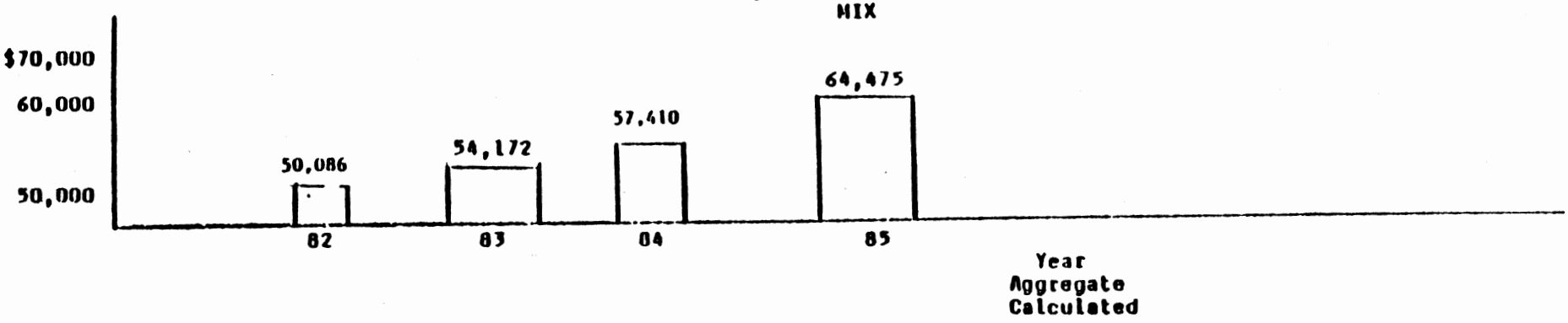


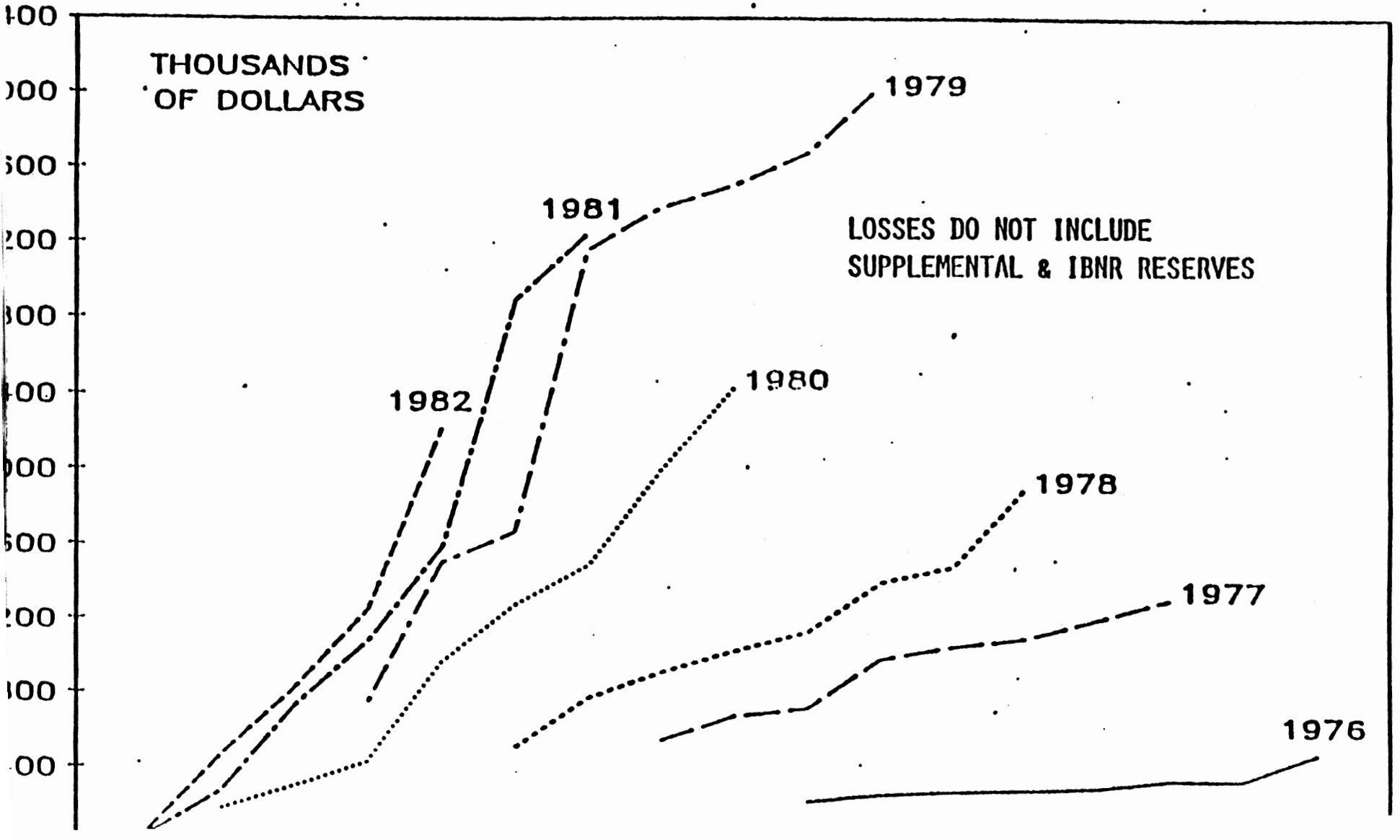
Chart IV
Average Payment to Plaintiffs
Average All-Years Combined
MIX



13X

CHART III

AMERICAN DENTAL ASSOCIATION
INCURRED LOSS DEVELOPMENT
NEW JERSEY – ALL CLASSES
TOTAL LIMITS – LIABILITY



X-41

Statistics from New Jersey alone are sketchy. In the 14 years between 1964 and 1978, juries awarded seven plaintiffs $1 million or more, but the decisions were spread across several kinds of liability cases.[18].

In 1980 through 1983, the only period for which data segregating New Jersey malpractice jury awards is available, there were five verdicts of $1 million or more. There was at least one in 1984 but reporting for that year is still incomplete.[19].

Frequency

While the trend on severity is mixed, the frequency with which doctors are sued shows a clear movement -- up. Studies by three separate sets of actuaries show that frequency doubled in New Jersey between 1970 and 1982, the last year for which full statistics are available.

The lowest estimate, produced by looking only at cases closed with payments, found that the number of suits per 100 physicians rose from 9.2 in 1970 to 21.7 in 1982.

The highest estimate, which included potential claims reported by doctors but not yet filed by patients, shows increases from 15.4 cases per 100 doctors in 1970 to 32 in 1982.[20].

Dentists also are being sued more often. Where approximately 50 claims have been filed over incidents in the year 1976, nearly 300 have been filed against 1981. For dentists, this is a particularly disturbing statistic, since there has been much less time for 1981 complaints to emerge. (See Chart V on following page)

The suit data puts New Jersey among the high-incidence states. Nationally, AMACO's survey found that overall frequency among Medical Society-related carriers stood at 20.3 in 1983, slightly below New Jersey's.

Here again, it seemed to be a case of the rest of the nation catching up to New Jersey. Frequency here increased rapidly in the late 1970s and then began to waver. Frequency in the northeastern states, on the other hand, increased 129 percent between 1979 and 1983. But the result was a figure of about 18.1 cases per 100 doctors, still below New Jersey's.

The proportion of unsuccessful cases is significant. About two of every three cases filed against the years 1977 through 1981 ended without a payment, the Medical Inter-Insurance Exchange reports. In 1982, the last year with enough claims to suggest the eventual pattern, 61 percent were closed without payment.

Reinsurance Association data indicates that about 60 percent of the claims closed in 1982 were shut without payment, about 40 percent in 1983 and 50 percent in 1984. (See chart VI on following page.)

Of more concern, from the insurers' standpoint is the overall increase in numbers of cases filed. To date, MIX has closed 830 cases from the 1977 year. But it has closed 1,111 cases against the 1980 year -- a bad omen considering that potential claimants have had more time to file over incidents which occurred in 1977.

There have been many studies in various states by groups with special viewpoints. But one of the few neutral organizations publishing research on the malpractice problem is The Rand Corporation.

The Rand researchers concluded that urbanization and the umber of doctors per capita played significant roles in pushing up laim frequency. "An increase of 100 doctors per 100,000 population s associated with an increase of 3.6 claims per 100,000 opulation."[21].

Statistics provided by the N.J. Department of Health ndicate an increase in doctors does not account for the increase in laims. DOH estimates that the number of physicians has risen from bout 156 per 100,000 in 1977 to 203 per 100,000 in 1983 --not nough to produce a significant increase in claim frequency.

Rand also found that, "The single most powerful predictor f claim frequency and severity is urbanization, even after ontrolling for higher physician and lawyer density in urban tates....Higher awards by urban courts is certainly one factor ontributing to the higher claim frequency. We have been unable to dentify the other characteristics of urban environments that ontribute to higher awards and frequency, but we have determined hat more complex medical facilities, per capita income and welfare nd unemployment rates are not significant."[22].

As auto insurance buyers are all too aware, New Jersey is urrently one of the most urbanized states in the nation.

HERE IT STARTS -- PHYSICIANS

All specialties have not been affected equally by the ising tide of suits and awards.

Insurance companies differentiate among specialties on the asis of experience. Specialties such as neurosurgery, obstetrics nd orthopedic surgey are, by definition, high-hazard occupations. he procedures are complicated, and the stakes are high -- paralysis r restored movement, brain damage or normal function, life or death.

The hazards are reflected in higher claim payments. The unaway leader in payments at MIX is obstetrics/gynecology with a otal of $34.6 million in claims paid. The next highest group is rthopedic surgeons with indemnity of about $23 million (see Chart II and VIII on following pages).[23].

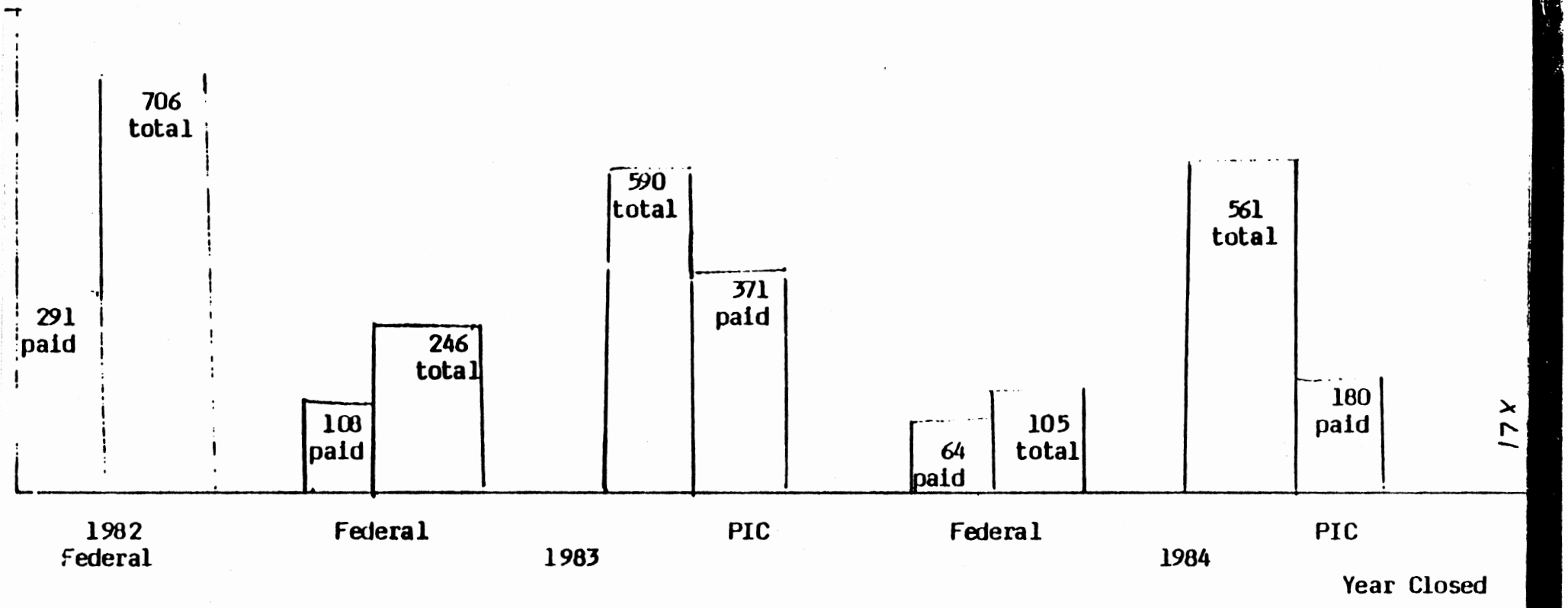
A 1981 summary of Reinsurance Association cases expected to nd with liability of $25,000 or more showed a similar pattern. Of 21 cases, 20 stemmed from obstetrics/gynecology (four involving eaths and 6 hysterectomies). Orthopedic cases ranked second with 12 ases, followed by emegency room physicians and a variety of other urgeons, each with 11. Six involved heart problems and six plastic urgery.

The high losses correspond with another trend: The size of laim payments for high-hazard specialties has been rising quickly, hile those for other forms of practice have not.

For years 1972 through 1979, Federal Insurance Company veraged payouts of $9,224 a year per obstetrician and gynecologist. n 1982, MIX was averaging payments of $13,123 a year for the same roup. For orthopedic surgeons, average payment was $8,832 per hysician in 1972-79, compared to $13,123 in 1982. (Both averages nclude cases closed without payments.)

Meanwhile, Federal's average payment on a general practice laim was $1,154, compared to MIX's average of $1,153 in 1982 -- irtually no change.

Chart VI
N.J. Medical Malpractice Reinsurance Association
All Closed Cases & Paid Cases
1977-1982



Federal data aggregates claims from incidents arising in 1977-1979 no matter when they were closed
Princeton (PIC) aggregates Reinsurance Association data for claims from incidents occuring in 1980-1982.

CHART V

AMERICAN DENTAL ASSOCIATION
REPORTED CLAIMS DEVELOPMENT
NEW JERSEY – ALL CLASSES
MEDICAL MALPRACTICE

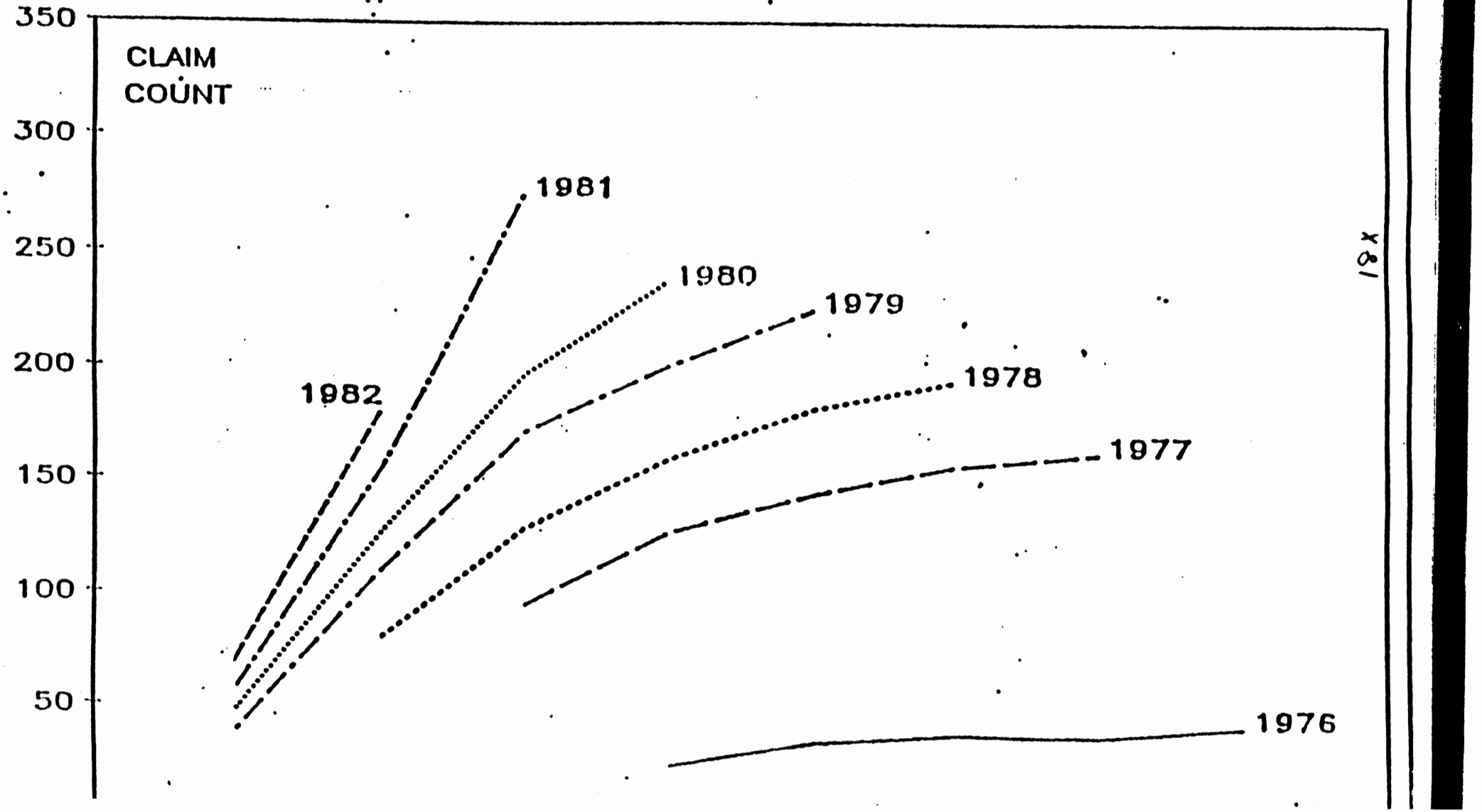
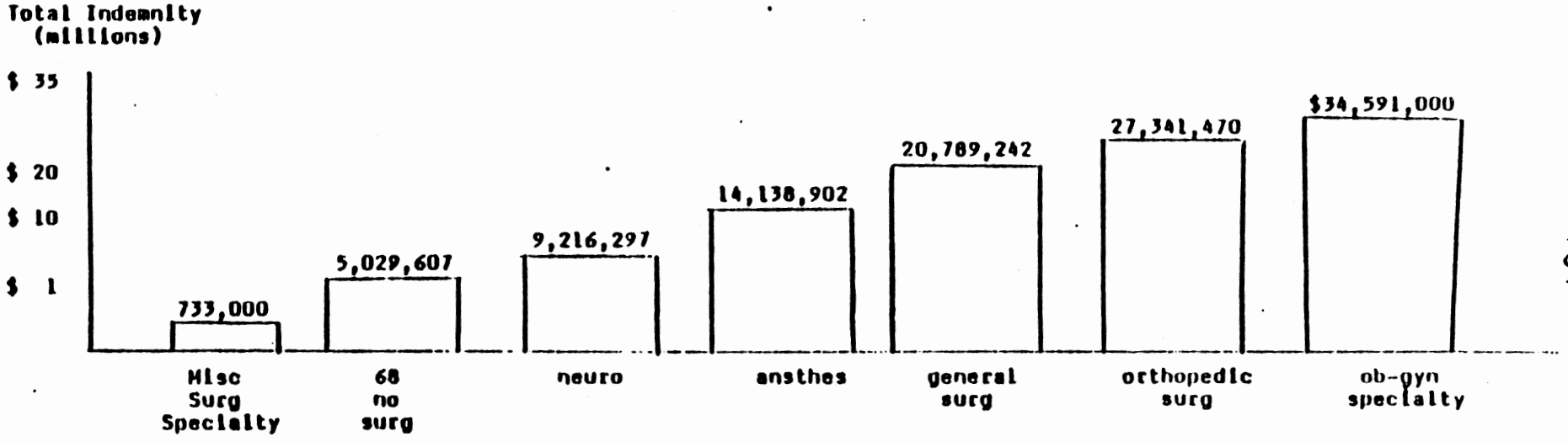


Chart VII

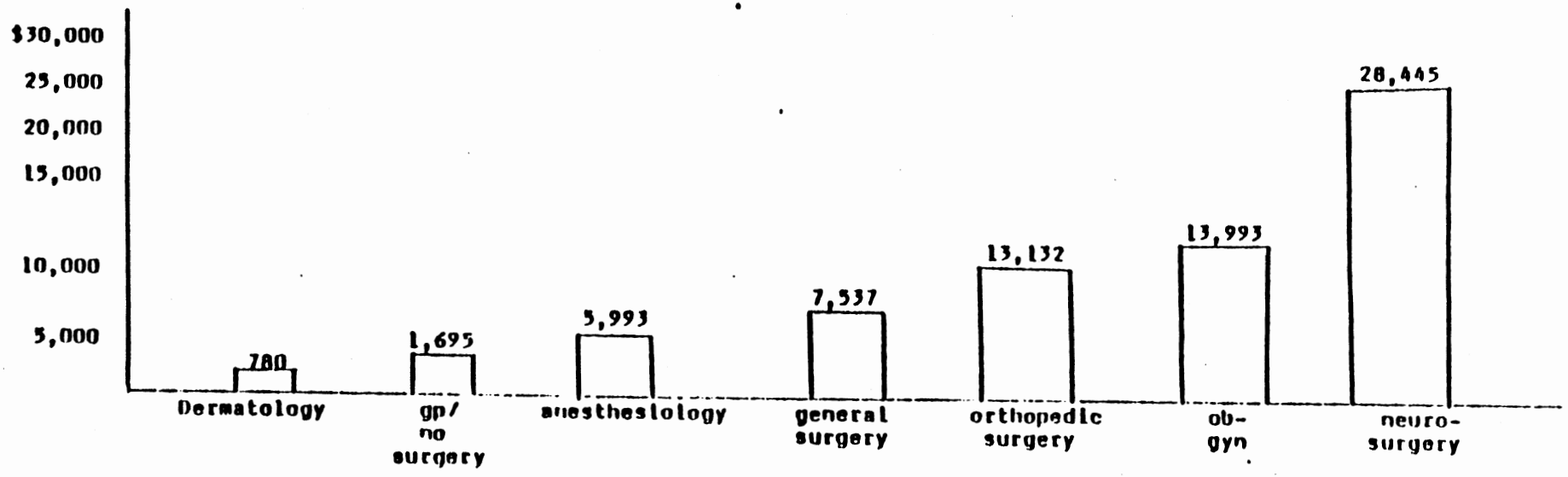
Incurred Losses by Specialty
1977-1984



* data from Medical Inter-Insurance Exchange

Chart VIII

Average Incurred Indemnity Per Physician by Specialty *
1977-1982 Combined



* data from Medical Inter-Insurance Exchange
Exhibit 3C, Physicians & Surgeons Liability Report

20 x

Specialties also tend to generate different kinds of claims. For surgical specialists covered by MIX, errors in peformance generated the most cases, but only the third highest payout. The most expensive problem with diagnosis error, at $17.7 million. For non-surgeons, diagnosis was overwhelmingly the problem -- 223 files and $14.3 million in paid indemnity. (See charts IX and X on next pages.)

Are the mistakes made by "bad doctors?" Insurance company representatives say the answer is no. MIX, for instance, points out that of 7,089 doctors covered by the company as of August 1, 1984, only 509 has been involved in more than one case in the previous five years. Of that group, only 45 had enough cases against them to be paying a surcharge.[24].

Princeton reports that it has rejected about 5 percent of the physicians who've applied for coverage and has either cancelled or restricted coverage for another 2 percent of its doctors. (PIC and HCIE cover about 5,000 physicians.)

Looking at it a different way, MIX has only 19 doctors with two paid claims of $100,000 or more and only two with three or more cases of $100,000 or more. Of those 21, MIX no longer insures 8.

If inexperience and advanced age were to blame, then new doctors and elderly physicians might be expected to produce the most cases.

Instead, the bulk of the claims are against doctors between ages 35 and 49. "...the physicians at the peak of their practice are having as much, if not more, of a problem than those just starting or those approaching retirement."[25].

A study of 1982 AMA national data on malpractice claims indicated that the claims rate for physicians was positively related to experience until the physician had been out of school for 27 years. "Thus it appears that the development of medical skills likely to occur during years of practice does not show up in a lower rate of malpractice claims until late in the physician's career."[26].

The study also indicated that physicians in group practices tended to incur more malpractice claims and that obstetrician/gynecologists and medical specialists who spent more time with their patients per office visit incurred fewer claims.[27].

