(1) New Jersey. (2) Legislature.
III

P U B L I C H E A R I N G

before the

(3) SPECIAL COMMITTEE TO INVESTIGATE AND STUDY
MEDICAL MALPRACTICE INSURANCE.

Held:
Senate Chamber
State House
Trenton, NJ
October 24, 1975

COMMITTEE MEMBERS PRESENT:

Senator Martin L. Greenberg, Chairman

Assemblyman Morton Salkind, Vice Chairman

Senator Garret W. Hagedorn

Senator Joseph L. McGahn

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I N D E X

SENATOR MARTIN G. GREENBERG (Chairman): I'd like to call this hearing to order, please. Will those present, who want to participate, come in and take their seats.

My name is Martin Greenberg. I am Chairman of this special Committee, which is to investigate and study the medical malpractice insurance problem. This Committee was created by Senate Concurrent Resolution 3001.

The Committee, as many of you know, is composed of six members, three Senators and three Assemblypersons. With me today are, on my extreme left, Senator Joseph McGahn; next to Senator McGahn is Assemblyman Morton Salkind, who is the Vice Chairman of this Commission; and on my right is Senator Garret Hagedorn.

In addition to those of us present, the other members of the Commission consist of Assemblyman John Gallagher and Assemblyman Thomas Kean, neither of whom are present at the moment.

Before we begin and hear from our first witness, I'd like to take a few minutes, at the outset, to discuss what I see as the task confronting this Commission. I will also indicate the time schedule and the procedures which we will follow during the hearing.

I think I need hardly state to those here today that there is a medical malpractice problem. All of you are obviously interested in the subject and most of you are directly affected by it.

The first task of this Commission, however, in my opinion, is to attempt to define what is the nature and scope of the problem. One of the most obvious and critical aspects of the problem concerns professional liability insurance for medical practitioners and health care facilities. Since the beginning of the year, there have been three major crises relative to medical malpractice liability insurance in this State.

In the early Spring a number of hospitals were in danger of losing their malpractice coverage when the Argonaut Insurance Company decided to stop writing such coverage in this State. The crisis was resolved when another carrier was found for these hospitals.

Then in June, a second crisis developed when practitioners in several high-risk specialties were in danger of losing their unbrella coverage. The dire consequences which would have flowed from that were averted when another carrier received approval for a rate increase and agreed to write that coverage in the State.

Now, this morning, we are confronted again with an additional crisis. A number of hospitals, I am advised, are in danger of losing their coverage. Their insurer, the St. Paul Insurance Company, has announced that it will not renew the coverage - that coverage - because its request to provide such insurance on a claims-made basis has been denied by the Commissioner of Insurance of this State.

I have a list, which was given to me yesterday, of expiration of insurance for the hospitals affected, most of which fall into the year 1976, but some of which - I think three - are scheduled to terminate this year, commencing, I think, with the month of November - that is one month from now.

In addition to these periodic crises, the number of insurers writing malpractice in this State we know to be very small, and growing smaller. These companies who still write this insurance have been requesting, and have received approval for substantial rate increases. The major insurer of doctors in this State has received approval for a rate increase which approximates 50%.

In brief, we seem to have a major problem with respect to both the cost and availability of medical malpractice liability insurance. It would be fallacious,

however, to assume that the malpractice - medical malpractice - problem is, or is primarily, an insurance problem. To be certain, our doctors and hospitals must have malpractice coverage and the reduced availability of this coverage, and its rapidly increasing cost, must be addressed by this Committee. But we cannot assume that what we are dealing with is essentially an insurance problem.

The State Department of Insurance has extensive regulatory authority over the insurers. Their rates must be approved by the Department before they are used. Unless we are to assume that the Department is not using their authority appropriately and that it has been derelict in carrying out its duties, we must assume that the current rates accurately reflect the experience of the insurers involved and the Department is satisfied that this is the case.

A representative of the Department will be testifying this morning and I would urge him, if this assumption is inaccurate, to correct me. In any event, we expect to have from him a discussion of that aspect of the problem, and I know that there are committee members quite interested in it and they would like to question him about it.

This is not to say, however, that no aspect of the current insurance situation, with respect to medical malpractice insurance, will be studied by the committee. The reserving practices of malpractice insurers and the current reporting requirements may well have to be reviewed.

In addition, it seems that the Commissioner of Insurance will have to be given some type of authority to handle availability crisis in the short term. It does seem clear that we cannot solve the malpractice problem, whatever it is, simply by making changes with respect to malpractice insurance.

Now, if it is not an insurance problem, primarily or exclusively, what kind of a problem is it? What are the underlying causes which have lead to the problem in the insurance area? The cost aspect of malpractice insurace is, of course, directly related to claims experience of the insurers, or should be.

It is alleged that the cost of malpractice insurance is rising because the number of malpractice claims and the dollar amounts involved are rising. Is there sufficient evidence to indicate that this is the case? If so, the cost of malpractice insurance is but a symptom of the problem, although it may be the major symptom with which this committee will have to deal.

Medical malpractice claims arise out of physician/patient contact and it is the physician/patient relationship which is at the core of the problem. Has the physician/patient relationship become so impersonal and deteriorated to such an extent that patients are frustrated and mistrustful and feel that malpractice claims are the only way they can express themselves with respect to the medical care they receive? Have the expectations of patients become so unrealistic that they expect a favorable result from every medical treatment, or to be compensated by way of malpractice claim if the result is unfavorable? If the expectations of patients have become unrealistic, have we, through our legal system, permitted these unrealistic expectations to be visited upon doctors to the detriment of their well-being, and justifiable interests and, more importantly, their ability to deliver medical care?

Or, if there is a rising number of malpractice claims, is that an indication that there is a significent level of malpractice? Is the State Board of Medical Examiners and the medical profession itself doing what is necessary to insure that physicians are, and remain,

competent and that any incompetent physicians are being identified and adequately dealt with? These are the questions with which the Commission must be concerned.

Physicians and patients both have rights which must be respected, and duties which must be recognized. Patients have a right to expect quality medical care, in accordance with the existing standards of the medical profession and an adequate means to recover for any injuries or untoward results from medical care that falls below these standards.

Patients have the duty to realize that medicine is as much an art as it is a science and that all human aliments and injuries cannot be cured and that all medical treatment has varying degrees of risk which must be anticipated and borne by the patients.

Doctors have the right to expect to be able to practice their profession for their own personal, professional, and economic self-interest, as well as for the good of society, in accordance with the standards of their profession, unfettered by unrealistic expectations that they should be guarantors of good health.

Doctors have a duty to uphold the standards of their profession and to render medical care in accordance with those standards and to bear the responsibility for injuries when their treatment falls below the standards.

This Committee will have to determine if the rights and duties of both doctors and patients are being respected and recognized, or if the system has become unbalanced, and the rights of one of the parties have not been fully respected, while the duties of the other side have not been fully recognized.

Consideration of these border issues will involve a number of narrower, specific issues which have been raised in this and other States, as underlying causes of the problem. These issues include: The statute

of limitations for malpractice claims; the extent of liability for practitioners and whether or not it should be limited; the legal doctrines of "res ipsa loquitor" and informed consent; extension of limit of liability of hospitals to their employees; an arbitration and medical malpractice review panel as a means of expediting the claims-handling process; a weeding-out of non-meritorious claims; of avoiding lengthy and expensive litigation; and providing realistic settlements for small claims. These are only some of the issues, more have been raised and I am sure others will be raised today.

All of these issues have to be related to the basic questions concerning the physician-patient relationship and the rights and duties of both.

Hopefully, this will provide you with a brief and a broad overview of what I see as the problem. Today's hearing is the first major activity of this committee and I am hopeful that the hearing will help the committee to further define the problem and identify the issues and areas we must consider.

So far as time is concerned, we will continue this morning until a lunch break, which I trust will be approximately at 1:00. We hope to reconvene at 2:00 and go on until about 4:00. There is a large number of witnesses who wish to testify. Many of you have submitted written reports of your testimony. I would urge you, in an effort to expedite this matter, to not read that statement and report. Assume that the committee members will read it and it will become a part of the record. You may refer to it, hit the highlights of it, and confine your remarks, as much as possible, to not more than ten minutes, for which the committee would be greatful. The committee members will then have an opportunity to question the witnesses and I would appreciate your cooperation in following those suggested procedures.

At the conclusion of this hearing today, I will attempt to schedule another date for a continuation of the hearing.

With that my remarks are concluded and I would ask any of the other members of this committee if they have any remarks to make. Assemblyman Salkind.

ASSEMBLYMAN SALKIND: Mr. Chairman, members of the committee, I certainly agree with everything that the Chairman, Senator Greenberg, has said. I think that the overview is absolutely right and that we are dealing with each of the matters and trying to see how the entire system can be changed for the better.

I would respectfully suggest that all of us keep in mind, as we go through these hearings, that we are not dealing with the word malpractice in its literal meaning; what we are talking about in this entire subject is the doctrine of patient protection. Our concern is to try and make sure that the people of New Jersey are properly protected in terms of being able to receive not only proper health care but, God forbid, in a situation where something adverse occurs, in all respects they are properly protected financially.

That is what it is all about. We are not just talking about the situation where there is a lessening of standards, or an inability to perform to those standards, we are even talking about situations where the physician or the health care facility performs up to the standards in every way, because the nature of the problem is such that difficulties and claims will occur.

Now, I am very concerned with what the Chairman outlined as the recent history of crises and the continuing crisis that is about to occur. I think we are all aware of the fact that not only are several of our hospitals now facing potential cut off of insurance and possible close down but the numbers that are involved in

rate raises that are coming in the State of New Jersey are far in excess of the 50% figure that was recently granted to the major carrier of doctors. The rates are going up not 50% but in some cases as high as 2,000%. I think we are all aware of the fact - or should be - that our own State institution, the College of Medicine and Dentistry in North Jersey, has been threatened with increases totaling $1 million. That is too much. We have to find out the whys and where we are going from here.

The role of this Joint Committee is not just to look at the past but primarily to look towards the future and to solve the problems which are occurring with increasing rapidity, before they continue not only to get out of hand but occur in any way. I appreciate everything the Chairman said and I think he spoke for every one of the members of the committee. Thank you, Mr. Chairman.

SENATOR GREENBERG: Thank you, Assemblyman. Senator McGahn, do you have any comments?

SENATOR MC GAHN: Thank you, Senator. No, in the interest of time I have no comment at this time. I will reserve the time for questioning the witnesses.

SENATOR GREENBERG: Thank you, Senator.

We will then commence with the witness list. Is Assemblywoman Totaro present?

(not present)

We will then take Commissioner Joanne Finley, the Commissioner of the Department of Health.

C O M M I S S I O N E R J O A N N E F I N L E Y: Thank you Senator Greenberg. I have submitted testimony in writing, so I will do as you suggest and just go over the highlights of it and try to answer questions.

I am speaking both as a public health official and as a physician, so my points of view will reflect that.

I would like to compliment both Senator Greenberg and Assemblyman Salkind for a really statesman-like and very

deep overview of the problem.

As I have stated in my testimony - much the same thing that you have stated - there really are four aspects - societal aspects - that we are concerned with. We are concerned with insurance companies and insurance protection to patients and to providers. We are concerned with physicians and health facilities. We are concerned with the legal profession. And we are concerned with some patients who are misinformed or ill advised. So, we have all four of these people to deal with - or groups.

I have suggested, in my testimony -- I would like to support the figures that I have given and just read one section. I think you are all aware that the experience in the Health Department would - and in the rate setting program - give us the most insight into the effect of rising malpractice premiums on hospitals. As you know, at this point, under State statutes, we have very little to do with the private practice of medicine so I cannot comment directly on that. But, based on information drawn from the Health Department's hospital rate setting program I offer the following examples of cost increases - and this is material that has come in with budgets, in budget review.

The Hunterdon Medical Center, for example, experienced a 763% increase in its malpractice insurance premium from 1974 to 1975.

SENATOR GREENBERG: Do you have the dollar amounts?

COMMISSIONER FINLEY: I do not have them with me. I can supply them.

Morristown Memorial Hospital showed an increase of 806%. St. Elizabeth Hospital suffered an increase of 1560%. So, Assemblyman Salkind was not incorrect when he said that it looks like it will be as much as 2000% for some institutions.

West Hudson Hospital, a small general hospital not performing the more sophisticated services that often are called high risk and provided at large medical centers and with a very good record of claims, still incurred a premium increase of 336% and I was informed yesterday that that is one of the hospitals that has depended on St. Paul's.

And, as has been stated - but I will put it in percent - at the teaching hospitals of the College of Medicine and Dentistry of New Jersey, malpractice insurance premiums, paid directly by State Government - which, therefore should concern us all - increased by 241% in the same period.

I have suggested in my testimony - which, again, I will just hit the highlights of - that, with this kind of clear evidence of a problem, the clear right of patients to relief, where they really have been wronged, but also the clear right of professionals to practice without these economic grievances, prompts me to support as a possible solution to problem number one, the insurance companies - the legislation that Commissioner Sheeran proposed and you introduced and that I think passed the Assembly - is that correct?

ASSEMBLYMAN SALKIND: It has passed both houses.

COMMISSIONER FINLEY: That, I think, is an extremely good and valid approach to the monopoly and possibly abusive practices of the insurance aspect.

I do think, though, that we need to go further and I think this is the purpose of your inquiry. I think that - as I have detailed in my testimony - a board of inquiry or an arbitration process is very necessary for the sorting - and the medical word is "triaging" of complaints. I think it would be intersting to look into - as we are, on the executive side, and as is done in many countries in Europe - even a public sort of trust fund, with all of the attendant sorting processes of arbitration, or inquiry, etc. I do feel that the board of inquiry, or

arbitration panel kind of concept can have a marked influence on the frivolous - I tend to call it - claim. Even though you cannot leave out the courts, or due process in the United States - since that is our style of life - I think it would tend to cut down on the number of claims filed and probably on the rather huge size of some awards.

So, that is the general gist of my remarks.

SENATOR GREENBERG: Thank you, Commissioner. This is, perhaps, as good a time as any - and I direct this question not really only to you but to everyone present - because this is something that has been troubling the commission and I am not quite sure how we ought to approach it - you state in your prepared statement: "In my opinion, however, the one element more responsible than any other for our present medical malpractice insurance crisis is the monopolistic practice of those insurance companies writing malpractice policies. The arbitrary decision of insurance underwriters to unilaterally increase premium rates to whatever level the market will bear has thrust the medical community into turmoil. Until steps are taken to restore a competitive marketplace to the writing of malpractice insurance policies -- or, at the very least, to restore some sense of reasonableness through government mandate, to the rates that are being charged -- little else can be done to solve our medical malpractice insurance woes."

One of the problems before this commission is the question - one of the issues is - whether or not there is a monopolistic practice and, if so, does it make any difference. By that I mean the following: If there is justification for the rate increases that have been requested and, to a limited extent, approved, then what difference does it make how many carriers there are writing? Will those rates come down as a result of an increase in competition?

You cannot answer that for me, I understand that. I am not sure anybody can. But that is one of the questions that this commission has to consider and your remarks brought that to my attention and I thought I would state it for the benefit of those present.

Yes, Commissioner?

COMMISSIONER FINLEY: I'd like to respond, briefly. Of course, we all realize that the Insurance Department can give more details about the situation in New Jersey but I have followed the situation, for example, in New York State and in California very closely also. I have been concerned about the possible health hazard that would occur if doctors felt that they had to walk out. That has been my reason for following it. I know that the New York State Medical Society, in hiring consultants to study the profit picture of Argonaut, for example, found - and this was when they had legislation to support their formation of their own medical society insurance system - that Argonaut had been a very profitable enterprise, even in relation just to the writing of medical malpractice. As I said, our Insurance Department has the details on this.

I, therefore, do, myself, view, with suspicion - even in the St. Paul situation this has happened currently and I think they are going to have to work very hard to prove it to good actuaries in the Insurance Department - whether they really have lost money. Still, however, I agree with your latter remarks. I do not think that you can attack just one aspect of the problem and even if you restore competition, or if you obviate competition by making it a public function - and I said I am also very interested in that possibility, this is what they do in Canada and many other countries-- They said, "The private system doesn't work, let's make it like workmen's compensation, a public fund into which the physicians still pay a premium."

This is why I think all of the issues that you

raise - the occasional small fraction of physicians who, perhaps, are not disciplined, as they should be, by their peers and who cause the rest of their peers trouble; the occasional attorney who really doesn't do his homework and does bring a case and clogs the courts; and the occasional patient - have to be addressed or no amount of restoration of competiton, or no amount of public assumption of the responsibility will solve the whole problem.

SENATOR GREENBERG: Thank you.

Mr. Vice Chairman, do you have a question?

ASSEMBLYMAN SALKIND: Yes. Thank you, Mr. Chairman.

Commissioner - Doctor, I would like to first compliment you on a very good presentation. I read your remarks in full while you were speaking.

I agree with your comments and I agree particularly with your thoughts about even the small things you just referred to - the small number of patients, perhaps, who are over-zealous in their attempts at recovery; the small number of doctors who aren't disciplined by their peers as they should be; and the small number of attorneys that are -- whatever they are, whatever they are doing. However, I don't think that is the problem, frankly, and I would suggest, respectfully, that it is very clear in the figures you have on the hospitals that this is certainly not the problem, and as this continues to get out of hand we will see that.

One of the County Societies - I believe it is the Morris County Society - has stated, in writing, to the members of the Joint Committee, that, in their opinion, 18% of all of the premiums in this field that are paid only end up getting back into claims. I can't speak to the representation of that but I am sure that the order of magnitude is correct.

Now, I'd like to go into one of your suggestions - and I appreciate what you said about availability and I will

come back to it - and that is the board. You are talking about a board within the Department of Health, as I understand it?

COMMISSIONER FINLEY: That would be a possible location. But I am talking about a public board.

ASSEMBLYMAN SALKIND: Would you just -- Do you think that the idea of a three-member board is correct? Do you think that is significant?

COMMISSIONER FINLEY: Everything that I have outlined is subject to discussion. In other words, I don't feel that what I have suggested is binding. As a matter of fact, having reviewed Senator Kennedy's legislation for a national system, which would be a public fund with these kinds of back-ups and inquiries and requirements on States for arbitration, I would say that we ought to watch, in New Jersey, what is likely to happen in Congress, not wait for it. There are too many things States wait on the Federal Government to do and then it is too late. But we should watch and see if we should be doing something a little different from what I have suggested to get ourselves ready to work with a Federal system.

But I think, possibly, three people is not enough. I do think the balance of public interest, legal profession, and medical profession - and I have suggested this - should be maintained.

ASSEMBLYMAN SALKIND: I take it then, your conclusion, yourself, is - speaking as Commissioner and as a physician - that the governmental responsibility is very real here and must be followed through. Your analogy - your reference to the Canadian situation - means that this works and you think it is a good idea.

COMMISSIONER FINLEY: Well, yes. I almost always feel about things that the government should take the proper and, perhaps, more responsibility.

ASSEMBLYMAN SALKIND: How concerned are you about the hospitals continuing into the current period that the Chairman referred to a minute ago? As we go past November of this year into 1976 and we are going to have a crisis which could result in shut-downs of institutions, are you concerned about that, as Commissioner of Health for New Jersey?

COMMISSIONER FINLEY: I am sufficiently concerned about it and have Deputy A. G.s researching the emergency powers. In many states those powers are rather clear; they are not clear in New Jersey. Under the police powers of the State, when there is a true threat to the public health and safety, what are the emergency powers of the Health Commissioner? I don't have the answer to that right now but I am thinking of the kinds of crises that I feel would occur to patients if situations, such as has happened in California, where I happen to know the administrator of Mt. Zion and where the anesthesiologists actually did walk out, or in New York City where operating rooms were shut down for a time, or the threat in Pennsylvania-- I am very concerned about this. I think that we have to keep most of our provider institutions running.

ASSEMBLYMAN SALKIND: One last point, you were talking about the legislation that I know the members of this committee wanted to see pass, and which I am sure will be-- We will call it anti-monopoly legislation for just a moment because that is one of its goals. The availability problem, obviously, can be assumed to have been attacked and solved by that situation and now we are going beyond that. In terms of cost, do you have any feeling after looking - and I realize this is primarily for the Department of Insurance and we will get into it later in more depth - at this, as to how much of the structure is actually based upon claims history and how much it has been based upon management fees? I am talking about the case of

Argonaut - some stock market losses in 1974, etc. - and their request of states, particularly our own, for a rate increase.

COMMISSIONER FINLEY: I have talked, of course, with Commissioner Sheeran and I have worked very closely on this issue. I think you have Mr. Stern on your list. He is going to be able to give you rather exact details. But, certainly, it was my impression, with data in front of me, when I talked with Commissioner Sheeran, that all of these underwriters do have some data on claims experience. If the underwriters are losing at all in the medical malpractice field, it is as a result of using the money in other ways. I am not putting this correctly but certainly you follow -- of I follow you.