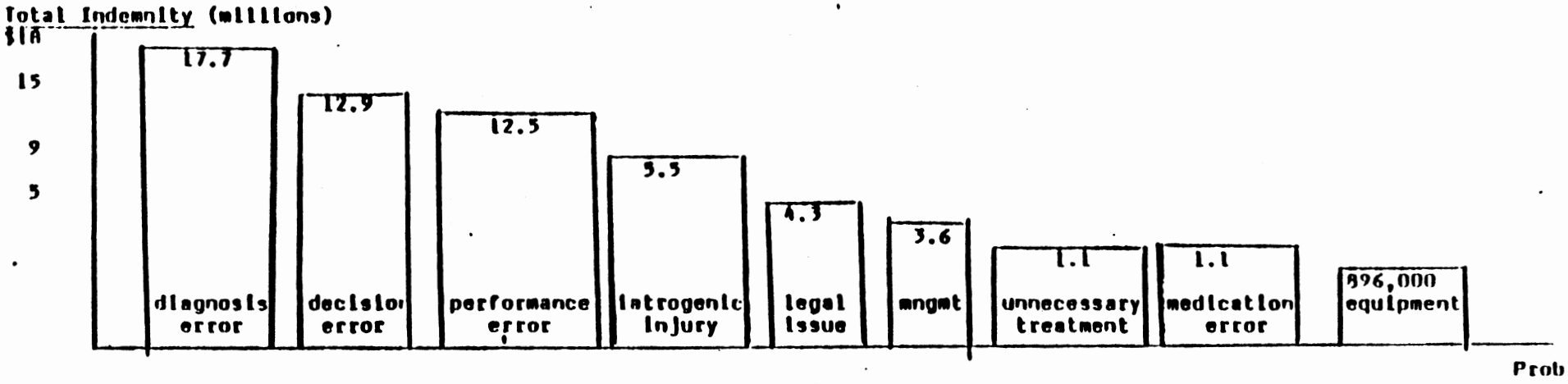
But the evidence on time in practice is mixed. The American College of Obstetricians and Gynecologists found in its survey that while physicians who had been in practice longer were more likely to have experienced a claim in the course of their careers, "the increased risk of being sued seems to happen in the first 10 years of practice; the proportions having been sued don't change much after those first 10 years."[28].

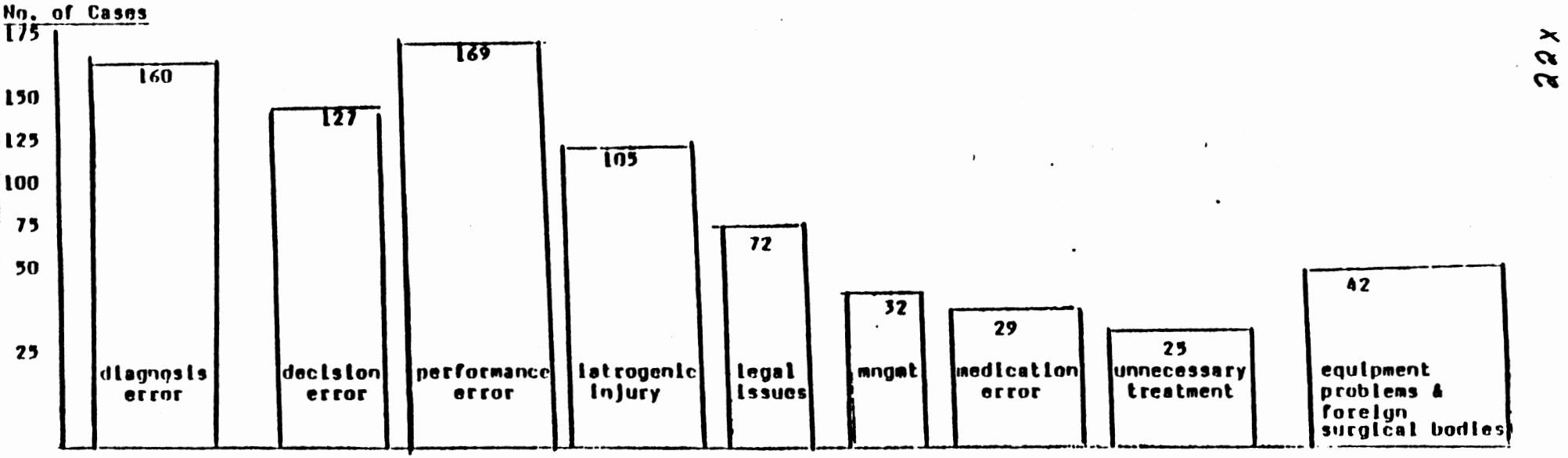
Board certification is not a guaranteed prevention measure. In one study of malpractice cases in Cook County, more than 80 percent of the doctors involved were board certified. [29].

WHERE IT STOPS -- ATTORNEYS AND THE COURTS

One popular theory holds that there is a correlation between the large number of lawyers in New Jersey and the large number of suits filed here.

Chart IX
Surgical Specialties
Medical Inter-Insurance Exchange
Closed Cases*
Cause of Loss
1977-1982

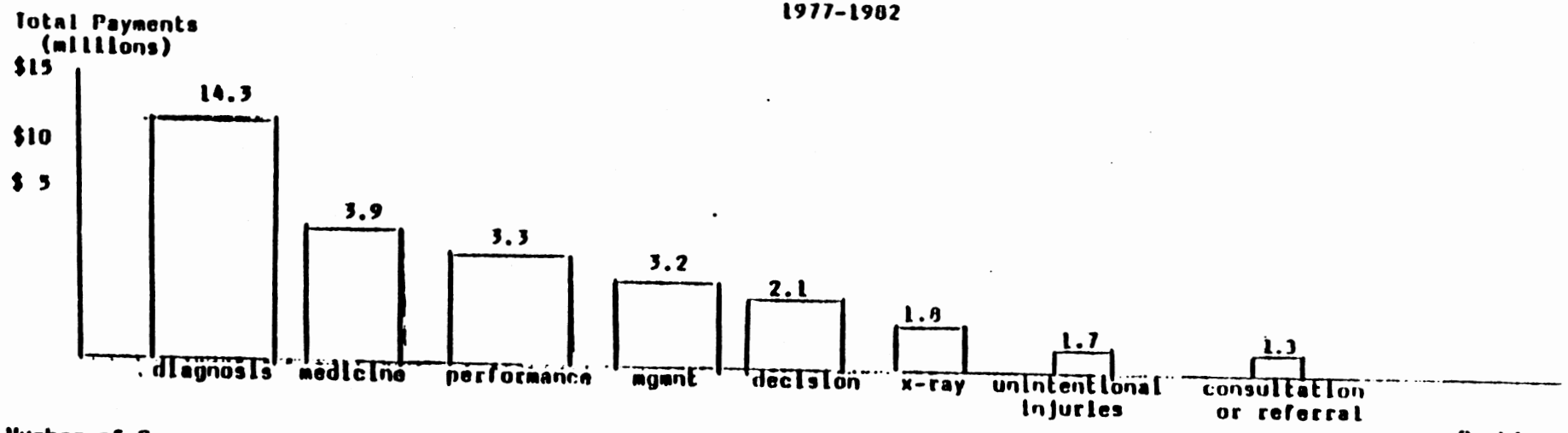


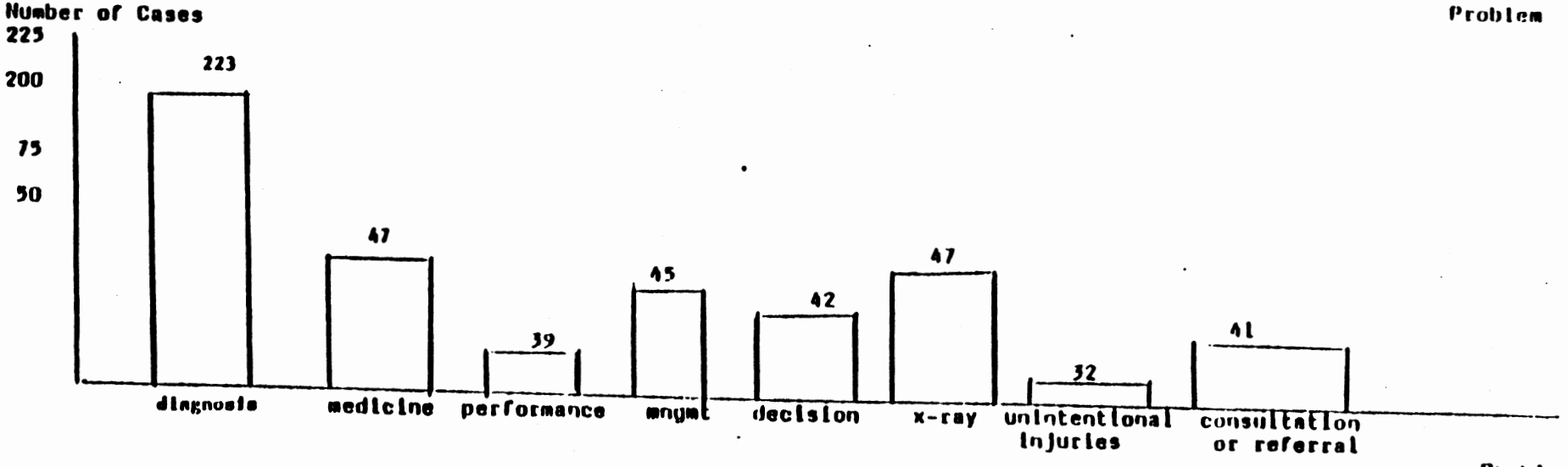


22x

* Source: Exhibit 4a, N.J. Physicians' & Surgeons' Professional Liability

Chart X
Non-Surgical Specialties
Medical Inter-Insurance Exchange
Closed Cases
1977-1982





Source: Exhibit 4b N.J. Physicians & Surgeons Professional Liability

23X

A Rand Institute study on national data found, however, that, "The number of lawyers per capita had little effect on claim frequency,"[30] but was correlated with higher average payments. The researcher theorized that the larger number of attorneys was an outgrowth of high demand for legal services.

There is also the chilling possibility that still more claims could be down the road. In a two-part study titled, "The Resoution of Medical Malpractice Claims," researchers developed a model of the bargaining process for medical malpractice claims, using a sample of 6,000 claims closed by a variety of insurers nationwide in 1974 and 1976. Authors Patricia Munch Danzon and Lee A. Lillard arrived at several conclusions:

+Settlements are closely related to court verdicts expected. On average, paid settlements amounted to about 74 percent of the likely award in court.

+Dropped claims had a lower probability of winning, 39 to 53 percent, than did settled cases, which had a 59 to 77 percent chance of winning in court.

+About half the claims dropped would have produced an award for the plaintiff if taken to verdict. Since the smaller the likely verdict, the greater the chance the case would be dropped, the finding raises the possibility that substantial numbers of small claims go uncompensated.

+Court congestion tends to reduce the size of settlements, possibly due to the erosive effects of delay on the value of expected awards and the differences in the impact of decay on the evidence.

+Some reforms could backfire, given the significant barrier posed by the expense of suit. "We estimate that, under plausible assumptions, a 30 percent cost reduction for both plaintiff and defendant per case of going to verdict would reduce total litigation costs by only 3 percent because more cases would be taken to verdict and fewer would be dropped without payment," Danzon and Lillard reported.

OTHER TRENDS

Many states are wrestling with malpractice-related problems. Illinois, Florida, Wisconsin and Kansas have appointed task forces to consider their problems, and New York's Governor Mario Cuomo recently signed a reform package aimed at slashing malpractice costs.

Increased public awareness alone may work to hold down cases for awhile. Following the last "malpractice crisis" of 1975, there was a still-unexplained decrease in frequency. In 1976, the number of claims filed nationally dropped approximately 27 percent, and then dropped again in 1977. By 1978, the number of claims filed annually had begun to rise anew but still had not returned to the 1975 rate.[31]

Some of the states which adopted drastic measures in the 1975-crisis era have seen them struck down by the courts.[32] And yet, in California, a $250,000 limit on non-economic damage withstood judicial scrutiny, as did a requirement that future damages of more than $50,000 be made part of a timed payment plan whenever requested by either party.

The AMA has announced formation of study groups to address the fundamental question of "customary practice standard." The Pennsylvania Bar Association last fall commissioned a study by an insurance consultant on potential solutions to soaring malpractice costs.

Meanwhile, some specialties have moved on their own to reduce malpractice. A few years ago, for instance, anesthesiology stood high in the ranks of claim-prone specialties. Today, anesthesiology mishaps still occur and tend to have serious consequences because of the nature of the practice. But in general, insurers point to the specialty as an example of how a situation can be turned around.

The equipment itself has been improved, so that alarms and monitors help physicians keep a closer watch on the patient; procedures have been tightened; reactions to anesthetics are watched more closely, and anesthesiologists supervise fewer nurse-anesthetists. This year, MIX lowered its rating on the specialty.[33].

Working with data from the insurers and a number of research reports and articles, the task force has debated ideas from other states as well as a few still untried.

In general, the proposals broke into four broad categories -- changes in the law; changes affecting attorneys; proposals for change in the medical community and those involving alteration of the insurance mechanism.

I. CHANGES IN THE LAW

A. THE COLLATERAL SOURCE RULE

Currently, awards to victims are based on two elements -- pain and suffering, and economic damages. Economic damages include past and future wage losses and medical costs, and proofs are presented by the plaintiff to establish how large the economic damages have been and will be. Current rules do not allow introduction of evidence that the plaintiff already has been paid by outside sources such as workers compensation insurance, health insurance and Social Security Disability. In effect, then, the plaintiff is compensated twice.

The proposal calls for altering the rule to define economic losses as those which remain after other kinds of insurance have been used. To avoid penalizing people for having protected themselves by securing insurance, the rule also would allow victims to recover their insurance premiums.

There are several methods for offsetting outside payments. One approach, used in California, allows the introduction of the evidence into court, leaving it to the jury to decide how much the evidence should affect the award.

A second method, which is proposed in Senate Bill 1135, now in the New Jersey Legislature, requires the judge to reduce the amount of the jury's award by the amount of payments already made from other sources.

The third, which is employed in New Jersey's Automobile Reparations Act, excludes from evidence expenses paid or payable by a collateral source. Other methods may also be suggested.

Disagreement over the best method centers around the reliability of juries. Those who prefer the California system believe that the final decision on award size should rest with the jury. Those who advocate post-verdict reduction contend that sympathetic juries discount the evidence that bills already have been paid, diluting the potential savings from the rule change.

Studies by Peat, Marwick, Mitchell & Co.have suggested savings from a collateral source rule of between 2 and 10 percent for Pennsylvania and at 11 percent (in 1981) and 6 percent (1985 estimate) in New York.

Defenders of the current practice raise several concerns. First, they say, offsetting would unilaterally benefit defendants and malpractice insurers at the expense of plaintiffs. Second, they argue that the change transfers some of the burden for physician errors to health insurers, who pay the treatment bills. They also point out that not all plaintiffs will suffer equally. Only those plaintiffs with insurance will be damaged, because only they will have collateral sources to use in offsetting.

They also point out that if the changed rule is applied only to malpractice claimants, it may fall as an unconstitutional violation of the equal protection clause.

18 states have enacted some form of legislation that requires reduction in the amount of awards to reflect payments from government programs or insurance companies. North Dakota's statute was struck down as a violation of due process and New Hampshire's as discrimination against malpractice claimants in favor of health care providers and their insurers.[34]. In California, the statute was held to be rationally related to the objective of reducing the cost of malpractice insurance.

The pending New Jersey bill, sponsored by Senator Daniel Dalton, would apply to any personal injury or wrongful death case and require courts to reduce economic awards to reflect any payment from a government program, insurance company or workers compensation program.

B. ALTERATION OF THE DISCOVERY RULE

New Jersey has a two-year statute of limitations, but the state's liberal discovery rule makes the actual statute much broader. Adults may file suit within two years of the time they discover or could reasonably have been expected to discover an injury.

Minors have an even broader right. Children have until two years after the time they turn 18 to file suit -- no matter when the injury was discovered. In the case of a birth injury, this means that a suit may be filed up to 20 years after the actual incident.

The virtually endless filing period makes it difficult for malpractice insurers to set a fair policy price and secure reinsurance, since no one is sure when the books on a year will finally be closed and what legal climate will prevail when cases come due years down the road.

Further, the older the case, the harder it is to reconstruct the facts, as memories fade and records become lost. The problem is particularly acute in obstetrics-gynecology.

To some degree, the amount of time it takes a particular company to discover its losses and pay them depends on company policies on reporting and settlement, so claims data from a particular company can provide only an indication of experience throughout the state.

The Medical Inter-Insurance Exchange reports that about 57 percent of its cases are filed within 35 months of policy inception, rising to 81 percent by 47 months. After that, the cases trickle in. The next 11 months brings in another 5 percent. And by 95 months -- eight years after policy inception -- 2 percent of the eventual claims are still unreported. (See Chart XI on next page.)

Some insurance companies have dealt with the long-tail problem by refusing to sell the traditional "occurrence" policy which covers all future claims against the year it was purchased. St. Paul Fire & Marine, for instance, has sold about 50 New Jersey physicians a policy that only pays claims for the year it is in force. When physicians retire or change insurance companies, the coverage against previous years stops, unless they agree to pay an additional sum set by the company to cover future claims against those years.

A different solution to the tail problem is an alteration of the discovery rule.

Senate Bill 1079, sponsored by Senator Wayne Dumont and now before the Senate Judiciary Committee, would simulataneously increase and limit adult plaintiffs' right to sue by setting a flat prohibition against suits brought by adults more than three years after the incident, except in cases of fraud, intentional concealment or presence of a foreign body which could not have been detected earlier. On one hand, the deadline would lengthen from two years to three, but on the other, it would vastly diminish the time plaintiffs have to discover their injuries, reducing it from no limit to three years.

The bill would give children under age 8 until their 11th birthdays to file for injuries which occurred prior to age 8.

Supporters of the Dumont bill argue that it is the only real hope for cost containment. They also say the three-year limit would make it easier to find reinsurance, since it dovetails with procedures at Lloyds of London, the major writer of medical malpractice reinsurance. Lloyds closes its books after three years.

A more liberal proposal, suggested by an American Bar Association committee a few years ago called for a two-year statutue, with an absolute maximum of eight years if the discovery rule applies. That proposal gives children until age 11 to apply.

Other states have considered absolute bars on suits after a certain time period. In Kansas, for example, injured parties have two years from the incident to file suit. If the cause of action is not ascertainable within the two years, the period for filing is extended to four years from the date of the act. After four years, the plaintiff has no further right to file.

In Kansas, the four-year restriction withstood a legal challenge, because the court found that it was reasonably related to the legislative goal of reducing the long tail.[35]

But in others states, alterations of the discovery rule have been defeated. The New Hampshire high court, for instance, struck down a 1977 statute restricting use of the discovery rule to

Chart XI

MEDICAL INTER-INSURANCE EXCHANGE OF NEW JERSEY

Actuarial Projection of Reporting Pattern*
(Related to Policy Period)

Time in Months ter Policy Inception	% of Ultimate Number of Files Reported
11	3.82
23	19.12
35	57.36
47	81.45
59	86.34
71	91.52
83	95.18
95	98.04

Calculated by Tillinghast, Nelson & Warren

court found that for malpractice claimants, the statute was an unconstitutional denial of equal protection.[36]

Children create a special problem, because they are not independent and because it may take time for a disability to become known.

However, New Jersey's new child education laws make it increasingly unlikely that parents will be unaware of injuries to their children.

In 1981, the Legislature approved an early intervention law requiring public schools to identify, evaluate and educate handicapped children aged three to five. The law also makes the state responsible for identifying and serving handicapped children from birth through age two.[37] School districts are required to refer parents of children under three to the appropriate agencies.

The theory is that the state can save money in the long run by intervening early in childrens' lives and seeing they get the kind of intensive education program that will enable them to become productive adults.

Efforts to assess the impact of legislative restrictions on discovery for either children or adults in New Jersey are complicated by the youth of the state's two active insurers, Princeton and MIX, and the lack of detailed data available from other companies.

According to MIX, in the year between May 1, 1984 and April, 1985, 22 claims came in involving incidents which occurred more than seven years ago. Of the 22, five involved patients between 18 and 50 years old and 10 involved children 17 or younger.[38]

In 1983 and 1984, Federal Insurance Company had 139 new cases filed against the years 1971 through 1977. The company did not know how many involved minors.

At least five states have opted to allow children a filing period longer than that for adults but subject to limitation.[39]

C. MODIFICATION OF THE CHARITABLE IMMUNITY STATUTE.

A third proposal calls for changing the charitable immunity statute as it applies to hospitals. Currently, almost all hospitals enjoy immunity from liability verdicts above $10,000, because they are non-profits.[40]

The change would remove that immunity. All hospital employees, such as residents, interns or nurses, would be included in suits brought against the hospital without the plaintiff having to name each employee as a separate named defendant. Non-employee physicians would still be sued individually.

Although statistics on the number of injuries occurring in hospitals in New Jersey are not available, the Health Care Insurance Exchange, which is the major hospital insurer in this state, estimates that 80 to 90 percent of all malpractice claims arise in hospitals. Nationally, about 78 percent of all claims filed against physicians involve the hospital as the site of the injury.[41] And in California in 1983, more than 80 percent of the claims resulting in payments of $100,000 or more arose from incidents occuring in hospitals.[42]

Proponents believe that removing the immunity would have two beneficial effects. First, they contend, it would reduce the number of malpractice incidents by increasing the pressure on hospitals to police the doctors who practice there. This argument holds that hospitals are overly sensitive to in-house politics, and that as a result, popular or well-connected physicians who have questionable claims histories or are showing signs of alcohol or drug addiction may be allowed to continue practicing.

They also note that the hiring of full-time risk managers with medical backgrounds has not become common practice in New Jersey as it has in other states without charitable immunity.

Currently,the Health Department does not require hospitals to have risk managers. However, the department does require medical staffs to have by-laws governing areas such as unethical conduct, pre-operative diagnosis, medical records and informed consent.[43].

Staff requirements vary from hospital to hospital. Some require on-the-job supervision for new physicians and others do not. Some require board certification for leadership positions and some don't.[44].

Those who favor removing immunity also predict the change would bring down legal costs. It would halt the practice of naming individual hospital employees, who require individual legal representation -- all paid by the hospital's insurance company -- and it would force an organized defense. Too often, proponents say, defendants wind up trying each other in an attempt to shift the blame away from themselves.

There is evidence on a national level that claimants win more often in situations involving multiple defendants. When Danzon and Lillard of the Rand Institute studied 6,000 claims closed in 1974 and 1976, they found:

> "The plaintiff was almost twice as likely to win against multiple defendants as against a single defendant. Contrary to the popular belief that plaintiffs add nonliable defendants solely in hopes that one or more of them will settle to avoid litigation costs, this finding suggests that such behavior is atypical....The data do not reveal, however, to what extent this is because multiple defendants try to shift liability among themselves and thus produce evidence that aids the plaintiff."[45].

Those who argue against altering the charitable immunity statute say it would make little difference in the number of cases filed or the costs of defense but might serve to drive up hospital costs and lead to an unacceptable level of in-fighting in hospitals.

They point out that while verdicts for charitable hospitals are capped, verdicts against employees, including staff doctors and nurses, are not. At the Health Care Insurance Exchange, the average size of cases closed with payments was $13,000, although one case which involved an employee physician of the hospital cost the company $1.7 million. For all claims closed, the average was $4,300.

Opponents also say that juries will be less sympathetic to hospitals than to individual employees, and that the deep-pocket theory may take over, driving up claim costs.

On the legal issues, since other states do not afford non-profit hospitals any sort of immunity, it seems possible that New Jersey could amend the $10,000 liability limit in N.J.S.A. 2A:53A-8. Total elimination would probably give rise to law suits based on an equal protection argument. However, the statute might prevail if the court found the elimination of the limit to be rationally related to a legitimate government interest.

D. MANDATORY ARBITRATION OF MALPRACTICE CLAIMS UNDER $50,000

A number of other states have been experimenting with arbitration for malpractice cases.[46].

Last year, New Jersey began its own experiment with mandatory arbitration, applying it (at the direction of the Governor and Legislature) to automobile injury cases with potential awards of $15,000 or less. The courts estimated that the law had the potential to divert 30 to 40 percent of the pending civil case load.

Following the success of a two-county pilot program, the N.J. Supreme Court acted earlier this year to expand it throughout the state. The Court also has left it up to the discretion of the assignment judge to determine whether claims for $15,000 or less in other kinds of bodily injury cases, including malpractice, also should be referred to arbitration.

In 1981 Camden County was authorized by the Supreme Court to implement a program of mandatory, non-binding arbitration for civil cases filed after a certain date. Both Mercer and Middlesex Counties were experimenting with a voluntary but binding resolution process. In those counties, the parties submit their claims to a judge in a less formal setting. The judge's award is not appealable.

The proposal before the task force called for instituting a mandatory arbitration program for medical malpractice claims of $50,000 or less. As in the auto system, the arbitration would be mandatory, but the results could be appealed at the risk of sanctions if the appeal was lost.

E. MANDATORY PRE-TRIAL SCREENING

This program seeks to reduce costs by weeding out non-meritorious cases early and by settling other cases before they get to court.

The New Jersey Supreme Court experimented with screening between mid-1978 and 1982 using three-member panels comprised of a doctor, an attorney and a trial judge. The panel decisions were non-binding, but unanimous decisions could be used in court trials. Unanimous panel findings were expected to spur settlements.

In 1982, the Court appointed a special committee of judges, attorneys and doctors to evaluate the experiment. The committee recommended abandoning the panels but strengthening the rules regarding case management. The court adopted their recommendation.

The committee felt the panels had become "...an onerous administrative responsibility with no empirical data which indicates a significant positive effect on malpractice litigation."[47].

The committee found that two major objectives had not been chieved. The time it took a case to go to trial (two years) had not een reduced, and the percentage of cases going to trial (5 percent) ad remained the same.

Worse, there was an increase of approximately 45 percent in he number of medical malpractice actions filed. The rate of ncrease of all civil cases brought in the Law Division during that eriod was approximately 32 percent, which meant that the number of alpractice cases were growing 12 percent faster than other kinds of ivil cases.[48].

In addition, both defendants and plaintiffs were being orced to spend money on what amounted to two trials, a burden hought to pose a problem for plaintiffs.

There was also growing difficulty with securing panelists, ho were volunteers. Some 962 panels were convened between Sept. 11, 978 and Jan. 31, 1982. But only 675 doctors and 385 lawyers served n one. In the eyes of the committee, "Too few practioners are erving on too many panels."[49].

The program was not without benefits, however. The ommittee did find a dramatic reduction in the time of disposition or summary judgments and some dismissals. Average disposition time y summary judgment had decreased by seven months, from 2.25 years o 1.75 years. The average disposition time for cases terminated by tipulation of dismissal dropped by six months, from an average of 2 ears to 1.5 years.[50].

The committee suggested that the panels served to "foster horough preparation at an earlier stage of the case" and that early preparation, rather than the mandatory panel procedure, was he reason for improvement" in disposition times.[51].

In addition to analyzing statistics, the committee surveyed ttorneys, judges and physicians who had worked with the panels. A ajority of those polled felt "the benefits of the mandatory panel rocedure are outweighed by practical problems...."[52].

However, the poll also found a significant split in ttitudes. A majority of attorneys thought the process was unfair to laintiffs but fair to defendants and resulted in a net loss of udicial time. Some attorneys said that a 3-0 finding in favor of he defendant tended to stiffen insurance company opposition so much hat it became an impediment to settlement.

Physicians, on the other hand, thought the panels were not nly fair to claimants but conserved judicial time.

A majority of judges perceived benefits from efficient case isposition but felt that the panels cost judges more time than they aved. Judges favored a system of improved individual case anagement.

Whatever the case, 81 percent of the panels rendered nanimous decisions, and 78 percent of those decisions were in favor f the physicians and hospitals."[53].

The perceptual disagreements continue. Many physicians till favor a return to the panels, with some changes to spread the esponsibility for service evenly among members of the legal and edical communities. Payment of panel members was one suggestion for mproving cooperation.

Some plaintiff attorneys consider the panels unfair and expensive, while insurers tend to see some limited benefits. Still others felt that it was impractical to try to revive an already discarded program.

F. CAP JURY AWARDS RELATED TO PAIN AND SUFFERING

In the mid-1970s, several states opted to limit plaintiff awards as a means of attacking spiraling malpractice costs. The most sweeping legislation simply capped awards. Currently, the N.J. Legislature is considering Senate Bill 112, sponsored by Senator James Hurley, which places a $100,000 limit on the portion of awards related to pain and suffering.

Proponents start from a perception that awards have grown too large to be reasonable, and that the element pushing them up is pain and suffering. They contend that large awards create a lottery psychology that fuels the filing of suits. And they argue that the strain on the insurance system is reaching a point where there isn't enough money to pay all the claims being generated.

Opponents argue that economic damages comprise the largest part of jury awards, and that the savings will not be what proponents predict, because there are so few cases in which the pain and suffering element comes to $100,000. Since out-of-court settlements are a private matter, they would not be affected directly by the cap.

Opponents worry that a limit could work to slow settlements if insurance companies believe the cap will bring the verdict below the plaintiff's demand. They also say the cap is unfair, because it would work to protect doctors and insurance companies at the expense of injured people.

They further contend that the cap strikes at the essence of the jury system. The economic damages, they say, are determined by the facts in the case. Therefore, the pain and suffering portion is the one opportunity for the jury to say how serious it considers the problem to be.

One of the other arguments frequently raised is over the effectiveness of the suit threat as a deterrant to malpractice. Those who believe the litigation process works to hold down the incidence of malpractice tend to oppose measures that would weaken the punishment.

On the legal front, 11 states have tried limiting damages. In four cases, the statutes survived legal challenges; in three, they were struck down by courts. One case was remanded.

Propments say there is a strong possibility a New Jersey statute would be subjected to court challenge. However, S-1112 would cap damages in all suits, making it less likely to fall to an equal protection challenge than one limited only to medical malpractice.

It is difficult to estimate potential savings because New Jersey awards are not currently broken into separate parts for economic loss and pain and suffering.

The Health Care Insurance Exchange/Princeton Insurance Company, for instance, estimates that about 20 percent of the average award goes for economic damage, while 80 percent relates to pain and suffering.

Some plaintiff attorneys say the numbers are the reverse -- hat about 80 percent of current awards are related to economic oss, which means the impact would be small, given the limited umber of $1 million awards and settlements in the state.

However, proponents say the effectiveness lies in the ture, when the $5 and $6 million awards seen in other states begin o appear in New Jersey as well.

One nationwide study did suggest, although not without eservations that caps on recoveries tended to reduce severity by oughly 20 percent.[54].

G. MANDATORY PERIODIC PAYMENTS

Awards usually are broken into several parts -- economic amages, past and future, and general suffering, past and future. In ew Jersey, awards generally come in a lump sum, although there is a rowing trend in out-of-court settlements toward phased payments.

Some states have tried to link future loss to future ayments. California, for instance, currently requires structured ayments for future damages of $50,000 or more if either side equests it. Florida uses a similar scheme, but applies it to sums f $200,000 or more.

The New Jersey Legislature is considering Senate Bill 1135, ponsored by Senator Daniel Dalton, which would require mandatory eriodic payment of future damages and halt payments to survivors or everything but lost wages at the death of the plaintiff.

The proposal involves two issues -- required future ayments and the reduction of awards. Both are controversial.

One of the major advantages to any future payment plan is he stretching of insurance company dollars. The company purchases n annuity, which pays the plaintiff on a scheduled agreed upon uring the trial or at settlement. In the instance of an injured wo-year-old, for example, a company might put $40,000 into an nnuity which starts paying on the child's 21st birthday. With nterest, the $40,000 can eventually pay the child over $1 million.

Proponents of the future payments plans say they also help o guarantee that the plaintiff will have a steady cash flow.

Those who oppose requiring future payments say it benefits nsurers at the expense of plaintiffs.

First, they argue that there is an important and frequently isunderstood distinction between settlements and verdicts. tructured settlements are an agreement reached between defendant nd plaintiff as to the value and timing of past and future losses. he annuity payments from the settlements are tax free.

Right now, they say, the lower cost of a periodic payment cheme works to induce companies to settle out of court. A required tructure might backfire by reducing one of the current advantages o settlement.

The two sides also disagree on the clarity of instructions ow provided to juries and the effect of those instructions.

Verdicts, opponents say, are lump sum payments meant to enerate enough income to produce the real award. The model charge o juries instructs them to take the future damages and then iscount them to present value. The lump sum with reasonable nvestment income, then, over time produces the true award, wh. h is axable.

Consequently, if the already discounted lump sum is phased in through a periodic payment plan, the award will have been cut three times -- once for the discounting to present value, once through phasing and once because the income from the investment is taxable.[55]

Proponents of structured future payments contend that there are two model charges. One, they say, advises juries that the effects of inflation and potential investment income offset each other, so there is no need to discount for present value. The other model jury charge includes a complex discussion of discounting to present value and leaves jurors so confused that they don't balance the issue anyway. It makes more sense, they say, to let the jury set a figure for the future and let the annuity carriers figure out the best way to provide it.

Opponents also express concern about the future health of insurance companies selling annuities. They point out that companies have only a few years' experience in dealing with payments based on market interest rates, and that it was booming sales of single premium deferred annuities that helped to drag Charter Insurance Company into problems.

Currently, attorneys try to reduce the risk to the clients by requiring companies to buy annuities from only A+-rated insurance companies. Nonetheless, claimants still run a risk that the company may go bankrupt.

New Jersey does not currently have a fund to cover annuity companies which go insolvent. It does have a property-liability guaranty fund and a surplus lines fund to help pay people with claims on bankrupt insurers. Some proponents of structured verdicts say they would be willing to support creation of a guaranty fund for annuity carriers.

The two sides also disagree on whether there is a benefit to plaintiffs in having guaranteed cash flow. Proponents contend that structured payments protect people who may not have the sophistication to invest large sums wisely. Others argue that court-required future payments amount to unfair confiscation of funds, and that people should be free to invest their money as they see fit.

The issue of stopping payments for medical care on the death of the plaintiff is also divisive. There are those who argue that the provision simply cuts off an unfair windfall to heirs. The money, they say, is alloted for medical care. If the care isn't needed, why give the family the money?

Others point out that the bulk of the unspent money would not remain with the malpractice carrier, but with the company providing the annuity, so that savings to the malpractice system would be limited. At the same time, they contend, families have a right to the jury's award, regardless of whether the plaintiff dies before the time the jury expected.

H. AFFIDAVIT OF REASONABLE CAUSE

This proposal would require plaintiffs to supply defendants with a physician affidavit of cause of action within 60 days of filing a complaint. Supporters of the proposal, which is embodied in Senate Bill 1140, sponsored by Senator Matthew Feldman, hope it will

force early disposition of no-cause cases. (S-1140 also sets standards for qualification as a physician-expert.)

The attorneys say that as a practical matter, most lawyers secure a physicians' report before they file suit. Some also say there is a question as to whether a move in this direction would be rebuffed by the N.J. Supreme Court as legislative intrusion, since timing of expert testimony is now a procedural rule under the court's jurisdiction.

I. SET STANDARDS FOR EXPERT WITNESSES

Senate Bill 1140, which seeks to impose a 60-day affidavit requirement,(see above) also proposes new standards for expert qualification.

The expert would be required to demonstrate particular expertise through either board certification or evidence of having devoted a substantial portion of time to the specialty during the last five years. In addition, the bill would require experts to be practicing, devoting at least three-quarters of their time to clinical practice or teaching at an accredited hospital or university.

Proponents say the standard is not so stiff that it rules out justifiable suits for lack of a willing expert witness.

Others say they have no objection to upgrading the quality of expert witnesses, but they argue that tighter standards are impractical until more physicians are willing to testify in cases (See page 23 "Increase Availability of Expert Witnesses').

J. CREATION OF A SPECIAL MALPRACTICE COURT

Advocates for creation of a special court for professional liability say they believe malpractice, like tax litigation, has become too specialized and burdensome to be thrown into the regular courts.

Others, however, warn that this already is an area of judicial activism and that attempts to determine court structure by outsiders are likely to be rebuffed as unconstitutional intrusion into the domain of the judiciary branch.

The courts already are moving toward increased specialization. In 1983, the N.J. Supreme Court appointed a 40-member Statewide Committee to undertake a comprehensive review of all civil case procedures.

One of the major themes of the committee's report was "the necessity of grouping cases onto tracks, according to the need and ability of the lawyers, litigants and court."[56].

Attorneys say malpractice cases are now among the most closely managed cases in the system, and most counties have a single judge who specializes in them.

II. CHANGES FOR ATTORNEYS

A. CERTIFICATION OF MEDICAL MALPRACTICE ATTORNEYS

This proposal, which aims at reducing unwarranted suits and inefficient court practices, would create an optional system of special certification in medical malpractice.

Malpractice certification would be similar to the process now used for certification of trial lawyers.[57]. Although it would not bar non-specialists from practicing in the field, it would bestow an advantage on those who did become specialists.

Proponents contend that since medical malpractice is a highly specialized branch of the law, it makes sense to set up special rules for it.

But while some attorneys believe certification could serve to weed out the least efficient lawyers, others worry that it will limit malpractice to "the big guys," and that people with relatively small claims of $25,000 or $30,000 will be left with no one to represent them, because the specialists will be making too much on large cases to want to bother.

As it is now, major firms specializing in malpractice frequently refer the smaller cases to other, less prominent firms.

If unsuccessful suits are a gauge of efficiency, then there is some indication of a need for change. National data suggests that two of every three cases is closed without payment, a situation which seems to hold true in New Jersey (see "Frequency," page 7).

A look at MIX's data on suits provides a glimpse of the degree of specialization now characteristic of plaintiff attorneys in malpractice suits.

In the first 7.5 years of its existence, MIX reports, its doctors were sued by at least 1,405 attorneys.

There was, however, more specialization than at first meets the eye. For instance, two law firms were in a class by themselves with at least $4.3 million and $5.4 million in paid indemnity.

A second group of 11 firms accounted for 295 closed cases. They had won about 62 percent of the cases they filed. [58].

In contrast, the 612 lawyers with only one closed case each had won 41.8 percent of their cases. And nearly a sixth of those successful cases resulted in payments of $10,000 or less.[59].

The non-specialists also wound up in court more often, with proportionately less success there. Attorneys with one closed claim took their malpractice cases to court 25 percent of the time and won only 8 of 165 court fights.

In stark contrast, one plaintiff attorney, who had won $1.3 million in payments to his clients, had not gone to court at all in 14 cases. There were settlements in 13 and a non-payment in the other.[60].

B. PEER REVIEW FOR ATTORNEYS

A second alternative for reducing inefficient litigation is peer review for attorneys. Physicians point out that their own professional practice is subject to utilization reviews by Medicare and health insurers, and their overall competency to review by the Board of Medical Examiners and hospital peer review boards. They suggest that attorneys should be subject to similar oversight.

The state is not currently without formal review mechanisms. The N.J. Bar Association has what is said to be one of the strongest ethics codes in the country, and it does include a rule on competence, which prohibits "gross negligence" and "a pattern of negligence or neglect."

However, the disciplinary process is complicated, lengthy and, for the most part, silent. Unless a case is serious enough to reach the Supreme Court, which can opt for a public reprimand, a suspension or disbarment, the action remains private. In 1984, the Supreme Court disciplined 42 attorneys publicly (26 were disbarred), gave private reprimands to 27 lawyers and required interim suspensions, transfers and practice oversight on 30 others. There are approximately 28,000 licensed attorneys in New Jersey.

Under the best of circumstances, the cases take eight or nine months to resolve. The Office on Ethics reports that the district review committees are making progress on a backlog of some 1,074 cases, some of which go back four years. As a consequence, action is reserved for serious cases. As one bar member put it, "If you've been neglectful, you might get disciplined. But if you do what you're supposed to do poorly, it won't get back."

On a separate level, the N.J. Bar Association does run a program in which younger members of the bar -- those who've practiced less than five years or are less than 35 -- can call older members for advice on how to handle a case. About 200-plus attorneys have volunteered to provide the free advice. About 62 of them are trial attorneys, but the program administrator is not sure how many of them handle malpractice cases.

The referral service is one part of a three-part recommendation by the American Bar Association's National Center for Professional Responsibility. The other two parts are periodic practice audits aimed at improving efficiency (how to interview, keep records, use tickler files), and disciplinary review for incompetency. The Center reports that the biggest objection to efficiency auditing is the potential breach of attorney-client privilege.

There is some evidence that attorneys are moving on their own to correct abuses of the system. The Supreme Court's Committee on Civil Case Management and Procedures has proposed "fee shifting," in which unnecessary costs incurred by lawyers or their clients could be charged to those who abuse the judicial process. The shifting would be aimed particularly at frivolous discovery requests.

In addition, attorneys point out that the most powerful spur to efficiency is economic self-interest. Since most attorneys work on a contingent fee, they lose money when they take on weak cases or waste time in discovery.

C. CHANGES IN THE CONTINGENT FEES FOR LAWYERS

Currently, plaintiff attorneys in New Jersey work on a contingent fee basis they say is the lowest in the country. Once the attorney has agreed to take the case, the attorney pays for the court fees, expert witness fees and other costs. If the attorney wins, the expenses are paid, and the lawyer takes a percentage of

the remainder -- 33.3 percent of the first $250,000, 25 percent of the next $250,000 and 20 percent of the next $500,000. If the case is lost, the attorney pays all or part of the expenses.

Opponents of the contigent fee system contend variously that the fees are so high that they push up the size of verdicts, that they deprive injured people of money intended for them and that they encourage attorneys to file and pursue questionable cases.

There is some weak evidence that contingent fees play a role in the pursuit of malpractice claims. Danzon and Lillard of the Rand Institute found, for instance, that limits on contingent fees:

> "...appear to have had moderately depressive effects on settlement amounts and on the number of cases that go to verdict, while somewhat increasing the proportion of cases dropped."[61].

Defenders of the system say it insures the availability of the courts to people who could not otherwise afford to pay an attorney and that the fees must be substantial to induce attorneys to accept the risk of losing time and money on a case that may not pan out.

New Jersey has had a sliding scale plan for years, and the scale has been changed at least twice.[62]. The most recent change, which occurred in January, 1984, was undertaken because, among other reasons, the Supreme Court found that the steep percentage drop at higher award levels put attorneys in a serious conflict of interest.[63].

Other critics of the sliding scale thought that the high percentage fee on small claims encouraged the filing of frivolous suits.

III. CHANGES IN THE MEDICAL COMMUNITY

A. STRENGTHEN MALPRACTICE EDUCATION

While all defensive medicine begins with good clinical practice, some doctors receive little or no formal training in ethics and the legal aspects of malpractice.

The University of Medicine and Dentistry's Rutgers Medical School, Piscataway, for instance, does not require students to take any training in medical jurisprudence for graduation. The Medical School estimates that about 75 percent of its graduates take one or more of the optional seminars and courses.

The UMDNJ - Newark gives seniors a required course called "Practice of Medicine," which devotes two or three hours to malpractice -- definitions of negligence, some sample court cases and informed consent.

UMDNJ-College of Osteopathic Medicine until this year required students to take a medical ethics course, which included one lecture on medical jurisprudence. The college is designing a special 21-hour, three-day seminar to be presented in December, 1985. Tentative plans calls for sections on medical jurisprudence, medical ethics, drug and alcohol abuse and injudicious prescribing of medications.

The state's two dental schools, UMDNJ and Fairleigh-Dickinson University, both include generic discussions about professional liability and risk management in a variety of courses, but neither devotes individual courses to the malpractice issue.

New Jersey does not have a school of podiatry. However, the N.J. Podiatry Society estimates that about 50 to 60 percent of its approximately 450 members are graduates of either the New York or Pennsylvania colleges of podiatry.

The New York College of Podiatry requires students to pass a 20-hour course in jurisprudence for graduation. In addition, malpractice issues comprise 18 of 75 questions on the community health segment of New Jersey's podiatry licensing examination, according to Educational Testing Service.

In informal conversations with task force members, podiatry students have reported that they find the jurisprudence course a bore. This may suggest that doctors already in the field have a deeper appreciation of the troubles which arise in everyday practice which may, in turn, indicate a need for stronger emphasis on continuing education for practicing physicians.

Currently, the Board of Medical Examiners requires no continuing education of either physicians or podiatrists. The Medical Society and Osteopathic Society of New Jersey require 150 hours every three years, at least 60 of it in intensive, direct treatment education. Membership in the societies is voluntary, but about three-quarters of the state's active medical doctors and osteopaths belong.[64].

The Medical Inter-Insurance Exchange, the physician-owned insurance company, offers a mail order clinico-legal course. Physicians who pass the 25-lesson course receive a two-point credit on MIX's surcharge plan. Physicians who review claims for MIX receive a premium discount because MIX reviewing is a valued education tool in itself.[65]. The course also counts as 20 credit hours toward the continuing education requirements of the Medical Society and the American Osteopathic Association.

The Podiatry Society, which includes about 20 percent of all podiatrists, requires 16 hours of continuing education annually for membership in the society. Recently, the requirements were amended to make society-approved risk management seminars eligible for the continuing education requirement.

The Dental Society encourages members to take continuing coursework, but none is mandated. The Board of Dentistry requires the approximately 200 oral surgeons with general anesthesia permits to compile 100 continuing education points every two years.

Several task force members saw a need to expand the amount of inter-disciplinary coursework available to physicians. One attorney points out, for example, that physicians sometimes provoke a suit by dunning clients too soon. The statute of limitations on collecting a fee is six years, while the personal injury statute is two years. Thus a physician who sues for fees within the two-year period may provoke a counterclaim for malpractice, especially if the patient isn't paying out of anger over the outcome of the procedure.

B. AMENDMENT OF $25,000 CLAIM REVIEW LAW

In 1983, the Legislature and Governor enacted Assembly Bill 784, which required malpractice insurers to notify the state Board of Medical Examiners of all settlements, judgments and arbitration awards of more than $25,000 after August 14, 1983.

The board's Medical Malpractice Review Committee studied the first batch of 80 to 100 reports. When it found no basis for action in any of them, the committee decided not to spend any more time on the reports until the board got a computer to assess them. The board still doesn't have a computer capable of data processing, although it is scheduled to get one in late fall.

Consequently, the cases continued to pile up until a few months ago, when the board decided to take interim action.

The board suspects that the $25,000 rule is too low and that some other standard is needed. One possibility is to increase the trigger level to, say, $50,000 or $100,000. Another is to allow for frequency, on the theory that many small claims might be more indicative of incompetence than is a single mistake which happened to result in a large verdict.

In order to determine what kind of legislative change might be needed, the board is sifting through the approximately 500- to 1,000-case backlog. The culling should point out repeaters and any serious cases, which will receive more intensive scrutiny.

In an effort to break the log jam, the Insurance Department last fall offered to promulgate a regulation requiring insurers to submit claims information for physicians with three or more claims to the department, which does have computers and could sift the data for the board. However, the proposal involved some privacy issues, and the Department may lack authority to demand names and specific case files without new legislation.

C. INCREASE AVAILABILITY OF EXPERT WITNESSES

Attorneys have complained for years about what they call the "conspiracy of silence," the unwillingness of physicians to testify against fellow doctors.

Insurance companies also complain -- that poor-quality experts sometimes win cases for plaintiffs who never should have won, because the jury couldn't distinguish real expertise in a specialty from general medical knowledge.

The problem appears to have moderated in the wake of the malpractice screening panels, which helped to break down the walls between attorneys and physicians.

Nonetheless, availability of experts remains a problem, driving up costs for plaintiffs (and the Board of Medical Examiners), when they are forced to seek experts from out of state.

One suggestion called for requiring physicians to serve, perhaps as part of the membership requirements for the podiatry, osteopathic and physician societies. Another was formulation of a list of volunteer experts something like that used for the screening panels.

One potential drawback is the possibility that a list could boomerang. The difficulty in finding experts may act as a brake on the number of suits filed by inexperienced attorneys. If it does, creation of a ready supply could cause an explosion in the number of suits.

X D. STRENGTHEN THE BOARD OF MEDICAL EXAMINERS

The Board of Medical Examiners is a 16-member volunteer group trying to monitor some 30,000 licensees in a hodgepodge of professions ranging from midwifery to thoracic surgery, with a 77-member staff that has access to two word processors.

A survey of its actions between January, 1980 and August, 1984, indicates that the board is best equipped to handle cases involving substance abuse. At least 118 of its 322 disciplinary actions related to improper prescription practices, especially drug peddling. Another 54 actions stemmed from allegations of physician impairment due to drugs, alcohol, mental illness or age.

Only seven disciplinary moves involved the kind of treatment error that generates malpractice claims. Of that group, two -- Mario Jascalavich and Peter DeMarco -- were famous. The others included a neurosurgeon accused of operating on a man too ill to withdstand the surgery, two surgeons suspended for unnecessary cutting, a physician whose license was revoked for endangering his patients' lives with thyroid hormone, and one elderly doctor who was given a stayed suspension for simple negligence of two patients. As of last fall, only DeMarco, Jascalavich and one of the surgeons was still barred from practice.

One of the problems the board faces is staffing. Currently, all of the board's legal work is handled by four assistant attorneys general. This creates not only backlogs, as the attorneys attempt to keep up with the caseload, but also what critics regard as a conflict of interest. State attorneys who serve as prosecutors on some cases serve as board counsel in others. To some, at least, the dual role breaks down the image of impartiality on the board's part and unfairly weights cases in favor of the prosecution.

The board has no full-time medical staff, relying instead on the expertise of the 11 doctors[66] who sit on it. Those physicians all have busy private practices to run at the same time. For a period of time, much of the medical work was handled by Dr. Edwin Albano, a former state medical examiners who took on the board as an unpaid full-time job. But he has since retired.

One reason for the board's success at drug cases is the increased staffing there. Consumer Affairs' Enforcement Bureau (which also serves some 20 other regulatory boards) does computerized prescription monitoring, which has proved an efficient way of finding evidence that leads to prosecution.

No such resource exists for experts. It cost the board $120,000 to prosecute the unnecessary surgery case -- $17,000 for expert fees, $75,000 to the Office of Administrative law to hear the case, and another $22,000 for travel, meals, lodging and fees for out-of-state witnesses.

In 1984, the board had a total budget of $1 million, some $500,000 of which was paid to other sections of Consumer Affairs for handling its license and enforcement work.

There were several suggestions for strengthening the board.

One was creation of a full-time medical director, a doctor who could screen cases himself and handle the medical administration of the board.

Those who opposed that concept thought it would create "a czar."

A second suggestion was to attack the potential conflict of interest at the board. Currently the deputy attorneys general who work with the board switch roles. A deputy attorney general who is prosecuting a doctor in the morning may switch hats in the afternoon and advise the board on the legal aspects of a case some other attorney is prosecuting.

One proposal calls for using a single attorney from outside the attorney general's office as board counsel and using the attorneys general to present cases to the board. Another possibility, which breaks down the separation but would involve a lesser conflict, would be assigning a single deputy attorney to advise the board and three attorneys to present cases to the board.

A third suggestion for strengthening the board calls for creation of a small subpanel. The panel would look for common practice problems patterns in board cases and establish education programs to resolve those problems in the future. The idea is to reduce the board's workload by reducing the number of problems.

A fourth suggestion envisions the transformation of the board from part-time to full-time status with paid physician members.

E. ADD A RISK MANAGEMENT OFFICER IN HOSPITALS

This proposal calls for promulgation of a law or regulation requiring hospitals to have risk managers with health care credentials. Florida has required risk managers in hospitals since 1975.[67]

Currently, neither insurance companies nor the N.J. Health Department regulations require hospitals to have a risk manager. While some hospitals do have them, HCIE reports, they are often people with backgrounds in security or maintenance, a carry-over from the days when hospital suits were heavily weighted toward everyday liability problems such as slippery slidewalks.