I think that if this is true and substantiated then there is a sort of monopoly kind of practice, because nevertheless the request is - and we have been lucky in New Jersey - for a rate increase, or another kind of special privilege, if you will, or, "We won't write the insurance at all." If it is not based on real, verifiable losses, I find this something that has to be controlled.

ASSEMBLYMAN SALKIND: Thank you, Commissioner. We are very proud to have you there and here. Thank you, Mr. Chairman.

SENATOR GREENBERG: Thank you. Senator McGahn, do you have any questions?

SENATOR MC GAHN: Yes. Madam Commissioner, thank you very much. I will be very brief. I am a little concerned, frankly - and I certainly hope the tenor of this inquiry does not continue along these lines - about the bottom line: What is medical malpractice? As far as I am concerned, it is injury as far as patients are concerned, whether they are real or imagined. These are the primary factors involved in it.

Certainly, while I think we have to go into what

the cost of this is - and, undoubtedly, the number of claims are going up yearly - I think, and I intend to question the insurance industry and also you, as the Commissioner of the Department of Health - possibly you do not have the staff to do it - whether or not you have considered taking any steps insofar as medical injury prevention programs in hospitals are concerned, or doing an analysis of the general causes for this or even specific types of problems? Maybe if you do not have this yourself, it could be done in conjunction with the Hospital Association.

I think the main thing here is that everybody is at fault. The medical profession is at fault. The insurance companies are at fault. And the legal profession is at fault. Certainly, maybe the patients, as well, are at fault because they are expecting, or anticipating, too much from medicine today, after looking at Marcus Welby.

Very, very honestly, I am very, very concerned here about actually preventing claims. I think we can talk retrospectively and I think we can talk prospectively about insurance rates but how are we going to cut down on the injuries? Most of these claims apparently occur as hospital-related incidents, not necessarily on the outside. I think we could dispense with a lot of myths today about incompetent physicians.

I would say, how would you feel? Would your Department be in a position where you could undertake this type of program?

COMMISSIONER FINLEY: I am delighted with your approach, it is preventive medicine in the legal field. In some respects, in this administration - which means mine and the Governor's - the Department is already undertaking some of the things that you are talking about and we would more than welcome the understanding and support of occasional legislators, and I don't mean you or anyone on the panel. But I think it is evident - it certainly is

evident in the nursing home field, it is perhaps less publicized but it is equally evident to me as an administrator in the hospital field - that our licensure inspections and that aspect of quality control is being conducted much more fairly and much more often and much more thoroughly than it was in the past.

I will not, because it would be improper, say what I am talking about, or which institution, but we had a situation that was uncovered in an inspection of a hospital in New Jersey that could have resulted, and I am surprised it did not -- it did; it was hospital practice and it did result in the death of a patient. I do not know that the family has brought suit. That is not my business. But I would have to say that if the day ever comes when we have to take a license away from a hospital - I have that authority under the law - I would really, really need the understanding of the Legislature and the public. I think we all know nursing homes are getting it all over the place these days and it is not so hard to do, in terms of public attitude. I think we would see a lot of angry headlines if I took a license away from a hospital. But once I have been confronted with this - at least if the hospital did not improve certain very important practices, such as prescribing drugs, etc. - I would have to face taking the license away.

As far as the other parts of your question, yes, there is now a hospital infection control program - surveillance of hospital infection control - that this Department administers. There is the clinical laboratory improvement bill that has recently been signed. All of these things, of course, will wind up back before you because they all require some modest funds to run them. New programs are not funded.

The Department has the staff capability; it has the know-how; it may lack some budget, in certain instances.

Then, when you get to the final bottom line of the physician, per se, I am not sure what you said about that. No, we have no authority in that field at this point.

SENATOR GREENBERG: Thank you, doctor. Thank you, Doctor McGahn. We appreciate your questions and your answers, Commissioner. Thank you for appearing before us this morning. (see page 1 x)

Assemblywoman Totaro. Good morning.

A S S E M B L Y W O M A N R O S E M A R I E T O T A R O: Good morning. Mr. Chairman and members of the committee, I would like to thank you for giving me this opportunity of sharing with you my views on medical malpractice. For the record, I am Rosemarie Totaro, Assemblywoman from the 23rd District, which encompasses Morris County. I have deep concern for this problem for my constituents and the people of New Jersey.

In speaking here today about malpractice and malpractice premiums, we must not suppose that these rates are affecting only the doctors they are charged to, and the insurance companies providing the insurance. High malpractice premiums affect every man, woman, and child in the State. Every citizen at one time or another finds himself a patient. Increased medical fees do not discriminate between rich and poor, black and white, male or female, or young and old. We all see the increases in malpractice insurance premiums reflected in higher medical fees we are now paying our physicians.

We are sadly mistaken if we do not recognize that physicians are not, themselves, absorbing the increased cost. We, the people of New Jersey, are, in fact, paying these increases. Middle class, impoverished, and unemployed citizens of New Jersey alike, at this time of economic strife, have enough financial burdens without watching their medical bills climb along with their mortgage payments, food and fuel bills.

We legislators must realize the magnitude of the problem and the scope of the implications it has for the people of our State. It is one special case where we must constantly keep in mind the welfare of our citizens because any decision made here, or as a result of what we may say here, will bear directly and heavily on the lives of all the people we represent.

May I also remind the people in attendance here today that malpractice insurance is unlike any other kind of insurance. It cannot be discussed as if it is car insurance. The reasons, I think, are obvious. When we hear the word insurance we tend to think of consumers. I cannot emphasize enough the fact that a patient is not a consumer and cannot be placed in the consumer role. The circumstances surrounding malpractice insurance differ from those surrounding any other sort of insurance.

High malpractice premiums will affect the public in less direct ways, other than simple increased cost, but which are probably, in the long run, just as detrimental to the public health of this State.

New Jersey is in great danger of losing its specialists because we are no longer offering them an atmosphere in which they can practice in comfort. High risk doctors - the specialists - are required to pay higher premiums and constant larger increases of these premiums are a discouragement to doctors who we, in this State, cannot afford to lose. Doctors in these special categories may find it easier to practice in other states. We have, in fact, almost lost a few neurosurgeons. In a state where we have only about 50 neurosurgeons, we should be doing what we can to make it easier for them to stay, rather than induce them to leave because of boosting rates with no controls in sight.

This State has been building up a fine community of cardiovascular surgeons and we should be fighting to

keep them by making it clear that this problem of boosting rates will not be allowed to prevail.

It is possible that a few of our young doctors and students considering high-risk areas of medicine as possible careers will be discouraged. We are faced with specialist shortages in the future if we cannot make these professions attractive to our young people. Already young doctors feel the pinch of impending malpractice premiums. They cannot set up the traditional individual family practices and they find that after years of medical schooling they still face further financial insecurity at the onset of their practices.

According to many people examining the crises of malpractice, there is a problem of malpractice insurance availability. I want to stress to you that the real crises of availability is that the high price of insurance limits its availability. This is the problem we must deal with here. It is the problem which is affecting the patients and the doctors alike.

The problem of high malpractice insurance rates cannot be attributed singularly to the insurance companies. It cannot be blamed on the few incompetent and negligent physicians. It is due, primarily, to the present structure of portions of our legal system that affect the way malpractice is handled and our lack of official channels for regulating doctors effectively.

At the present time, the statute of limitation that applies to malpractice cases is two years from the time of discovery of injury, supposedly due to the negligence of a physician. Since there is no definite limit to the time during which a case can be brought to court, doctors must be prepared to defend themselves in cases brought to the court by patients treated for an aliment many years before. This means that the insurance company must be prepared to fund court cases and pay

damages for almost every patient that any physician has ever seen. For this, they must maintain giant reserves that are funded by skyrocketing insurance premiums.

When setting up their reserves they must take into consideration the price of legal cost and damages, whose prices are continually rising, and the toll of inflation and time on the reserves. If there was a more definite statute of limitations, insurance companies would only have to be prepared to deal with cases that related to treatment of patients during a smaller period of time. The need for giant reserves would be wiped out and insurance companies would not have to charge such exorbitant malpractice insurance premiums. The people of New Jersey, so burdened with financial problems, might not have to deal with rising medical costs as well.

Commissioner Jay Jackson, Insurance Commissioner for the State of Connecticut, has said that his State's definite statute of limitations of three years, has been a factor in holding malpractice premiums down. This law has been in effect for at least five years. Now other states are following Connecticut's example. California has just voted into law the same type of legislation with a statute of limitations of three years.

In order to bring the benefits of this experience from our sister states to New Jersey, I have introduced in the Assembly a bill to establish a separate, definite statute of limitations for medical malpractice cases. It would require that a malpractice case be instituted within three years from the date of the medical treatment or procedure upon which the claim is based, or else it would be barred by the statute. For minors, the statute of limitations would be seven years, also from the date of the relevant medical treatment or procedure. Under existing law, a minor has two years from the date he reaches the age of majority, 18, to file an action. Adding the discovery

rule to this potentially long period and the liability of a doctor or hospital could continue for a lifetime. The time period provided in this bill should be more than sufficient to allow negligence-related injuries to surface and be recognized. Patients would have sufficient protection against the untoward results of negligent medical treatment. The people of New Jersey would be spared from another rapidly rising cost factor related to their medical bills, which are already too high.

Another problem faced by insurance companies, doctors and patients alike, is that too often a patient will bring a case to court which has little or no merit. Too often much money is wasted on these cases as well as the time and energy of all the parties involved. Insurance companies must be prepared financially to handle all cases even if they have no merit. If we could screen all cases and perhaps weed out the invalid cases before they reach the courts, the legal costs involved with such claims might be reduced. This could lead to a reduction in premiums.

To provide for such screening, I have also introduced legislation which would provide for the screening of medical malpractice claims by a medical malpractice review panel. A permanent panel of attorneys, doctors and public representatives would be appointed by the Governor. For each case, an attorney, doctor, and public member from the permanent panel, and one doctor selected by each side in the case, would serve as the review panel. The panel would review the claim and make a recommendation with respect to both liability and damages. The recommendation of the panel would be admissible in a subsequent court action, if the court found that the panel's findings were not clearly erroneous, its decision was in accord with applicable law, and procedural requirements were met. A party would still be able to bring a court action

on his claim after review from the panel, but he may be required to pay the additional legal cost of the other party if he receives 25% less in damages in the court action than he would have received under the panel's recommendation.

We need in this State an agency capable of allowing doctors to police themselves, and to seek out and take action to alleviate the problem of incompetence in the profession. The State licensing board should have the power and means to suspend licenses, put doctors on probation and investigate doctors who the public and the profession feel are incompetent. We can see by the number of cases with little merit that are brought to court, that patients feel they have little recourse other than to bring suit when they fear they are being treated incompetently.

I have introduced legislation which spells out more clearly, and expands the powers and options of the State Board of Medical Examiners to deal with the incompetence in the practice of medicine and surgery. In addition to their power to suspend and revoke licenses, the Board would be given the authority to suspend judgment in any case, to place a licensee on probation, to place practice limitations upon a licensee, and to take such other disciplinary action which the Board, in its discretion, deems appropriate. It would be authorized to investigate any evidence of incompetence by any licensee, to order mental, physical or medical competency examinations, and to require a licensee to participate in informal interviews related to his competency. Members of the profession, hospitals, and insurers would be required to report to the Board evidence of incompetence and malpractice claims. Licensees would be required to inform the Board of any disciplinary activities against them in other jurisdictions, by professional associations or health care facilities. Lincensees would also be required to have 150 hours of

continuing medical education activities to their credit every three years in order to maintain their licenses. Hopefully, this approach will provide a better means for dealing with incompetence in the medical profession than the hit-or-miss approach of medical malpractice court actions. It could lead to stopping much malpractice before it can occur.

Other measures may be needed but I feel this legislation is a real start and lays a foundation upon which we can build more malpractice protection policy. It is not a patch-up job on a system that cannot sustain its own costs. We can get down to the roots of these most damaging high costs by acting upon this legislation and by investigating fully every proposed rate increase by insurance carriers. And never while we look at this or any other malpractice proposal may we allow ourselves to forget that in this instance, the words citizen and patient are one and the same.

In New Jersey medical care is rapidly becoming a luxury that many people may soon be unable to afford. We as legislators and government officials must not allow this to happen. Good health should not be the right of only the rich. All people should be able to get health care and there is no reason why people should pay exorbitant medical fees when we can alleviate here and now the pressures of rising costs. Thank you.

ASSEMBLYMAN SALKIND: Thank you, Assemblywoman. I just have one question. I think just before you arrived the Commissioner of Health for the State of New Jersey was testifying - a very excellent presentation - and during the course of that testimoney she was talking about the hospital rate increases which have occurred and which are continuing to occur. In your particular district she made reference to Morristown Memorial Hospital having increases in its malpractice insurance premium, from 1974 to 1975 - just one year - of 806%. In your district

have the hospitals expressed any concern about this subject and, if so, what are your thoughts on that matter?

ASSEMBLYWOMAN TOTARO: The hospitals in the Morris County Medical society have been extremely concerned and instead of just complaining they have been working very constructively with me, bringing me data of what was developing in other states. In fact, I had a statistic that was furnished by one of the physicians in the area showing what they were averaging out in New York City - every patient who went to the hospital had a bill that would show a reflection of $50 passed on to them from the cost of premiums the hospital has to pay.

So, I think in all instances we have to do something constructive about it and that is why I am here today.

ASSEMBLYMAN SALKIND: Thank you very much again. Senator McGahn.

SENATOR MC GAHN: Thank you very much, Assemblywoman. I certainly would concur and support the bill you are talking about, as far as. . .

ASSEMBLYWOMAN TOTARO: Three bills.

SENATOR MC GAHN: I am talking about one, if you don't mind, please, and I will get to the others.

However, I would like to put at rest one myth, and that is the effect of the incompetent physician upon the malpractice rates. I would like substantiated, if you will, the number of claims brought in this State that are brought on behalf of incompetent physicians.

ASSEMBLYWOMAN TOTARO: The recommenation for..

SENATOR MC GAHN: I am not talking about a recommendation, Assemblywoman, I am talking about facts.

ASSEMBLYWOMAN TOTARO: I don't have any statistics with me, Doctor McGahn, but the physicians themselves in the Medical Society, or some of the suggestions that were encompassed in strengthening the Medical Board and its investigatory powers, and the continuing training program -

these were not something that I made up out of my own mind.

SENATOR MC GAHN: Oh, no. I am fully aware of that.

ASSEMBLYWOMAN TOTARO: I am not saying, and I could not myself, and that is why we need the courts now and we need malpractice insurance, because it does exist and I think if we want statistics the insurance companies can supply them.

SENATOR MC GAHN: I think one will find, basically, in going back that the incompetent physician is an extremely small part of the problem, as far as this is concerned.

Number two, as you already know, the State of New Jersey has a fairly good statute limitation - two years, as against Connecticut's three. Granted, one thing - there are two exceptions, one is date of discovery and the other is the continuing treatment rule, which certainly should stand. Continuing treatment -- no difficulty, no problem about that.

Time limit started from date of discovery is unavoidable. Discovery then should be related to the existence of the injury and not to knowledge of negligent causation, and that could, of course, be in there a little bit.

I, of course, certainly have a personal interest in the statute of limitations, as far as minors are concerned, or infants are concerned. At the time, I think, as you know, when we came up with and passed the bill making adulthood at age 18, we failed at that particular time to also amend the statute of limitations on that, to make it 18, so that consequently a suit can be brought today to 23 years, minus one day. Certainly, I feel, under that circumstance, that six years is a reasonable period of time and I would even go as far as eight because generally most births today that occur, occur at hospitals. You have them under the care of pediatricians, and certainly by the time

a child is ready for school, he has had a pre-school examination and if there is anything that has happened as a result of medical negligence, it should have been picked up by that time and, given that period of time, certainly a claim should be filed. That is the only comment I have to make.

ASSEMBLYWOMAN TOTARO: On that, Senator, the reason that I adopted the Connecticut legislation for New Jersey was because it has an experience factor. I think in this case we don't want to try hit-and-miss; we want to have some definite impact on it. That was the reason. Connecticut is very similar to New Jersey and it has worked successfully there and this does reflect in the rates that are charged in Connecticut, versus New Jersey. I think when the Insurance Department testifies they can give you the data on it.

But that was the reason for, as a legislator, I tried to find some state that was not adopting something new but something that was tried and had proven true.

SENATOR MC GAHN: Assemblywoman, I think that you will find - and unfortunately this is true - that the experience, the rates, the situations are going to vary from state to state and each state is going to have to come up with its own particular package. There is no way that we can compare ourselves with any additional state, albeit New Jersey versus Connecticut, California, New York, Pennsylvania, Florida, or what not.

SENATOR GREENBERG: Thank you very much, Assemblywoman. I appreciate your appearance here today. (see page 12 x

We will take next the representative of the Association of Trial Lawyers of America, Herbert Greenstone.

H E R B E R T G R E E N S T O N E: Mr. Chairman, members of the committee, I appreciate this opportunity to appear here before you today, after 35 years of practice at the trial bar, some of which time was spent in representing

this type of case.

There are certain things I have on my chest and perhaps this is as good a time as any to have a mental catharsis.

Let's bear in mind that this whole problem involves not just doctors, not just lawyers, not just insurance companies, but the public, and who speaks on behalf of the public? The Legislative representatives represent the public. Doctors and lawyers are professional people. They are licensed to practice their respective professions by a license granted by the State. And if any of them conduct themselves in an improper professional manner then, of course, it is incumbent upon the State to take necessary measures with respect to the licenses that have been granted to its professional men.

You know, lawyers don't make malpractice litigation. The Department of Health, Education and Welfare conducted a study on medical malpractice and it was determined that malpractice was caused by poor quality medical care, not by litigation. I am thinking of, perhaps, someone saying that we ought to do something about infant mortality. How are we going to safeguard against infant mortality? So, someone comes along and says, "Let's propose a bill. We will pass a bill prohibiting childbirth - prohibiting people from having babies - and, therefore, we won't have infant mortality."

Now, it is submitted that by the Legislature abolishing any litigation that would abolish a right or a remedy to recover for damages due to malpractice is not going to solve the problem. Doctor McGahn pointed out the case of a doctor in Sacramento who operated to support a drug habit, on 38 patients, all of whom suffered horrible injuries. The New York Times recently carried a story of two doctors who were on the staff of a hospital, under the influence of drugs, one having ripped off an oxygen

mask on a patient during an operation to give it to himself because of his drug reaction - and then these doctors committed suicide.

Dr. John Knowles of the Massachusetts General Hospital, now of the Rockefeller Foundation, is reported as saying, in the Reader's Digest, twenty to thirty percent of surgery in this country is unwarranted, listing hysterectomies, laminectomies, tonsillectomies, and all sorts of other "ectomies."

But, what is the problem? The problem is this: The public is entitled to basic rights. If someone causes harm to you - and this is the "golden rule" under our tort system - you are entitled to recovery and redress.

Now, if - and that is a broad "if" - a professional man does not conduct himself in accordance with the standards of his profession and commits error, the individual should be compensated. This doesn't mean that the doctor is always going to commit error. It is just like Denny Doyle who made an error in the ball game and it cost the team a pennant.

But, if on one particular occasion - whatever damage is caused by failure to practice in accordance with standards - an error occurs, the injured party is entitled to redress. That's basically the legal problem.

Now, with respect to how can doctors afford protection - insurance protection - they are entitled to get insurance protection if they are practicing medicine in this State. They are entitled to protect themselves and the public is entitled to be protected and obtain financial retribution if they are injured.

Do doctors have to pay unreasonable rates? I am not an actuary. This will be left for the more professional actuaries. But I do know this, in reading the Wall Street Journal, it was reported that Argonaut Insurance Company paid out, within one year after taking - Teledyne

that is, the parent company - after taking over, Argonaut paid out within one year as parent company to its parent company, Teledyne,eighteen million dollars, 20% return on its investment. Argonaut assumed monopoly of the State practice in New York - the State Medical Society. This monopoly practice was such that it caused a threat to the doctors to withdraw coverage. Monopoly in our democratic system has no place.

In Rhode Island a group of doctors have instituted a suit against certain insurance companies on the basis of a violation of the Sherman Anti Trust Act. Monopoly is bad. Whichever way you look at it it is undemocratic.

We say - and I agree with Commissioner Sheeran and I agree with Assemblyman Salkind - Assembly Bill number 3094 is necessary. A company that is writing insurance in this State must take the good with the bad. If you operate a supermarket, you can't just sell products that you make the biggest profits on, you have to sell your butter, eggs, and milk, and other necessary items. That is the way to do business in this country. You must satisfy the public need.

Now, some suggestions: I think doctors who just start out in practice should not have to pay the same kind of a premium as doctors who have been in practice many years and who have a greater income. I think there should be rate fixing according to the income of the doctor and his years of practice. I think there must be back-up reinsurance so that there must be a basic coverage; whether it is $100 thousand or $250 thousand there has to be some type of reinsurance program. This program, whether it is a joint underwriting association of reinsurance by the medical society-- If the county medical societies can't do it or the specialties can't do it the State Medical Society must step in. If they don't step in, then the government has to step in. If the State government doesn't do it, the Federal

government is going to do it, and we have enough Federal bureaucracy right now. I think we, here in the State of New Jersey, can handle our own problem.

There has to be a study made of insurance experience in this State; claims made; the cost of claims; what gave rise to the claims; an analysis of investments and returns; settlements; what caused the malpractice; there must be some type of input. The government departments can do this, just as the National Electronic Injury Surveillance System does. This is conducted by the Consumer Products Safety Commission. There are several in every state. Every injury recorded as a result of a consumer product - like a toy or a lawn mower - is reported by the emergency room of the hospitals, sent to Washington, Washington and the NEISS Program computes this and makes available to manufacturers how their product has hurt and affected the public. There must be an input of some central agency in this State and in the Federal Government to categorize various types of injury, whether they arise from cardiac arrest or anaesthesia, orthopedics, neurology, whatever the case may be - what caused it and how it could have been prevented.

Now, lawyers can't engage in preventive medicine; what we can do is say that litigation has a therapeutic effect. If a person is going to have to pay they are going to be careful. In other words, liability breeds care, immunity from liability breeds neglect. That is why we feel that we serve some purpose in the community. I feel that I'd like to address myself specifically, quickly and succinctly to certain problems arising out of litigation.

Number one, the medical expert. You can't try a case without calling in a medical expert who informs the jury what is standard practice in a particular case and whether or not there was a deviation of standard practice. You have heard the expression "conspiracy of silence" and

you have heard that doctors feel they may face social ostracism if they testify against professional colleagues. Fortunately, there are men in the medical profession who have the courage of their convictions and will stand up and come to court and aid the court and express their opinion. We have had to go out of the State for these men a great deal but there are some men in the State.

I call upon organized medicine to adopt an official policy to encourage members of their profession to stand up and be counted, cooperate with the courts and be willing to testify in these cases.

Screening Panels - I think a screening panel is a good thing. I think it can help to weed out non-meritorious claims. Yet, in New Jersey we have had Supreme Court Panels under Rule 4:21, which have, in my opinion, been a complete failure. What are the reasons for the failure? I think, perhaps, a study should be made by this committee to ascertain how many claims were made to the Supreme Court Panel; what were the dispositions of these claims; and what were the recommendations?

Right to a Jury Trial - I think that this is one of the basic rights of our citizenry in a democracy - the right to a jury trial. I don't know how many of you watched television last night - chanel 4 - but it ended up where the doctor felt he was right. The patient had RLF, Dr. McGahn, and after 22 years suit was brought and the end was, the doctor admitted that there was some talk that oxygen was the cause of this blindness - retrolental fibroplasia - but then, while the insurance adjuster would settle the case, he said, "I'd rather take my chances with a jury."

Now, that is all well and good but litigation is very expensive. I respectfully submit, on behalf of our member organization of 25,000 trial lawyers, we would recommend that cases under a limit of either $15 or $25

thousand be submitted to mandatory arbitration. This would be a great cost-saving factor in your litigation.

Several legal doctrines also come under attack. The Res Ipsa Loquitor doctrine - the thing speaks for itself. The fear has been that, "well, you just present the facts and then you don't need the medical testimony or proof. But, where there is a foreign body, hardware, sponges, left in the abdomen after surgery - the thing speaks for itself. This is a doctrine that has been criticize but it is a necessary doctrine. It is not used that often because there are not that many "res ipsa loquitor" cases.

The informed consent rule - doctors are worried about whether they are advising the patient properly and fully concerning the risks of surgery. They feel that the law puts an undue burden upon them. The answer is, self determination - what you do with your body. Self determination is a basic right of free men.

The statute of limitations - you know, the statute of limitations - the long statute - helps doctors in a way because, as the patient knows - or his legal representative - he has, within a certain time, the right to bring the action and he will wait and see. Take the case of damage caused by childbirth, you very often don't know whether there is brain damage, whether a child is hyper-active or if there is something wrong with the child until the child starts school at 6, 7 or 8 years old and, fortunately, gets under the care of a psychologist or a neurologist who will determine that the maladjustment of the child is due to a prior injury at childbirth. The statute of limitations, as I say, is a double edged sword for doctors.

But, I do think that when you are dealing with malpractice, keep in mind the constitutional guarantees of basic rights. The basic right of a person is to have redress against someone who causes harm and there is no reason why a doctor or an insurance company or anybody

else has to be treated any different than anybody else in our society.

Just recently, in the State of Idaho the Supreme Court declared unconstitutional an act which limited the amount of recovery in malpractice cases. It held it was a violation of due process and equal protection clause.

Contingent fees - there has been criticism of lawyers saying they reap great funds of money because of malpractice litigation. Let me tell you this: Handling a malpractice case is one of the most trying experiences taxing any lawyer and the lawyers who agree to undertake it are knowledgeable, they are honest and honorable, and they are persevering. They have to learn a whole new language. They hit the medical books and they render a service. What the lawyers receive by way of percentages on their recovery certainly does not affect the insurance cost.

Prevention of medical malpractice - I recommend the extension of professional standards review organizations - the PSRO. There must be peer review by doctors of their own men. You can't tell me that the hospital in Sacramento didn't know what Doctor Nork was doing; as a matter of fact the court held they should have known. Or Dr. Marcus - the Marcus brothers in New York - you can't tell me their colleagues didn't know what they were doing.

There must be PSRO committees set up for peer review.

With respect to hospital care - in New Jersey we have a statute which limits liability against a hospital to $10,000. That statute has encouraged the bringing of actions not only against the hospital but against the attendants, the residents, the nurses, the staff, etc. where the limitation doesn't apply. This is necessary because the attorney is afraid he might leave somebody out who was necessary to the case and may have caused the

malpractice.

I recommend the abolition of the $10,000 limitation for hospitals. This will encourage hospitals to exercise greater supervision of the medical staff, and take greater aseptic measures to prevent infection.

One last point - I have occasion to speak before Casper Weinberger in Washington recently and Eli Bernzweig, who is the Secretary of the Commission of Health, Education and Welfare that studied the medical profession. Mr. Bernzweig was formerly with Argonaut. His parting words to me were this: Don't permit monopoly insurance in your State because if you do, the insurance company has the doctors in a bind. There must be available insurance coverage.

Again, I think it is wonderful that this committee is considering this problem before the public so that it can be aired and preventive measures can be taken to protect the rights of the public. Thank you, again.

ASSEMBLYMAN SALKIND: Thank you very much, Counsel. I have just one or two questions. You made reference to the New Jersey Supreme Court Rule 4:21 and the screening panel, and said that it was not working. Do you have any idea how many cases have been so submitted in the State last year?

MR. GREENSTONE: I haven't seen any statistics on that. There may have been an article in the New Jersey Law Journal two months ago but the article more or less concluded that there was a need to study the reasons why the panel has not been successful.

ASSEMBLYMAN SALKIND: One more question. In the beginning of your testimony you referred to the Argonout payment to Teledyne of $18 million. Do you have any specifics on that?

MR. GREENSTONE: I have the Wall Street Journal here - the article that I mentioned.

ASSEMBLYMAN SALKIND: May I have the date of that article?

MR. GREENSTONE: Yes. The date is January 30, 1975.

ASSEMBLYMAN SALKIND: I must say I certainly agree with your comment against monopoly; it is a very critical problem. We all recognize that and, obviously, that is the purpose of the original legislation.

I thank you very much, Counselor. Senator McGahn.

SENATOR MC GAHN: Counselor, thank you very much. For the record, if I may I'd like to establish your position as a member of the American Association of Trial Lawyers and repudiate your initial statement where you said malpractice, according to the H.E.W. Report, was because of poor quality medical care. That is basically incorrect, I think, as you well know. This was not the primary cause.

Number two, I think your Association is on record saying that in this type of situation - untoward injury - that a trial by jury is the appropriate means of compensating, if you will, the individual. I find this somewhat inconsistent with your remarks, however, and with your concern for the patient. I think the question here is, number one, is this the only method of compensating the patient, or are there other ways by which an injured patient could have reparation other than through the jury trial system?

You are a plaintiff's attorney. Number one, I would like to ask you, in your experience of the total amount of awards, awarded by the insurance company, what percentage goes to the patient?

MR. GREENSTONE: The last case I had, Dr. McGahn, I recovered for a patient - an infant patient - with brain damage. The award was $275 thousand. My percentage was, I believe, less than 20%.

SENATOR MC GAHN: Don't get me wrong, I am not

talking about -- You practice in New Jersey. I know how much you are getting.

MR. GREENSTONE: Are you talking about me, personally or about the group?

SENATOR MC GAHN: I am talking about how much is the individual getting of the total award - the percentage? Is it 17%? Is it 25%? We find - and I think you will find in various studies - that the percentages can be anywhere from 17% to 25% of the total award actually going to the patient.

Now, these are valid figures.

MR. GREENSTONE: No, that is not accurate. You say 25% of the award goes to the patient?

SENATOR MC GAHN: The total award.

MR. GREENSTONE: No, that is not accurate. I would say it ranges anywhere from two-thirds to twenty five or twenty percent - even less. I might also add - this is an aside - on contingent fees, that doctors utilize the contingent fee system in collecting their bills and they turn their bills over to lawyers on a contingency basis. So, they find some salutary means of using the contingency system.

SENATOR MC GAHN: Sir, would you mind repeating that again?

MR. GREENSTONE: I said, doctors in the collection of bills...

ASSEMBLYMAN SALKIND: For the record, I don't think that is pertinent to this subject.

SENATOR MC GAHN: Okay, fine. Basically, in this particular situation, in the award that you mentioned here, was this a lump sum award to the patient? You have a brain damaged patient who is unable to care for himself. Is there any possible chance for rehabilitation? It is a lump sum award that is going to the patient and/or the family and this is it for the rest of this patient's life?

MR. GREENSTONE: As a matter of fact, we arranged to have the child taken care of in Miami in the Child Development Hospital - Mt. Sinai Hospital - with the First National State Bank acting as guardian of the funds of the child. So, the fund will be given over for the child.

SENATOR MC GAHN: Do you then favor legislation of this type, instead of a single lump sum award so that actually there would be a continuing payment over a period of time, including rehabilitation of that individual who has been injured?

MR. GREENSTONE: Well, some companies have recommended this type of periodic payment but I think that where there is a fund involved, and the fund is properly administered by the proper authorities, it is a protective measure to safeguard the future welfare of the child.

SENATOR MC GAHN: You are a plaintiff's attorney?

MR. GREENSTONE: Yes.

SENATOR MC GAHN: You represent plaintiffs in malpractice suits against physicians?

MR. GREENSTONE: I would say that is a small percentage of my practice, fortunately.

SENATOR MC GAHN: Have you represented any legal malpractice or educational malpractice suits?

MR. GREENSTONE: Of attorneys?

SENATOR MC GAHN: That's correct.

MR. GREENSTONE: When you say represented, I haven't represented attorneys but I have been called in as a...

SENATOR MC GAHN: Have you represented a client against a fellow attorney?

MR. GREENSTONE: I know. I have been called in as an expert by the insurance company to pass judgment on other attorneys and I have given my recommendation as to his shortcomings.

SENATOR MC GAHN: But you, yourself, have not actually taken action?

MR. GREENSTONE: The reason for that-- You said to bring an action against another attorney? No, I have not.

SENATOR MC GAHN: I think that you realize also - I agree, I am not too sure what the experience has been in the State concerning "res ipsa loquitur" - that we are not talking about the doctrine, as such; we are taling about the legal extension of this that courts have actually done. So, in essence, the plaintiff does not have to, basically, present a case. The physician has to defend against it.

MR. GREENSTONE: No, not necessarily. The court -- An incident arises and the facts speak for themselves. If after surgery an abdomen is found, five years later, let's say, to contain some hardware and this is related back to the surgery the patient underwent, the court will say there is no need for expert testimony. It will say that it was not proper to leave a sponge or hardware in the patient's abdomen.

SENATOR MC GAHN: Another myth I would like to put to rest - I think that type of situation is not prevalent at the present time. I am not saying it has not occurred in the past. I am not saying that there may not be something. But this, again, is one of injury prevention programs every hospital has come up with, where today there is an extremely strict count, as far as instruments, sponges, and everything else is concerned. Very frankly, if there is any question about it, an X ray is brought into the operating room and the patient is X rayed right on the table. So, I would like to get to the crux of this thing and let's forget all of the myths that I keep reading about.

MR. GREENSTONE: The "res ipsa loquitur" doctrine, which has been criticized by professional proponents is a myth because there are not that many cases that speak for themselves. I submit that. That's what I am saying: It

is a very unusual case where the facts will speak for themselves.

SENATOR MC GAHN: Incidentally, on that basis I would tend to agree with you because the H.E.W., at least up 'till 1972, showed that there was no extension of that doctrine in this State. What has happened since that time I do not know.

The informed consent doctrine, however, is a horse of another color and I think that it has been extended beyond the original concept. Certainly the Canterbury case has opened up a completely new sphere. In a number of instances in which the statute of limitations had run out, this was again a back-door way of getting in and initiating cause of action against a physician.

Do you feel that, basically, the physician should be a guaranteer of services?

MR. GREENSTONE: No.

SENATOR MC GAHN: Thank you very much. Do you feel that as far as an oral agreement is concerned, or any type of an oral situation between patient and doctor should be, frankly, honored in court, or should it be written?

MR. GREENSTONE: An oral agreement as to what?

SENATOR MC GAHN: As to, basically, the extent of treatment and what the patient may actually hope to accomplish as a result of that treatment, without coming up with and possibly going down a check-list of possible adverse effects, or adverse reactions, that might result from the process.

MR. GREENSTONE: I think that a patient is entitled to make the decision. If a woman has breast cancer that is advancing and the doctor says, "I am going to have to give you radiation therapy that may severely burn you, but it may save your life", she is entitled to make that decision of whether she wants to have a breast

that is scarred or whether she wants to be alive. This is a decision for her to make and I think she is entitled to that decision.

SENATOR MC GAHN: Counselor, one final question, if I may. With adverse reactions - iatrogenic injury, therapeutic misadventures, and pure negligence - do you feel that there is any other alternate system that would be applicable here other than the tort liability and trial by jury?

MR. GREENSTONE: I can just briefly mention that as a member of the American Bar Association Committee meeting in Montreal and Vice Chairman of the Committee on Consumer Protection, we were giving a talk on medical malpractice insurance and mentioned an article by Thomas Sheehan of the G.A.T.X. Insurance Company of Chicago. He indicated - and I assume you are talking about some kind of "no fault" compensation type of remuneration - that medical malpractice insurance written on a no fault basis cannot be written by private insurance companies, nor by doctors, nor can the patients pay for its cost. No fault medical malpractice insurance would require the Federal Government to subsidize its excess cost under a Social Security program which would plunge Social Security into bankruptcy, requiring the use of general revenues to bail out, financially, an insolvent Social Security system.

SENATOR MC GAHN: I agree with that as far as the no fault is concerned. However, may I also quote from Robert E. Cartwright who is the President, I think, of the...

MR. GREENSTONE: Past President.

SENATOR MC GAHN: Past President, I am sorry. But, in the June issue of Trial magazene he said, "It, accordingly, should be clear to even the casual observer, upon reflection, that the doctors want to eliminate the contingent fee system not because it isn't a fair and beneficial fee arrangement for the client, but because

they wish to eliminate medical malpractice or negligence cases altogether, to the detriment of the public. Without the contingent fee system, there would be few injured, mangled, and butchered patients who would be able to afford to proceed with such a suit."

He then goes on to say, "The tort Law, with the plaintiff trial lawyer to carry out its purpose, is the very cement of our society. It encompasses the ideas and institutions which have been central to our civilization and culture since the very beginnings of our country...", etc. In other words, I think that you will agree.

MR. GREENSTONE: Yes, I would.

SENATOR MC GAHN: I think that you feel there is only one system, and that is the adversary system with trial by jury.

MR. GREENSTONE: Yes. But I did, in my talk, make certain concessions with respect to claims under a certain value, to submit to mandatory arbitration. I also say that it might we worth looking into a screening panel for airing out claims.

ASSEMBLYMAN SALKIND: Thank you very much, Mr. Greenstone. You have one last qualification I want to get into. You are a 3rd Circuit Governor. Would you define, for the record, what that encompasses?

MR. GREENSTONE: The Board of Governors of the Association of Trial Lawyers is organized according to the Federal Judicial Circuits. The 3rd circuit embraces Pennsylvania, New Jersey, Delaware, and the Virgin Islands. I am a 3rd Circuit representative.

ASSEMBLYMAN SALKIND: Thank you very much. (see page 20 x)

I'd like to next call Mr. Thomas Hooper.

T H O M A S H O O P E R: Assemblyman Salkind, members of the committee, my name is Thomas Hooper. I am fron the Department of Insurance. My purpose in being here this morning is to read a short statement on behalf of Commissioner

James J. Sheeran. I quote:

"I regret that I am not able to be present at you meeting today. Unfortunately, a prior commitment will tak me out of the State, appropriately enough for a meeting with a group of my fellow State Commissioners, at which malpractice insurance will be discussed. My presence at that meeting is essential because out of it is expected to come a policy position, possibly from both a majority and minority perspective.

Your Chairman has assured me that I will be given the opportunity to appear before you at your next meeting, at which time I expect to emphasize the following:

1) The disastrous impact of monopoly in the medical malpractice insurance marketplace;

2) My adamant opposition to any dilution or erosion of the rights of the people under the tort liabilit system, against those who would limit the amount of malpractice awards, abandon the jury system, and render the statute of limitations virtually useless;

3) The preoccupation of the medical profession with changing the system to the exclusion of the development of effective programs for identifying and rooting out the causes of malpractice;

4) The importance of A-1552, which would empower me to establish a Medical Malpractice Reinsurance Facility, in making sure that this insurance is readily available to medical practitioners.

Thank you for your attention and I look forward to making a full presentation of my views at a later date."

ASSEMBLYMAN SALKIND: Thank you very much. We will expect to hear from the Commissioner and we will look forward to it. Do you have a copy of that for us?

MR. HOOPER: Yes, I do.

ASSEMBLYMAN SALKIND: Are there any questions?

SENATOR MC GAHN: One - the same question, incide

that I asked Commissioner Finley. The insurance companies that are writing medical malpractice insurance - at the current time are they doing anything about medical insurance prevention systems in order to cut down on the medical injuries in hospitals, thereby reducing the rate?

MR. HOOPER: Senator, I'd like to beg off from answering that question. I am no expert. Our actuarial staff will be happy to answer that.

ASSEMBLYMAN SALKIND: Thank you very much.

I will next call on Mr. John J. Nangle from the National Association of Independent Insurers.

J O H N J. N A N G L E: Thank you, Mr. Chairman.

The chair has requested that we limit our statements to a few brief remarks. Relying upon your promise to read my statement thoroughly, I would like to just emasculate it and with your permission read about a page and a quarter on a subject that is very important to us.

First of all, the NAII is a national trade association of some 533 insurers of all types, both stock and non-stock, whose membership provides a representative cross-section of the casualty and fire insurance business in America. We extimate that our members write approximately 50 percent of the insured vehicles in the State of New Jersey. They generally do not write medical malpractice insurance, although some of them have medical malpractice premiums.

Within the past year or so, a considerable amount of national publicity has focussed on the subject of medical malpractice, sprinkled liberally with half truths, erroneous statistics and accusations of blame, but essentially devoid of critical analysis. Perhaps this is understandable to some degree since the subject is, after all, not a single indentifiable problem, but a complex of interrelated problems which seem to be changing dynamically almost daily. Yet most discussion of the subject today continues to focus on symptoms rather than causes.

What has disturbed us in the past year are the hasty and ill-conceived proposals put to paper over the problems that have not come to grips with what really are the basic issues. A common characteristic of these band-aid responses is the plan to distribute medical malpractice losses by assessing all companies writing liability coverages, regardless of whether they have ever written malpractice insurance.

The NAII does not believe that a Joint Underwriting Authority or a similar pooling mechanism can possibly

solve the medical malpractice problem. The effect of such an authority or pooling mechanism is not to reduce the cost of malpractice insurance, but simply to distribute medial malpractice losses by assessing companies writing other types of liability coverage regardless of whether they have ever written malpractice insurance. Needless to say, the cost of such distribution will eventually be passed on to the policyholders. It seems grossly inequitable that a homeowner, businessman or automobile owner pay an increased insurance premium in order to cover medical malpractice losses. Why should these consumers be compelled to subsidize the medical profession? Such a system obviously does not come to grips with the real problem of medical malpractice. In no way would such a system reduce overall costs of medical malpractice. Admittedly, it would reduce the premiums charged to the doctors purchasing the insurance but would spread the actual cost to the purchasers of other types of insurance. Such a procedure may alleviate the symptom temporarily, but it does not cure the illness.