Proponents for the requirement argue that it would force hospitals to assess hospital practices as a whole.

IV. CHANGES IN INSURANCE

A. RESTRICTED ENDORSEMENTS

One way to try to reduce costs is to identify risky medical practices and refuse to insure them.

At least one insurance company in California has tried this approach with anesthesiology, which, in some states is still a

high-risk specialty. The company began offering a restrictive endorsement requiring anesthesiologists to remain in the room during an operation, except during a bona fide emergency, when a doctor or nurse trained in cardiopulmonary resuscitation was available.[68].

Some members opposed restricted endorsements as having the capacity to make the insurer the arbiter of hospital practice. They also point out that New Jersey was able to accomplish the same objective California did by working with the anesthesiologists' professional society.

B. CREATION OF SPECIAL MATERIALS AND FORMS

Although there may be some beneficial effect from increased consumer education, which could be expected to decrease the number of suits stemming from lack of informed consent, many task force members felt that the potential impact was probably not major, because informed consent cases tend to be unsuccessful.

The Health Department already requires hospitals to have "proper informed consent before procedures with special risks."[69].

One specialty that did seem to have a problem with informed consent was podiatry, which is practiced mostly outside of hospitals.

In August, 1984, Public Service Mutual, which insured New Jersey podiatrists between 1977 and 1982, undertook a survey of 153 open and closed claims at the request of the Insurance Commissioner. It found that informed consent was an issue in about 58 percent of them (79 cases).

In response to the survey, the N.J. Podiatry Society developed a special consent form for its members to use. The form is now being distributed.

Beyond podiatry, however, most task force members felt that while informed consent might generate some cases, they were too weak to result in large payments to claimants.

Nationally, the Rand Institute research also found that informed consent cases were not likely winners:

> "In cases taken to verdict, the plaintiff was 21 percent less likely to prevail if the charge was misdiagnosis and 34 percent less likely if the suit alleged lack of informed consent to the injurious procedure".[70].

C. ADOPT A CURTAILED TORT SYSTEM

Some observors believe that the current malpractice system has become so expensive and painful that it should not be maintained. They suggest two proposals for change.

The first, which applies the no-fault concept to malpractice, suggests that patients should purchase mal-occurrence insurance, which would pay all claims of more than $100,000 against a physician and any medical bills above what health insurance would pay.

This school of thought holds that the heart of the problem is not poor medical practice but unhappy outcome, and that patients are not so much determined to punish doctors as they are seeking to cover their economic losses. The $100,000 would act as a brake on malpractice and malpractice premiums.

A second possibility is a system resembling that now used by 30 schools in New Jersey for covering high school athletes against catastrophic injury. Under the program, athletes injured in high school events may sign an agreement in which they give up their right to sue for pain and suffering, in return for automatic reimbursement once a threshold of $10,000 in economic damages has been reached. Payments cover net economic loss including unlimited medical expenses plus a $300 a week reimbursement for lost wages, if the person has less than $300 in income from other sources. Sponsored by the National Federation of State High School Associations, the program currently costs about $1.25 a year per athlete.

The Virginia Insurance Reciprocal recently announced plans to try a pilot program with a similar concept. In large-loss cases, the Reciprocal will offer to pay a plaintiff's economic lossees without admitting fault. In return, the plaintiff must waive the right to sue. If the offer is rejected, the right to sue remains, but the plaintiff must, as always, prove both injury and negligence.

The major advantage to such a plan is speedy settlement, lower litigation costs, a guarantee of payment for injury and a specified level of payment.

One potential disadvantage is expense. Although there are those who say the link between fault and compensation already has been severed, the tort system is aimed at paying for poor physician performance, not poor outcome. Some unhappy results do go uncompensated.

A no-fault system would pay for all untoward results, which could drive up costs. Those who believe the potential for a malpractice case acts as a beneficial spur to good physician performance also fear a no-fault system would break the link, increasing the number of unhappy incidents.

D. CHANGE THE FUNDING SYSTEM

Currently, the medical malpractice system is funded entirely through malpractice premiums paid by health practioners and health care facilities, the costs of which are passed on to patients

Other states have chosen to use different funding mechanisms. Pennsylvania, for instance, requires physicians to buy insurance with limits of at least $200,000 per occurrence and $600,000 aggregate, then provides insurance for up to $1 million per occurrence, $3 million aggregate through its Medical Professional Liability Catastrophe Loss Fund. Physicians pay a surcharge to the fund for the coverage.

Alternative mechanisms may spread costs more evenly among health care providers, removing the onus from individual doctors. However, a few states, such as Kansas and Wisconsin, have experienced difficulties with keeping their special funds solvent.

CONCLUSIONS AND RECOMMENDATIONS

Medical malpractice has not yet reached crisis pitch in New
. The two major medical malpractice insurance carriers here
:ill solvent. Physicians' premiums are high but not so steep as
ıstitute the major force behind rising health care costs. The
.llion award is still relatively rare, and there have been no
:ts soaring into the $5 or $6 million range.

But trouble flags are flying everywhere. The frequency with
patients sue doctors has doubled since 1970. Jury awards are
ing upward, and the state recently saw its first $2 million
ıctice verdict. Premiums are starting to spurt upward at a rate
to 25 percent a year. And reinsurance is becoming increasingly
:ult to obtain.

There is little reason to expect the current situation to
ve itself. Without action, the state can expect the pressure
ysicians, patient bills and the health care system to increase,
ing with it all the attendant ills -- deterioration in the
ionship between doctors and patients, higher costs for
sive medicine, and perhaps even deprivation of care.

As the pressure increases, the calls for draconian
ions will grow louder and more insistent.

This task force of attorneys, insurers and physicians has
commissioned to study the medical, insurance and legal systems
ey relate to the medical malpractice problem in New Jersey and
fer the state a plan for averting crisis before it strikes.

In trying to do that, the task force has sought to
stand why New Jersey ranks as one of the high-risk states for
al malpractice.

A major factor may be the very character of the state. One
e most powerful predictors of claim frequency and severity is
ization. New Jersey is the most urbanized state in the nation.

Beyond that, high malpractice costs can be ascribed to no
e factor -- not incompetent doctors, generous juries, or
ssive attorneys. Rather, the growing problem reflects an
tion of weaknesses in several aspects of the malpractice system.

The task force looked at all four parts of the system --
cians, insurance companies, attorneys and the justice system --
eighed approximately two dozen proposals. A few, such as a
e in the contingent fee for attorneys, were rejected because
tate has prior experience with them.

Others, among them a cap on awards for pain and suffering
andatory periodic payments, were not included because the
neys and the insurers and physicians disagreed completely on
eed for them and their fairness.

The task force was, however, able to reach nearly unanimous
ment on 13 recommendations and substantial agreement on others.
is, on its own, "the answer" to high medical malpractice costs.
n sum, they should effect dramatic reductions in cost
ation and insure continued availability of malpractice
ance.

1. Amend the Collateral Source Rule

The task force unanimously recommends a change from
urrent rule, so that plaintiffs in malpractice cases do not

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urce. The amendment would put malpractice plaintiffs and claimants no-fault auto cases on more equal footing, and it may reduce sses to the malpractice system by 15 percent, if New Jersey reaps e same savings other states have seen (unanimous).

2. Abolish Charitable Immunity for Hospitals

Most of the task force members believe the current le, which limits claims payments by hospitals to $10,000, is tmoded, serving to drive costs up, not down. The panel recommends moving the immunity, but linking the change to a requirement that the future, plaintiffs sue only the hospital and non-employee ysicians. The change would reduce defense costs, because hospital surers would no longer be obliged to secure an attorney for every ployee named in a suit. It would increase pressure on hospitals to sue aggressive risk management, including the hiring of ofessional risk managers with medical backgrounds, and it may rve to improve a hospital's chance of winning, since it will allow r an organized defense (Durst and Smith, no; Benton abstaining).

3. Revise the Statute of Limitations for Adults.

The task force recommends changing the law, so that e adults have an absolute maximum of four years from the date of ncident in which to file. The group has attempted to balance the eds of injured parties for economic relief against the threat of n-availability that continued uncertainty in the malpractice surance markets implies. To that end, it has agreed to recommend xtending the time that injured parties have to file from two years four years, while cutting off the endless filing time that the iscovery rule creates by placing an absolute, four-year limit on uits (Maurer, no; Sweetland, Benton, Fares, Durst, abstaining).

4. Alteration of the Discovery Rule for Children

Children currently have the right to sue until two ears after they reach the age of majority -- a period of up to 20 ears, no matter when the injury was discovered. In view of the ecial problems now arising in the field of obstetrics, the task rce recommends altering that rule, so that children have until heir 11th birthday to sue for injuries which occurred before age 8 t were not discovered until later. The suggested rule, which is tterned on other states, accords children extra time in view of heir special status in society. It also recognizes the existence of ew Jersey's extensive new child testing laws, which vastly reduce he liklihood that a parent would be unaware of a child's isability. The task force expects the shortened time for filing to nance predictability, especially for the troubled field of bstetrics (Unanimous).

5. Institute Mandatory Arbitration for Cases Worth $50,000 or Less

To alleviate the pressure on the courts, the task rce recommends extension of the mandatory arbitration now in place r auto insurance injury claims of up to $15,000 insurance to alpractice claims of $50,000 or less. The arbitration would be n-binding, but as in auto insurance, there would be sanctions gainst those who appealed unsuccessfully (Slattery abstaining).

6. Require Filing of Affidavit of Reasonable Cause

This recommendation is aimed at reducing the volume of k cases by requiring attorneys to file a medical opinion within days. Task force members suggest that the proposed requirement is onerous, because many attorneys won't file a suit unless they e a physician opinion indicating they have a case. However, the t that two of three malpractice suits ends in defeat for the intiff suggests that some attorneys are filing before securing a sician's opinion. The affidavit requirement is expected to reduce al costs by ending that practice (Medvin abstaining).

7. Increased Cooperation from Physicians

The task force also recommends that the Insurance missioner enlist the cooperation of the Medical Society, Dental iety, Chiropractic Association, Podiatry Society and Osteopathic ociation and their component societies in seeing that expert nesses are available to review cases and testify. Both defendants plaintiffs complain that juries are sometimes swayed by timony from non-experts. An increased pool of qualified witnesses review potential cases for plaintiffs and defendants will improve quality of justice rendered. (Unanimous).

8. Additional Education Requirements for New Physicians

There is evidence that new doctors and dentists have been getting a strong grounding in the thorny clinico-legal ues of malpractice. The state's medical school programs do not e a major malpractice component, and there is some suggestion t what programs do exist are weak.

The Task Force recommends that as a condition for ensure, students at the state medical schools be required to take least one course focused especially on ethics, risk management the clinico-legal issues related to medical malpractice.

Students coming into New Jersey from out-of-state ools would be required to submit evidence of acceptable rsework. If they could not, they would be expected to take the ired course during the first post-graduate year (Durst no).

9. Require Ongoing Education for Continued Physician Licensure

Although medicine is a fast-changing field, the state s not require physicians to remain current. Hospitals do not uire continuing education of their staffs, and the state has no tinuing education requirement for licensure of physicians, iatrists, chiropractors, or dentists. Most of the professional ieties -- the Medical Society, the Osteopathic Association, and Podiatry Society -- have education requirements, but some bers do not belong to them. The Dental society has no continuing cation requirement.

There is some evidence to suggest that doctors may be osing themselves unnecessarily to suit because they have not kept rent on legal and medical issues. The Board of Medical miners, which keeps a tight rein on prescription practices in the te, frequently forces older physicians accused of improprieties take coursework on the uses of various drugs. Lately, it has n exploring creation of a program to review basic practice niques.

On the positive side, a recen. survey by the AMA's .cioeconomic Monitoring System found that in 1984, more than 60 ercent of physicians reported that in response to an increased .areness of malpractice, they had improved their practice rocedures through better record-keeping, increased tests and reatment, increased follow-up visits and increased patient time. his suggests that higher awareness could decrease the number of uits.

The Academy concluded that the risk of future suits might e reduced by exposing students to the gravity of a malpractice case efore they enter practice.

Given the complexity of the laws related to lpractice and the speed with which medical technology is changing, he Task Force sees a clear need for the Board of Medical Examiners o require 150 hours of continuing education every three years as a ondition of licensure, with 15 of the hours to be in medical/legal ssues.(Durst no.)

10. Improve Patient Relations

The plaintiff attorneys on the task force say that the ajor source of dissatisfaction among patients is lack of nderstanding. Patients frequently do not realize that their unhappy ondition is a known, predictable risk of whatever treatment they ave undergone. Where an attorney specializing in medical alpractice may understand and explain that there was only bad luck nd not negligence, another lawyer might file a case that will ventually end in defeat for the plaintiff, wasting time and money. he task force recommends that education programs for physicians emphasize the importance of "the old bedside manner," so that atients both understand their illnesses, and come away from even a ad outcome certain that they received adequate care.

11. Strengthen the Board of Medical Examiners with Increased Staff and Technical Resources

The Board of Medical Examiners is overworked and nderstaffed, with the result that it takes months and years for tion on cases. At minimum, the Board needs increased computer apacity and staffing (unanimous).

12. Change the Criteria for Transfer of Malpractice Cases to the Board

The current statute, which requires insurance ompanies to give the Board of Medical Examiners notice of all paid laims of $25,000 or more, adds to the board's burden by burying it ith small claims which may say little about a physician's level of ompetency.

The Task Force recommends the Legislature amend the tatute, so that companies are required to provide the board with otice of claim payments of $100,000 or more, or three claims of any ize against a single physician in five years (unanimous).

13. Creation of a Certified Malpractice Attorney Program

Although medical malpractice is a specialized area of he law, it is is not treated as such. Consequently, th. system is eing overwhelmed with unsuccessful suits.

Two-thirds of the malpractice cases filed in this ate end with no payment. More than 1,400 attorneys have filed its against a single insurance company. And there is a significant sparity in the success rates of malpractice specialists as mpared to attorneys in general practice.

Recognizing that plaintiffs have the legal right to lect any attorney they choose, the Task Force recommends creation a Certified Medical Malpractice Attorney program patterned after e Certified Trial Lawyer program. The group also recommends that ntention of certification hinge upon completion of courses in ntinuing legal education (Unanimous).

14. Peer Review for Attorneys

The Task Force also recommends that the Supreme Court tablish a peer review mechanism for attorneys akin to the ilization review programs that physicians undergo (Medvin, staining).

Footnotes

A $100,000/$300,000 policy is available to podiatrists, but to date, all podiatrists have purchased $1 million/$3 million coverage.

Zuckerman, Stephen. Data from AMA Socio-Economic Monitoring System, Periodic Survey of Physicians, 1984.

Ibid.

Ibid.

"Self-Preservation of a Privileged Class," The Academy of Florida Trial Lawyers, 1982, p. 3.

American College of Obstetricians and Gynecologists, "Professional Liability Insurance and Its Effects: Report of a Survey of ACOG's Membership," August 31, 1983.

"Professional Liability in the '80s," Report I, American Medical Asscciation Special Task Force on Professional Liability and Insurance, October, 1984, p. 16.

Raymond Scalettar, M.D., quoted in "Professional Liability in the '80s," p. 16.

F. Allan Hubbell, M.D., M.S.P.H., Sheldon Greenfield, M.D., Judy L. Tyler, M.P.H., Kota Cherry, M.D. and Frederic A. Wyle, M.D., "The Impact of Routine Chest X-Ray Films on Patient Care," New England Journal of Medicine, Vol. 312, No. 4, pp. 209-213.

9. Sara Charles, M.D., Jeffrey Wilbert, M.A. and Eugene Kennedy, PH.D., "Physicians' Self-Reports of Reactions to Malpractice Litigation," American Journal of Psychiatry, 141:4, April, 1984, pp. 563-565.

1. Albert J. Lipson, "Medical Malpractice: The Response of Physicians to Premium Increases in California," The Rand Corporation, 1976, p. vii.

2. "Malpractice, Nobody Win$...Everybody Pay$," Illinois State Medical Society, 1984, p. 3.

3. There are five major bodies of data on medical malpractice in New Jersey. They come from Federal Insurance Company, which wrote medical malpractice insurance on its own until 1976 and from 1977 to 1979 wrote malpractice insurance reinsured 100 percent by the N.J. Medical Malpractice Reinsurance Association; the N.J. Medical Malpractice Reinsurance Association, which sold policies between 1979 and 1982; the Medical Inter-Insurance Exchange, which opened its doors in 1977; the Health Care Insurance Exchange, which started insuring hospitals and hospital employees in 1976, and HCIE's subsidiary, Princeton Insurance Company, which started business in 1982. The data is not kept in such a way as to mesh precisely.

"Physicians' and Surgeons' Professional Liability," August, 1984, p. 2.

Data is for period ending June 30, 1985.

The Association's data is different from MIX's in that the average for each year consists of all claims closed in that year. The incidents may have occurred anywhere between 1977 and 1982.

Jury Verdicts Research, Solon, Ohio.

Ibid. Statistics would not include New Jersey cases settled in New York or Pennsylvania.

At the end of 1984, MIX had on its books two $1 million settlements, one settlement for $950,000 and a jury verdict of $975,000. The company had paid five other losses of between $800,000 and $900,000. Federal Insurance Company which wrote malpractice insurance in New Jersey between 1972 and 1979, has not had any $1 million payments in the last three years. It closed one case for $941,000 in 1982 and had two other large settlements in 1984 -- one for $500,000 and one for $750,000. Princeton, in its young life, has not closed any cases in seven figures. But in 1983, it settled a case for $1 million on behalf of the Reinsurance Association, and its parent company, the Health Care Insurance Exchange, had a $2 million verdict in a case involving a Hudson County hospital. Princeton reports it had two $1 million verdicts on Reinsurance Association clients last year. Since 1976, Princeton and the Health Care Exchange together have recorded 21 cases with either reserves or final payments of more than $500,000.

"N.J. Physicians' and Surgeons' Professional Liability Report," Exhibit 1a.

"The Frequency and Severity of Medical Malpractice Claims," Patricia Munch Danzon, The Rand Institute for Civil Justice, 1982, p. v.

Ibid., p. 36

"Physicians' and Surgeons' Professional Liability".

Over the years, MIX has cancelled about 100 physicians, some for having too many claims, some for being uncooperative, some for lying on their applications. Cancellation is not necessarily final. The company does occasionally reinstate a doctor who has shown significant change likely to reduce future claims.

"Physicians' and Surgeons' Liability," Age of Insured Loss Study, Exhibit 5.

E. Kathleen Adams, Stephen Zuckerman, "Variation in the Growth and Incidence of Medical Malpractice Claims," Journal of Health Politics, Policy and Law, Vol. 9, No. 3, Fall, 1984, p. 485..

27. Ibid., pp. 475-488.

28. "Professional Liability Insurance and Its Effects: Report of a Survey of ACOG's Membership," Section 3.9.

29. "Physicians' Self-Reports of Reactions to Malpractice Litigation," p. 365.

30. "The Frequency and Severity of Malpractice Claims", p. 563.

31. Ibid., pp. 7-8.

32. The high courts of three states, Illinois, New Hampshire and North Dakota, have struck down limits on plaintiffs' recoveries as unconstitutional.

33. The Board of Medical Examiners has proposed a rule which would codify what MIX says is current practice -- supervision of no more than two registered nurse-anesthetists by a single anesthesiologist.

34. "The Frequency and Severity of Medical Malpractice Claims," pp. 40-41.

35. "Medical Malpractice Legislation: The Kansas Response to the Medical Malpractice Crisis," Washburn Law Journal, 1984, p. 566.

36. "The Frequency and Severity of Medical Malpractice Claims," p. 47.

37. The definition of handicapped is broad, embodying a general philosophy that if there's a question, the child should get the extra attention, according to Education Department officials. All school districts reportedly are complying with the 1981 law, and in fiscal 1986, the Education Department expects to spend $10 million to fund 35 programs for children two or under. The N.J. Developmental Disabilities Council recently gave $150,000 each to the Education Department and the University of Medicine and Dentistry for outreach programs. The Education Department will handle community outreach; UMDNJ, outreach to the medical community.

38. Of the 10, two patients were 17, two were 15, three were 12 and the rest were younger. There also were seven cases involving people older than 50.

Indiana, two years from occurrence, except children under six have until their eighth birthdays; Missouri, modified discovery rule with 10-year limit, minor under 10 has until 12th birthday; New Mexico, adults have 3 years from occurrence, minor under 6 has until 9th birthday. "Medical Malpractice Legislation," p. 590.

The state's only for-profit hospital is Riverside General in Secaucus.

"Report of the Insurance Commissioner to the Florida Legislature on Medical Malpractice Insurance in the State of Florida," February, 1983, p. 8.

"California Large Loss Trend Study Malpractice - 1983 Update," Medical Underwriters of California.

The rule (Section 602) directs hospital governing boards to be guided by standards set by the N.J. Medical Society, the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association. The JCAH says it always has required physician peer review.

At Jersey City Medical Center, for instance, clinical department heads are full-time, salaried positions filled by search committees. Board certification is not a requirement. Jersey City has a three-step application process for new doctors but does not require supervision on the job. At Overlook Hospital, where clinical department heads are elected, the criteria are: 1) demonstrated experience in the hospital; and 2)the respect of other people in the field. Overlook has a six-step application procedure and requires supervision (in the Department of Medicine) for at least 10 cases. If the first 10 are unsatisfactory, the supervision can be extended, or privileges may be limited. St. Barnabas does require board certification for leadership positions. The Health Care Insurance Exchange's model by-laws for member hospitals allow hospitals to set their own rules on whether attainment of specialty board certification will be prerequisite for maintaining privileges.

"The Resolution of Medical Malpractice Claims, Research Results and Policy Implications," p. x.

46. Michigan was in the forefront of those states. The arbitration was conducted by three-member panels (one lay person, one health care provider and one attorney), whose decision was binding. Arbitration was not mandated. Rather, patients being admitted to hospitals were given an explanation of the arbitration system and a form to sign saying they later decided they were the victims of malpractice. A 1983 survey of the system found that arbitration cases moved about five months faster and cost the defense about $300 less, with payments to plaintiffs averaging abut $900 less. Interestingly, the researchers found that "approximately 40 percent of all the respondents could not recall being presented with the Patient Information booklet at admission." Of those (who could not remember it), half had signed the agreement. In addition, 49 percent of those who signed agreements hadn't read the book explaining them, and 67 percent of those who signed thought they could go to court afterward if they weren't satified with the results. Hospital personnel also were confused. Only 4 percent of the admissions personnel were able to correctly answer a dozen questions about the arbitration program, and only 32 percent got nine of the answers right. "Evaluation State of Michigan Medical Malpractice Arbitration Program, Summary Report," Submitted by Applied Social Research Inc., October, 1983, pp. 12, 19, 20-22.

47. N.J. Supreme Court. "Report on the Committee to Evaluate R. 4:21" January, 1983, p. 2.

48. Ibid., p. 5.

49. N.J. Law Journal.,"Report of the Supreme Court's Committee on Relations with the Medical Profession," June 3, 1982.

50. "Report of the Committee to Evaluate Rule R.4:21," p. 6.

51. Ibid., p. 7.

52. Ibid., p. 4.

53. Ibid., Appendix A.

54. "The Frequency and Severity of Medical Malpractice Claims," p. 36.

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). "Report of the Committee to Evaluate Rule R.4:21," p. 6.

1. Ibid., p. 7.

2. Ibid., p. 4.

3. Ibid., Appendix A.

4. "The Frequency and Severity of Medical Malpractice Claims," p. 36.

55. California's model charge to juries in cases involving future lost wages, says that "After finding the value in dollars of what the plaintiff's loss of future earnings capacity is reasonably certain to be, you must then find and award him only the present cash value of such future damage. Present cash value is the present sum of money which, together with the interest thereon when invested so as to yield the highest rate of interest consistent with reasonable security, will pay to the plaintiff the equivalent of his loss of earning capacity at the times, in the amounts, and for the period that you find the plaintiff would have received earnings in the future had he not been injured. The present cash value will, of course, be less than the amount you find to be his loss of future earning capacity." (BAJI 5th ed. 1969 14.70) However, in Wilson v. Gilbert, the California appellate court found that in the absence of adequate evidence to allow a reasoned finding on present cash value, the trial court could refuse discounting. Florida does not require reduction to present value of future damages when payouts are structured.

56. N.J. Supreme Court, Civil Judicial Conference Committee, "Toward a Theory of Civil Case Management," June 15, 1984, p. 30.

57. Certification is not mandatory, but it does confer special privileges, such as the right to negotiate a fee not necessarily related to the amount of work performed on a referral case.

58. A third group of 82 firms and individuals had filed five or more cases. Taken together, the top 98 firms accounted for 54 percent of the closed claims and 39 percent of the total payout. "Physicians and Surgeons Liability."

59. Of the 256 suits the group had won, more than half resulted in payments of $50,000 or less, and 91 cases involved payments of $10,000 of less.

60. PIC, which is pursuing a "fight-all-reasonably defendable cases" strategy reports that in 1984, it lost only 19.5 percent of the 195 cases that went to trial or ended on the courthouse steps. The company believes that it will win so many of the gray-area cases that it will, over the long term, discourage prospective plaintiffs from filing suit. MIX, on the other hand, practices a pay-early-and-cut-the-expense philosophy. The idea is to hold down defense expense and the size of payments to plaintiffs by paying the justified claims as early as possible. MIX reports that it lost 18 percent of the cases that went to trial. If cases dismissed before trial are added, the company's win rate at the courthouse is 92 percent.

1. "The Resolution of Malpractice Claims," p. 32. They reported a 9 percent reduction in the average settlement size and suggested that the caps served to reduce the effort attorneys put into cases, to the detriment of plaintiffs. (p. 21.)

2. The scale was: 50 percent of the first $1,000; 40 percent of the next $2,000; 33.3 percent of the next $47,000; 25 percent of the next $50,000, 20 percent of the next $150,000 and 10 percent of any amount above $250,000. On a $1 million verdict, the fee was $132,911 or about 13 percent.

3. To illustrate: Consider a case in which the attorney believes the award should be $600,000 or $700,000 and an insurance company has offered half that. The client stands to gain hundreds of thousands of dollars by going to court. The attorney, however, has little to gain. If the attorney has advanced $10,000 or $15,000 in costs, the conflict is worse. At any rate, the attorney can make much more money by settling for the company offer and devoting time to newer cases with values of $75,000 to $125,000.

4. As of November, 1984, the Board of Medical Examiners had 22,973 medical doctors, 1,937 osteopaths and 794 podiatrists on file as licensed and registered. However, many are believed to be either practicing out of the state or retired.

5. MIX's High Risk Evaluation Program works on a point-system. One point is assigned for the filing of a claim or suit, for a reserve (or actual payment) of $10,000 or more, for a peer review decision of not defensible and the claim department's assessment of probable liability. The maximum for any one claim is four points. Non-surgeons are reviewed for a surcharge after eight points, intermediate surgical classes after 12 and high risk surgical groups (such as neurosurgeons, orthopedists and obstetrician/gynecologists) after 16.

6. The board includes nine medical doctors, one osteopath, one chiropractor, one podiatrist, one director of a clinical laboratory and three members of the public (consumers).

7. Florida requires risk managers to have a bachelors level college degree in business administration or accounting plus either: one year's experience with a risk management program in a health care setting, or two year's experience in risk management, or other evidence of cost control and claims handling acceptable to the governing body of the facility. Florida also requires hospitals and other health care institutions to have an internal risk management program which includes investigation and analysis of the frequency and cause of types of injuries and to develop measures to minimize the risk of injuries.

68. Richard Gibbs, M.D., "Clamping Down on the High Cost of Malpractice Insurance," Legal Perspectives on Anesthesia, September/October, 1984.

69. N.J. Department of Health, "Manual of Standards for Hospital Facilities," p. 602.

70. "The Resolution of Medical Malpractice Claims," p. 15.

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October 31, 1985

Testimony before Senate Judiciary Committee

on Medical Malpractice

(S-1079, 1112, 1135, 1140)

My name is Myron Kronisch and I am a member of the New Jersey Affiliate of the Association of Trial Lawyers of America (ATLA-NJ). I speak to you today in opposition to the four bills now before the Senate Judiciary Committee concerning medical malpractice suits. I will limit my comments to S-1112 which would place a monetary cap on damages awarded by a jury, and to S-1079 which would change the statute of limitations.

These legislative initiatives are presented at a time when no medical malpractice crisis exists in New Jersey. Since 1976, the cost of malpractice insurance has steadily declined as a percentage of total health care costs. The cost of malpractice insurance is not only low when compared to the cost of health care, it is low in absolute terms. In 1983, the average American spent nearly $1,500 on health care and of that only $6.08, or eleven cents a week, went to malpractice insurance premiums.

In limiting the period for personal injury actions brought against physicians and other health care providers, S-1079 would negate an injured person's right to seek compensation before he is aware of the medical negligence or before he is even aware that medical negligence has caused an injury. In many cases, particularly among children, injury from medical malpractice may not be detected until long after the two

year period specified in this bill.

We also oppose S-1112, a bill that would place a $100,000 cap on all awards for pain and suffering. We see no demonstrated need for this type of legislation. What is fair compensation for the permanent loss of the use of a child's brain? How are damages to be determined for the permanent loss of sight or ability to walk? Our juries, presented with the facts, should continue to determine such awards as they do in cases resulting from the actions of drunk drivers, defective products and other cases involving human carelessness.

Victims who have become seriously handicapped or otherwise subjected to a life of pain and suffering, and whose economic losses as determined by a jury exceed the $100,000 cap, would be the ones who would suffer by this proposed legislation. If this bill becomes law, the worse the injury caused by malpractice, the greater the immunity the doctor obtains.

Would society benefit from this cap on compensation? No. Medical costs would not be reduced. Any monetary cap on pain and suffering ignores inflation. The cut-off of $100,000 is arbitrary and discriminates against those most catastrophically injured. Existing law already empowers both trial and appellate courts to modify or set aside excessive verdicts.

ATLA-NJ respectfully recommends that both S-1112 and S-1079 be opposed by the Senate Judicary Committee.

Thank you for the opportunity to present our views. I would also like to leave with you several copies of a document prepared by the Association of Trial Lawyers of America for the U.S. General Accounting Office regarding Medical Malpractice.

RESPONSE TO QUESTIONNAIRE OF THE U.S. GENERAL ACCOUNTING OFFICE REGARDING MEDICAL MALPRACTICE

Public Affairs Department

Association of Trial Lawyers of America

RESPONSE TO QUESTIONNAIRE OF THE U.S. GENERAL ACCOUNTING OFFICE REGARDING MEDICAL MALPRACTICE

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SECTION ONE

MALPRACTICE CLAIM FREQUENCY AND SEVERITY

A frequently heard explanation of the "crises" of availability and cost in the mid-1970's and the mid-1980's has been based upon a supposed increase in both claim frequency and claim severity. In fact, there has been no substantial increase in either frequency or severity of malpractice claims.

1. Malpractice Claim Frequency

Vital to the claims of the medical-insurance complex is this myth that we live in a "litigious society." This part of the argument holds both that we, as a people, are more likely to sue than other people, and that we are more likely to sue than we used to be. Neither turns out to be true.

A recent survey of the litigiousness of citizens of major industrial nations clearly showed that Americans are really quite normal in terms of their tendency to sue:

> "[T]he United States rate of per capita use of the regular civil courts in 1975 was just below 44 per thousand. This is in the same range as England, Ontario, Australia, Denmark, New Zealand, somewhat higher than Germany or Sweden, and far higher than Japan, Spain or Italy. ... According to a recent report, some five million cases are filed in Yugoslavia each year, an astonishing figure for a country of 22 million persons." (1)

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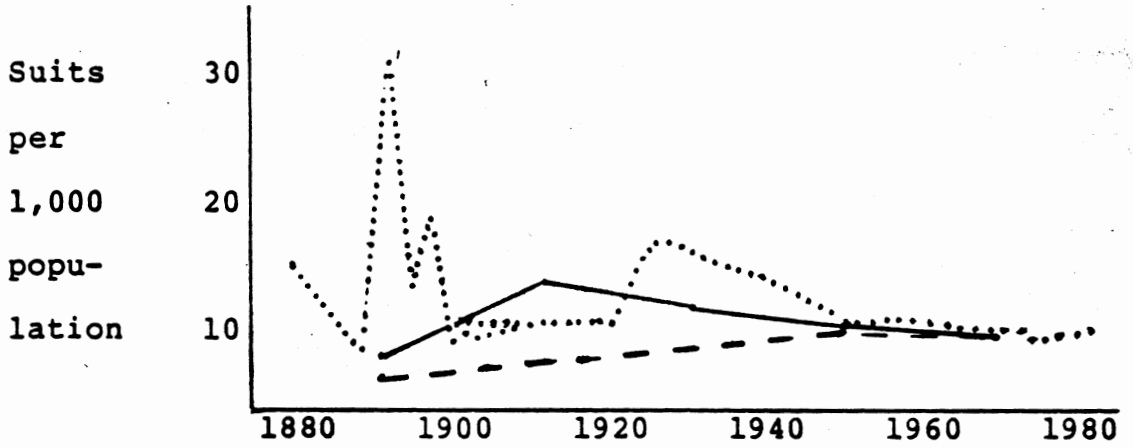
(1) Galanter, Marc, "Reading the Landscape of Disputes: What We Know and Don't Know (and Think We

If we are not particularly likely to sue when compared with our industrial brethren, are we more likely to sue than we use to be? Again, the answer is a clear no. As the following graph indicates, there is no clear trend toward an increase in the tendency of Americans to bring a civil lawsuit.



Los Angeles County, CA = ·····
Alameda County, CA = ——————
San Benito County, CA = — — — —

Sources: Galanter, supra at fn (1), p.40; Selvin, M. and Ebener, P., Managing the Unmanageable: A History of Civil Delay in the Los Angeles Superior Court, The Institute for Civil Justice, Rand Corporation (1984), p.34.

As Professor Galanter explains, then, "the pattern of use [of the law to resolve disputes] is conservative, departing relatively little from earlier patterns." (2)

These findings are echoed in a recent report by Stephen Daniels of the American Bar Association:

> "Generally speaking, ... there is no single, consistent overall trend shared by all the courts ..., and there does not appear to have been any golden age of low caseload rates." (3)

What, then, of such facts that nearly twice as many civil actions were filed in federal district courts in 1983 as in 1977? (4) Doesn't that prove we

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Know) About Our Allegedly Contentious and Litigious Society," 31 U.C.L.A. L.Rev. 4, 55-56 (October, 1983).
(2) Galanter, supra at fn (1), at 70.
(3) Daniels, Stephen, "We're Not a Litigious Society," The Judges' Journal (Spring 1985) 18, 47.
(4) "Federal Judicial Workload Statistics During the

are more likely to sue than we used to be? No, as Professor Galanter explains:

> "[O]ne third of the whole increase consisted of a jump from 600 to 41,000 cases filed by the federal government to reclaim overpayment of veterans' or Social Security benefits or to collect on student loans. The next largest gain was an increase from 3,000 to 20,000 in claims to restore disability payments cut off by the Reagan Administration. ... These numbers reflect specific social and political events and don't point to any across-the-board increase or decrease in litigiousness." (5)

This lack of increase in claim frequency is likewise true with respect to medical malpractice claims. While data in this area is quite incomplete, we do know that in 1975, 23,240 medical malpractice claims were filed, or about 6.4 per 100 physicians. (6) In 1983, approximately 42,000 claims were filed, or about 8.1 per 100 physicians. (7) In other words, at worst, the increase in frequency over the last decade has been at an annual rate of about 3.4%. This rate of growth is entirely explained by several sociological and demographic changes in our society: the over 25% increase in physician density (8), the sharp increase in number of potentially injury-producing patient contacts (9),

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Twelve Month Period Period Ended December 31, 1983," Administrative Office of the United States Courts, (1984).

(5) "Americans' 'Litigation Binge' Is a Myth," U.S. News & World Report (November 1984).

(6) Danzon, P.M., "The Frequency and Severity of Medical Malpractice Claims", The Institute For Civil Justice, Rand Corporation, p.6 (1982); Statistical Abstract of the United States 1984, 104th Edition, U.S. Department of Commerce, Bureau of the Census, pp.6, 109 [hereafter referred to as "Statistical Abstract"].

(7) AMA Report I, p.10; Statistical Abstract, pp. 6, 109.

(8) Statistical Abstract, pp.6, 109; People's Medical Society (February 1985), p. 7. Dr. Danzon has estimated that [a]n increase of 100 doctors per 100,000 population is associated with an increase of 3.6 claims per 100,000 population." "Frequency and Severity...", supra at fn (5), p. v.

(9) There was a 62 percent increase in the number of surgical operations in short-stay hospitals from 1971 to 1981. Statistical Abstract, p. 117.

and the increasing complexity and intensity of medical care, to mention but a few. A recent study of the Pennsylvania medical malpractice situation sponsored by, among others, the Hospital Association of Pennsylvania, the Pennsylvania Bar Association, the Pennsylvania Defense Institute, the Pennsylvania Medical Society and the Pennsylvania Trial Lawyers Association, agreed that there was "no verifiable increase in actual malpractice occurrence." (10)

As was recently concluded by the Florida Governor's Task Force on Medical Malpractice:

> "The increase in malpractice actions can be attributed to a variety of factors. With health insurance and government funding, more people have access to medical care. Technological advances have increased the risks of iatrogenic injury. Care is being rendered in a variety of locations and the number of providers has not only increased, but care by specialty has increased. There are significantly more variables, more actors, more settings, more procedures, and more risks." (11)

Once all these factors are considered, it becomes clear that there has been no statistically significant increase in claim frequency.

One point must be made regarding the tendency of newly-formed doctor-owned insurance companies, such as New York's Medical Liability Mutual Insurance Company (MLMIC) to claim startling increases in claim frequency: such claims completely ignore the fact that the first decade of any new malpractice company, underwriting association, or catastrophic injury fund is marked by "pseudo-growth" characteristic of all new insurers. A highly simplistic example will demonstrate this growth. Assume a medical malpractice insurance company is formed in 1979 and that, for the next several years, the company's insureds incur 100 claims for each policy year, i.e., the company experiences no growth in claim frequency per policy year. Assume also

(10) Hofflander, Alfred E., Ph.D. and Nye, Blaine F., Ph.D., "Medical Malpractice Insurance in Pennsylvania," Management Analysis Center, Inc. p.26 (1985).
(11) "Toward Prevention and Early Resolution, Report and Recommendations of the [Florida] Governor's Task Force on Medical Malpractice," (April 1985) p. 34.

that claims are filed against this company at the rate found to be typical of the industry in the 1978 HEW/Industry Study. (12) The following table demonstrates how a zero-growth claims frequency can produce an apparently startling rate of growth. (13)

HYPOTHETICAL CLAIM FREQUENCY DEVELOPMENT

	YEAR CLAIM FILED									
POLICY YEAR	1979	80	81	82	83	84	85	86	87	88
1979	56	25	11	3	2	1	1	1		
1980		56	25	11	3	2	1	1	1	
1981			56	25	11	3	2	1	1	1
1982				56	25	11	3	2	1	1
1983					56	25	11	3	2	1
1984						56	25	11	3	2
1985							56	25	11	3
1986								56	25	11
1987									56	25
1988										56
TOTAL	56	81	92	95	97	98	99	100	100	100
% INCR. SINCE 1979	-	45	64	70	73	75	77	79	79	79

Using MLMIC's "analysis", one could claim that our hypothetical company, while in fact experiencing absolutely no true growth in claims frequency whatsoever, suffered a "73 percent increase in claims frequency from 1979 through 1983." While this exercise is in no way intended to serve as an actuarial model for

(12) According to that study, 56% of malpractice claims are filed within the first year, 25% in the second, 11% in the third, 5% in the fourth and fifth years, and 3% after the fifth year. "Medical Malpractice Claims - Synopsis of the HEW/Industry Study of the Medical Malpractice Insurance Claims," Public Health Service and Health Care Financing Administration (October 20, 1978), Table 7-7.

(13) For the purposes of this example, the 5% filed in years four and five will be split between the two years (3% in year four, 2 % in year 5), and the 3% of claims filed after the fifth year will be presumed to have been filed 1% at a time over the sixth, seventh, and eighth years, even though, in reality, those claims would be filed over a number of years after the eighth year.

comparison of physician-owned companies, it does reveal why, under MLMIC's analysis, physician-owned companies have apparently experienced a substantially higher growth in claims frequency than have the older corporate insurers.

Finally, no discussion of increases in frequency of malpractice claims can fairly overlook one important issue to be discussed more completely later: virtually every study which has examined the question of the incidence of actual malpractice has shown that there is at least ten times as much actual malpractice as there are claims for malpractice, and fewer than half of those claims are paid. In other words, fewer than one in twenty-five instances of malpractice are compensated by the "system". (14) How, then, can this "system" be criticized as being overly generous in its compensation of the victims of medical carelessness? The truth is, it cannot.

2. Malpractice Claim Severity

The twin horsemen of any insurance "crisis" are increased frequency and severity of claims. As we have seen, there is certainly no crisis of frequency. Is there, then, a crisis of severity? Are American juries handing out unjustifiably large awards which are not merited by the facts? Again, the answer is no.

The critical question at this juncture is: by what standard are we to measure increases in severity? Given inflationary pressures, what could we have expected to have happened to the size of the average claim? While the standard consumer price index (CPI) is one possible standard, it does not reflect the fact that the great bulk of medical malpractice verdicts and settlements are based upon medical expenses. (15) It would therefore seem more appropriate, as a general principle, to use the Medical Cost Index (MCI) or national health care expenditures (HCE) when examining trends in medical malpractice claims, settlements, verdicts, and insurance.

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(14) Danzon, P.M., "An Economic Analysis of the Medical Malpractice System," 1 Behavioral Sciences & The Law 39, 40 (1983)

(15) Economic Report of the President, 1984 Edition; "Congress Should Consider Changing Federal Income Taxation Of The Property/Casualty Insurance Industry," U.S. General Accounting Office, GAO/GGD-85-10 (March 25, 1985), p. 6.

The 38% rise in claim severity for the years 1981-1984 recently reported by St. Paul is, in fact, a growth rate of only 8.4% per year, well under the annual 10.5% growth in MCI and the 13.3% growth in HCE for that period of time.

At first glance, the more extreme growth figures for the doctor-owned companies seem much harder to understand. However an important and often-overlooked fact about doctor-owned companies is that, as new companies with less than a decade of experience, these companies generally have only recently started to encounter the larger, slower-developing claims, such as the brain-damaged infant cases. In other words, malpractice claims paid soon after the precipitating incident are the less expensive claims - the less serious injuries. The NAIC Closed Claims Study of 1975-1978 revealed that the average value of claims settled more than four years after the incident was over 13 times as great as that of claims settled in the first six months, and over 4-1/2 times as great as that of claims settled in the first two years. (16)

The combination of inflation (both MCI and HCE) and this form of "pseudo-growth" which produces apparently severe growth rates in the average claim of newly-formed companies can be illustrated in a hypothetical involving a company which began operations in 1979. In this hypothetical, the company incurred 100 claims in each policy year. The values for average claims are taken from the HEW/Industry Study.

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(16) "Medical Malpractice Claims: Synopsis of the HEW/Industry Study of the Medical Malpractice Insurance Claims," Health Care Financing Administration, U.S. Department of Health Education and Welfare, HCFA-02108 (1979), Table 7-8.

HYPOTHETICAL CLAIM SEVERITY DEVELOPMENT

(The top figure of each pair of figures reflects the value of the average claim; the bottom reflects the number of claims.)

POLICY YEAR	YEAR CLAIM FILED 1979	1980	1981	1982	1983
1979	5215	16039	26940	36799	49040
	19	21	22	24	5 (17)
1980		5215	16039	26940	36799
		19	21	22	24
1981			5215	16039	26940
			19	21	22
1982				5215	16039
				19	21
1983					5215
					19
TOTALS					
CLAIMS:	19	40	62	86	91
INDMNTY:	99085	435904	1028584	1911760	2156960
AVG.CLM: (no inflation)	5215	10897	16590	22230	23703
AVG.CLM: (MCI):	5215	12041	20256	28500	35338
(HCE):	5215	12325	21221	32161	38784

The last two lines of the above chart reflect the potential for apparently startling magnitudes of growth of the average claims of young malpractice insurance companies in an inflationary society in a situation in which the actually severity of claims is not increasing.

(17) Because the HEW/Industry Study groups all claims closed more than four years after the incident in one category, the estimates for average claim and frequency are very rough estimates. The reader is asked to bear in mind that this chart is for illustrative purposes only.

When one examines other admittedly rough indicators of the growth of claims severity, one finds ample evidence to disprove any claims of remarkable growth in verdicts and settlements. For example, the average growth rate of incurred costs per claim against physicians and surgeons was 12.4 percent per year from 1971-1978, again, exactly within the range of the growth of health care costs. (18)

Another measure of severity is the size of jury verdicts. This is a very uncertain measure because data is incomplete and average jury verdicts fluctuate wildly from one year to the next. (19) However, whether you take the long view or the short view, malpractice verdicts have generally risen at or below the rate of increase in health care expenditures:

> From 1981 through 1984, the average malpractice verdict increased at an annual rate of only 3.9%, while the mid-point verdict actually decreased at the rate of 3.5%. Health care expenditures increased at a rate of 11.8% during that period.
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> From 1977 through 1984, on the other hand, the average malpractice verdict increased at an annual rate of 14.7%, and the mid-point by only 8.7%. Health care expenditures increased at a rate of 13.1% for that 7-year period. (20)

One component of the claim that jury verdicts are

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(18) Danzon, P.M., "The Frequency and Severity of Medical Malpractice Claims," The Institute For Civil Justice, Rand Corporation (1982) p. 7.

(19) To say that these fluctuations in award averages provide ample opportunity for statistical mischief is to understate the danger. A recent column by James Kirkpatrick (March 5, 1985) reported that malpractice verdicts in California had skyrocketed, citing an Insurance Information Institute figure prominently featured in the AMA Report I (p. 21) that the average verdict had risen from $257,222 to $649,210 from 1982 to 1983. An examination of that publication reveals that 1983 was a quite unusual year for high verdicts (64% higher than any other year), and that 1982 was an unusual year for low verdicts, (the lowest since 1978). In fact, in 1984, according to these same sources the average California malpractice dropped 39% to $396,662. "California Superior Court Verdicts - Medical Malpractice Cases 1972 - 1984, Insurance Information Institute.

(20) "Injury Valuation Reports," No. 292, Jury Verdict Research, Inc. (1985), p. 18; Census.

grossly distorted asserts that juries are increasingly likely to award large verdicts out of sympathy, not because the facts of a case merit a large verdict. In fact, researchers have consistently found that, by and large, jury verdicts in malpractice claims are based primarily on rational decisions about actual injuries to malpractice victims, (21) and, in fact, generally undercompensate the victim of medical carelessness. (22)

(21) Danzon, P.M., "An Economic Analysis," supra at p. 44 (1983).
(22) "Medical Malpractice Claims: Synopsis of the HEW/Industry Study," supra at p. VI-3.

SECTION TWO

MALPRACTICE, HEALTH CARE COSTS, AND DEFENSIVE MEDICINE

One of the claims of proponents of restrictions on the rights of the victims of medical malpractice is that the current cost of malpractice insurance is a significant contributor to rising health care costs. This claim is without foundation. The costs of malpractice simply are "not a significant cause of increased health care costs." (23) There may be a health care cost problem which has to do with malpractice, but it certainly is not the cost of malpractice insurance. Malpractice insurance premiums in 1984 amounted to less than $2 billion, about one-half of one percent of the approximately $400 billion Americans spent on health care that year. (24) Since 1976, the cost of malpractice insurance has actually been steadily declining as a percentage of total health care costs. (25) Put another way, medical malpractice premiums have actually declined by 45% as a percentage of health care costs. Even the insurance industry's estimates of incurred loss and loss expense payments have remained quite constant at the one-half percent mark ($1.92 billion). (26)

The cost of malpractice insurance is not only low when compared to the cost of health care, it is low in

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(23) Posner, J.R., Marsh & McLennan, "Trends In Liability Insurance," Abstract from Presentation at National Medical Malpractice Conference, The Urban Institute (February 21-22, 1985). See, also, Natielly, Thomas A., Ph.D., untitled research paper on medical malpractice, in which the University of Miami professor concluded that the impact of medical malpractice costs on health care costs is "insignificant compared to the impact of other factors, namely inflation, increasing elderly population, increasing cost of technology, and finally increasing third party payments." Page 29.

(24) A.M.Best's Casualty Loss Reserve Development 1985; Gibson, Robert M., et al, "National Health Expenditures, 1983," 6 Health Care Financing Review 1 (Winter 1984).

(25) Figures from the Statistical Abstract, supra, and from Best's Casualty Loss Reserve Development indicate that this decline has been unbroken from 0.75% in 1976 to 0.42% in 1984.

(26) A.M.Best's, Id.

absolute terms: in 1983, the average American spent nearly $1,500 on health care (27); of that, only $6.08, or eleven cents a week, went to malpractice insurance premiums (28).

The true cost of malpractice is in the shattered lives and depleted pocketbooks of the victims of medical carelessness, over 95% of which receive no compensation for their injuries through the "malpractice system". (29) An estimate of the financial costs of this uncompensated injury from medical negligence is $24 billion. (30) Thus, even if the deterrent value of the existing medical malpractice system were only 10% effective at reducing medical carelessness, the costs of insurance would be more than offset by very real savings in health care costs, not to mention the tens of thousands of human lives involved.

Clearly, the cost of medical malpractice insurance is not a burden on the average citizen, particularly compared with total health care costs. But is that cost a burden on physicians? The answer is, by and large, no. In 1984, the average American physician spent only 2.9% of his or her gross income (currently estimated at around $200,000) on medical malpractice insurance. (31) This is just slightly more than the 2.3% spent on "professional-car upkeep," but, interestingly enough, well over the 1.2% spent on continuing education. (32) In fact, an examination of U.S. Census Bureau statistics relating to the growth in the number of physicians in the United States indicates that the average premium per physician actually declined from 1977 to 1981 by 6.5%. (33) Obviously, some physicians spend a greater percentage of their gross income than 2.9% on malpractice premiums, but even neurosurgeons, who pay the highest percentage of gross income of any specialty, are spending only 5.8%. (34)

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(27) Gibson, supra.
(28) From A.M.Best's, supra.
(29) Danzon, P.M., "An Economic Analysis of the Medical Malpractice System," supra.
(30) Danzon, P.M., testimony before the Committee on Labor and Human Resources of the United States senate, July 10, 1984.
(31) Kirchner, Merian, "Is Your Practice Begging For More Money?," Medical Economics 214, 230 (November 12, 1984).
(32) Id. at 231.
(33) From Statistical Abstract, p.111, and A.M. Best's Casualty Loss Reserve Development, 1978 through 1984.
(34) Id. at 230. See, also, Danzon, P.M., Duke University, "Evaluation of the Current Malpractice System," Abstract of presentation delivered at The Urban

The very high premiums that are so highly publicized are very rare - 57% of doctors spend less than $5,000 on malpractice premiums, while only 12% spend over $15,000 (35), with these highest premiums being paid by those well-paid surgical specialists whose work constitutes the greatest risk of harm to health care consumers. In short, as New York trial lawyer Richard Shandell put it recently, a New York City doctor, who pays the highest premiums in the country, pays a smaller percentage of his gross income on liability insurance than does a New York City cab driver. (36)

Advocates of radical restrictions on the rights of health care consumers argue that it is the cost of defensive medicine which bears the true price tag of the so-called medical malpractice insurance "crisis."