For a study of the long-range solution, it is necessary to look to the roots and primary causes of the crisis and attempt corrective measures. We feel that some of the main causes of the malpractice claims crisis are the following:

At this point I will just mention what I have gone into in not too great a detail, but in greater detail in the statement; and they encompass just about everything that has been mentioned here today.

The statute of limitations; "claims made" policy; contingent fees; the doctrine of "res ipsa loquitur"; informed consent; arbitration; medical review and enforcement of the medical review; limitation on malpractice damage; and the no-fault approach and the workmen's compensation approach.

There are no easy answers to the malpractice problem. We, however, submit that the Joint Underwriting Authority approach does not solve it, but simply passes on to the consuming public in the form of premiums they pay for the other insurance the cost of malpractice insurance. The public is already complaining about the high cost of other insurance.

With that, Mr. Chairman, I will be happy to answer any questions I can. Thank you very much.

(Complete statement submitted by Mr. Nangle can be found beginning on page 28X.)

ASSEMBLYMAN SALKIND: Thank you, Mr. Nangle. Senator McGahn has a question.

SENATOR MC GAHN: Mr. Nangle, I will address my question to you in this fashion: It is my understanding that the insurance industry as such does have accident prevention programs as far as underwriting for fire, auto and various other types.

MR. NANGLE: Workmen's compensation.

SENATOR MC GAHN: -- and workmen's compenation. What at the present time are the medical malpractice insurers doing in this particular area; what are they doing?

MR. NANGLE: Once again, Senator, our companies are not generally known as malpractice insurers, but this question has come up in other forums and it has been answered in the affirmative, that insurance companies are physicially present in hospitals on loss prevention programs and the like.

SENATOR MC GAHN: Okay - fine. Let me make a comment. I think insurance carriers should initiate loss prevention programs, not only for institutions but also for individual practitioners, as the case may be. They should be based upon both injury and claims presentation

and techniques.

I want to ask this of you and Chubb if they are here today: Does a carrier allocate a specific portion of the malpractice dollar to loss prevention programs; if not, why not? And should they not analyze claims and make this data available? The insurance industry has an obligation to help educate and provide a few ancillary personnel and post-safety and injury-prevention programs. Have they been living up to this obligation?

MR. NANGLE: Senator, in answer to your first question. First of all, with the same caviat that my expertise is in the automobile and property field and workmen's compensation, it is my impression that the malpractice premium probably does not have a loading for loss prevention as does the workmen's compensation premium. The workmen's compensation premium is heavily loaded, I believe, in loss-prevention allocations.

I would agree with you -- if we came to a system of compensation or no-fault, that certainly would without a doubt be a large portion of the premium dollar. I think your suggestion is a good one. Heretofore, liability premiums generally have not been rated on loss-prevention factors.

SENATOR MC GAHN: Thank you.

The previous speaker stated that he felt that two-thirds of the malpractice premium dollar went in awards to the successful claimant. I have information that says it is anywheres from 15 to 38 cents, as against patient share in workmen's compensation being approximately 70 to 75 cents. Would you like to comment on either one or both, workmen's compensation or the other?

MR. NANGLE: The claimant return on workmen's compensation is fairly high. I am not sure whether your question is directed to the judgment or to the

premium dollar. In other words, Senator, are you asking me whether or not out of every premium dollar, 15 to 38 percent goes to the patient? I would say that was more nearly correct than the 66 percent.

SENATOR MC GAHN: Thank you.

ASSEMBLYMAN SALKIND: In all fairness, I think the previous witness misunderstood that question. I think he was talking in terms of the award settlement rather than the premium dollar. The figures that seem to be stated are in the lower end of the range that the Senator referred to.

SENATOR HAGEDORN: Would you have information to indicate the breakdown on the judgments, how much to the patient - how much to the attorney?

MR. NANGLE: I believe there are figures available. I would be very happy to get them, collate them, and submit them to the Committee.

SENATOR HAGEDORN: You mentioned also that contingent fees were a contributing factor to the high cost.

MR. NANGLE: Yes, sir, generally across the country they are. We have some limitations here in New Jersey.

SENATOR HAGEDORN: I was wondering if you would elaborate on your opinion why contingent fees contribute to that high cost.

MR. NANGLE: Well, sir, if I may digress for just one or two sentences, in the DOT studies analyzing the costs of the present tort liability system, it was very surprising to me that about 33 percent of all claims payments were going to attorneys. I thought it was lower than that. In all due regard for my friend who spoke before representing the Trial Lawyers, we have had many disagreements through the years, not personally, but with that Association.

In malpractice cases, I believe they have a point, that many lawyers are just not qualified. They will take the cases and probably give them to some other more capable trial attorney. But they are just not qualified to try malpractice cases as they are an every-day, run-of-the-mill automobile case. It requires much more expertise. Many malpractice cases are hard ones to make. I think the fees generally - and here again I can't put my finger on it - would run higher across the board; not necessarily in New Jersey, but generally, they run higher than the automobile cases. In many cases, they deserve to run higher if you consider the time and expertise it takes.

I am not in the camp of the trial attorneys. But I would have to make that observation.

SENATOR HAGEDORN: Thank you.

SENATOR MC GAHN: In the absence of Senator Greenberg, I think for the record I must defend at least the contingent system as far as the State of New Jersey is concerned.

What has been noted in national statistics does not apply to New Jersey because this is the one that has been held to be the greatest because of the Supreme Court rules in 1972. At the present time, of course, contingent fees are limited in New Jersey as well as in Michigan, the only two states in which they are. An attorney getting a judgment over $100,000, his fee can be only 10 percent of whatever it may be over $100,000.

MR. NANGLE: I made that point in my statement.

SENATOR SALKIND: Thank you, Senator. Thank you, Mr. Nangle.

Our next witness is the Chairman of the Board of Trustees of the New Jersey Medical Society, Dr. James Todd.

D R. J A M E S S. T O D D: Good morning.

Gentlemen, we appreciate this opportunity to speak

for the 8,000 doctors in the State of New Jersey and we are comforted that the public and the Legislature are finally joining in on a problem that we have had for a good many years.

I think the Committee is clearly aware that the vigor with which anyone speaks on malpractice and professional liability has a direct relationship to where the shoe pinches and should be taken in that light. The magnitude of our potential problem is speculative, but if we assume that all suits filed are legitimate and that in 1975 there will be approximately 1.5 billion patient-physician contacts, and assuming doctors do the right things 999 times out of 1,000, we will still have one and a half million potential malpractice cases a year.

But come closer to the truth, assume that doctors make only one mistake out of every 10,000 contacts and we still have 150,000 potential suits. Contrast this with the 40,000 cases estimated to be filed in 1975. Even this, is an increase of 225 percent in the past five years. Add to this, the prospect of further inflation; it becomes clear that neither the physicians' incomes and consequently patient payments can long endure.

Slowly, but surely, the public will take interest in the problem. A recent Gallup poll has showed that nine out of ten Americans have heard or read about malpractice difficulties, and the majority of those questioned support limits on awards, use of out-of-court settlements, limiting time in which suits may be filed, advance determination of attorney fees, and increased policing of the medical profession.

The public's views on this issue are the most important views since it is they who eventually will have to pay the costs of increased medical insurance

through higher fees. The federal estimates are that, because of the higher rates doctors and hospitals must pay, each visit to a doctor's office now costs a patient an additional $1.50 to $2.00, and a hospital bed an additional $10 to $15 a day. Furthermore, there is no question that the rash of malpractice lawsuits is leading doctors to practice "defensive medicine." This necessary practice may well cost the public an additional 3 billion a year in health costs.

The reasons for the increase in malpractice claims are not immediately obvious. Ironically, one major reason may be the fact that physicians are better trained than ever before, and use vastly improved technology in caring for patients. Utilizing such technologies saves lives, but results in greater risks.

The increase in medical malpractice litigation to a large measure parallels that in other areas. No-fault automobile insurance was the response to the great increase in liability suits. Personal liability, legal liability, and compensation suits are all rising at an increasingly rapid rate. Indeed, litigation may well replace baseball as our national pastime.

Insurance companies have come in for their share of criticism and implication as a cause for increasing costs. Paradoxically, while being charged with monopolistic profit-making practices, they drop from the market unable to sustain their losses which, by the nature of the liability lag, are often not measurable for some years after the occurrence. For example, in New Jersey, for the carrier of record from 1960 to 1968, the losses to date are 250 percent of the available premium. For the company insuring our Society 1968 to 1971, the losses to date are 228 percent of the available premium. Calculate the investment income no matter how you want,

at any reasonable level, and there still is no profit to be seen.

The incompetent physician has received great attention as a source of malpractice claims, but the simple demonstrable fact is that the poorer physician is not the one who is most often sued. Rather, it is the progressive, pioneering, and inventive physician who is willing through greater knowledge to assume greater risk to preserve life. Senator Lombardi of New York was startled to learn that the distinguished mendical school professor testifying on professional liability had eleven outstanding suits against him.

And finally, and perhaps most significantly, some patients, particularly those presenting a complex array of medical problems, will suffer adverse results or will fail to respond to all known methods of treatment, despite a physician's best efforts. Society, which once limited awards to patients who could prove negligence, now is inclined to reimburse every patient for any adverse result or unavoidable accident that occurs in the course of medical treatment. Indeed, in a recent case, the Supreme Court of New Jersey held that injury even without negligence should be compensated. The burden of this new social philosophy apparently falls upon those insurance companies underwriting professional liability policies and upon the physicians who must pay for the coverage.

If anything is certain in our current problems today, however, it is that no matter how acute the situation, we cannot allow ourselves into ill-advised, short-term remedies; we cannot allow ourselves to abridge the rights of anyone; and we can no longer ignore the obvious inequities in the existing system.

The Medical Society of New Jersey has developed a unique program for insuring professional liability. In

many states this program is envied and being imitated. Through its loss control program maintained by its agent, the Society has amassed information concerning premiums, losses, and operating expenses which guages the need for changing carriers. Since 1960, three different companies have written our liability insurance. The most recent carrier began in 1971 with increases of 10 to 20 percent and this year an average of 49.8 percent, which while it sounds high, looks pretty good when you compare it with the 200 to 400 percent elsewhere.

Furthermore, this loss control program eliminates the costly defense of bona fide malpractice suits, while at the same time giving notice that the frivolous suits or those not representing malpractice will be defended, the result being that in the last 274 cases going to trial, there were 246 verdicts of dismissal, 19 defendant verdicts on other issues, and only 9 plaintiff recoveries. During the same period, 338 cases were settled out of court as non-defensible. This record suggests that nearly half of the suits filed have no validity in terms of malpractice. At $30,000 to $40,000 defense costs per case, the defense of unjustified suits has to be a factor.

Other areas of pride for New Jersey have been mentioned: the sliding contingency fee; the voluntary screening panel, which, parenthetically, unfortunately fails of its goal because the proceedings are voluntary and the findings of the panel are inadmissible in any subsequent court hearing.

An additional accomplishment of the New Jersey liability program is its overall efficiency of operation. We have heard quoted this morning that only 16 to 17 cents of the premium dollar goes to the plaintiff. Our statistics indicate that 82 percent of the premium dollar in

New Jersey goes to the plaintiff and his attorney and only 17 percent, more recently reduced to 14 1/2 percent, is retained by the company for commissions, legal defenses and profit.

Finally, should be mentioned the matter of availability of insurance. Nationwide, ten states have a critical problem with either no insurance available, or the premiums beyond support. Fifteen states see a problem coming. So severe is the situation in some states that anywhere from 25 to 100 percent of physicians in those states may be without insurance by the year's end. Overall premiums have jumped 540 percent and of the 44 states for which accurate data are available, only 7 have lower rate hikes than those recently approved in New Jersey. And, indeed, New Jersey had the 18th lowest rates in the country.

Despite statements by some officials, our conversations with osteopathic physicians, podiatrists, optometrists and nurses reveal no evidence of unavailability of insurance.

The current hospital crisis in insurance is a direct consequence of the actions of the Commissioner of Insurance. Consequently, the Medical Society has opposed the concept of a Joint Underwriting Association, as envisioned by Assembly Bill 1552.

State-managed underwriting associations are calculated to do only one thing, guarantee that insurance is available. There can be no long-term control on rates, no guarantee of actuarial soundness since they are a new creation, and most importantly they beg the basic issue of how to reorganize an already long intolerable situation. Indeed, the concept of Joint Underwriting Associations may be counter-productive because the Travelers Insurance Company, one of the largest medical

liabilities in the country, has indicated that it may have to pull out of several of its group programs because of the additional exposure and reserves retained by the Joint Underwriting Association.

Everything I have said so far only strengthens the conviction of the physicians that fundamental changes in three areas must occur if any control is to result:

First, remedial legislation is required to eliminate the inequities and abuse of the present system.

Second, remedial legislation is required to foster, achieve, and control professional competence and responsibility.

Third, new solutions must be found for the old problems.

There can be no substitute for case law in defining malpractice or professional liability, but there has to be circumspection in accumulating that case law. There is no intent, as some charge, to erode the traditions of tort law, but rather the medical profession has a strong desire to return to the strict interpretation of that law.

The Medical Society has and will continue to introduce proposals having to do with the statute of limitation, res ipsa loquitur, structured payments, informed consent, and most of those are known to you.

A little known impediment, however, to medical discipline and requirements for excellence is the current judicial posture that maintains due process must be available to all physicians, and that membership in a medical society as a requirement to practice medicine is unconstitutional. The consequence is that hospitals are forced to accept incompetent physicians on their staffs as the result of court decisions. Medical societies have no clout over doctors who would rather resign than

face regulations. And the State Board of Medical Examiners, as currently constituted under the control of an understaffed Attorney General's Office, has all it can do to handle the obvious infractions of the Medical Practice Act, let alone deal with the ethical and competence aspects of the profession.

We need a mechanism whereby the medical profession can exert meaningful control over the performance, continuing medical education, competence, ethics, physical and mental wellbeing of its members. Equally important, there needs to be developed a mechanism whereby the public may easily and anonymously bring to our attention the deviant physician with expectation of prompt action. The Medical Society is currently proposing areas in this regard.

Lastly, it should be eminently clear that no solution thus far advanced is adequate to the problem of malpractice and professional liability. As mentioned earlier, it appears that the American public - rightly or wrongly - has decided that it should be compensated for all untoward or unexpected results of medical treatment whether or not negligence was involved. If this is so and if the American people want progressive first-class medical care, then no longer can 360,000 physicians underwrite the liability for 220 million Americans. It just cannot be done and the public and the legislatures will have to recognize it.

Consequently, a new financing mechanism for compensating the untoward and unexpected results of medical treatment as distinguished from medical negligence must be developed.

We as physicians stand ready to participate in any program calculated to improve the health - both physical and economic - of the people we serve. But we do not

stand ready to be swallowed in a convulsive revolution of health care and its financing which will sacrifice quality and individuality for expediency.

Thus it is with a keen sense of responsibility and desire to cooperate that we present our views today. Thank you.

(Complete statement submitted by Dr. Todd can be found beginning on page 35X.)

ASSEMBLYMAN SALKIND: Thank you, Doctor.

I have read your remarks in full. I read them, as a matter of fact, yesterday. I appreciate them and understand the view.

I have one question I cannot resisting asking or one series of questions. The Medical Society of New Jersey as part of its requirements for membership requires, I understand, that physicians have malpractice insurance. Is that correct?

DR. TODD: No.

ASSEMBLYMAN SALKIND: Do any members of the Medical Society not have malpractice insurance?

DR. TODD: I don't have any direct figures, but I assume that there are some who do not.

ASSEMBLYMAN SALKIND: In other words, your relationship with the one approved carrier is that it is just required to make it available, not that everyone take it.

DR. TODD: No. It is made available for the members of the Society under a group program. The same carrier makes it available to nonmembers under a surcharge program since they have no way of knowing what their performance and activities in loss control may be.

ASSEMBLYMAN SALKIND: You would agree that today, under the circumstance that we have, any physician practicing in the State would be well advised to have such insurance?

DR. TODD: I don't see how anyone could afford not

to have the insurance.

ASSEMBLYMAN SALKIND: On that basis, may I question you as to why the Society at the State level at least - of course, the counties vary a little bit on this -- why the Society at the State level is in opposition to mandating at least a minimum amount of such coverage be required as a condition of licensure? Is it just because you are afraid of any conditions of licensure?

DR. TODD: No, not at all. I think the individual person has a right to decide where his priorities and responsibilities shall lie. And I don't see why he should be required, if he is willing to take the risk and behave in an otherwise fashion, to carry medical liability insurance in order to practice medicine. It has no bearing on his competence or his activities as a physician.

ASSEMBLYMAN SALKIND: Don't you think that the State, since the State is the licensing agent and the State in effect is the people and people are supposed to be protected -- don't you think that a patient walking into a doctor's office or a health care facility should have the right under today's circumstance, in view of - and here I'll use my word - the idiocy of anyone not having it, to expect at least a minimum amount of coverage is available?

DR. TODD: Better, I would think the patient should expect that that physician is not going to commit malpractice, that the Licensing Board has done its job in assuring the competency of that particular physician, and also that if an untoward, not a negligent but an untoward result occurs, there will be public financing to protect that patient, such as hepatitis from the carefully-tested unit of blood. There is no way that that can be warranted to the patient. There is also no reason why that case should have to go to court.

ASSEMBLYMAN SALKIND: That is an interesting subject that you have brought up. Let's for the moment assume -- and I don't like the word "malpractice," as you know, because malpractice involves wrongdoing. Let's by definition say that we are not talking now about the very small cases where there is a negligent action on the part of the physician. By definition, we are saying that. Let's say that the statistical accident occurs with the best physician, with the best training and the best protection and the best care, particularly in some of the more specialized areas. Apparently what you said is that you think then that it becomes a public responsibility to protect the patient in severe cases of that kind which are not the fault of the physician.

DR. TODD: I think it is. I think we see this in other areas, such as the compensation program, such as unemployment programs - the individual who buys insurance to protect himself for loss of income while he is disabled from his job. This is accepted as a public responsibility. Since the physician cannot control the vagaries of human disease and since under our current system of sophistication there are going to be many untoward results which are the fault of no one except the basic disease, I can see no reason why the physician should bear that responsibility. This is a society problem just like workmen's compensation is a society problem and just like unemployment insurance is a society problem.

ASSEMBLYMAN SALKIND: What you are saying is that the public has a responsibility to assume this. Where you use "society," let's change your word to the "public."

DR. TODD: Assuming that there is no medical malpractice, the public should be willing to assume the consequences of the untoward medical events. If they are not willing to assume this, then there is no percentage

in further research, investigation or advance in medicine because it exposes the physicians to an impossible risk in the practice of their profession.

ASSEMBLYMAN SALKIND: Then I wonder why you wouldn't advocate having the whole thing a public responsibility analogous to what the Commissioner of Health said before, ala Canada.

DR. TODD: Not at all. There is a professional responsibility and there is a private responsibility. And all we are asking is that these be sorted out into proper compartments.

ASSEMBLYMAN SALKIND: Let's forget the word "malpractice" and talk about either professional liability or, as I would prefer, patient protection. Don't you feel that the patient should be fully protected at any moment when he or she walks into the medical arena against a totally disabling act occurring, analogous to workmen's compensation?

DR. TODD: Fine. I will buy that. The profession has no problem with that. All the profession is saying is that that is not a professional responsibility to protect 220 million Americans against events over which they have no control.

ASSEMBLYMAN SALKIND: Whose responsibility is that?

DR. TODD: It is a public responsibility.

ASSEMBLYMAN SALKIND: In other words, you are saying it is the responsibility of the public or the duly-elected representatives of government?

DR. TODD: Well, you can carry it all the way down. It becomes an individual responsibility, just like social security becomes an individual responsibility basically. The guarantee of social security becomes a legislative or administrative process, but the actual participation in social security to a large measure is a public individual responsibility.

ASSEMBLYMAN SALKIND: I think the analogies we are getting into are interesting. The analogies used so far are workmen's compensation and now social security. If that is where you feel the analogy is, I think we are opening up a whole new area.

DR. TODD: What I am saying, Assemblyman, is that we feel that the profession,if the public wants forward, progressive medical care,cannot expect to underwrite the untoward events of that care. Now when I talk about public responsibility in this regard, there are many ways this can be done. What I am pointing out, as I said before, is that 360,000 doctors cannot underwrite the liability for 220 million Americans. It just cannot be done.

Ultimately, even if it were done, these people are going to bear those costs. It would be much more equitable if they knew exactly what those costs were, and they don't know what they are now. If you had a separate system whereby this protection would be available at determined rates, you would have a much better handle on the cost.

ASSEMBLYMAN SALKIND: What do you think about some kind of a ratio setup to physician income? For example, would you agree that the physician by the nature of his practice - let's say it is a highly specialized neurosurgical practice - I'm defining it deliberately - and his gross income is in the area of $250,000 to $500,000 a year -- you would certainly agree that he should be paying more in some fashion for that protection or his patients should be paying more,because after all the patients pay it one way or another, than the general practitioner who might be making a gross income of $50,000, would you not?

DR. TODD: Not without qualification, no, because

I think you have to look at it as to his experience. I can conceive of a general practitioner having greater losses through his activities than the best of neurosurgeons. I think you have to qualify this as to what is actually happening in that physician's individual practice what his experience is.

ASSEMBLYMAN SALKIND: You think, therefore, that the performance record should be the determining factor?

DR. TODD: The loss record in terms of professional malpractice - and I agree with you, I don't like the term malpractice ---

ASSEMBLYMAN SALKIND: I don't even want to use it.

DR. TODD: We have to recognize the fact that there are categories of malpractice and negligence and that there are areas where this is no malpractice, where there is no negligence, but still injury. What I am saying is that an individual physician's malpractice record should have something to do with the rate he pays for insurance.

Actuarily probably the guy who is having the greater patient contact has the greater liability and probably is going to have a higher rate of liability experience. But I think that has to be documented and proven. I don't think you can put a blanket percentage on anybody's premium.

ASSEMBLYMAN SALKIND: I think one of the problems here is that all of us are trying - and I am sure it is equally true of the Society and its members and certainly its chairman and any of the professional categories -- we are all trying to work toward some objective. The problem is we are not sure what our objective is. We are all concerned about the runaway costs. How does the Society feel about the problem of the runaway costs on the hospitals that we have alluded to, the Commissioner of Health alluded to, and the

Chairman mentioned briefly at the beginning?

DR. TODD: I think probably basically the same problems apply, but I think it would be inappropriate where we have so many problems of our own to comment on the hospitals' problems when we are not really conversant with the dollar and cents figures of the problems. We have in all our hospitals obviously various committees which review professional performance and competence. We feel that on the medical profession's side of the fence, we are doing a good job. As you have heard earlier this morning, many hospitals have their infection surveillance programs and other programs calculated to reduce the incidence of liability. But this is a hospital problem.

ASSEMBLYMAN SALKIND: I don't know. I wonder if it really is. I served on the Board of Trustees of a hospital for a good many years. Our medical staff took great part in the deliberations of that board because, after all, the hospital was the practicing vehicle for the physicians.

I wonder what your opinion would be regarding the elimination of the $10,000 limitation that was referred to earlier? Would that solve some of the problem in any way?

DR. TODD: It probably would spread the risk. Again I am not really qualified to comment on that particular issue.

ASSEMBLYMAN SALKIND: Okay. At this point, I think I have concluded my questions and I thank you.

Senator McGahn.

SENATOR MC GAHN: Thank you, Senator Kennedy.

ASSEMBLYMAN SALKIND: I should be as good-looking --

SENATOR MC GAHN: But you are talking about national health insurance.

Let me respond by saying, certainly the total reparation system of no-fault is without the ability to be practiced or put into effect in this country without the

federal government subsidizing it. Indirectly, of course, every taxpayer pays the federal government.

I think there are a couple of things that have not been mentioned before. Since you were talking about the fact that you did not want to use the term "medical malpractice" - and I think certainly it should not be - "professional liability" or what not, I might suggest there has been one little doctrine that has been neatly bypassed up until this time, and that is basically the doctrine of proximate cause as far as the injury is concerned. I would say in a number of circumstances in a cause for action, this is neatly circumscribed. Basically, is the adverse effect that occurs the result of a positive action, an inadvertent action on the part of the physician, or is it part of the disease or illness that the patient is suffering? I think this, very frankly, is another important consideration.

Assemblyman, it would be an extremely difficult thing - and I think this is something that has not been solved yet - to legally define what is a compensable event or what is a compensable injury in a medical sense, as far as that is concerned.

Doctor, you mentioned loss control programs and you had statistics concerning this. I think in the absence of Senator Greenberg, this Commission would appreciate a copy of those if they are available for our perusal.

On page 14 of your testimony - and, very frankly I think this is a very important thing that should be corrected by legislation - you mention, "A little known impediment to medical discipline and requirements for excellence is the current judicial posture. . .," etc. I think you are aware of the Darling decision and the corporate liability as far as hospitals are concerned and basically their responsibility as to the members of

the staff under them.

My own personal feeling is that the legislation that should be enacted would be to permit rules and regulations of a hospital to discipline their staff members and then, of course, give them immunity against this type of thing. I think this would be the proper approach here rather than have the general statute putting it down. I could not agree with you in that particular respect. Other than that, I have no further comment.

DR. TODD: Could I respond to that last statement? The simple fact is that the Joint Commission on Accreditation of Hospitals, the Darling decision, and all the other decisions that have been promulgated have not solved the problem of the Norks and the Marcuses. The profession has to do this. The hospital is three businesses under one roof, if you will: It is the care of patients, the maintenance of a staff and the maintenance of a physical plant.

The tensions within a hospital in the interpersonal relations make it very difficult for any hospital staff to adequately protect itself against these events. Therefore, it has to have some third party disinterested group who will promulgate the regulations, investigate the situations under which they occur, and make recommendations to the appropriate authority.

ASSEMBLYMAN SALKIND: Senator Hagedorn.

SENATOR HAGEDORN In your talk you indicated that the suits have increased approximately 225 percent in five years. I was wondering if you would want to elaborate on that, particularly when we have better-trained physicians today than we have ever had. I know that most of the problems have been directed against physicians, at least the inference has been there. Is it possible that the wide latitude on the part of the Supreme Court decisions has promoted that kind of a situation?

DR. TODD: I think there are several factors involved. One, first of all, is that there are just more people seeing doctors. The more people that see doctors, the more untoward results may occur, the more hostilities that may be generated, the more anxieties that may occur.

Secondly, the techniques that are available to physicians are much greater than they ever were. The individual, for example, who has had a heart attack and who requires a cardiac catheterization - a certain percentage of these patients will have further damage to the heart during the course of the catheterization. Yet, if it were not done, many, many patients would go on and die of uncorrected heart disease that is correctible. So if the American people want progressive medical care, there are certain inherent risks that they must assume.

Thirdly, is the judicial attitude on the statute of limitations as seen through the loophole of the discovery clause. In effect, there is no statute of limitations. When you see in New York State the acts that a doctor performed a decade ago, under the best of medical standards, now held to the light of 1975 standards, found guilty of negligence, it makes no sense whatsoever.

It is a many-faceted area. I think also lastly is the public attitude and, as I suggested, litigation has become a way of life. Everybody sues everybody for everything they can think of.

So it is a societal problem as well as a professional problem.

SENATOR HAGEDORN: You also say that 82 percent of the judgments went to the plaintiff and that would include the attorneys' fees?

DR. TODD: We do not have figures to break that down any further. But our figures indicate that 82 percent

of our premium dollar goes to the plaintiff and his attorney.

SENATOR HAGEDORN: That's all I have.

SENATOR MC GAHN: I intended to hold this for Chubb, but since you apparently are knowledgeable in this field, what is the average cost of settling a claim in the State today?

DR. TODD: I would have to defer to Chubb on that. I can tell you what the average cost of defense is, but I can't tell you the average settlement cost.

ASSEMBLYMAN SALKIND: Doctor, you get me again. And I am not Senator Kennedy. If I were, I could really zero in.

DR. TODD: We grew up in the same town together. So it wouldn't be hard to ---

ASSEMBLYMAN SALKIND: Congressman Howard and Secretary Simon grew up together and I grew up with Commissioner Bardin, but I am not sure what that matters in terms of outlook.

The problem here is outlook, and I must say it very sincerely. I see some problems between us: the reference, for example, just a moment ago to the 82 percent. I don't mean to be insulting. Please don't take it that way. I don't believe the figure; it is absolutely wrong. Of course, part of it could be what you shove in and say goes to the plaintiff. I think that the figures that I see, which frankly come right out of your own Society, down the line, are much more realistic, in the order of specifically 18 percent the other way, that the plaintiff or the patient ends up only getting that order of magnitude and that 80 percent plus of the moneys that get collected, if you will, for the insurance premiums, end up going to other ends, whether it is contingent fees or administration or profit or management fees by the parent companies or

dividends or whatever. I can't believe there would be that great a discrepancy unless we are defining our terms differently.

DR. TODD: I think we probably are because we are not trying to define where that 82 percent went. All we are saying is that our figures show that of the premium dollars, 82 percent go to other than maintenance of the insurance company, defense of the cases, and physicians. What happens to the 82 percent after it leaves the insurance company, we don't have records on: How much does the attorney get? How much goes into court costs, administrative, etc., etc.?

ASSEMBLYMAN SALKIND: Why don't we have good records. I would think that the Medical Society of New Jersey would be one of the strongest forces in wanting to know.

DR. TODD: We would love to get that information if we could.

ASSEMBLYMAN SALKIND: I think maybe one of the purposes of this Committee will be to get that kind of information so that we know what the truth is. As we go through our hearings, I am sure we will be asking this of both the insurer to the Society and other witnesses. That is something I know that I want to see and I think we all should know what the actual figures are.

I have been working very closely with our County Society, which indeed will have some presentations later, and have developed some thoughts as to what does need reform. Indeed, I am prepared to initiate legislation on that already, but want to hear some of your thoughts. There are some areas in which I agree with you and some I don't.

One of the things you advocated earlier was a limitation on the amount of awards. Do you have a specific figure in mind?

DR. TODD: The Medical Society, if approved by the House of Delegates, is thinking in terms of limitation of physician liability, not necessarily limitation in award, because as you are well aware there are other sources of revenues available. We are talking at the moment in terms of limitation of physician liability in terms of $500,000.

ASSEMBLYMAN SALKIND: So you are advocating that the physician liability - physician would include, for example, surgeon and any other speciality - would be limited under all circumstances to $500,000.

DR. TODD: Except in the face of wanton disregard for human life and activity.

ASSEMBLYMAN SALKIND: Let's say that there is a situation which I will make up, which is not necessarily negligence, but where a patient who is a young adult or an older child, ends up being completely destroyed as far as potential for activity, but very alive in terms of over-all body activity. That patient is now bedridden, requiring full maintenance. And by definition, I will say according to our normal statistics that patient has a 50-year plus life expectancy at that particular time and will require $30,000 a year for maintenance. What are you suggesting that we do - pull the plug out after $500,000 has been used up?

DR. TODD: No. First of all, you have to once and for all establish the fact that this act was the true result of professional negligence before I will buy that the physician must be responsible for his entire sustenance. Secondly, if the individual is given $500,000 and if this is in a structured payment or in an appropriate investment program, what is going to be the income from that over the years? And could perhaps not this $500,000 be the principal of an investment program which would sustain

that individual forever?

ASSEMBLYMAN SALKIND: In other words, you are saying that annuity methodology would satisfy it.

DR. TODD: We plan to make proposals regarding structured payments, taking into account this very problem. As it is now, an individual may get a large sum of money in a lump sum and through either bad advice or other means, it may be gone in a very short space of time.

ASSEMBLYMAN SALKIND: We agree then that the limitation you are thinking in terms of what it costs rather than the utilization of it.

I agree that a $500,000 cash settlement would translate into $30,000 a year over many, many years. You would agree that in that circumstance that would be satisfactory. You are not trying to limit the total amount of receipts to $500,000.

DR. TODD: Not at all.

ASSEMBLYMAN SALKIND: Then I don't think we have a difference of opinion in that regard. I think this has to be covered very clearly because the general public is confused by what are apparent differences. I think we would agree under the circumstance as we have just interchanged it.

Anything else, Senator?

SENATOR MC GAHN: Since you brought up the question of a ceiling on awards, I think the Doctor is well cognizant of the fact that this has been declared unconstitutional in Idaho. And it is quite possible it would be declared unconstitutional in most other states.

I would like to hear your comments, however, in relationship to what Assemblyman -- What's your name? Bardin?

ASSEMBLYMAN SALKIND: I'm Kennedy.

SENATOR MC GAHN: I'm sorry.

Don't you think there is need for something other

than a lump-sum award in the circumstance that Assemblyman Salkind cited where it is necessary to have continuing care over a certain period of time and then rehabilitation beyond that time? I mentioned this to the gentleman from the American Trial Lawyers Association this morning. I wish you would address yourself to the issue of lump-sum awards as opposed to continuing awards with rehabilitation.

DR. TODD: First of all, let me say that we are not in favor of limiting the award. What I said was that we were in favor of limiting the physician's liability in the award. They are two different things.

Secondly, it becomes, I think, very important that the lump sum, if indeed it is a lump sum, have some sort of administrative leash put on it or it be a structured payment, which is available in some states under court control, where the total dollar amount of the award is determined and then the method of pay-out determined by the court, either into an annuity or into a program calculated in the best possible fashion to return that individual to a self-supporting state or to maintain him throughout the rest of his life, whichever is more feasible.

This is one of the big problems at the moment: What happens to some of these severely injured people who never again are self-supporting, whose moneys run out after their settlement? Some ten or fifteen years later they become wards of the state.

ASSEMBLYMAN SALKIND: I have three rhetorical comments.

First, obviously I will never understand why the Society objected or objects to mandating required minimum malpractice insurance. Obviously, I would be willing to work with the Society on the figure, but the concept is what I question.

Secondly, I will never understand why the Society wouldn't have really stood fast against the recent proposed increase and any future increases because I don't think we have enough statistics to justify them.

My third comment: I just want to compliment the Doctor as being one of the finest witnesses I have ever heard anywhere. Thank you very much.

DR. TODD: Thank you.

ASSEMBLYMAN SALKIND: Our next witness - and we are going to continue until one o'clock - will be Dr. Burt, representing the Morris County Medical Society, whom we thank for the communications we have gotten the last several weeks.

D R. D O N A L D P. B U R T: Assemblyman Salkind and members of the Committee: By way of introduction, I would like to introduce myself as a physician in private practice, internal medicine and primary-care physician. I am not a super-specialist. I am the President of the Morris County Medical Society. We thank you for allowing us to make a statement here. We represent approximately only 460 physicians, but we have many different specialists included. However, our consumers or recipients of health care are in the order of some 400,000 people.

At the Chairman's request and because much of this has been covered in previous testimony, I will try to hit the highlights of our statement.

The first thing I would like to say is, yes, we do agree that there is a crisis in availability and costs of physician liability insurance.

We would also like to state that doctors are human and that we have been at fault more than once, like anybody else, and it is important for us to "clean our own house." I would like to point out that with the multiplicity

of hospital controls at the present time - doctors' tissue committees, audit committees, etc., on down the line - we are attempting to do this type of thing in our own local hospitals.

The Morris County Medical Society also has a claims review or peer review committee, which has reviewed many cases - some 70 in the last two years have been brought before its attention - and we also have as part of the Medical Society of New Jersey a judicial committee which considers malpractice or moral issues.

Now, with that out of the way, yes, I have heard that there are some doctors that are thinking of leaving the practice of medicine. That is true. These are usually in the high-risk groups. None in our county has left so far. But the possibility is there as is also the very definite possibility of the practicing of defensive medicine, increasing the cost of medical care.

As mentioned before, we feel that the cost of medical care eventually will be passed on to the consumer and we do not like to see this in the least. Who then should assume the cost of medical care? Should it be the medical profession? We feel not,for reasons that you have heard previously. Should the insurance industry? We feel that they should not be entirely responsible. We have talked at the county level with our brokers and with other insurance men and we do see that they do have a definite problem.

Finally, should the consumer assume the cost? And the answer should definitely be no. We don't think so.

Therefore, we have investigated to the best of our ability what the potential answers are to this. We don't feel that reinsurance is the only answer. We don't feel that just having insurance available is the only answer. As a matter of fact, as you have heard,

in New Jersey it is available to us at less cost than other states.

So, therefore, we have come up with the same conclusions you have heard previously: that the laws must be changed in some fashion to get a more equitable system. One is the creation of a panel composed of medical experts, lawyers, and perhaps a judge. I heard it mentioned earlier that this is present in New Jersey and isn't working. I have, myself, served on such a panel, and the reason it isn't working is because it isn't binding unless the plaintiff so states that he will be bound. And what plaintiff is going to state that?

A second corrective thing that we would like to see is the establishment of a realistic limitation on the time in which a patient may formally file a medical malpractice charge. You have heard much about this also.

We also feel that a statutory definition which limits medical practice to any proven act, not in conformity with accepted standards of care is reasonable - res ipsa loquitur.

We believe consideration should be given to a plaintiff's collateral sources of income, including insurance or employment benefits, before the final value of a malpractice claim is set.

We realize that there are many other solutions to this problem that you will be looking into and that these are not the only answers.

We would like to again thank you for your consideration and I will be glad to answer any questions if I can. (Complete statement of Dr. Burt begins on page 52X.)

ASSEMBLYMAN SALKIND: Thank you, Doctor. I must again thank you for the series of communications that I know you sent to me and I assume you sent to all members of the Joint Committee over the last several weeks. I have read each of them and they have been most informative.

DR. BURT: Thank you.

ASSEMBLYMAN SALKIND: My questions will be limited to the general area that I addressed to Dr. Todd.

Don't you think that in this day of suits and everything else we should mandate at least a minimum amount of coverage to all physicians and health care institutions?

DR. BURT: Well, it is one possibility that I haven't really thought too much about. Of course, with the usual American system where you have freedom to do what you want, I think that this is a factor to be considered. I personally think very few physicians will go without malpractice insurance, although I have heard of one who is threatening to drop it at the county level.

ASSEMBLYMAN SALKIND: I must tell you that the Commissioner of Insurance presented me with data which show, particularly as you get away from the most urban areas and the better suburban areas, such as your area, it tends to become more and more of a problem, also where you have some of our State and federal institutions where the practice generally is limited to that, but every so often someone goes outside. It becomes a problem with some of these physicians who for reasons of their own choose not to have such insurance.

Don't you feel, if we get away from the word "malpractice" and talk in terms of patient protection as well as doctor responsibility, that in reality the patient should have the right to be fully protected when he or she walks into a physician's office or a health care facility?

DR. BURT: That is a very good point. I would like to point out that the reason physicians now are choosing to drop insurance is because of the premiums and I think this is a very real problem on our part. If they had such a rule at the present time, you would certainly hear a big uproar from the physician who wanted to drop out of certain high-premium risks if he was not allowed to do so.

ASSEMBLYMAN SALKIND: You heard Dr. Finley talk about the various hospitals. She mentioned the one in Morristown with an 806 percent - I'll look it up, but I think it was 806 percent - increase over the last year. Now are the doctors in Morris County concerned about that kind of thing?

DR. BURT: Well, we are very greatly concerned with it. I know our hospital trustees and the physicians on the board are very concerned with this absolutely fabulous increase in premium that amounts to, I think, $5 or $10 per patient that will have to be an extra charge apparently.

ASSEMBLYMAN SALKIND: Don't you feel that that gets so out of hand so quickly that something has to be done about it, if you will, even on an emergency basis to stop that kind of continuing increase?

DR. BURT: It is not my place to say so. I certainly hope that it will be solved very quickly.

ASSEMBLYMAN SALKIND: I have a problem and I hope the very next person who is going to be testifying for the Hospital Association doesn't take offense at what I am going to say. Maybe in western Monmouth County this is the way we think, but I always thought - and I served quite a term as a member of the Board of Trustees of our hospital - that the physicians run the hospital, not the administrator, not the Board of Trustees, but, in reality, the physicians, the senior physicians particularly, run the hospital philosophically. Am I wrong?

DR. BURT: They run the hospital regarding policy. But when it comes to costs, when a physician wants a new piece of equipment, he has got to buckle down to the hard facts of his Board of Trustees and this is a problem also, especially with the rising cost of hospital care.

ASSEMBLYMAN SALKIND: All right, I understand what you are saying. One last area of concern, and that is on the

limitation of awards, as you heard me asking Dr. Todd. Would you buy, I don't mean to call it compromise, but the change in terminology that he and I ended up agreeing to; namely, that we would have the $500,000 limitation to the physician, but it would translate into an ongoing annuity, so that whatever the cost of maintenance over even a 50-year period would be covered? Would you buy that concept?

DR. BURT: I would buy the concept, but I am not an accountant and I don't know what the ins and outs are. But I certainly would limit the $500,000 to the physician liability part of it.

ASSEMBLYMAN SALKIND: See, the annuity idea is a very sound idea. It is one that I remember advocating at an earlier meeting of our own committee back in the summer. I feel very strongly that that is an aswer and it is a good answer. I don't like the straight limitation, but if the limitation translates into an annuity, therefore, it becomes effective. As long as the patient is protected that's what the whole thing is all about - and having nothing to do with negligence. I think our problem is that the doctors have really focussed in on the word "malpractice" and I hope that one of the easy things we will be able to do is define the word because I think once and for all that is not our problem. I think our problem is patient protection and the soaring costs that are costing the medical profession in the greater sense, which includes hospitals as well as physicians, so much. It seems to me that that is our number one problem.