The first question that must be answered is, "what is defensive medicine?" There is no consensus on the answer to that question. As it was once put, "... what might appear to be defensive medical practice to one clinician may, to another, be quality medical care." (37) Interestingly enough, the medical community has not always been so opposed to "defensive medicine" as it now seems to be. In 1975, an article in the Journal of the American Medical Association proclaimed:

> "The possibility of suit may serve as a deterrent to some individual physicians who might otherwise be tempted to undertake experimental treatment involving excessive risks. Similarly, self-protection may motivate some physicians to confirm findings already known. This may increase the costs of patient care, but the additional cost is justified if even on rare occasions the result is a change in diagnosis that contributes to saving the life and health of the patient.
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> "Generally, it is recognized that 'defensive driving' is a good practice for motorists to follow. Similarly, it appears that

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Institute's National Medical Malpractice Conference, February 21-22, 1985 (stating that 1982 premiums averaged only 3% of physician gross income, ranging from 1% for general practitioners to 6% for some specialities);
(35) Kirschner, M., supra at fn (27), p. 229.
(36) Shandell, Richard, Letter to the Editor of the Wall Street Journal, October 6, 1983.
(37) Tancredi and Barondess, "The Problem of Defensive Medicine, 200 Science 879 (May 1978).

"defensive medicine" is essentially beneficial for patients." (38)

A Past President of the Federation of State Medical Boards of the United States has applauded the benefits of "defensive medicine":

> A by-product of the malpractice situation, related indirectly to medical discipline, is its deterrent effect. It is sad but true that many physicians practice more carefully than they did in the past because they have one eye on the potential litigant malpractice become the most important disciplinary weapons in medicine--distasteful as the idea may be to physicians--so be it." (39)

One noted economist recently testified before a U.S. Senate Committee on the subject of "defensive medicine":

> "There are no reliable estimates for 'defensive medicine,' but again, I think there is a tendency to exaggerate. There are certainly a lot of unnecessary testing and unnecessary procedures being done, but much of this results from the incentives being created by the fee-for-service reimbursement system. It would not go away if we abolished liability for malpractice. Moreover, many of the responses that physicians report, such as spending more time with patients or referring difficult cases, these are precisely the sorts of care that the malpractice system is intended to encourage. They should not be considered wasteful." (40)

When doctors do alter their practice because of the threat of litigation, what kind of changes do they make? "[P]roviding written or taped information to their patients," "obtaining written informed consent,"

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(38) "Defensive Medicine is Good Medicine," Journal of the American Medical Society (May 27, 1975).

(39) Derbyshire, R.C., "Malpractice, Medical Discipline, and the Public," in Hospital Practice (January 1984).

(40) Danzon, P.M., testimony before the Committee on Labor and Human Resources of the United States senate, July 10, 1984.

documenting activities," "referrals to other physicians," "consultations," "testing and diagnostic procedures," "monitoring procedures," and "staff presence at examinations". (41) More specifically, one report has concluded that, while increased electronic fetal monitoring and cesarean sections probably were caused by the growing number of suits around fetal injuries, those procedures did increase the survival of newborn babies. (42)

It should also be noted that defensive medicine can not only cost money, but can also save money. It is a common characteristic of first-party health insurance plans to require a second opinion as a prerequisite to full compensation for a surgical procedure.

One of the distressing things about the medical industry's claims that the threat of litigation forces health care providers to provide unnecessary treatment is that it is a violation of the medical profession's own ethical code to "provide or prescribe unnecessary services". (43) This decidedly minuscule economic burden of medical malpractice insurance surely would not lead a significant number of physicians to violate such a clear ethical mandate.

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

Another of the "costs" of malpractice which has been asserted by the medical-insurance complex is that some doctors are curtailing the high-risk aspects of their practice, decreasing the availability of health care. The most notable claim has been that large numbers of Florida obstetrician/gynecologists are no longer delivering babies. Even if this is true, and the anecdotal nature of the "evidence" calls that into

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(41) "Professional Liability Insurance and Its Effects: Report of a Survey of ACOG's [The American College of Obstetricians and Gynecologists] Membership," [Hereafter referred to as ACOG], Prepared by Porter, Novelli & Associates, August 31, 1983, Table 23.
(42) Tancredi and Barondess, supra at p. 882.
(43) Section 2.12, Current Opinion of the Judicial Council of the American Medical Association.

doubt, a more likely explanation is that, as a Florida Governor's Task Force found, there has been a "phenomenal increase in physicians" in that state, leading to an oversupply of doctors. (44) In this situation, it is hardly surprising that some doctors are curtailing some aspects of their practice - there is less for each Florida doctor to do these days. As recently as August 31, 1983, 86.5% of OBGYN's engaged in the practice of obstetrics. (45) In fact, fewer than one-in-ten OBGYNs have given up the practice of obstetrics because of high risk. (46) In short, the claims that doctors are curtailing the high-risk aspects of their practices are not borne out by the available evidence.

The current medical malpractice problems have little to do with the soaring cost of health care. Malpractice insurance is too infinitesimal a portion of the total health care bill to have any impact on it. System-wide, the average doctor pays a small portion of his or her income on malpractice insurance, although, for some high-risk specialities, premiums are higher. Defensive medicine is not something to be condemned, but is exactly the kind of deterrence of careless or substandard behavior that the tort system is intended to produce. In short, the "health care cost issue" has no basis in fact.

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(44) "Toward Prevention and Early Resolution, Report and Recommendations of the [Florida] Governor's Task Force on Medical Malpractice," (April 1985) p. 31.
(45) "Professional Liability Insurance and Its Effects: Report of ACOG's [The American College of Obstetricians and Gynecologists] Membership," [Hereafter referred to as ACOG], Prepared by Porter, Novelli & Associates, August 31, 1983, Table 8.
(46) Id.

SECTION THREE

INVESTMENT INCOME AND THE MALPRACTICE INSURANCE INDUSTRY

As we have seen, the recent, sometimes severe, increases in medical malpractice premiums have virtually nothing to do with either the frequency with which malpractice claims are being filed, or with the size of jury verdicts. This perhaps has never been made more clear than this year, as the following news has been revealed:

> In 1984, insurance industry's own estimate of incurred loss and loss expense payments increased by the smallest amount since 1977. Yet, at the same time as the rate of growth of losses was declining, premiums increased by the largest margin since 1976, over 13%. (47)

To understand what lies behind the fluctuations in malpractice premiums, it is important first to appreciate the role of investment income in the medical malpractice insurance industry. While such income is important to any property/casualty insurer, it is truly the lifeblood of the medical malpractice insurer. The fact that malpractice claims are paid relatively slowly compared to claims in other lines of insurance leads to the creation of comparatively high loss and loss expense reserves, which in turn leads to a heavy reliance on investment income by malpractice insurers. From 1980 through 1983, malpractice investment gain was between 29% and 43% of premiums earned, while such income for the entire property/casualty insurance industry ranged between only 7% and 10% of premiums earned. (48) Further evidence of the magnitude of investment income in malpractice insurance can be found in the fact that, as of December 31, 1984, the malpractice insurance industry had earned, on assets encumbered by reserves for the occurrence years 1979-1984, over $330 million more in investment income than it had paid to victims of medical negligence. (49) Medical

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(47) A.M.Best's Casualty Loss Reserve Development, 1985.

(48) Best's Aggregates and Averages, 1984, supra, pp. 4-5.

(49) "Investment Income Analysis of Medical Malpractice Insurance," Public Affairs Department, Association of Trial Lawyers of America, October 1985; A.M.Best's, supra.

Liability Mutual Insurance Company, the largest malpractice insurer in New York and the second largest malpractice insurer in the nation, has, for occurrence years 1976-1984, in investment income on assets encumbered by reserves, over $210 million more than it has paid to victims. (50)

Traditional underwriting practices focus on estimates of incurred losses and loss expenses without regard to anticipated investment income, and therefore overstate liabilities in the form of reserves for known claims and reserves for claims incurred but not reported. The U.S. General Accounting Office recognized this practice in a report released earlier this year (51), concluding that property/casualty insurers in general, and medical malpractice insurers in particular, avoid paying their fair share of federal income taxes through accounting practices which allow insurers to fully deduct incurred losses, which includes reserves for future claims, thereby understating "the periodic determination of income for p/c companies," leading to a tendency to "overstate the amounts needed to satisfy future claims."

In other words, this tendency of the industry to overlook the role of investment income has allowed that industry to paint a unrealistically bleak picture of its losses, leading to high premiums and inappropriately low taxation. This phenomenon, however, does not explain the violently cyclical nature of medical malpractice premiums. The primary problem which, in some states, has led to sudden and substantial increases in medical malpractice premiums stems from the confluence of two factors: (1) The investment portfolio of the property/casualty insurance industry has suffered drastic decreases in its yield, and (2) that industry has, on the whole, ignored the gradual, normal increases in malpractice losses since 1977 and has instead based its premiums on competitive considerations rather than sound underwriting practices. Put another way, insurers have, over the last decade, paid too much attention to winning the war for "market share" and too little attention to paying for their losses. They were able to do this because their protective padding of high investment income insulated them from the consequences of their actions. Now that

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(50) Id.

(51) "Congress Should Consider Changing Federal Income Taxation Of The Property/Casualty Insurance Industry," United States General Accounting Office, GAO/GGD-85-10 (March 25, 1985) [Hereafter referred to as "GAO"].

interest rates have dropped, they not only can no longer charge too little for their product, they seem to feel that they must overcharge to compensate for their past mistakes. That is the primary reason that enormous malpractice premium increases are being imposed upon unsuspecting doctors from New York to California, from Texas to Wisconsin.

A closer look at the investment cycle is warranted here. All industries which involve investment are subject to cycles in which the yield of their investment portfolios rises and falls. The insurance industry is, however, prone to more extreme versions of these "profitability cycles" than are most other industries (52) because as much as 55% of the industry's assets are invested in bonds. (53) In a nutshell, the property/casualty insurance industry is now, as it was in 1974, in the depths of a rather severe decline the the yield of its investment portfolio. It is clear that this happened a decade ago:

> "In 1974, the Dow Jones Index of Industrial Stocks fell 400 points. Stock companies in the property-liability insurance industry reported a capital loss of $10 billion, four times as large as any previously on record. These adverse investment and underwriting results combined to reduce the yield of insurers' capital by over 26%." (54)

The net effect was to reduce the incentive of insurers to take risks and to increase the incentive to raise premiums - the dual crises of availability and cost. (55) Observers of the industry, understanding this relationship between this "cycle of profitability" and premiums, predicted in the early 1980's that, once interest rates started to fall significantly, premiums would once again rise, probably sharply. (56) As we have seen, they were correct.

This "boom-bust" cycle in the insurance industry is reflected in the behavior of insurers:

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(52) Id. at p. 7; Conning and Company, "A Study of Why Underwriting Cycles Occur," (November 1979) p. 1.
(53) Best's Aggregates & Averages, Property-Casualty, 1985, p. 2.
(54) Danzon, P.M., "An Economic Analysis of The Medical Malpractice System," supra, p. 49.
(55) Id.
(56) Id.

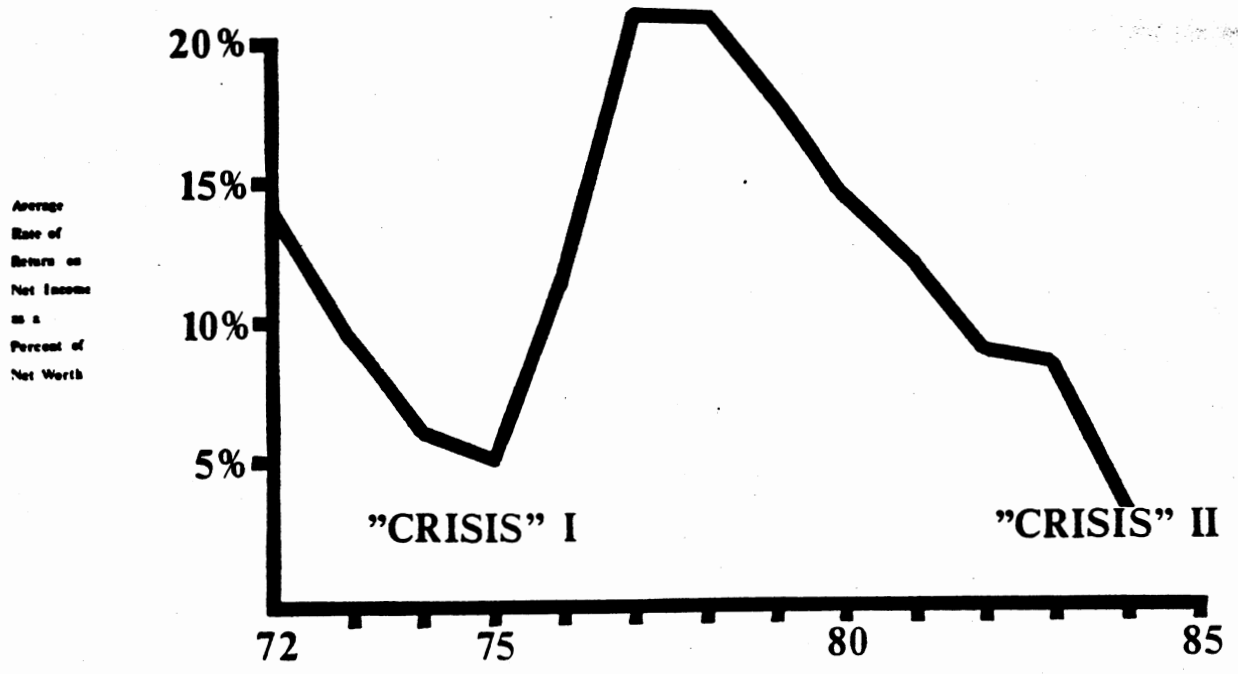
> "It is amazing to see what happens in an insurance cycle to the mental state of underwriters. At the top of the cycle, in 1981, insurers were willing to not only take all of the risks they are shunning today, but were willing to go so far as to insure the liability of MGM after their Grand Hotel burned down. Compare that with today's doomsday attitude toward risks that the underwriters have subjectively declared to be taboo." (57)

This cycle of profitability for insurers can be seen in the following chart showing annual rates of return from 1972-1984.

(57) "The Insurance Crisis of 1985: What Can Be Done?" National Insurance Consumers Organization (June 1985) p. 2.

INVESTMENT INCOME

PROPERTY – CASUALTY INDUSTRY



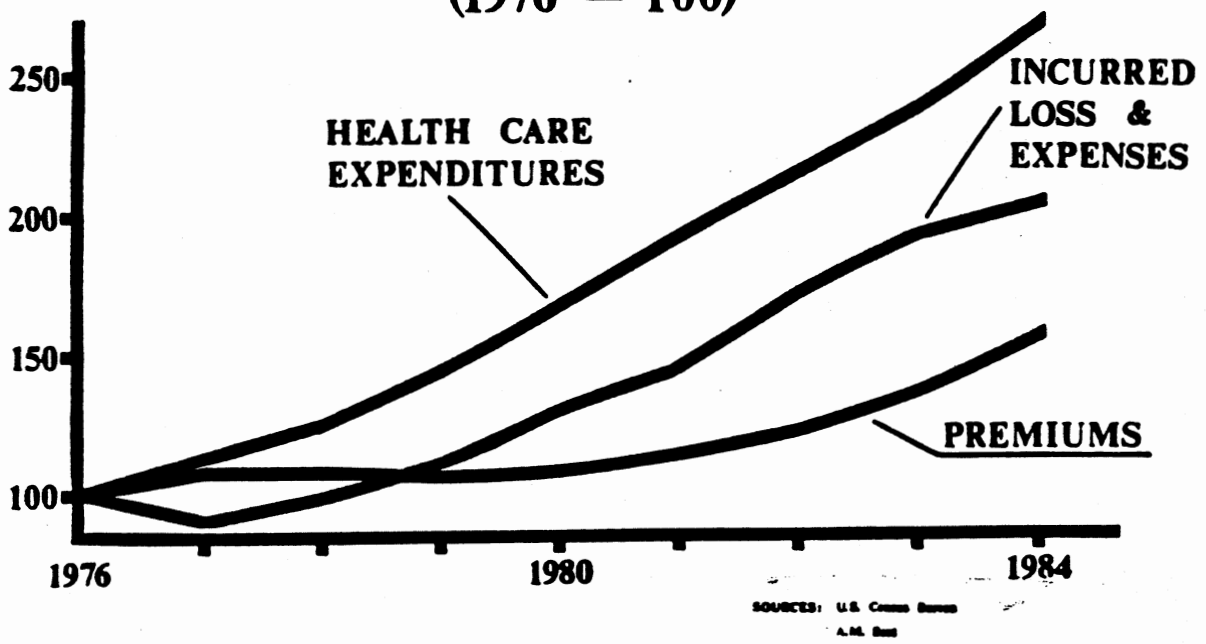
SOURCE: U.S. General Accounting Office

The fact that the property/casualty insurance industry is at the bottom of a profitability cycle is only part of the story of skyrocketing premiums, however. Insurers have been far more interested in slashing prices to grab larger and larger shares of the malpractice "pie" than in providing their insured doctors and hospitals with sensible underwriting and stable premium growth. Often this competition has been between the established stock companies who dominated the market before 1975 and the newer doctor-owned companies, but even in those states where a doctor-owned company dominates the insurance market, there has been intense competition. (58) The effects of this

competition on premiums can be illustrated in several ways. First, a simple comparison of the growth in premiums and the growth in the industry's own estimates of incurred loss and loss expenses shows that premiums simply have not kept up with the normal growth in incurred losses. This can be clearly seen in the following graph, which includes the growth in the cost of health care to demonstrate that incurred losses have grown relatively slowly.

PREMIUM GROWTH

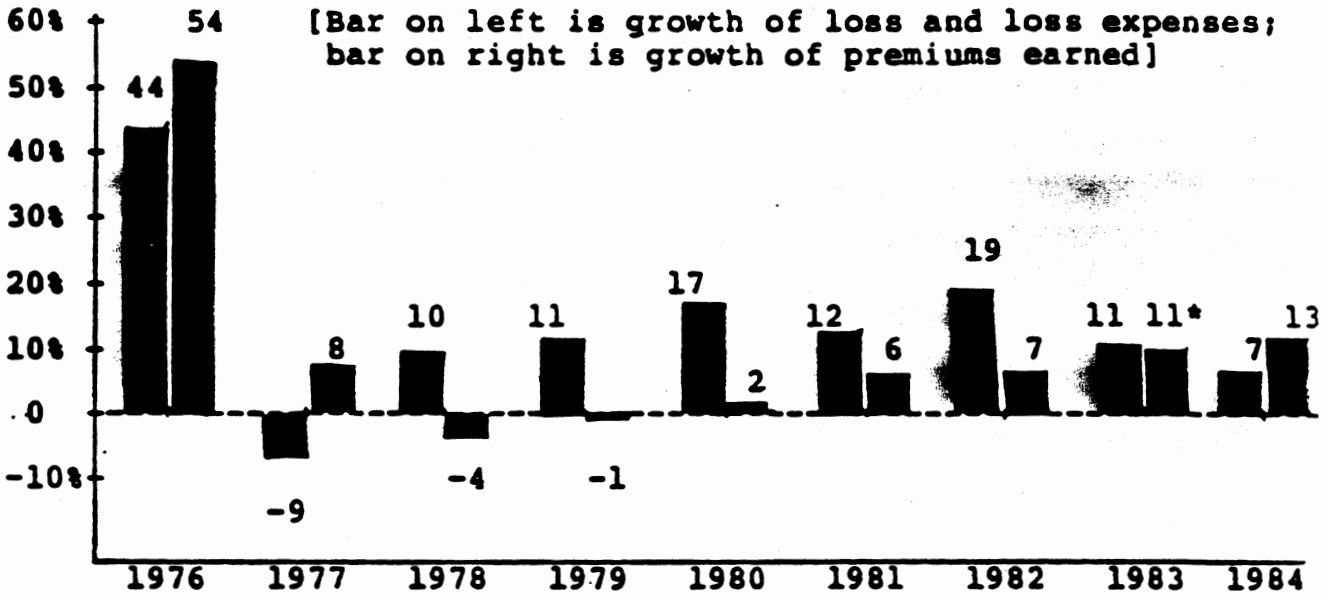
MEDICAL MALPRACTICE
(1976 = 100)



The odd news, from an underwriting perspective, that 1984 was the first year since 1977 that the growth in premiums earned kept up with incurred loss and loss expenses is revealed by the following graph.

(58) Danzon, P.M., "Why Are Malpractice Premiums So High, Or So Low," Rand Corporation 1978, p. 3.

RATE OF GROWTH - 1976-1984 (59)
EARNED PREMIUMS AND INCURRED LOSS AND LOSS EXPENSES



* - Because the figures are rounded for purposes of the graph, the do not reflect that, in 1983, incurred loss and loss expense rose by 11.12%, while premiums rose only 11.07%.

This failure of insurers to adequately raise premiums to keep up with losses year after year has put insurers further and further behind the normal growth of losses from increases in the cost of living. This failure represents industry-wide irresponsibility in underwriting. As the President of the Continental Corporation recently said:

> "The proper role of the underwriter, as opposed to the recent tendencies of malpractice insurers, is "properly evaluating risk and avoiding the temptations of the marketplace that divert the underwriter's attention from the bottom line." (60)

(59) Best's Aggregates & Averages, 1979-1984; Best's Casualty Loss Reserve Development, 1979-1984.
(60) John Bretherick, Jr., President, Continental Corp., in an interview in "Property/Casualty Executives Speak Out," 85 Best's Review, Property/Casualty Insurance Edition 18, 19 (July 1985).

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As long as investment income was relatively high, the industry did not have to face the consequences of its underwriting practices. However, as interest rates dropped the past two years, reducing the yield of the industry's investment portfolio, the cumulative effect of this poor underwriting caught up with insurers, inducing them to begin to raise rates. The steepness of recent rate hikes reflects, then, not just a return to proper ratemaking, but an overcompensation for past underwriting errors. As one industry observer recently commented:

> "The insurance companies themselves have exacerbated the malpractice crisis. The high investment yields of the early 1980's and the influx of new carriers led to continued price- cutting. In late 1984, and particularly in 1985, the strong dollar reduced the amount of insurance and reinsurance capacity available from London, and emerging losses in the U.S. finally forced companies to raise premiums." (61)

Thus are insurance "crises" created: overly competitive and fiscally careless insurers, virtually unregulated and untaxed, keep premiums low during times of high investment yield, only to be forced to overcompensate with enormous premium increases and limited or non-existent underwriting in riskier lines. All in the name of a non-existent increase in losses.

(61) Posner, J.R., Marsh & McLennan, "Trends in Liability Insurance," Abstract from Presentation at National Medical Malpractice Conference, The Urban Institute (February 21-22, 1985).

SECTION FOUR

THE MEDICAL CARELESSNESS PROBLEM

As has always been the case, the fundamental cause of medical malpractice claims is medical carelessness. While, by and large, the quality of health care in this country is the finest in the world, a few health care providers are causing too many serious injuries to health care consumers, while the rest of the medical profession and taxpayers are left with the bill. With the exception of the tort system, there are too few effective mechanisms to discipline this small percentage of frequently careless doctors and hospitals.

It is clear from the evidence that there is substantially more medical negligence than there are malpractice suits. Various studies have indicated that as many as ten percent, or 50,000, of America's doctors are impaired, or unable to practice medicine with reasonable skill because of physical or mental illness, or excessive use of drugs or alcohol. (62) A study included in the Report of the Secretary's Commission on Medical Malpractice revealed that only one in every fifteen severe injuries resulting from medical negligence led to malpractice claims. (63) Similarly, a Rand Corporation study found that "at most one in ten incidents of malpractice result in a claim, and of these, less than half, or one in 25, receive payment". (64)

Economists have likewise made it clear that the problems of malpractice are fundamentally medical, not legal:

> "[F]actors specific to malpractice have significant explanatory power, whereas measures of litigation in general have little." (65)

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(62) "Impaired Physicians: Medicine Bites the Bullet," Med. World News, July 24, 1984.
(63) Pocincki, L.S., et al, "The Incidence of Iatrogenic Injuries," Appendix, Report of the Secretary's Commission on Medical Malpractice (DHEW Publication No [OS] 73-89), Washington, D.C., Government Printing Office, 1973, pp. 50-70.
(64) Danzon, P.M., Ph.D., "An Economic Analysis", supra at fn (10).
(65) Danzon, P.M., "Frequency and Severity" supra, p. 36.