Thank you again for a very, very fine job of keeping us informed.

Dr. McGahn.

SENATOR MC GAHN: Thank you, Assemblyman Salkind. What he is actually proposing here is a new form of the New Jersey State Lottery. Go in for elective surgery and

get $25,000 a year for the rest of life.

I would like to ask the doctor a couple of questions and also respond, if I may, to something that is disturbing my colleague to my right, and that is: Why will a physician not take out malpractice insurance? I think there can be a number of reasons. But I have not heard here today one of the primary causes for suits being filed, and that stems back to the rapport between physician and patient. One can find in a number of circumstances that patients may not get, should I say, the end result they expect, but good rapport is had and the patients are not simply considered as numbers. I think unfortunately this happens to be the difference between primary health care physicians and internists. Individuals referred to surgeons sometimes may not see them until they are in the anesthesia room outside of surgery. They may or may not see them afterward. Then they are sent back to the referring physician.

I think this is an extremely important thing. I believe your family physicians and your old family doctors, those involved in primary health care, take time with their patients and,because of that,informed consent is never a problem.

You may wish to comment upon that aspect of it, if you would, Doctor, but I would like to ask you now: In Morris County, given a particular set of circumstances in which there is a claim brought against a physician - let's say in this instance it is malpractice on the basis of negligence, and negligence very definitely has been proven and it is a rather obvious type of thing -- assuming this occurs in the hospital - I'm not talking about outside - do you have any mechanism whereby the man is not disciplined, but at least is brought before some type of board or panel where the results are actually pointed out with the hope, of course, that this type of situation will not be repeated?

DR. BURT: The answer to that is, yes; whether it is 100 percent adequate or not, we are not prepared to say at the moment. Yes, there are several checks and balances which are under the control of the medical staff rather than the non-medical staff. It comes right from the initial complaint committee right on up to the chief of medical staff, the executive committee, etc.

We have at the Morristown Memorial Hospital in the last 15 years or so I have been there - 20 years - had two or three instances come to our attention, which were corrected to the best of our ability in that respect. So there is a mechanism handy at the moment. As you have also heard, the PSRO is now becoming active in all of New Jersey.

I agree with you on your first comments that the physician-patient relationship, the one-to-one relationship is perhaps the most potent detriment to malpractice or physician liability that we have at the present time. I think it should be preserved.

SENATOR MC GAHN: Doctor, thank you for that. Incidentally, most medical societies, county medical societies and most hospital staffs have that same mechanism that you are talking about.

Very frankly, in repudiation of the learned gentleman this morning who was appearing for the Trial Lawyers Association and who said that the chief cause of malpractice was poor quality medical care, again I disagree with that blanket statement.

ASSEMBLYMAN SALKIND: Thank you, Senator.

I thank you very much, Doctor, for your appearance and I think it has been most helpful. I agree with the comments between you and my senior colleague to my left on the importance of the physician-patient relationship. I think our whole problem certainly has been catalyzed by the elimination of what was such a very close relationship into more of an impersonal one - no question about that.

DR. BURT: Thank you very much.

ASSEMBLYMAN SALKIND: Before I move to recess, which I will do because it would be unfair to the next witness to do otherwise, I would like to point out that we are running somewhat behind schedule. We will continue to follow the order Senator Greenberg has given me here. But it may be there is someone who will wish to defer until the next meeting,because we do want to hear everyone, particularly some of the specialized and qualified people, and we will be holding additional hearings here in Trenton as well as elsewhere, I hope, in a very, very short time. The record will not be closed and we are anxious to hear from all of you. If there is anyone who wishes because of time delay on this Friday to be scheduled for the next time, if you will see me when we recess, I will appreciate it.

(Recess for Lunch)

AFTERNOON SESSION

SENATOR GREENBERG: Ladies and gentlemen, the hearing will now reconvene, and our next witness will be Mr. Jack Owen of the New Jersey Hospital Association.

J A C K W. O W E N: Gentlemen, Senator, thank you. I will not read my statement since you have copies of it and in view of the time restraints you have, but I would like to make some comments regarding it. (The complete text of Mr. Owen's statement may be found at 59 X.)

First, I think in view of what happened yesterday in regard to the Insurance Commissioner's decision to not allow St. Paul to go on a claims-made basis, that we are again facing a very serious problem in New Jersey with regard to our hospitals. We have some 39 hospitals which are insured by St. Paul, and we have been notified that over the next two years, they will not be picked up when their policies expire.

I would like to, if I may, just briefly state that I think our problem, and one this committee has to address itself to, is one of, first of all, public policy. It is a problem of how do you tackle the whole issue in the best interests of the public and the providers and the insurance companies. It seems to us that the two major sources of the problem right now are the availability of insurance and the cost of insurance.

The cost of insurance in the past year has risen, actually soared, in our hospitals almost 1000 percent. Hospitals who were paying $70,000 or $80,000 a year for total coverage are now paying somewhere around $700,000 to $800,000 a year.

It seems to us, as we look at the problem that exists here in New Jersey, there are several reasons why availability is difficult and why costs are beginning to grow. Basically, it has to do with some very important

issues: the statute of limitations being one, collateral source being another and the way in which funds are handled. We think this committee has got to take a look at all of these problems because we are not going to have insurance available.

The insurance companies can't reserve funds at today's premiums not knowing what the economics are going to be and what is going to happen 20 years from now. I can cite that we had 27 hospitals with Argonaut Insurance Company for ten years. During that ten-year period of time, the hospitals paid some $7 million in premiums, and the insurance company paid out about $1.6 million, so they are still sitting on some $5.5 million of hospital money in reserve. Yet, they tell us they cannot release any of this. They, in fact, withdrew from the market primarily because there is no statute of limitations to solve the problem.

So, it seems to us that there are certain things that need to be done, and first, we believe that a statute of limitations must be enacted. We think it has to be a short statute of limitations from this standpoint: If you are going to look at "no cap" on award, if you are talking about unlimited awards, the statute of limitations should be something like two years. For the protection of those patients who have a late discovery problem or are in a situation where they need longer than two years, there ought to be a patient compensation fund of some sort out of which the awards will be made rather than out of insurance premiums. We think a special compensation fund should be established and that an award on that special fund should be limited to $500,000.

ASSEMBLYMAN SALKIND: I'm sorry; would you repeat that?

MR. OWEN: We think that a special compensation fund should be established to take over after the two-year

statute of limitations and that any award on that be limited to $500,000.

ASSEMBLYMAN SALKIND: Five hundred thousand dollars?

MR. OWEN: Yes.

SENATOR GREENBERG: I want to be sure I understand this. Is $500,000 the limit you are suggesting for the patient compensation fund?

MR. OWEN: What I am saying is this: If a patient is injured, within two years' time of that injury, he should be allowed to bring suit for whatever amount the jury will award. After that - we find that most injuries are discoverable within the two-year period of time - if a patient for some reason has been unable to discover such injury, at that point he would be handled through a special patient compensation fund, and there would be a $500,000 maximum award. That doesn't mean he would get $500,000; it would still go through due process, but the award would be limited to that amount. He would bring action in court the same way he would during the first two-year period.

In order to treat minors, we think the statute of limitations should again be two years, and for later discovery, it should run to five years past majority, or 23, at the present time, so that a minor would be protected for a late discovery.

We think a medical review panel should be established, and the panel should consist of physicians and lawyers, and evidence coming from this panel review would then be used in court.

We think also that the issue of collateral source is one that needs to be looked at. I f a patient has been paid for his medical claims through an insurance policy, we have worked for many years on what we call "coordination of benefits," so that he will not make money on the fact

the he has gotten sick. We think that same rule should apply on awards; money that has been paid for his care should be deducted from the award.

From the standpoint of what we can do while we are waiting for some legislation - we realize there will be many hearings, and we understand that everyone has different ideas about how it should be done - we think we have a very serious problem here in New Jersey, and I think we are doing something about it. One of the things we have been doing in the past year is developing programs which will help prevent as many of these malpractice claims as possible. At the present time, we have some 30 engineers with the New Jersey Hospital Association working with hospitals on safety and on cost containment. This has been part of a program developed five or six years ago at the time we were looking at hospital costs.

Just recently we started a second program which we call the "biomedical engineering program" in which we have biomedical engineers visiting hospitals and inspecting equipment from the standpoint of whether they are electrically safe and reviewing all of the monitoring equipment to see that it is calibrated, those things which could, in the long run, create problems and lead to law suits.

In regard to covering hospitals insofar as liability insurance is concerned, we have been looking for the last eight months, since the Argonaut situation, at the possibility of establishing a captive company in New Jersey. We have had actuaries review the statistics in New Jersey, and we feel that this is a very necessary program and one that can be handled in our State.

We have not had the large awards that you see in New York and California. In the ten years we had the Argonaut program, we had only three awards over $25,000.

One was for about $26,500, another was $52,000, and another was $106,000. So we don't think the large awards, at this point anyway, are a problem here in New Jersey.

ASSEMBLYMAN SALKIND: Is that in your prepared text?

MR. OWEN: No.

ASSEMBLYMAN SALKIND: Would you please repeat it then?

MR. OWEN: I did say I would comment on the prepared statement, and I apologize. I said that in New Jersey we have not had the large awards made against hospitals that we have seen in California and New York. In the ten years that the 27 hospitals were in the Argonaut program, there were only three awards over $25,000. One was $26,500, one was $52,000, and one was about $106,000.

SENATOR GREENBERG: May I interrupt you a moment? Do you have a source for that information?

MR. OWEN: Yes, I do.

SENATOR GREENBERG: What is that source?

MR. OWEN: The source is the statistical data from the Argonaut Insurance Company. These were the figures we obtained from them through a New Jersey Hospital Association-sponsored program. I can make the statistics available to the committee.

SENATOR GREENBERG: Would you be kind enough to submit the report from which you derived these figures to the committee?

MR. OWEN: Certainly.

SENATOR GREENBERG: Thank you.

MR. OWEN: In summary, I might say that we think any legislation you come up with must protect the public as well as the providers, and I think it is important that you understand that medicine is not a science; it is

an art. As long as there are different ways of determining what is good medical care and different judgments, there are going to be questions raised as to whether it was done properly. Such questions are going to lead to claims, and there must be a mechanism to protect and equitably balance the interests of all involved.

SENATOR GREENBERG: Thank you, Mr. Owen. I appreciate very much your appearance and your thoughts. Would you mind repeating for me your position with regard to the statute of limitations as it would affect minors?

MR. OWEN: Our position with regard to minors is this: We think there should be a two-year statute of limitations for everyone. However, in addition to that, in order to protect the minor, we think that the minor should be allowed to bring late action up to five years past his majority, or, in other words, age 23. We are saying there would be a ten-year statute of limitations after which no action could be brought. The first two years would be unlimited, and the next eight would be through a patient compensation fund rather than through the regular insurance premium. We suggest that this patient compensation fund might be established by having a pool developed based upon a surcharge to the providers not to exceed 10 percent of the---

SENATOR GREENBERG: I'm clear on that, but I'm still confused on the minor statute of limitations.

MR. OWEN: If you are a child of six and you have something happen to you in an institution, you have two years to sue for unlimited damages. During those two years, you know pretty much what is going to happen if it's a bad case. If it's not and it is just a case of waiting to see, you have until age 23 at which time you would be limited to the $500,000. After two years, you

would come under the patient compensation fund.

SENATOR GREENBERG: Your proposal, then, is that there would be a limit of $500,000, with regard to minors, up to age 23, that is, age 18 plus five years, and there would then be a cutoff.

MR. OWEN: That's right.

ASSEMBLYMAN SALKIND: I want to make sure I understand this. Basically, what you are saying then is that there are two years unlimited.

MR. OWEN: Right.

ASSEMBLYMAN SALKIND: Then in the case of an adult, there are eight years additional, and in the case of a minor, it is up to age 23.

MR. OWEN: That's correct.

SENATOR GREENBERG: On that subject, as well as the other areas dealing with collateral source, review panel, the other statute of limitations, the maximum, patient compensation fund, etc., isn't it fair to say that what you are really doing is giving us the view of the insurance companies since that is the business they are in?

MR. OWEN: I beg to differ; I don't think so. I think if the insurance companies had their way, they would probably say a flat two-year statute of limitations and maybe an award on top of that two years. We met with a coalition, if you want to call it that, with trial lawyers in attendance. The New Jersey Bar was in attendance as well as the Medical Society, the Dental Association, and a patients' rights group representing patients. We talked about what these concepts might be. It seems to us that every bill that has been written in every other State was either designed by hospitals or lawyers or insurance companies. We felt there had to be a public policy issue here and that the public had to be protected. At the same time, we recognize that letting the public go

the way they are now, the costs are going to be so high that nobody will be able to afford any kind of health insurance.

What is happening is that every patient who comes into the hospital gets a whole battery of tests where he may not even need them, but the doctor must protect himself, and he practices defensive medicine. I cannot say that I blame him.

So there has to be an overriding interest on both sides. And the feeling was that with this concept, these groups could buy this kind of approach.

SENATOR GREENBERG: What you are doing then in effect is assuming the reliability of the insurance company's estimate, or position, that there is no way they can determine what portion, if any, of the $5.5 million, for example, can be utilized or credited. They don't know where they stand with the $5.5 million because of detail, and you are assuming that that position is correct.

MR. OWEN: I think you have to assume that since anyone can bring a suit today from 1963, and the premium at that time was about $1200 per hospital.

SENATOR GREENBERG: Except that if you took the figures you gave us having to do with awards against hospitals, for example, and the number in excess of $100,000 and below $500,000, and did an actuarial study, not only in the State of New Jersey, but nationwide, you could, could you not, conclude that that assumption is not correct?

MR. OWEN: We have done a lot of arguing with insurance companies because we have made that assumption, but we cannot really back it up because tomorrow there could be a $4 million case that would wipe it out. I am not an actuary, and I don't know whether that would be the case or not, but the potential does exist.

The other problem, of course, is that a company

may be insuring New Jersey hospitals as well as hospitals in other States, and these awards have existed, and they point to them very quickly and say, "Here is a case in California where a $10 million award was made. What is to prevent that from happening in New Jersey tomorrow? So $7 million isn't nearly enough, and we're going to lose money."

SENATOR GREENBERG: Ten million might not be enough.

MR. OWEN: That's correct.

SENATOR GREENBERG: What is the position of the hospitals with regard to the establishment of their own insurance facility?

MR. OWEN: The hospitals have taken a formal action to establish a facility. We have been working on it since last March, and we are about ready to incorporate. We are hoping we can get assurances through the Insurance Commissioner's office that this company will be licensed. We are planning at this point to utilize an insurance company to provide the service for claims, etc., since we are not experts in insurance, and we want to have that kind of expertise.

SENATOR GREENBERG: Do I understand you to say that you are proceeding in this direction with the desire to accomplish that objective no matter what happens?

MR. OWEN: Yes, I think we must.

SENATOR GREENBERG: Let's take a step back then to the immediate problem. You have a number of hospitals in this State, do you not, who are now in jeopardy with regard to the unavailability of insurance?

MR. OWEN: That is correct.

SENATOR GREENBERG: What are you doing about that?

MR. OWEN: We have been meeting with insurance companies, and to date, we are not finding any companies that want to pick up any more risks in the State of New Jersey. We have, not in writing, but verbally, some assurances from several companies that if we were to move on a captive company, they would be willing to bind these hospitals until such time as the captive company were in operation. The 39 hospitals that are now faced with termination do not all come due at the same time. We have only three in which that will happen before January, and after that, it's about a two-year spread.

SENATOR GREENBERG: One of those three hospitals is Fairlawn Memorial, and I have it listed as December 2, 1975.

MR. OWEN: That's correct.

SENATOR GREENBERG: You're not going to have anything in place by then with regard to a new facility, I assume.

MR. OWEN: We may not have it in place by then, but we should have it well enough along the way to know that it's going to work, and if we can get a binder to hold the hospital until such time as all clearances and licensure takes place, that would be our approach. We have some verbal commitment to this at this point.

SENATOR GREENBERG: Will you tell this committee what specific carriers have refused to expand their coverage in this State?

MR. OWEN: Have refused to expand coverage?

SENATOR GREENBERG: Yes.

MR. OWEN: St. Paul, of course, is the one that is moving out. As far as those refusing definitely, I don't know that I could really say that because I haven't seen it in writing, but we have talked with Hartford, Continental, Maryland Casualty, and Federal, and all of them, I would say at this point, are very relunctant.

But we have not been informed in writing yet that they are not going to pick it up.

SENATOR GREENBERG: Which companies have you spoken with that might give you a binder subject to another facility taking over?

MR. OWEN: St. Paul and Federal. Again, this is only verbal at this stage of the game; we have had conversations with them.

SENATOR GREENBERG: Mr. Owen, have you been here during the course of the day?

MR. OWEN: Yes.

SENATOR GREENBERG: I suspect then that you heard, and are otherwise familiar with, some of the concepts of peer review which you alluded to briefly in your remarks. Can the Hospital Association be prepared to submit a proposal to this committee as to what it intends to do by way of recommendation to its member hospitals or what it might suggest be done by way of legislation in this field, and if so, when?

MR. OWEN: Yes, we can make that recommendation probably by next week. The bill has been drafted, but I would like to clear it with my executive committee before their meeting Wednesday.

SENATOR GREENBERG: How do you feel about the necessity for doctors to have periodic courses so that their qualifications can constantly be updated and a certification to that effect be required in order for them to practice in this State?

MR. OWEN: I don't think I am the right person to ask. I think the Medical Society does have a program requiring a physician to get 50 hours over a three-year period, and my personal feeling is that that is a good program, and I think it is progressing very well.

SENATOR GREENBERG: What is your position with regard to the existing $10,000 limitation insofar as

hospitals are concerned? You didn't mention that.

MR. OWEN: I mentioned it in my prepared statement. I think we are faced with a problem here. The $10,000 really doesn't mean anything to us, to be very honest with you, because it only covers hospital corporations. Of course, when anyone is suing, they sue the nurses, the administrator, the Board of Trustees, and everyone else, and they are not limited to $10,000 liability. If the $10,000 liability covered the hospitals and its agents, we wouldn't even be here, but I don't think that would be in the best interests of public policy. The $10,000 limit, as such, has been sitting there for -- well, I've been in the State for 13 years, and I don't know for how long before that. From a practical standpoint, it has had little or no effect on premiums or on awards to my knowledge.

SENATOR GREENBERG: Does the list of hospitals which are insured by St. Paul represent the majority of hospitals in the State?

MR. OWEN: No. There are 105 general hospitals, and about 140 including the specialists and county and government-operated hospitals, and they represent 39, or about one-third.

SENATOR GREENBERG: Who represents the next largest group?

MR. OWEN: The next largest group is Chubb, Federal Insurance Company.

SENATOR GREENBERG: When does that contract expire if there is a contract for that group?

MR. OWEN: Each hospital has a contract of its own, and they come due at various times during the year. Some contracts are for a year, and some are for three years. Lately, they have all been annual.

SENATOR GREENBERG: Have you had conversations with Chubb with regard to their intentions in connection

with premium increases applicable to hospitals?

MR. OWEN: We've had conversations with them. I'm not sure I quite follow you. Do you mean with regard to what St. Paul has done?

SENATOR GREENBERG: Yes.

MR. OWEN: Yes, we have.

SENATOR GREENBERG: Could you tell us the results of those conversations?

MR. OWEN: Again, they were only preliminary, and I could not commit Chubb and would not want to give the impression I was, but our preliminary discussions gave the impression - again, this is my personal opinion - they are not anxious to pick up any more hospitals. They have a large number of hospitals in the State, but I think they might be willing to give a binder until such time as a captive company can be started. I cannot put words in the company's mouth.

SENATOR GREENBERG: Have you had meetings with the Commissioner concerning the structuring of this captive company?

MR. OWEN: We have had some preliminary meetings with his department, yes.

SENATOR GREENBERG: Is anyone in the process of preparing legislation to that effect?

MR. OWEN: Legislation?

SENATOR GREENBERG: Yes.

MR. OWEN: No, we don't believe it requires legislation.

SENATOR GREENBERG: Is your position that you only need permission from the Commissioner?

MR. OWEN: Yes.

SENATOR GREENBERG: Have you gotten preliminary indications from the department as to its feeling?

MR. OWEN: Yes, we have.

SENATOR GREENBERG: What are they?

MR. OWEN: The preliminary indications are that we can form a company and that the actuarial assistance we have had indicates that it could probably be operated at, we hope, less cost than what we are paying now for premiums.

SENATOR GREENBERG: Are there hospitals that are nonmembers of your Association?

MR. OWEN: No.

SENATOR GREENBERG: Are they all members?

MR. OWEN: Yes.

SENATOR GREENBERG: Would you make it mandatory or permissive that they participate in this program?

MR. OWEN: It would be permissive. It is not our plan to force every hospital into it if they can get coverage somewhere else.

SENATOR GREENBERG: Assemblyman Salkind, do you have any questions?

ASSEMBLYMAN SALKIND: Mr. Chairman, I want you to know it was a pleasure listening to your questions because you covered everything I ever thought of.

Mr. Owen, I would like to continue on the subject that the chairman was on. Chubb picked up approximately 30 hospitals that Argonaut dropped back in February, is that correct?

MR. OWEN: That's correct.

ASSEMBLYMAN SALKIND: They don't insure any other hospitals at present, do they?

MR. OWEN: Yes, they do.

ASSEMBLYMAN SALKIND: They do? How many others do they insure?

MR. OWEN: I don't have the figures, but I would guess four or five. I can think of Newark Beth and Overlook off the top of my head, and there are probably three or four others.

ASSEMBLYMAN SALKIND: So they are insuring

somewhere around 35 right now. According to what you said earlier, St. Paul is insuring 39. So those two represent approximately 70 percent of the 105.

MR. OWEN: That is correct.

ASSEMBLYMAN SALKIND: Who is the next largest?

MR. OWEN: I think it is Maryland Casulty, then Hartford and Continental, and there are a couple that have single hospitals.

ASSEMBLYMAN SALKIND: Senator Greenberg asked you before about the imminent jeopardy, and you said there were three this year; Fairlawn Memorial was cited as December 2, 1975.

MR. OWEN: Right.

ASSEMBLYMAN SALKIND: Who are the other two?

MR. OWEN: I think Dover is January 1, but I cannot remember the other one; I didn't bring that information with me.

ASSEMBLYMAN SALKIND: What happened with Helene Fuld? Have they been able to renew? Their date was indicated as August of this year.

MR. OWEN: They have been renewed then.

ASSEMBLYMAN SALKIND: They have been renewed?

MR. OWEN: Yes, we don't have anyone sitting.

ASSEMBLYMAN SALKIND: Dover, as you say, lists as January 1; Franklin lists as January 1; Middlesex County Hospital lists as January 1.

MR. OWEN: Are you talking about Roosevelt Hospital? I think that was the other one.

ASSEMBLYMAN SALKIND: Roosevelt is January 1; Reynolds in Berkeley Heights is January 1; Riverview in Red Bank in my area is January 1.

MR. OWEN: I don't know what list you're looking at. I only checked up to January to see what the immediate problem would be.

ASSEMBLYMAN SALKIND: You said there were three.

MR. OWEN: Fairlawn is the first one; that's December 2.

ASSEMBLYMAN SALKIND: If you go to January 1, there are a half dozen.

MR. OWEN: Beyond January, that is correct.

ASSEMBLYMAN SALKIND: January 1.

MR. OWEN: I didn't think there were that many. Is that 1976 or 1977?

ASSEMBLYMAN SALKIND: Nineteen seventy-six. Of course, at best, we are dealing with secondary, tertiary information, but we show as January 1 the following: Dover, Franklin, Middlesex County - I'm not sure what we're showing on Newcolmb; it shows January but no specific date - Riverview, Reynolds in Berkeley Heights, and Roosevelt in Menlo Park.

MR. OWEN: I have to check those against my list, but I was under the impression as I went down the list that there were only three due on January 1.

ASSEMBLYMAN SALKIND: I would like to ask you to send me a note on that directly, and I am sure the chairman and every member of the committee would like to have that. If we are going to have another real problem, it's better to know we're going to have a real problem.

MR. OWEN: I agree.

ASSEMBLYMAN SALKIND: Now I would like to get back to something you mentioned in your earlier remarks. You said that in 27 hospitals over a ten-year period - I guess you were talking about Federal, Chubb---

MR. OWEN: No, that was Argonaut.

ASSEMBLYMAN SALKIND: Argonaut?

MR. OWEN: Yes.

ASSEMBLYMAN SALKIND: These were 27 hospitals then that they gave up last February?

MR. OWEN: That's correct.

ASSEMBLYMAN SALKIND: So you are saying that during the ten years prior to last February, there were only three awards over $25,000.

MR. OWEN: That is correct.

ASSEMBLYMAN SALKIND: And those three didn't amount to a hill of beans when you look at it in terms of numbers.

MR. OWEN: That is correct.

ASSEMBLYMAN SALKIND: So the total claims paid out, in actual fact, to those 27 hospitals did not amount to a big number. Do you have that total?

MR. OWEN: They were paying out about 13¢ on a dollar premium.

ASSEMBLYMAN SALKIND: Thirteen cents on a dollar?

MR. OWEN: Yes.

ASSEMBLYMAN SALKIND: Thirteen cents on a dollar was paid out.

MR. OWEN: On a dollar premium.

ASSEMBLYMAN SALKIND: Yes, I understand.

Can you tell me how many awards there were of under $25,000?

MR. OWEN: The average award was $6,000.

ASSEMBLYMAN SALKIND: But you don't know how many awards were paid out?

MR. OWEN: I have that information, but I didn't bring it with me.

ASSEMBLYMAN SALKIND: Can you send that to me and the members of the committee?

MR. OWEN: Yes.

ASSEMBLYMAN SALKIND: Whenever I ask you to send something to me, I also am asking you to send it to every member of the committee.

MR. OWEN: Yes.

ASSEMBLYMAN SALKIND: Senator Greenberg covered minors and the general statute of limitations. The concept

of the secondary period, I think, is very interesting. Personally speaking, I think it has some real merit. I am concerned about the whole situation as to why you think you can get a binder from the same company that doesn't want to give you the insurance renewal.

MR. OWEN: In all fairness to the company, I think you would have to talk to them, but I think what they are saying is that they cannot really afford to take the risk of picking up that many more hospitals not knowing what is going to happen in the future with awards and no statute of limitations. I think perhaps they feel our captive company is going to become a reality, and to g i v e us enough time to get it established, they will hold them for that length of time.

ASSEMBLYMAN SALKIND: I look at the award history you just cited, and I assume it is projectable, and I recognize the fear factor that exists in the uncertainty because of the lack of limitations, and I think there is some validity in that. I look at the numbers that the Commissioner of Health testified to earlier this morning in terms of the rate increases for hospitals, plus the article I referred to in yesterday's statewide press, which talked in even larger terms, and I wonder whether you, representing the Hospital Association, could comment on the justification for the increasing dollar premiums based upon the experience you have seen.

MR. OWEN: I cannot justify it because I have been opposing it. I don't see the justification. We have nothing that indicates that justification. However, I do know that the ISO, which is the industry rating bureau, has increased the cost per bed in New Jersey from two hundred and some dollars to $536. Or maybe it was from one hundred and some dollars to $536; it was about 535 percent; I remember the rating figures. So that is where it starts. Again, the claims made don't

justify it, in our opinion, but again, I am not an actuary. I recognize the problem they are faced with with the economy going up, not knowing what the dollar will be worth tomorrow, and the fact that some big claim could wipe them out.

ASSEMBLYMAN SALKIND: You don't have any information on what happens to the rest of the dollar, do you? You said that 13¢ of the dollar premium is paid out. Does that include the amount of lawyers' contingency fees?

MR. OWEN: That would include everything paid out.

ASSEMBLYMAN SALKIND: In other words, the 13¢ includes everything including the amount that goes to the attorneys?

MR. OWEN: I think you have to be careful to not confuse the dollar award and break that up; that's not what I'm talking about.

ASSEMBLYMAN SALKIND: You're talking about each dollar of premium.

MR. OWEN: If the hospital paid $100 in premium, $13 of that was paid out.

ASSEMBLYMAN SALKIND: Including the lawyer's contingency fee?

MR. OWEN: That would include the whole award.

ASSEMBLYMAN SALKIND: So 87¢ is not getting paid out?

MR. OWEN: It's in reserve, that's right.

ASSEMBLYMAN SALKIND: My next question was going to be, how much is in reserve?

MR. OWEN: I would have to go back and look at my figures. The full 87¢ does not go in reserve. We had about a 20 percent administrative charge if I remember correctly. So about 20¢ of that went into the cost of operating the company, and I think the rest went

in reserve. I have those figures, but I didn't bring them with me.

ASSEMBLYMAN SALKIND: Would you supply us with those figures--

MR. OWEN: I'm sorry I didn't bring them with me.

ASSEMBLYMAN SALKIND: --and with as much breakdown as possible?

MR. OWEN: Yes.

ASSEMBLYMAN SALKIND: I might say parenthetically - unfortunately, I'm going to have to be leaving; I should have been in Monmouth County 15 minutes ago, and I'm not going to be able to question Chubb - I would like to see similar information supplied by Chubb on this particular point.

Is there any feeling from the hospitals themselves as to the point at which they can no longer afford to continue operations? At what point will their backs get broken in terms of rate increases? Can they take another 2000 percent? Is there a limit that they physically cannot take?

MR. OWEN: I hate to say that. I remember back in 1958 I was giving a speech down in South Carolina to a Rotary Club, and I said that the cost of hospital care had reached $25 per day and it might get up to $35, and someone said, "We cannot afford to be sick at that level." Of course, we all know what it is today. I don't know if there is a breaking point. I cannot imagine a hospital operating without insurance, however. I don't think they would have any staff. Who is going to work in a hospital if they are not covered? As I said, medicine is an art; it's not a science.

ASSEMBLYMAN SALKIND: The public institutions aren't included in your membership, are they?

MR. OWEN: Yes, they are part of our membership.

We don't cover them with insurance, but they are part of the membership.

ASSEMBLYMAN SALKIND: They are members of your Association?

MR. OWEN: Yes, they are included.

ASSEMBLYMAN SALKIND: Is, for instance, Marlboro State Hospital included?

MR. OWEN: Yes, they are members.

ASSEMBLYMAN SALKIND: What is the insurance situation with them? Is there insurance for state institutions?

MR. OWEN: If we had a captive company, the state hospitals could participate the same as any other hospital.

ASSEMBLYMAN SALKIND: What is the present status of insurance for them?

MR. OWEN: They have to go to an outside source the same as any other hospital.

ASSEMBLYMAN SALKIND: Do they in fact?

MR. OWEN: I don't know how the State insures. I know, for instance, that the College of Medicine and Dentistry, which is a state institution, has Belfonte at the present time, which is an unlicensed company.

ASSEMBLYMAN SALKIND: A representation was made that their premiums increased by $1 million.

MR. OWEN: I know; it went up to six hundred and something last year.

ASSEMBLYMAN SALKIND: Mr. Chairman, I wonder if we could have the staff seek out the information about present practices of public institutions in New Jersey, both federal and state institutions.

SENATOR GREENBERG: All right.

ASSEMBLYMAN SALKIND: Thank you, Mr. Owen.

SENATOR GREENBERG: Senator McGahn.

SENATOR MC GAHN: Mr. Owen, my apologies for

coming in late; I did not hear most of your testimony. I would assume, of course, that you are talking primarily about malpractice suits against the hospitals and not the physicians involved in service in the hospitals. Do you have figures, from the standpoint of medical malpractice, of how many claims were made against physicians where the incidents took place in the hospitals as opposed to taking place outside the hospitals in private practice in the physicians' own offices?

MR. OWEN: I don't think I can answer that. If something happens in the hospital, an incident report is made and filed with the insurance company. They would be the only ones we would have - if it happened in the operating room and the physician was there.

SENATOR MC GAHN: In the circumstance in which an attorney, using the shotgun approach, sues everybody in sight including the physician, the hospital, and everybody involved, and hoping, of course, in the discovery procedure, to produce his own particular suit, would you favor a statute that would permit a countersuit for abuse of judicial process?

MR. OWEN: I haven't thought about it, but off the top of my head, I wouldn't oppose it.

SENATOR MC GAHN: What would be your position regarding a patient, upon entering a hospital, agreeing to arbitrate any particular adverse effect that might occur within that hospital and, of course, during a 30-day withdrawal period after leaving the hospital?

MR. OWEN: We tried to work out a program like that. It's been going on in southern California, and to date, the experience doesn't show that it has been very effective in holding down insurance costs out there. As to whether enough patients will actually agree to arbitration, I think, there again, it's a question of public policy. I think it would be good if it were really carried out and if

it were binding arbitration, but it is a difficult one to really develop and work.

SENATOR MC GAHN: I think the Kaiser experience has been good; the Loos has not been so good.

MR. OWEN: That is correct.

SENATOR MC GAHN: Thank you.

SENATOR GREENBERG: I have just one more question. Mr. Owen, what action, if any, do you presently take, and if none, what do you contemplate taking, if any, with regard to physicians against whom malpractice judgments are entered?

MR. OWEN: Do you mean in a hospital?

SENATOR GREENBERG: Yes.

MR. OWEN: That is usually taken up by the medical staff through its rules and regulations, although the Board of Trustees is legally responsible for what happens within that institution. I think, in most institutions, if a physician has several malpractice cases against him, he is looked at very closely by his peers on the medical staff and is either limited in privileges or limited in some other fashion until they are cleared up. If he were found guilty, he would probably be dismissed from the staff. I think it is handled a little differently in each hospital, but almost every hospital has a requirement that these be reported so that at least the medical staff knows where they stand.

SENATOR GREENBERG: Is that in fact a function or is that the ideal objective?

MR. OWEN: That in fact is a function. I think, since the Darling case in Illinois which really placed the legal responsibility on the Board of Trustees, and placed it there squarely for the practice of medicine, there have been a lot of changes and different attitudes by hospital Boards. I think it is a fact.

SENATOR GREENBERG: What would your reaction be - and I suspect you haven't discussed this yet, so please just give me your reaction - to a statutory mandate to that effect?

MR. OWEN: A statutory mandate to the effect of what?

SENATOR GREENBERG: A procedure by which hospitals would be compelled to establish some sort of review for situations such as this.

MR. OWEN: I am not sure that is the kind of thing that is best served by legislation. I think it can be done through existing Department of Health regulations. They have the responsibility for quality of care. It can be done through licensing, and it can be done through a lot of existing mechanisms. If the question is, should a physician be reviewed after a suit against him - I think that's what you are driving at---

SENATOR GREENBERG: I'm thinking about a final judgment; I'm not talking about mere accusations.

MR. OWEN: I think that is what we have to be careful of because he may be sued 100 times and not found guilty in any one of them. If a final judgment was reached, then I think most Boards and medical staffs would be very relunctant to allow that physician to go any further unless it was an isolated case. I think it shows up pretty readily in most of your licensure procedures and in other ways.

SENATOR GREENBERG: The problem with it is that that would tend to discourage settlements, for example. I could see it resulting in that type of situation.

MR. OWEN: That is correct. In other words, you would really have to go all the way through the court system in order to--- That's correct.

SENATOR GREENBERG: Your answer indicated that

it is being done, but my question really is, should there be some sort of uniform standards established somewhere, either by regulation or legislation? That is the question rather than leaving it to the individual hospitals themselves.

MR. OWEN: Again, I say that I would hate to see it in legislation as such. I haven't thought it through well enough. Right now the Board of Medical Examiners requires that any disciplinary action taken against a doctor be reported to the Board of Medical Examiners by the Boards.

SENATOR MC GAHN: Senator Greenberg, in answer to that, I think, in your absence this morning, that question was addressed very ably by Dr. Todd. I think there are two aspects to it: One, of course, is that under the corporate liability situation, which existed in the Darling case, basically the response is the reaction of members of the Board that are practicing in the hospital. This is one thing and I think any action taken by the Board to expel a physician should result in immunity as far as the Board itself is concerned. However, I think, as Dr. Todd very ably pointed out, the basic responsibility should be with the Board of Medical Examiners to carry out disciplinary action albeit suspension or whatever the case may be. I think this is the area in which statutory law should be enacted.

SENATOR GREENBERG: Thank you very much, Mr. Owen. We appreciate your appearance here today.

Ladies and gentlemen, we are not going to finish with the list of witnesses today. I say that so that those of you who are at the bottom of the list will know that you may not be able to testify today. It is now almost 3:00, and we plan to end the hearing at 4:00. We are moving as quickly as we can, but we are not going

to finish. As I have already said, I intend to follow the agenda as it has been prepared. So the next witness will be Mr. Newell Alford, General Counsel of Chubb and Son, followed by Fred Harvey, Gary Haggard, Philip Angeloni, Assemblyman MacInnes, Andrew Clark, Dr. Maurer, Leon Wilson, and I cannot envision reaching the other witnesses. Frankly, I cannot envision even reaching all those I just named. We intend to have another hearing in the near future, and at that time, we will be able to hear from those we cannot reach today. If there is anyone here who wishes to testify and whose name does not appear on the agenda, please notify us of that fact immediately. You are all welcome to stay, and we'll do our best to hear from as many of you as possible.

Mr. Alford. We worked it out just right, Mr. Alford; Assemblyman Salkind has left.

N E W E L L G. A L F O R D, J R.:
I'm sorry about that; I want the record to show that I'm disappointed, and I hope to be able to come back so that I can answer his questions.

As I told the staff of the committee, I do not have a prepared statement. I think it would be rather strange if you held this hearing without someone from Chubb and Federal appearing, but I frankly want to say that today I regard us as a kind of resource to the committee. You have asked a number of questions already today that I cannot answer off-hand because I did not bring the data and my actuary with me. We want to review those questions and answer them the best we can and any other questions you want to bring to our attention prior to your next hearing.

We are involved in a number of things at the moment as Mr. Owen just testified to. I am not really up to date on those because the most recent meeting on

them was this morning, and I was here.

If there are any questions you want to put to me today about anything, I will either try to answer them or tell you that I cannot today but will try to do so later.

I should say that we do not have an insurance company position -- a kind of check list of changes in law, etc. We are working with the Conference Committee of the State Bar Association on medical-legal problems. We are working with the ad hoc group which Mr. Owen referred to on these very things, but we don't really have a position ourselves on those specific matters at this time.

SENATOR GREENBERG: We would appreciate your coming back, and we will communicate with you between now and then to fill you in on our areas of interest that are not mentioned today.

MR. ALFORD: That's fine.

SENATOR GREENBERG: Will you be the individual returning?

MR. ALFORD: I will take care of seeing that the information is supplied. I will probably come, and I may have to bring some other people with me depending on what you want to go into.

SENATOR GREENBERG: Are you General Counsel?

MR. ALFORD: Yes.

SENATOR GREENBERG: Mr. Alford, let me put a question to you that is really on the minds of the entire committee. I don't know that we can get the kind of answer today that will be helpful to us, but maybe you can shed some light on it. You have heard it alluded to today that we are proceeding on the basis of certain assumptions, one of which is that the request for increased premiums is justified or at least that the Commissioner's approval with regard to the recent 50 percent increase was justified.

We envision, as part of our responsibility, an analysis of that justification. We have certain powers with regard to subpeona and the resources of our committee, which are quite limited, neverless might be helpful to us. Can you make any suggestions to us with regard to how we might satisfy ourselves on what appears to be a tremendous need for increased monies in this industry?

MR. ALFORD: Senator Greenberg, before I try to answer that, let me say this: In your introductory remarks this morning, I don't think you said anything I couldn't agree with. I was very impressed to hear of the scope of the investigation that you laid out for the committee.

As to your question, I'm not sure I know quite how to answer it. I was responsible, as the lawyer for our company, in effect presenting our case to the Insurance Department for that rate increase which, as you know, was the subject of a public hearing where the Public Advocate appeared. I've tried to put the record of the whole thing out of my mind for the moment, but I was familiar with it. I don't know whether you mean things that were not presented to the department or asked for by the Public Advocate and are therefore not in the record or something else. The record is certainly available, and indeed any other statistics we have are available. Indeed, we have information on file regularly with the Insurance Department about claims and losses, etc., that is not necessarily part of the rate filing; it is just regular reporting to them. I don't quite know what you have in mind.

SENATOR GREENBERG: For example, we have just heard, and you have heard, some testimony concerning, I think, $5.5 million---

MR. ALFORD: Do you mean Argonaut?

SENATOR GREENBERG: I'm talking about the testimony

that 13¢ on the dollar was paid out. I'm really not asking you about Chubb now; I'm asking you about the industry. I'm not really asking you about New Jersey for the moment. Is that a general kind of situation? Does that appear generally throughout the country in your experience, that is, a relatively small amount is actually dispersed by way of payments against claims, a deduction is made for your expenses to which you are entitled, and then a rather large balance is held in a "never never land" awaiting the results of a tail that doesn't stop wagging? Is that common?

MR. ALFORD: I don't think it is common. I don't think Argonaut is a good example. My own feeling is they weren't a very good example of anything. But it is true that if we were talking of this year, for example, and the premiums we have received, a very small amount would have been paid out by the end of the year. We would be holding a very large amount in reserve. I'm familiar now with medical malpractice for doctors' insurance, at least in New Jersey, because of my experience with this rate case, but I really don't know anything about the pattern of settlements and reserve, etc., for hospitals. I just cannot believe it is that different. By the end of ten years - and that was the period referred to - we would have expected practically every claim that was going to be brought, at least in New Jersey, to have been brought and settled. Anything left would be fairly minor. By ten years, we have run off that policy year and can account for it completely. I don't know what the Argonaut situation is, how they keep their books, or anything else. It's a mystery to me.