It is a relatively small group of doctors that both is responsible for a disproportionate number of claims paid and is costing the malpractice system a disproportionate amount of money. A recent study of Pennsylvania's experience revealed that as few as ten hospitals are responsible for a very large portion of malpractice losses in that state. (66) In Pennsylvania, 1% of the doctors have been responsible for over 25% of the payments out of that state's excess liability fund since it was created in 1976. (67) This pattern also shows up in those high-risk specialties recently faced with the highest premiums: in Pennsylvania only one-in-ten neurosurgeons and one-in-twenty-five orthopedic surgeons account for about half of the excess liability payments. (68) Further evidence that it is a relatively small group of physicians that are responsible for the bulk of malpractice is that one-fifth of obstetrician/gynecologists have been sued three or more times, while two-thirds have been sued zero or one times in their entire career. (69) These "repeaters" have a substantial impact on losses paid. A closed claims study released in 1983 by Florida Insurance Commissioner Gunter revealed that, from 1975 through 1982, a group of "repeaters" comprising only 0.7% of the total number of Florida physicians were responsible for 24% of the claims in which indemnity payments were made. (70) A four-year California study reveals similar findings: 0.6% of the 8,000 Los Angeles area physicians studied accounted for 10% of all claims and 30% of all payments. (71)

One of the primary causes of the high incidence of malpractice among a relatively small number of health care providers is the general lack of self-discipline by the medical profession, both by hospital peer-review panels and by state medical disciplinary boards. A recent article in the New England Journal of Medicine declared that the "claim that the [medical] profession can be trusted to discipline members on the rare occasions when misconduct has occurred is ... no longer acceptable to society." (72)

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(66) Hoflander, A., and Nye, B., "Medical Malpractice Insurance In Pennsylvania," Management Analysis Center (1985) p. xviii.
(67) Id., pp. xx., 75.
(68) Id., xx.
(69) ACOG, supra at Table 31.
(70) Florida Closed Claim Study, supra.
(71) Ferber, S., Sheridan, B., "Six Cherished Malpractice Myths Put To Rest, 52 Medical Economics 150 (1975).
(72) Feinstein, R.J., M.D., "Special Report: The Ethics of Professional Regulation," 312 The New England

According to a report issued by the Oversight and Investigations Subcommittee of the United States House of Representatives Committee on Interstate and Foreign Commerce. One of the findings of that report was that professional standard review organizations entrusted with the responsibility of measuring care at hospitals were not fulfilling their responsibility. (73)

State medical disciplinary boards are likewise generally ineffective in weeding out doctors who are a threat to society. In 1983, 22 states reported fewer than one serious disciplinary action per one thousand doctors. (74) New York is one such state, taking serious disciplinary action against fewer than one of every 2,000 physicians in that state. (75) As one physician put it,

> "It is difficult to believe that in any given year any state or territory would not have at least one physician per thousand who posed a threat to the health and safety of its citizens. (76)

Because the Federation of State Medical Disciplinary Boards does not have national figures on the number of disciplinary actions taken against doctors "quality of care" issues, we have only glimpses of individual state experiences. However, from the few states about which we do have information comes one disturbing truth: state medical disciplinary boards are inadequate when it comes to protecting the public from frequently careless doctors.

In 1977 and 1978, among the approximately 48,000 physicians in Michigan, Ohio, and Pennsylvania, only 189 were disciplined for "quality of care" violations. (77)

Journal of Medicine 801 (March 21, 1985).
(73) Surgical Performance, Necessity and Quality," Oversight and Investigations Subcommittee of the United States House of Representatives Committee on Interstate and Foreign Commerce, December, 1978.
(74) Wolfe, Sidney M., M.D., Bergman, Henry, and Silver, George, M.D., "Medical Malpractice: The Need For Disciplinary Reform, Not Tort Reform," Public Citizen Health Research Group, 1985 (data from the Federation of State Medical Disciplinary Boards of the United States).
(75) Id.
(76) Feinstein, supra, p. 803.
(77) Statistical Abstract, p. 110; "Expanded Federal Authority Needed To Protect Medicare And Medicade Pa-

Recent articles in the Philadelphia Daily News, the Milwaukee Journal, the Cleveland Plain Dealer, and the Detroit Free Press explored the effectiveness of the medical disciplinary boards in Pennsylvania, Wisconsin, Ohio, and Michigan, respectively, and all concluded that the boards were entirely inadequate in affording protection from dangerous doctors. (78)

Likewise are California doctors seldom disciplined by that state's disciplinary board. Testimony last year by a Duke University economist indicated that in 1976 there were 1,500 paid malpractice claims in California, but only six disciplinary actions for quality of care violations. (79)

In the State of Washington, with over a 30% increase in the number of licensed physicians between 1976 and 1981 and an approximate 400% increase in the number of referrals to the State Medical Disciplinary Board, not one physician's licensed was revoked in 1981. (80)

What are the reasons medical disciplinary boards do not adequately discipline physicians? Recently, the U.S. General Accounting Office surveyed medical disciplinary boards with regard to the adequacy of their disciplinary capability, particularly regarding doctors who had been disciplined in other states. The primary reasons these boards gave for inadequate discipline were:

> "--The state licensing board was not informed or was not informed in a timely manner of the other state's action.
>
> "--The state licensing board did not have sufficient staff to handle the number of cases involved.

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tients From Health Practitioners Who Lose Their Licenses," U.S. General Accounting Office, GAO/HRD-84-53 (May 1, 1984), p. 22.

(78) Rodden, B., "Who's Watching the Doctors", Philadelphia Daily News, February 19-22, 1985; Fee, Walter, "Bad Doctors Can Pay Up Quietly, Keep Licenses," Milwaukee Journal; "Bad Doctors/License to Err?" Detroit Free Press (April 1-8, 1985); Webb, G., "Doctoring the Truth," The Plain Dealer (April 7-13, 1985).

(79) Danzon, P.M., July 10, 1985 testimony, supra.

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

"--State licensing law did not permit taking sanctioning action based on another state's action.

"--Due process requirements stretched out the sanctioning process.

"--A combination of two or more of the above reasons resulted in the lack of or delay in action." (81)

Thirty-one states have no laws requiring that insurance companies or courts inform the board about malpractice cases. (82) Fewer than twenty states have approved legislation allowing disciplinary action to be taken against a physician in one state on the basis that he was disciplined in another state. (83)

A sub-issue of doctor discipline is the requirement of continuing education of physicians. Only about half of the states require continuing education as a condition of relicensure. (84) While there is no guarantee that such a requirement will reduce iatrogenic injuries, there evidence that it can improve performance. (85)

Apparently, one cause of the ineffectiveness of some state medical disciplinary boards is the dominance of doctors on the board. One study indicated that disciplinary boards dominated by non-physicians are significantly more effective than those without such dominance. (86)

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(81) "Expanded Federal Authority Needed To Protect Medicare And Medicade Patients From Health Practitioners Who Lose Their Licenses," U.S. General Accounting Office, GAO/HRD-84-53 (May 1, 1984), pp. iv., 14-16.
(82) Rodden, supra, p. 2.
(83) Statement of R. Thomas Carter, Louisville, Kentucky, Legal Counsel, Kentucky State Board of Medical Licensure, Hearing Before the Special Committee On Aging, United States Senate, Ninety-Eighth Congress Special Session (May 1, 1984), on "Protecting Medicare and Medicaid Patients From Sanctioned Health Practitioners, p. 44.
(84) Derbyshire, R., "How Effective is Medical Self-Regulation?", 7 Law & Hum. Behav. 193, 200 (1983).
(85) Id.
(86) Dolan & Urban, "The Determinants of Effectiveness of Medical Disciplinary Boards: 1960-1977," 7 Law & Hum. Behav. 203 (1983).

Whatever the causes of inadequate discipline, it is clear that (1) a great deal needs to be done to upgrade the system by which incompetent or frequently careless doctors are disciplined, and (2) progress in this area of physician discipline would reap substantial benefits in terms of reducing malpractice losses.

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

> "By finding fault and assessing damages against the negligent provider, the system sends all providers a signal that discourages future carelessness and reduces future damages." (87)

When the tort system is viewed in this deterrent context, as opposed to nothing more than a system of compensation, its beauty and utility becomes more apparent:

> "[L]itigation, beyond providing a means to redress the loss and suffering caused by carelessness, signals potentially negligent individuals that it will cost them more to be careless than to invest in an appropriate level of prevention. ... The malpractice system exists to discipline the occasional physician who does not (or cannot) protect his patients." (88)

This deterrent aspect of the tort system, besides providing a measure of protection for the health of health care consumers, provides an important economic benefit to society:

> "The real cost of malpractice -- the injuries that occur due to medical negligence -- exceeds the visible costs of the malpractice system. Although we cannot measure the deterrence benefits of the malpractice system

(87) Schwartz, William B., M.D., and Komesar, Neil K., J.D., Ph.D., "Doctors, Damages and Deterrence," 298 New England Journal of Medicine 1282 (June 8, 1978) (From the Rand Corporation, Santa Monica, California).
(88) Id., pp. 3-4.

precisely, rough estimates suggest a 20%-30% reduction in the incidence of negligent injury would justify the costs of operating the fault-based system." (89)

Several conclusions can thus be drawn from the evidence on medical negligence and the discipline of health care providers:

The root cause of malpractice claims is malpractice. In fact, malpractice claims represent only the tip of the iceberg of injuries caused by medical carelessness.

A very large proportion of this careless medicine is practiced by a very small number of doctors and hospitals.

The medical profession has done a very poor job of protecting the health and safety of the public from these few practitioners.

The tort system provides an effective deterrent to the careless practice medicine, a protection which, particularly in light of the lack of other protections, is well worth retaining.

(89) Danzon, P.M., "Evaluation of the Current Malpractice System, Abstract" for presentation at National Medical Malpractice Conference, The Urban Institute (February 21-22, 1985).

CONCLUSION

There is a problem with medical malpractice. It is not, however, what the medical-insurance complex claims it is, overly litigious citizens obtaining excessive verdicts against innocent doctors. The problems are fundamentally those of the insurance industry and of the medical profession: both fields must uphold their responsibility to the consumers of health care far better than they have so far. The stripping away of legal rights from victims of medical carelessness has not worked (90), and can never be expected to work: so-called tort "reform" does not address the true problems of medical carelessness. Until this basic truth is understood by all of us, voters, public officials, and professionals, we shall continue to pursue solutions which offer not only the false hope of solving the important problems which face us, but the threat of serious erosion of valuable legal rights upon which our system of justice has been based.

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(90) Sloan, Frank A., ""State Responses to the Malpractice Insurance Health Politics, Policy and Law 629 (Winter 1985). Professor Sloan concludes from his regression analysis of the impact of tort "reform" on premiums that there is "no indication that individual state legislative actions, or actions taken collectively, have had their intended effects on premiums." Page 643.

GLOSSARY

CLAIM-a demand to recover under an insurance policy for loss covered by that policy.

EARNED PREMIUMS-the portion of the premium which is the property of the insurance company, based on the expired portion of the policy period.

INVESTMENT INCOME-the portion of a company's income which is derived from its investments, including interest and dividends on stocks and bonds.

LIABILITY-an legally enforceable obligation.

LOSS-the basis on which an insurance claim is submitted and/or paid.

LOSS AND LOSS EXPENSES INCURRED-an insurer's estimate of the losses and losses incurred (but not necessarily yet paid) in a given policy year.

MALPRACTICE INSURANCE-coverage for a professional practitioner, such as a doctor or a lawyer, against liability claims resulting from alleged malpractice in the performance of the insured's services.

OCCURRENCE YEAR-the year during which the coverage of an insurance policy is effective. Under an "occurrence policy," any actions which occur during an occurrence year, whether the claim for injury from that occurrence is brought that year or in later years, is considered to be within the occurrence year covered by the insurance policy. Contrast with a "claims made policy" which provides coverage only if the claim is brought within the effective year of the policy.

POLICY-a contract of insurance.

POLICYHOLDER-a person who pays a premium to an insurance company in exchange for insurance protection provided by a policy of insurance.

PREMIUM-the sum paid for an insurance policy. Net Premiums Written represent premium income retained by insurance companies, direct or through reinsurance, less payments made for business reinsured. Direct Written Premiums are amounts actually paid by policyholders.

RATE-the pricing factor upon which the insurance buyer's premium is based.

REGULATION-supervision of business practices by a governmental entity.

REINSURANCE-assumption by one insurance company of all or part of a risk undertaken by another insurance company.

RESERVE-(1) An amount representing actual or potential liabilities kept by an insurer to cover obligation to policyholders. (2) An amount allocated for a special purpose. Note that a reserve is usually a liability and not an extra fund. On occasion a reserve may be an asset, such as a reserve for taxes not yet due.

RISK-the chance of a loss. Also used to refer to the insured or property covered by a policy.

TORT-a wrongful act, resulting in injury or damage, on which a civil action may be based. Does not apply to a breach of contract.

UNDERWRITING-the process of selecting risk for insurance and determining in what amounts and on what terms the insurance company will accept the risks.

UNEARNED PREMIUMS-the portion of a premium a company has collected but has yet to earn becaused the policy still has unexpired time to run.

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Testimony
Medical Malpractice
Senate Judiciary Committee — October 31, 1985

For the second time in a decade, the medical profession and its insurance industry are telling the Legislature that because of a "crisis" in medical malpractice insurance rates, it is necessary to drastically alter our court system and severely limit the rights of the victims of medical malpractice from holding accountable negligent physicians.

The facts are that a "crisis" exists only in the minds of the medical profession and its representatives. The facts demonstrate otherwise. According to the medical professions' own surveys, the average New Jersey doctor paid $6,700 for malpractice insurance in 1983. This was approximately 4% of their gross income. It was also approximately the same amount of money that doctors spent on professional car upkeep. (See Chart Attached).

It should also be noted that the entire cost of medical malpractice insurance amounts to approximately one-half of one percent of the health care dollar.

Furthermore, there were only five jury verdicts in malpractice cases that exceeded $500,000. We ask the same question that was asked in the Star-Ledger article "There Is No Need To Hit Panic Button On Malpractice Reform", June 27, 1985, "Where are the multi-million dollar awards that are supposed to be the par for the course in malpractice?"

We bring these facts to your attention merely to put in context the discussion on the proposed legislation to remedy the alleged "crisis". The facts certainly do not demonstrate the necessity to drastically limit the rights of the victims of malpractice, such as placing a cap of $100,000 on pain and suffering damages. All other similar bills that restrict the rights of malpractice victims must be viewed in the context of what Robert Hunter, Former Federal Insurance Law Administrator and now head of the National Insurance Consumer Organization, and Ralph Nadar call, "a manufactured crisis". The State Bar Association, therefore, asks you to look critically and skeptically at self proclaimed cries of "crisis" when reviewing the legislation proposed by the medical profession.

The New Jersey State Bar Association vigorously opposes S-1112, which limits damages for pain, suffering and loss of quality of life to $100,000 in all personal injury and wrongful death actions. It should be noted that this

legislation applies to all personal injury actions, not just medical malpractice cases. A cap of $100,000 hurts those that have been most severely injured. Those suffering catastrophic injury or death because of the negligence of a doctor or another will arbitrarily have their awards reduced. This is just plain unfair.

The legislation also has the perverse affect of rewarding those that cause the greatest harm by limiting their liability. A cap of $100,000 has no relation whatsoever to the nature and severity of the injuries, but merely seeks to limit the liability by placing an arbitrary cap on damages.

The State Bar Association believes it is unreasonable to limit an injured person's lifetime pain and suffering damages to $100,000 to benefit a doctor who makes more than that in a single year. This onerous provision clearly revictimizes the victim once again.

Finally, it is important to note that a judgment against the defendant doctor only comes after a judge or jury has determined that the victim has proven that the doctor was negligent, and did not adhere to the standard of care necessary. The State Bar Association believes that once negligence is proven the victim should be made as whole as possible. In many cases, the innocent victim's life will never be the same. The victim should at least be able to recover all the damages that a judge or jury says is owed to him/her and not have it arbitrarily reduced to $100,000.

Similarly, the Association opposes S-1135, which reduces the personal injury award of the victim because of the negligence of the doctor by the amount of any health insurance, disability income or government entitlement benefits received by the victim. This too applies to all personal injury cases, not just medical malpractice. The bill lets the negligent doctor or driver escape or limit the consequences of his negligence because of the fortunate circumstances that the victim has ensured himself. To point out the inequity of the bill, it would require that the award against the negligent doctor be reduced by the amount of social security disability payments that the plaintiff receives because of his disability. We do not believe that the negligent doctor's liability should be reduced because of social security disability benefits for which the injured party has paid taxes.

Furthermore, in those instances where people have purchased disability income protection, it is inequitable to reduce the liability of the negligent defendant because of this. The plaintiff in such cases has paid hefty premiums for many years to obtain this benefit. It would be a windfall to the negligent doctor to reduce his liability because of the foresight of the victim in protecting himself by buying a disability policy.

Furthermore, most personal injury awards are generally for pain and suffering damages, not medical payments. Therefore, health insurance payments should not be deducted from the pain and suffering award. What this bill actually does is shift the cost for being careless from the negligent doctor to the victim or another insurer who has done nothing wrong.

The second major provision of S-1135 requires all awards of $100,000 or more to be paid in periodic payments rather than in one lump sum. The bill requires the periodic payments to be stopped, except for wage loss benefits, if the victim dies during the course of the periodic payment.

The bill does not state that the periodic payment shall include the payment of interest in future years to compensate for inflation. The bill, therefore, is actually a large reduction of the award. Mandatory periodic

payments may also fail to ensure the necessary flexibility to pe mit the victim to meet the future costs of medical expenses. The victim, better than the person who harmed him, knows when he will need medical care, particularly in the early years following his injury, and how best to provide for himself and how best to invest his money.

The bill also works another injustice on the victim in that it actually is a large reduction of the award. Currently, juries compute the amount of future damages and discount them to the present value. Consequently, if an already discounted lump sum judgment is phased in through a periodic payment plan, the award will have been cut again.

The Association views as outrageous the section of the bill that would terminate all portions of the award in the future, except for income loss, if the victim dies during the course of the periodic payment. This has the affect of almost eliminating the liability of the negligent doctor because of the death of the person whom he injured. Indeed, in many cases the death may have been as a result of the negligence committed by the doctor. The State Bar Association does not believe that the death of the victim should in any way diminish the liability of the defendant. We note that there is no corresponding provision in the bill that should the victim outlive the life expectancy on which the periodic payment is based, the payments would be extended.

Finally, the Association opposes S-1140, which requires the plaintiff in a medical malpractice case to provide the defendant within sixty days of filing the complaint, an expert's affidavit stating that there is a reasonable probability that the care exercised by the defendant fell below acceptable professional standards. The time limitations set forth in this legislation are much too short. For example, if a defendant consumed the entire 45 days provided for in the bill to provide the information, the plaintiff would only have 15 days to gather an expert affidavit. This is impractical. Medical malpractice cases are extremely complex and the ultimate conclusion that negligence occurred is often possible only after examination of all of the circumstances and exchange of interrogatories and depositions.

The requirements in this legislation are extremely burdensome and set up an initial obstacle to using the Courts. Furthermore, the legislation may run afoul of the Supreme Court's powers to determine the time limitations for pleadings and affidavits.

The bill also sets unreasonable standards that an expert must meet in order to testify. The bill is actually designed to limit the pool of available witnesses to testify in medical malpractice cases on behalf of victims. The standards in the legislation limit the availability of esteemed retired physicians who are less susceptible to peer pressure. It also restricts the use of those engaged in general practice as opposed to a specialty.

The Bar Association objects to the bill because it believes that the victim should be able to choose the experts that he or she believes are most appropriate. A judge currently determines whether a doctor is qualified to testify as an expert. This is sufficient protection to ensure the qualifications of experts. This legislation to extend the conspiracy of silence should be rejected.

The State Bar Association believes that all of the above legislation is unjust and serves to arbitrarily hurt the rights of innocent victims to benefit a privileged class of people. The facts do not justify its passage and it should be soundly rejected by the Legislature.

10/28/85

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MEDICAL SOCIETY OF NEW JERSEY

EXECUTIVE OFFICES ☐ TWO PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648 ☐ TELEPHONE 609-896-1766

DR. FIORE

October 23, 1985

Hazel Frank Gluck
Commissioner of Insurance
New Jersey Department of Insurance
201 East State Street
Trenton, New Jersey 08625

Re: Commissioner's Task Force on Medical Malpractice

Dear Commissioner Gluck:

The Board of Trustees has had the opportunity to review the recommendations of the Commissioner's Task Force on Medical Malpractice. Our comments regarding the 14 proposals are as follows:

1. Amend the collateral source rule.

The Medical Society of New Jersey fully supports this recommendation.

2. Restrict the statute of limitations for adults to four years.

The Medical Society of New Jersey gives qualified support to the proposal. We believe a 3-year statute rather than a 4-year statute would be more effective in terms of a favorable impact on rate development, and would not prevent the legitimate claim from being pursued on a timely basis. The exception to fraud and foreign objects unintentionally left would be quite acceptable.

3. Amend the Statute of Limitations for Minors.

The Medical Society of New Jersey fully supports this recommendation.

4. Eliminate a hospital's immunity to suits of more than $10,000.

The Medical Society of New Jersey fully supports this recommendation. All providers of care should be responsible to the same degree and extent for their negligent acts in terms of accountability.

5. Require plaintiffs to file an affidavit of reasonable cause within 60 days of filing a suit.

The Medical Society of New Jersey gives qualified support to this recommendation. We fully support the concept that the affidavit of a specialty board certified physician, in the same medical discipline as the defendant, be required.

6. Institute mandatory arbitration for malpractice cases with claims of $50,000 or less.

The Medical Society of New Jersey fully supports this recommendation. It is our understanding that the arbitration panel will be authorized to dismiss a matter if there has not been a negligent act causing injury.

7. Create a pool of better qualified expert witnesses.

We do not agree with the conclusion that plaintiffs have difficulty finding local qualified experts. This Society has provided the names of expert reviewers to any plaintiff's attorney that has requested them as a matter of record since 1967 and we will continue to do so. The problem may well be that plaintiffs' attorneys are seeking a local physician to support their theory of the case, regardless of the facts. We cannot ask doctors to do anything other than provide an objective review.

We believe that Court Rule 4:21 which is currently voluntary should be reinstituted as a mandatory pre-trial mechanism.

8. Strengthen the State Board of Medical Examiners.

The Medical Society of New Jersey is generally supportive of this proposal. We do believe that a multi-faceted committee to study the best means of achieving the desired goal should be established and chaired by the Insurance Commissioner. The Medical Inter-Insurance Exchange,the Princeton Insurance Company, the Medical Society of New Jersey, the New Jersey Hospital Association, the State Board of Medical Examiners and the Public Advocate should all be represented. The task of strengthening the disciplinary system without unnecessary disruption to the practice of medicine and the prerogatives of the professional liability carriers will require a deliberate and balanced approach.

9. Amend legislation requiring all claims of $25,000 or more be transmitted to the State Board of Medical Examiners.

The Medical Society of New Jersey fully supports this proposal. We recommend that only claims of $100,000 or more be reported to the State Board.

10. Require medical students to take courses focused on ethical, medical-legal issues.

The Medical Society of New Jersey fully supports this proposal.

11. Require continuing education for physicians.

The Medical Society of New Jersey fully supports this proposal. We have a requirement that our members complete 150 hours of recognized continuing medical education every three years.

12. Encourage physicians to better explain all ramifications of a procedure to patients.

The Medical Society of New Jersey fully supports this proposal. It has been part of our ongoing risk prevention effort for several years.

13. Create a special certified malpractice attorney program.

The Medical Society of New Jersey takes no position on this recommendation. Unless the Rules of Court establish that only certified attorneys may file suits, we do not see how any measurable favorable impact will be achieved.

14. Institute a peer review program for lawyers.

The Medical Society of New Jersey favors this proposal and will so advise the Bar Association.

We hope you will consider these additional thoughts: We understand the Task Force protocol was such that topics not unanimously endorsed were not reported. That was unfortunate since we believe three significant areas warrant recommendation.

Structured Settlements

We believe legislation requiring structured settlements in large value cases should be enacted and will have a considerable impact on rate moderation.

Non-Economic Loss

We believe a limitation should be placed on non-economic loss. We are observing an upward spiral of severity in that regard. Newspapers have indicated that large awards against municipalities, physicians, attorneys and manufacturers are collapsing the insurance industry. Recoverable damages for non-economic loss should be limited.

Defense Costs & Attorneys' Fees in Non-Meritorious Cases

The American Bar Association Code of Professional Responsibility provides that lawyers should not file frivolous suits or pleadings.

Federal statutes and rules provide that when a non-meritorious pleading is filed the court, upon motion or its own initiative, may include an order to pay to the party or parties the reasonable expenses incurred because of the filing, including attorneys' fees.

Recently the Second Circuit Court of Appeals issued sanctions against the attorney and his client because it was evident that "no competent attorney, after reasonable inquiry" would reach any other conclusion but that the claim would fail.

We fully recognize that such matters are, in New Jersey, within the purview of either the Supreme Court or the Legislature. We urge you to request the Supreme Court to address this issue. There are too many meritless cases being filed in New Jersey at great expense to all concerned.

The Society thanks you for the challenge and opportunity you have presented to us. We look forward to working with you toward establishing and maintaining an acceptable professional liability insurance market in New Jersey.

Respectfully submitted,

Ralph J. Fioretti, M.D.
President

RJF/jbd

Copies: County Society Presidents
County Society Executive Directors/Secretaries
Specialty Society Presidents
Specialty Society Executive Directors/Secretaries
AMA-HMSS-MSNJ Governing Council

NEW JERSEY ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

1212 STUYVESANT AVENUE
TRENTON, NEW JERSEY 08618-3498
(609) 393-8114

JEROME B. COHEN, D.O., PRESIDENT
ELEANORE A. FARLEY, EXECUTIVE DIRECTOR

My name is Dr. Jerome B. Cohen. I am President of the New Jersey Association of Osteopathic Physicians and Surgeons and represent over 2500 physicians in the State of New Jersey. 75 to 80% are General Practitioners rendering quality health care to the consumer.

On behalf of the New Jersey Association of Osteopathic Physicians, we would like to support the report from the Insurance Commissioner's Task Force on Medical Malpractice. We are fully appreciative of the effort, time and thought that went into the preparation of the report. We do support the 14 recommendations made by the Task Force, fully understanding, that many of them are a result of compromise.

On Item No. 2, we agree that the statute of limitations should be restricted to two (2) years, with a three (3) year absolute discovery clause. We do take absolute exception to Item No. 8. We feel that additional duties should not be imposed upon, nor additional powers given to the State Board of Medical Examiners. We do feel that Item No. 9 should be amended with a considerably higher figure and even consider completely eliminating transferring of any claims to the Board of Medical Examiners.

We also feel that a major consideration would be the addition of:

1. A cap on damages
2. Utilization of periodic payments of settlements.
3. Restrict Punitive damages

We feel these are very important points and certainly should be included in your consideration.

We feel that the continued escalation of malpractice premiums and lack of malpractice insurance to various physicians, has caused a hardship upon patients. There are physicians with a great expertise who are no longer available and there are others who are unwilling to be available because of their exposure. Furthermore, a general adversarial feeling has arisen between physician and patient, which is unhealthy. Knowing that the specter of a suit always exists, many physicians practice defensive medicine, which causes frequent ordering of sometimes unnecessary but very frequently expensive contemporary testing.

We are very pleased that you have given us the opportunity to express our opinions and we will be most happy to continue cooperating in any way we can in the future.

TESTIMONY PRESENTED BY THE NEW JERSEY PHARMACEUTICAL ASSOCIATION
TO THE SENATE JUDICIARY COMMITTEE
OCTOBER 31, 1985

THANK YOU FOR THIS OPPORTUNITY TO PRESENT PHARMACY'S PROBLEMS REGARDING PROFESSIONAL LIABILITY INSURANCE. MY NAME IS ARTHUR TAUB -- I AM A PHARMACISTS AND I AM THE DIRECTOR OF MEMBER SERVICES FOR THE 3,500-MEMBER NEW JERSEY PHARMACEUTICAL ASSOCIATION. OUR MEMBERSHIP IS COMPOSED OF APPROXIMATELY 1,000 PHARMACY OWNERS, WITH THE BALANCE OF OUR MEMBERSHIP BEING EMPLOYEE PHARMACISTS.

I UNDERSTAND THE PURPOSE OF THIS HEARING IS TO TRY AND PREVENT A CRISIS SITUATION REGARDING PROFESSIONAL LIABILITY INSURANCE FROM DEVELOPING IN NEW JERSEY. UNFORTUNATELY, THAT CRISIS SITUATION IN THE PRACTICE OF PHARMACY DID OCCUR ON OCTOBER 1ST OF THIS YEAR AND IS SERIOUSLY AFFECTING BOTH PHARMACY OWNERS AND EMPLOYED PHARMACISTS.

OUR ASSOCIATION HAS ALWAYS ENCOURAGED EMPLOYEE PHARMACISTS TO CARRY THEIR OWN PERSONAL PROFESSIONAL LIABILITY INSURANCE IN ADDITION TO BEING NAMED IN THE INSURANCE PROVIDED BY THE THEIR EMPLOYER PHARMACY. OUR EMPLOYEE PHARMACIST MEMBERS WERE OBTAINING THEIR PERSONAL LIABILITY INSURANCE IN TWO WAYS. ONE THROUGH OUR NATIONAL ASSOCIATION, THE AMERICAN PHARMACEUTICAL ASSOCIATION, AND THE OTHER THROUGH THE NEW JERSEY PHARMACEUTICAL ASSOCIATION WHOSE PLAN IS ADMINISTERED BY ASSOCIATION UNDERWRITERS OF AMERICA. THOSE PHARMACISTS WHO WERE INSURED THROUGH OUR NATIONAL ASSOCIATION WERE DROPPED ON OCTOBER 1ST AND CANNOT OBTAIN THEIR OWN PROFESSIONAL LIABILITY INSURANCE ANYPLACE. IN LATE SUMMER, ASSOCIATION UNDERWRITERS OF AMERICA ANNOUNCED THAT THEY WOULD NO LONGER BE ABLE TO SUPPLY PERSONAL PROFESSIONAL LIABILITY

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INSURANCE BEGINNING OCTOBER 1ST, BUT THEY DID RESPOND TO THE GOVERNOR'S ORDE AND WILL CONTINUE THOSE POLICIES ALREADY IN EFFECT FOR ONE MORE YEAR HOWEVER, THEY WILL NOT PICK UP ANY NEW APPLICATIONS.

PHARMACY OWNERS ARE FACING A MUCH MORE DIFFICULT SITUATION. PHARMAC OWNERS BUY CASUALTY INSURANCE WHICH INSURES FOR ALL ASPECTS OF THEI BUSINESS -- FIRE, THEFT, PROFESSIONAL LIABILITY, BUSINESS INTERRUPTION, AN SO FORTH. SOME INSURERS, AS THESE POLICIES COME UP FOR RENEWAL, AR ABSOLUTELY REFUSING TO RENEW AND ARE SIMPLY ABANDONING THESE PHARMACY OWNERS OTHER INSURERS ARE DEMANDING 100% INCREASES IN THE PREMIUM FOR RENEWAL THOSE FEW INSURERS THAT ARE STILL WRITING THESE OVERALL POLICIES ARE NO LOOKING FOR NEW BUSINESS AND ARE REFUSING TO PICK UP THOSE PHARMACY OWNER WHO WERE ABANDONED BY THEIR ORIGINAL INSURERS.

IN THE PAST YEAR, WE HAVE ATTEMPTED TO IMPROVE AND ALSO REPLACE TH POLICY FOR OUR PHARMACY OWNERS CONCERNING LIABILITY. IN BOTH INSTANCES W WERE PROMISED PROPOSALS BY HIGHLY REPUTABLE FIRMS WHICH AT THE VERY LAS MINUTE WERE WITHDRAWN. IN ONE INSTANCE, WE ACTUALLY HAVE A LETTER OF INTEN FROM THE COMPANY TO DELIVER A PROPOSAL, BUT THEY DECIDED NOT TO DO SO A THESE CHANGES WERE TAKING PLACE IN THE MARKETPLACE ALMOST ON A REVOLUTIONAR BASIS.

IN OTHER WORDS, THE CRISES SITUATION THAT THE OTHER HEALTH CAR PROFESSIONALS ARE LOOKING AT DOWN THE ROAD HAS ALREADY ARRIVED FOR PHARMAC IN THIS STATE. THE IMPLICATIONS OF NOT BEING ABLE TO OBTAIN PROFESSIONA LIABILITY INSURANCE FOR PHARMACISTS ARE ENORMOUS. I CANNOT ACCURATEL PREDICT THE RESULTS THAT THIS CRISES MIGHT HAVE ON THE PRESCRIPTION DRU CONSUMERS OF NEW JERSEY.

OUR ASSOCIATION DOES SUPPORT THE REPORT MADE BY THE INSURANCE COMMISSIONER'S TASK FORCE ON MEDICAL MALPRACTICE, AND WE ALSO SUPPORT THI

SEVERAL BILLS CURRENTLY BEING CONSIDERED BY THIS COMMITTEE. WE WOULD ASK THAT SENATE BILL 1079 BE AMENDED TO SPECIFICALLY INCLUDE PHARMACISTS. WE WOULD ALSO ASK THAT PHARMACY, SPECIFICALLY CHAPTER 14 OF TITLE 45 OF THE REVISED STATUTES, BE SPECIFICALLY WRITTEN INTO SENATE BILL 1140.

WE DO BELIEVE THAT THE ONLY RESOLUTION TO THIS VERY SERIOUS PROBLEM IS THROUGH LEGISLATIVE ACTION AND WE ARE WILLING TO WORK WITH THE DEPARTMENT OF INSURANCE AND THE LEGISLATURE IN ARRIVING AT THAT RESOLUTION.

THANK YOU FOR ALLOWING ME TO PRESENT PHARMACY'S PROBLEMS ON THIS ISSUE AND I SINCERELY HOPE FOR AN EARLY RESOLUTION.

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Senators,

My name is Joseph Sturtz. I am a resident of the State of New Jersey. I have a personal interest in medical malpractice for two reasons, 1) prior to my present employment, I was a surgical orderly, and 2) I have filed suit against a physician for medical malpractice in another state.

My situation is somewhat unique, because of my experience. I,ve been a first hand observer in the operating room as well as the recipient of an alleged malpractice. I can assure you that the problems concerning medical practice at this time is like an iceberg the size of the United States, without a tip above the surface.

In first addressing the present proposed bills, I'd like to read a letter that I found on the editorial page in the Asbury Park Press not too long ago, that was written by Russell S. Kussman of Glendale, California. Mr Kussman holds a medical degree, and also practices law.

WHY SHOULDN'T PHYSICIANS PAY FOR MISTAKES LIKE THE REST OF US????????????????

Last month a Los Angeles jury awarded Harry Jordan $5.2 million dollars in damages because doctors took out the wrong kidney by mistake-- leaving a tumor the size of a basketball in his remaining kidney. Most of the jury' s award was provided to compensate Mr. Jordan for the unnecessary pain, suffering and emotional distress.

The day before the jury reached its verdict, the California Supreme Court upheld a statute that limited damages for pain and suffering to a maximum of $250,000. Harry Jordan and his wife were therefore awarded nearly $5 million less than the jury found they were entitled to.

Is this a just result? To decide, one must look at the reason for medical malpractice suits. A basic tenet of civilized society is that each of us is responsible for our own wrongs. If we injure someone through our own negligence, we must accept the consequences . This applies to all--- doctors, businessmen, truck drivers, drug manufactures and lawyers alike. Our system of civil jurisprudence, for the most part, mirrors this philosophy. Liability is based on fault.

We tend to forget that, no matter how serious an injury, a doctor, or other health care professional, is not held legally responsible unless the injury is caused negligently. Unless the doctor violates the standard of care set by his own colleagues he cannot be held responsible, and liable.

Consistant with the axiom that each citizen is responsible for his own wrongs, is the maxim that "for every wrong there is a remedy." Lawsuits remain the socially acceptable means to resolve disputes. A jury determines whether an injured patient has a legitimate claim for medical malpractice and, if he is entitled to a remedy, how much to award.

In 1975, however, insurance companies proclaimed a "medical malpractice crisis." Juries were allegedly awarding higher verdicts for victims; insurance companies profit margins fell. They began to raise rates; some left the medical insurance business. Doctors were caught in the hysteria and some threatened to "go bare"- practice without insurance- while others threatened to quit. There was talk of a shortage of medical services.

As one who was then practicing medicine, I thought the doctors reaction somewhat strange. Would Physicians, typically making more than $100,000 per year , stop practicing the most highly paid, highly respected profession, simply because they had to pay an average of 3% of their annual income for malpractice insurance.- a cost they could pass along to patients in any event? Obviously not .
Nonetheless, then-Govenor Edmund G. Brown Jr. called an emergency special session of the Legislature to deal with the "CRISIS." Under heavy pressure from the most potent lobbies in Sacramento- and with little public debate- the Legislature passed the Medical Injury Compensation Reform Act.

This law limits the amount of damages a plaintiff can receive for pain, suffering and emotional distress to a $250,000 maximum. MICRA also provides that if the plaintiff was prudent enough to have purchased his own health insurance, then the doctor's insurance company is entitled to an set-off for those amounts. Finally, the law severly limits the amount of fees a plaintiff can pay his attorney, thus discouraging some good attorneys from accepting medical malpractice cases. At the same time there is no on the amount that insurance companies can pay their defence attorneys.

Suddenly, the potential defendant --the alleged wrongdoer-- was dictating the rules of the game. The insurance companies had stood the problem on its head. They turned the victim into the wrongdoer, blaming medical malpractice suits on plaintiffs rather than the negligent health care providers.

The most outrageous effect, to date, is the Jordan case, with its arbitrary limit of damages- despite the express finding of the jury. Somehow, in the case of medical malpractice, we must now abandon the jury"s decision. It has suddenly become too cumbersome.

An important function of malpractice suits is to deter the careless practice of medicine. MICRA runs a real risk of crippling society's best check on the negligent practitioner. It provides short term savings for the insurance industry but may impose unacceptable long-term costs for the rest of society.

The Legislature should immediately repeal MICRA, and the govenor should appoint a broad-spectrum , blue-ribbon committee to study medical malpractice, to recommend new legislation within six months-- legislation that will protect the individual's right to a true trial by jury. END

SITES OF INCIDENTS LEADING TO MEDICAL MALPRACTICE

IN HOSPITALS:	PERCENTAGE	
Operating Room	39.7	
Patient's Room	11.9	
Emergency Room	9.8	
X-ray Room	4.2	
Recovery Room	0.7	
Intensive Care Unit	0.6	
Cardiac Care Unit,	0.2	
Unspecified	11.7	
Total Hospital		78.8%
Non--Hospital Sites		
Doctor's Office	18.8	
Patient's Home	0.6	
Nursing Home	0.6	
All Other	1.2	
Total Non--Hospital		21.2%

The preceding table has been agreed upon by all three major studies, 1) the study done by the Department of Health , Education And Welfare, 2) another study done by the statistical arm of the malpractice insurers, the Insurance Services Office (ISO), and a third completed by the National Association of Insurance Commissioners in 1977.

The stastic that most sticks out is the percentage of claims that arise from incidents in the Operating Room. As an ex--surgical orderly I can personnaly tell you that I do not feel that a patient is duly protected from the possibility of medical malpractice. If something happens in the Operating Room, the attending surgeon isn't going to inform you of any foul-ups, espically his; his assistant won't either; neither will the anesthesiologist or the anesthesist, which ever the case may be; nor the scrub nurse or the circulating nurse.. In fact , with you asleep on the table, the medical staff whom you've entrusted your life to, if yoo live, can turn out to be your own worst enemy.

However I feel that there is a solution. With the advancements of video technology, it seems to me that a patients life can be protected by having his or her operation video-taped. This video tape, upon the completion of the surgery, should become the soul property of the patient or his or her guardian..

I might add here that there has been a number of cases where the surgeon that the patient went to, in order for him specifically to do the surgery, turns around and lets another surgeon operate, while the fee is divided in some proportion amongst both surgeons.

Senators, I have been a chessplayer for the last twenty years. If its one thing that Chess has taught me, its that in order to make a decision you have to be completely objective. I, in my situation, working with doctors as well as filling a suit against one, have had to do some reading into this medical malpractice mess. Many years ago I came across a book entitled "THE MALPRACTITIONERS" written by John Guinther.

I have found this book to be the most objective work that I have ever found on medical malpractice. In this book I found that the American public has not been properly informed of the actual rate of medical malpractice committed as opposed to the number of medical malpractice claims that are filed.

In 1972 the Department of Health Education and Welfare's Malpractice Commission made a study of two hospitals that were deemed typical of the nation as a whole. It was determined that more than seven (7.6) of every one-hundred people who are admitted to a hospital are injured by the treatment they receive.

In 1975, there were 35million hospital admissions; consequently there would be 2.6 million treatment related injuries. In 1975, only 20,000 medical malpractice claims were filed. The only crisis I could see at this time was that not enough patients were filing suit against their malpractitioners.

This 2.6 million figure is a relatively conservative. This figur does not include, for example, patients served by outpatient clinics (175 million in 1977) and office visits or house calls (over 900 million in 1977).

This information is staggering. Before any decision can be made about the proposed bills, I feel that all should read both the REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, And John Guinther's book entitled " THE MALPRACTITIONERS". I feel it will only be then that an objective decision can be made.

There is a definite need for new legislation in order to protect the American citizen. I'm sure everyone has read in the newspapers recently of the number of incidents where people were practicing medicine without a license. It seems to me that the American Medical Association with the computer technology we have today, should be able to prevent these unqualified people from "practicing " on the unsuspecting patient. According to Dr. Robert Derbyshire, a past president of the National Federation of State Medical Boards, five percent of all physicans and surgeons that are in active practice in the United States are definably incompetent. Certainly we could use legislation in this area, requiring and mandating long term prison terms for those people "playing Doctor".

new jersey dental association

PUBLIC HEARING
ON
MALPRACTICE INSURANCE
REFORM

TESTIMONY DELIVERED BEFORE
SENATE JUDICIARY COMMITTEE

OCTOBER 31, 1985

ONE DENTAL PLAZA, NORTH BRUNSWICK, NEW JERSEY 08902 / 201 821-9400

new jersey dental association

MR. CHAIRMAN AND MEMBERS OF THE SENATE JUDICIARY COMMITTEE, I THANK YOU FOR GIVING ME THE OPPORTUNITY TO SPEAK BEFORE YOU TODAY ON THE NEED FOR MALPRACTICE INSURANCE REFORM.

I AM HERBERT DOLINSKY, D.D.S. AN ORAL SURGEON IN PRIVATE PRACTICE IN JERSEY CITY. I AM AN AD HOC MEMBER OF INSURANCE COMMISSIONER HAZEL GLUCK'S TASK FORCE ON MEDICAL MALPRACTICE, AND I AM CHAIRMAN OF THE MALPRACTICE TASK FORCE FOR THE 5000 MEMBER NEW JERSEY DENTAL ASSOCIATION.

THE DENTAL PROFESSION IN THIS STATE IS IN THE MIDST OF A MALPRACTICE INSURANCE CRISIS.

THIS YEAR DENTISTS IN NEW JERSEY EXPERIENCED NEARLY A 400% INCREASE IN THEIR MALPRACTICE PREMINUMS, A 400% INCREASE IN LESS THAN ONE YEAR. THE EXPECTATIONS FOR WHAT NEXT YEAR COULD BRING MAKE ME TREMBLE.

NINETY PERCENT OF THE DENTISTS OF NEW JERSEY ARE IN GENERAL PRACTICE. DURING 1985, INSURED PREDOMINANTLY BY AN AMERICAN DENTAL ASSOCIATION LIABILITY PROGRAM, THEY SAW THEIR PREMIUMS INCREASE FROM $872. TO $3,625. RATES FOR ORAL AND MAXILLOFACIAL SURGEONS WHO FOR MANY PRIOR YEARS EXPERIENCED SUBSTANTIAL INCREASES, WENT IN 1985, UNDER THE ADA POLICY, FROM $8,522 TO $30,896. THESE INCREASES MAY REPRESENT AMONG THE HIGHEST PROPORTIONATE INCREASES EXPERIENCED BY ANY HEALTH CARE PROFESSIONAL IN ONE YEAR IN NEW JERSEY!

ONE DENTAL PLAZA, NORTH BRUNSWICK, NEW JERSEY 08902 / 201 821-9400

THE AVAILABLE DENTAL PROFESSIONAL LIABILITY INSURANCE MARKETS ARE CONTRACTING AND THE PRACTICING DENTIST FACES FEWER AND FEWER OPTIONS. CLAIMS-MADE POLICIES ARE BECOMING THE RULE RATHER THAN THE EXCEPTION, FOR FINANCIAL NECESSITIES.

THESE INCREASES IN PREMIUMS WILL ONLY BE PASSED THROUGH TO THE CONSUMER OF DENTAL SERVICES, MAKING THE HEALTH CARE BURDEN FOR FAMILIES EVEN MORE DIFFICULT. THERE IS EVIDENCE THAT WITHOUT SUBSTANTIAL TORT REFORMS IN NEW JERSEY, DENTAL CONSUMERS CAN EXPECT TO SHOULDER THE EVER INCREASING COSTS OF THEIR DENTISTS PROFESSIONAL LIABILITY COSTS. THE RECORD IS CLEAR. WE MUST REFORM THE SYSTEM TO MAKE IT FAIRER, MORE EQUITABLE, MORE REASONABLE AND CERTAINLY MORE COST EFFECTIVE.

IN DENTISTRY, WE ARE EXPERIENCING SOME INCREASE IN FREQUENCY OF SUITS, BUT AS ELSEWHERE THERE IS A DRAMATIC INCREASE IN THE SEVERITY OF SETTLEMENTS AND JURY VERDICTS IN DENTAL MALPRACTICE CASES. THOUGH SETTLEMENTS HAVE AVERAGED ABOUT $25,000.-$30,000., DENTAL SETTLEMENTS OF $100,000. OR MORE ARE NO LONGER UNUSUAL.

THE NEW JERSEY DENTAL ASSOCIATION SUPPORTS A WIDE RANGE OF CHANGES AND REFORMS THAT WILL IMPROVE THE PROFESSIONAL LIABILITY PROCESS AND IMPROVE THE EQUITABILITY OF THE SYSTEM.

WE SUPPORT PROPOSALS TO AMEND THE COLLATERAL SOURCE RULE AND TO RESTRICT THE STATUTES OF LIMITATIONS FOR ADULTS AND FOR MINORS. WE AGREE WITH PROPOSALS THAT SEEK TO ELIMINATE WEAK CASES AND FOCUS ON CASES WHERE DEMONSTABLE LIABILITY PROBABLY EXISTS. WE PLEDGE VOLUNTARY COOPERATION OF OUR ASSOCIATION IN MAKING BETTER EXPERTISE AVAILABLE TO THE COURT SYSTEM. WE PLEDGE OUR ASSOCIATION TO EDUCATE DENTISTS IN RISK MANAGEMENT, PATIENT RAPPORT AND ETHICAL-LEGAL ISSUES RELATED TO PROFESSIONAL LIABILITY.

WE SUPPORT EFFORTS IN IMPROVING THE EFFICIENCY OF CASE HANDLING AND SCREENING AND THE EFFICIENCY AS WELL AS THE EXPERTISE OF ATTORNEYS INVOLVED IN MALPRACTICE LITIGATION. FOR DENTISTRY IN PARTICULAR, WE SUPPORT REFORM THAT WILL INSTITUTE MANDATORY ARBITRATION FOR MALPRACTICE CASES OF CLAIMS OF $50,000. OR LESS. WE BELIEVE THIS WILL CERTAINLY DECREASE COSTS FOR DENTAL CASES. FURTHER, WE SUPPORT A CAP ON "PAIN AND SUFFERING", PERHAPS AT THE $250,000. LIMIT. IT IS OUR VIEW THAT PLAINTIFFS SHOULD BE ADEQUATELY COMPENSATED FOR LEGITIMATE INJURIES BUT THE SYSTEM CANNOT LONG ENDURE WITHOUT REALISTIC LIMITS. WE ARE OPPOSED TO WINDFALL LEVEL SETTLEMENTS AND AWARDS. STILL FURTHER, WE BELIEVE ALLOWING FOR STRUCTURED MANDATORY PERIODIC PAYMENTS BY INSURANCE CARRIERS TO BE A REASONABLE COST CONTAINING MEASURE.

IN CONCLUSION, WE BELIEVE THE CURRENT MALPRACTICE CRISIS IS REAL AND EXTREMELY WORRISOME. THIS CRISIS INCLUDES THE DENTAL PROFESSION AND THE NEW JERSEY DENTAL ASSOCIATION BELIEVES THAT A TORT REFORM PACKAGE IS ABSOLUTELY NECESSARY FOR THE HEALTH CARE CONSUMERS OF THE STATE.

NEW JERSEY STATE
CHAMBER OF COMMERCE
GOVERNMENTAL RELATIONS OFFICE
240 WEST STATE ST. - SUITE 1518
TRENTON, N.J. 08608 • (609) 989-7888

STATEMENT OF THE

NEW JERSEY STATE CHAMBER OF COMMERCE

BEFORE THE

SENATE JUDICIARY COMMITTEE

ON THE SUBJECT OF

MEDICAL MALPRACTICE REFORM LEGISLATION

PRESENTED BY

PATRICK J. WITMER, DIRECTOR OF LEGISLATIVE AFFAIRS

OCTOBER 31, 1985

It is a pleasure to present the views of the State Chamber of Commerce before the Committee on a subject with which the business community is so strongly concerned.

The State Chamber believes the bills before the Committee this morning - S-1079, S-1112, S-1135 and S-1140 - represent a prudent and responsible effort to reform the medical malpractice laws of our State. The State Chamber strongly supports these proposals.

Testimony has already been presented by industry representatives and medical professionals which demonstrates the urgent need for medical malpractice reform. I will not restate these facts. Rather, the State Chamber wishes to point out to the Committee that the tremendous cost of health care insurance is having a direct impact on the cost of doing business in New Jersey.

Employers in the United States pay about $80 billion in group health care premiums, an amount just about equal to their payments on other health-related items, such as taxes for Medicare and Medicaid, paid sick leave, and compliance with safety and health regulations. About eighty percent of all group health insurance is bought through the workplace, with employers paying about 75 percent of the cost. Clearly, the amount of health care offered to employees and the cost of this health care paid by employers is affected by the rising cost of premiums. The direct relationship here is that as insurance costs rise, the cost of business goes up, and everyone suffers.

With such high costs associated between medical malpractice insurance and employee health care, and because these costs continue to escalate Nationwide, the State Chamber suggests that reform of our medical malpractice laws is long overdue.

The New Jersey business community is exploring many options in an effort to address this situation. Many of our corporations are implementing employee "wellness habits" - paying employees to quit smoking or lose weight - in an effort to reduce their health care costs. But the fact remains, medical malpractice insurance is so high that these efforts cannot solve the problem alone. Smaller companies in particular need help now to hold the line on their health care costs.

Mr. Chairman, the State Chamber of Commerce urges this Committee to act favorably on the four bills being discussed this morning.

Again, thank you for the opportunity to present these views.