SENATOR GREENBERG: In other words, if you had a ten-year statute of limitations, it wouldn't change your assumptions actuarily as to the premium payments

you would need because you are operating on a ten-year period.

MR. ALFORD: I'm sorry; I cannot relate that to the statute of limitations at all. It really has very little to do with it.

SENATOR GREENBERG: Why is that?

MR. ALFORD: I'm not an expert in this field. I'm telling you what the pattern is here in New Jersey. By ten years from the beginning of the policy year, we are pretty darn sure we can account for the premium entirely. I think there is no doubt about that. New Jersey doesn't have what you would call a ten-year statute of limitations really. You are assuming a change in the statute in New Jersey which might lengthen the so-called "loss lag," but I don't know whether it would or not. I just cannot tell. In many cases, I don't think lawyers typically wait until the statute is about to run to file a claim, but if they do, a ten-year statute as compared to what we have in New Jersey would make them wait a lot longer.

SENATOR GREENBERG: It really isn't a statute we are talking about as much as a cutoff. The statute would remain at two years with a maximum period within which to file in any event.

MR. ALFORD: I don't think it would make that much difference because we are talking about the time in which it takes to administer in effect a law suit whenever you bring it. Typically in New Jersey at least half of them are closed out and settled by the fifth year. It may be 60 percent by the beginning of the sixth year, etc., etc. There is a pattern on this that we can show the committee.

SENATOR GREENBERG: Let me go back a step with you and get some basic information that the committee can use. What business is Chubb in in the malpractice

area in New Jersey?

MR. ALFORD: As you probably know, the largest volume of our premium in this field is for medical malpractice, principally doctors' medical malpractice written for the New Jersey State Medical Society. We write some dental; we write some psychiatric, we write some osteopaths, we write the hospitals that have been referred to, and we may write a few New Jersey doctors who are members of the American College of Obstetrics and Gynecology because we do have a program for them which is separate from the others. I may have missed one or two.

SENATOR GREENBERG: Do you write those areas in other States as well?

MR. ALFORD: New Jersey is really our principal medical malpractice State. I would say we have our largest exposure here. There are some other States in which we, particularly when we have these national programs for dentists, psychiatrists, osteopaths, etc., do have a fair number of insureds for this kind of insurance, but New Jersey is our principal State for it.

SENATOR GREENBERG: What is the present intention of Chubb with regard to remaining in this field?

MR. ALFORD: It's no different now than it was last spring when we had the first of our crises. Let's take this field by field. The hospital field is something we kind of got into without long-range planning. I think I have stated before, certainly to the Senate Committee and publicly, that we are not trying to get rid of the Medical Society program. We think it works, and we want to make it continue to work well, and we really are not trying to get out of this field. Frankly, I personally would be happy if we were, but as a company, we are not. What we don't want to do is to find ourselves in a position of being forced to take larger exposures than we think we can

commit ourselves to. In other words, we would like to stick with the programs we have and make them work, but we cannot really afford to write very much more medical malpractice liability. We are not the largest company in the world, we have other insurance commitments, and we don't want our so-called "book of business" to get too out of balance. We are not going to be a medical malpractice specialist.

SENATOR GREENBERG: I can understand that. You are satisfied at the moment with the book you have in this State, and you would like to make it work.

MR. ALFORD: Right. That is our attitude in New Jersey.

SENATOR GREENBERG: Can you give us an opinion as to why it is that there are not other companies willing to jump into that water with you?

MR. ALFORD: I would say there are a number of reasons that I would like to give you later after a little more thought, but I think something is very obvious: At one time, we had a substantial medical malpractice program in California, Los Angeles County Medical Association. That was really going long before we got into New Jersey. We lost that program through competition. I have a hunch that the companies that are now, for instance, writing in other States feel the same kind of pressure we do. They don't mind staying perhaps with what they have cut themselves back to now, but they really don't have the capacity to come into New Jersey as well. I think it's kind of because of the limited resources available. This is completely apart from the companies being concerned about the unpredictability of the business.

SENATOR GREENBERG: You say it's apart from that?

MR. ALFORD: Yes. I think medical malpractice is really a specialized kind of thing. It does take

people trained in special relationships with doctors and hospitals. This includes both insurance company personnel and lawyers. It just isn't a field in which the ordinary company that can do a perfectly good job in automobile insurance wants to get into or perhaps should get into.

SENATOR GREENBERG: Then insofar as Chubb is concerned, it would not be interested in expanding its coverage even in other States based upon what you said.

MR. ALFORD: I think we have bitten off as much as we can chew. We don't want to disrupt things in New Jersey, we want to keep this program going, and we want to devote our attention to that.

SENATOR GREENBERG: Do you think it would make any difference as to the number of companies willing to write in this State if we made some of the modifications that have been suggested here today or have been proposed for a year now with regard to limiting the risk further than it is already limited by legislation or otherwise?

MR. ALFORD: I think it would be optimistic to think there would be any change in the very near future. Perhaps over a period of years, when the thing proves out, there might be a change. I am kind of pessimistic myself.

SENATOR GREENBERG: Why are you pessimistic? Assuming we were to limit it to $250,000 and the statute of limitations---

MR. ALFORD: I think changes could be made which would make the exposure loss predictable enough so that the company actuaries would not feel uncertain about it and company executives would not feel afraid. They could say, "Okay, we know how many dollars we need to run this insurance program and that's it. If we're wrong, we're not going to be very far wrong." Those changes in the law could be made. I think most of them

are probably publicly unacceptable. Without going that far, changes could be made and may actually be being made in some States - I really cannot keep up with them - which will make the medical profession and the legal profession and the insurance companies more comfortable with the whole thing. I think you can do things here that will help. I am just not going to say that if you pass bills so-and-so and so-and-so, a year from now you'll see ten companies come in here competing for this business that we are laboring to manage.

SENATOR GREENBERG: How long has Chubb been in the malpractice insurance field?

MR. ALFORD: We kind of got into it by accident. As you know, we got into it here in New Jersey in 1971. We learned something about it through the southern California program, which is a very large program in which a lot of money was lost, because we bought a company called the Pacific Indemnity Company which had been managing the insurance program for ten or twelve years, I believe. When we acquired the company, Pacific Indemnity, that was doing that, we had to learn something about the business. That is essentially the history of it; there may be a little bit more to it. We have not been in it as long as the Employer's Mutual or the American Wakefield or some of these other companies that have specialized in it to some degree for quite a long time.

SENATOR GREENBERG: Do you have any questions, Senator McGahn?

SENATOR MC GAHN: Mr. Alford, I do not honestly expect to get answers to these questions, but these are some of the questions we very frankly hope we will get answers to, and they will be submitted to you. I am concerned about the State of New Jersey; I am not concerned about anybody else. And I am concerned about

Chubb and not the other insurance companies because we are addressing ourselves to you.

How much of the malpractice premium dollar ends up back in the patients' hands? I think this is an extremely important thing as far as we are concerned.

What is the average cost of processing each and every claim, and what is the average time limit for processing said claims?

I would like to know something about percentages of claims that are undercompensated and the percentages of claims that are actually fraudulent. I would like to know something about percentages of claims that are made without merit even though they are made in good faith.

To what extent do investments of insurance premium dollars offset unanticipated claims due to the long-tail phenomenon?

What percentage of claims are settled before a law suit is filed, after a suit is filed but before a final decision, and after a verdict or judgment?

At what time do you set aside reserves? Is it at the time a claim is filed?

What is your experience with regard to claims incurred but not paid?

These are questions that this committee needs answers to. This is the data we need to be able to make any type of decision on what is necessary.

I know you are a new company in this, as you have said, but as I mentioned this morning, most insurance companies that underwrite fire, auto, etc., do come up with some type of loss prevention programs. What has your company been doing along those lines, not only as far as the institutions are concerned, but as far as private practitioners are concerned? This should be based on both injury and claim prevention

techniques. If you are carrying out these, do you allocate a specific portion of the premium dollar to these loss prevention programs? If not, why not?

MR. ALFORD: Senator, I will be very happy to try to give you complete answers to those questions.

I would like to make one comment with regard to something that has troubled everyone. One of the initial questions today was, what percentage of the pay-out of premium to the claimant goes to his attorney or to cover his legal costs? This is something that I don't think anyone has a way of getting at unless you go through the court system. I don't know exactly what documents lawyers have to file in the New Jersey courts with information about their retainers, but I do know, for instance, that in New York, at one time you had to file both a retainer statement and a closing statement indicating what actually happened after the fact. You could tell from that what the actual dollar pay-out to a lawyer was. The trouble was that the New York courts, when they set it up, never distinguished professional liability cases from others, so there was no way statistically that you could easily sort these out. This kind of figure is one that people speculate about, but I don't think you can get it from any insurance company. However, if there is another source in New Jersey, perhaps your staff can find out for you.

SENATOR MC GAHN: I may be wrong on this and please correct me if I am. Even in instances when a claim is settled out of court, this information is not readily available to the physician against whom the malpractice claim has been filed.

MR. ALFORD: How much was paid to the claimant's lawyer?

SENATOR MC GAHN: That's correct.

MR. ALFORD: I don't think it would be.

SENATOR GREENBERG: Mr. Alford, do you have any suggestions or recommendations to make to this committee with regard to what, if any, action it should contemplate taking regarding this overall problem?

MR. ALFORD: I didn't come here today to try to answer that question, if you will forgive me, but I'll try to do it at the next session.

SENATOR GREENBERG: We would be interested in hearing your views.

MR. ALFORD: We just cannot sit back by ourselves in the insurance company in a little vacuum and look at the law and look at our own problems and try to propose a legislative solution. We really have to talk to the other people who are interested in that information. By that I mean we have to talk to the trial bar, whatever cast there is of plaintiffs or defendants, the doctors and the hospitals. We have to at least consider and think about the patients' rights in these things. So we don't want to just make a proposal to you that is something that seems all right to us if there is no chance of it flying. We want to make a practical proposal to you. This is really why we cannot come up here with a laundry list of things, although many of the suggestions you have received today, I think, are pretty sound, and probably some of them are actually feasible.

SENATOR GREENBERG: I don't want to mislead you; this committee has not yet determined that there is justification for the increases in premiums. In fact, it is the view of some members that perhaps that is not the case. The committee is concerned with the fact that there appears to be a total absence of competition in the field and wonders what causes that, whether it is something that naturally developed or occurred as a result of some other influence. Let me speak for myself:

I believe that physicians and, to a large extent, hospitals have been put in the middle, so to speak, as well as the ultimate consumer, of a battle between the carrier on the one hand and the Commissioner on the other. When the carrier seeks an increase which the Commissioner will not grant, some modification is generally worked out. The hospitals and doctors then wind up paying it and passing it on without any real significant understanding, in my judgment, of the underlying problem or effort being made to solve it. That which has been accomplished in other States dealing with statutes of limitations and modifications in the law, I agree with you: It's going to take a long, long time to tell whether that is going to have any impact on anything, especially when we start with the assumption that we really don't know how much reserves have to be or should be. I am really frustrated with that. Of all the areas of insurance with which I am familiar, this is the one area where I cannot get answers based on actuarial evaluations that are satisfactory to me.

So what we would like to do - and we are going to use Chubb for this purpose with your consent because Chubb is here, Chubb has cooperated to a large extent with the State, and Chubb has indicated a desire to continue to cooperate - is pose some of these questions to you between now and the time we hold our next hearing. We would sincerely appreciate your response. Thank you for coming.

MR. ALFORD: Thank you, sir.

SENATOR GREENBERG: Our agenda shows the next witness will be Dr. Harvey of the New Jersey Dental Association.

D E N N I S Y O U N G: Dr. Harvey is President of the New Jersey Dental Association, but he was unable to attend today's hearing. His wife was involved in a minor

accident, and he asked me to replace him. I am Dennis Young, Executive Director of the New Jersey Dental Association.

We have submitted copies of our prepared statement to the committee, but one of the benefits of being ninth or tenth on the program is that much of what you intended to say has already been said. So I am not going to waste the time of the committee by repeating much of what was said by the other representatives of various groups.

One of the things that should be brought out insofar as the dental profession is concerned is this: Dentistry is a low-risk profession with respect to malpractice or medical liability claims. The average dentist is paying anywhere from $200 to $300 per year for malpractice insurance, and this would vary depending on his speciality. Oral surgeons, for example, would pay a little more than that.

In dentistry in New Jersey, we have experienced no significant availability problem. Malpractice insurance is readily available to any dentist who so desires it in the State. However, we certainly believe there is a problem in the malpractice area. In listening to the testimony, there is no question that most of us feel very strongly that it is a comedy of errors that we find ourselves in this position today. I don't think it is going to be productive to throw accusations that it is either the professionals' fault or the insurance companies' fault or the attorneys' fault. I think it is all of our faults, and unfortunately it is the consumer, in the final analysis, who is going to pay the bill for it. I think that is what the committee really has to understand. What we are really talking about here is that the cost of malpractice, or professional liability, insurance in actuality is borne by the consumer.

I think we all recognize that. Wherever the rates go, in the final analysis, the consumer is going to pay for it.

There is a clear mandate to the committee - one that I think needs to be discussed - and that is that there is no clear definition of what malpractice is. Everybody seems to have a different idea of what it is supposed to be. The committee should seriously consider a definition that would be acceptable to all segments of the professional groups and move in that area.

I think most of the representatives have touched on the area of the limited amount of recovery. Currently 25 States have a maximum in this area of $500,000, and this seems to be a reasonable approach. There has to be some type of limit on the amount of recovery.

There needs to be a very careful study of the reduction in the statute of limitations.

We certainly concur - and it is in our prepared statement - that there is a definite necessity for review panels. There are too many frivolous and capricious cases that are brought to trial or resolved out of court that are of significant expense to the plaintiff and to the individual practitioner or hospital involved that need not be there. One of the interesting things - and this comes out of the Legal Department of the American Dental Association - is that 90 percent of all dental malpractice cases are resolved in favor of the dentist. So if you want to get down to the brass tacks, the consumer has about a 10 percent chance of winning a malpractice case against a practitioner, at least in dentistry. I don't want to leave you with the wrong impression. The point I am trying to make is this: In most instances, in the statistics we have

available, the 90 percent, it is reasonable to assume, did not have sufficient grounds to bring such an action. That really comes to the heart of the problem. There are many stimuli to bring an action against a practitioner, and we feel statistics bear out the fact that a majority of the cases should be reviewed by a review panel before there is any type of court action thereby at least saving the cost of discovery which is certainly the most expensive portion of the transaction.

Many States have been involved in the area of catastrophic funds for over $100,000. There is a Pennsylvania bill, which you may be familiar with, which is financed by a 10 percent surcharge on the existing rates the practitioners are paying.

We certainly feel there should be some movement in the direction of informed consent where the practitioner should be required to inform the patient of any procedure that is a possible risk to his health and safety. This should be in writing. This is an area that may have an impact on our current malpractice situation.

I think the point we would like to leave you with is that while the dental profession is a low-risk profession, and while we judge based on the amount of premiums the professionals are paying, certainly we are not in the league with the neurosurgeon or orthopedic surgeon. But we have to be concerned, and we are concerned because in the last two to three years, malpractice coverage for dental practitioners increased over 200 or 300 percent. So obviously we can see a trend to this. Something has to be done sooner or later to come up with some tangible solutions to this particular problem. Unfortunately there is no easy solution and is one that is going to involve a number of different actions and a number of different professions. But the dental profession certainly stands

ready to assist the committee in any of its deliberations. (The statement submitted by the New Jersey Dental Association may be found at 66 X.)

SENATOR GREENBERG: Thank you, Mr. Young. What is your position with the Association?

MR. YOUNG: I am the Executive Director of the Association.

SENATOR GREENBERG: Do you have figures applicable to your Association which would indicate what portion of your total premium is ultimately paid to plaintiffs?

MR. YOUNG: No, I do not. I wish we did. Again, I think that goes to the heart of the subject. We do not have those figures because they do not seem to be readily available. I have to qualify that also by saying that unlike the Medical Society of New Jersey that, I would imagine, several years was forced into a situation to create its own master policy or group policy for malpractice, the Dental Association was not in that position and therefore we do not maintain a group policy for malpractice insurance, so that information was never developed.

SENATOR GREENBERG: I gather from what you say that there is no availability problem.

MR. YOUNG: No, there isn't.

SENATOR GREENBERG: What carriers write dental malpractice insurance?

MR. YOUNG: Pretty much the same carriers that write medical malpractice: Argonaut, Etna, St. Paul, the major carriers.

SENATOR GREENBERG: Did you indicate that the average cost is about $200 per year?

MR. YOUNG: The average for a general dental practitioner is about $200 a year. For an oral surgeon, it may be $300 or $350.

SENATOR GREENBERG: Senator McGahn.

SENATOR MC GAHN: Mr. Young, are the majority of laims against oral surgeons as opposed to general ental practitioners?

MR. YOUNG: I really couldn't answer that. I ssume they may be, but I really cannot give you pecifics.

SENATOR MC GAHN: My assumption would be the same. nder these circumstances, most probably they would be ospital-based claims rather than office-based claims, lthough that is not necessarily borne out by the tatistics.

MR. YOUNG: That's true.

SENATOR MC GAHN: Do you have any difficulty in btaining this information from the insurance companies? s it like pulling teeth to get it? (Laughter)

MR. YOUNG: Yes. That seems to be one of the roblems that has to be looked at. I just walked in t the end of the testimony by the representative of hubb, and I must admit I was not any more enlightened hen he left than I was before. Again, I think we are eyond the point of criticizing any particular segment f the groups involved in this issue, but I do think we ave to take a long and hard look at just exactly where he tangible figures are that relate to the amount the atient ultimately receives for a malpractice claim nd how that relates to the premium dollar. These igures do not seem to be available, and no matter who ou contact, it seems they are buried within so many ubsidiaries and offsetting figures and escrow accounts, tc., that I think it would be very difficult, to say he least, to come up with figures. I think the nsurance industry is the only group that can supply hat information.

SENATOR GREENBERG: Thank you very much, Mr. Young. e appreciate your appearance here today.

MR. YOUNG: Thank you.

SENATOR GREENBERG: Gary Haggart of the New Jersey Optometric Association.

SENATOR MC GAHN: While we are waiting for Mr. Haggart to make his way to the microphone, may I be permitted a remark? Today it is the medical profession; tomorrow it may be the world. I think what we are talking about is professional liability insurance. Today it is the medical profession, the dental profession, the optometrists, the podiatrists, and very soon it will be educational malpractice.

G A R Y W. H A G G A R T: Mr. Chairman, due to the lateness of the hour, I will submit our prepared statement for the record and will outline the recommendations of the Association. I am Gary Haggart, Executive Director of the New Jersey Optometric Association. Dr. Campell, Chairman of the Insurance Committee of the Association, was here earlier but had to leave.

Some of the suggestions of the Optometric Association are as follows:

First, limitations should be placed on the amounts recoverable by patients in various malpractice suits. The total amount recoverable for injury or death should not exceed $500,000.

Second, clear statutes of limitations should be formulated, making any claim filed after two years of an alleged occurance invalid.

Third, attorney fees should be limited to a small percentage of any claim awarded.

Fourth, a medical review panel should be set up sufficiently representing all calsses of health care practitioners in the State.

Fifth, payment of awards should be payable not necessarily in one lump sum, but spread over a period of time.

We feel that these basic measures would remove a great deal of the pressure from those who are licensed to provide services which are basic to the individual and the community welfare. (The complete text of the Association's statement may be found at 72 X.)

If there are any questions, Mr. Chairman, I will be happy to answer them.

SENATOR GREENBERG: Are you prepared to discuss the source of your statement that since 1960, there have been rapid increases in three areas, the number of claims, the amount paid to insured patients, and the insurance premiums paid? Can you give us the source of that statement?

MR. HAGGART: That is from the Library of Congress.

SENATOR GREENBERG: Can you give us the specific source of it?

MR. HAGGART: I do not have that available, Mr. Chairman, but I will submit it to you.

SENATOR GREENBERG: Thank you. What is your position, sir, with the Association?

MR. HAGGART: I am the Executive Director.

SENATOR GREENBERG: Senator McGahn, are there any questions?

SENATOR MC GAHN: Senator, in answer to your question, I think these are statistics that are bandied about. These are nationwide; they do not pertain specifically to the State of New Jersey. We are concerned with the State of New Jersey, and the situation from State to State is a completely different thing. We are more concerned with the State of New Jersey than what is happening on a nationwide basis.

SENATOR GREENBERG: Mr. Haggart, can you tell me what the average cost, mean average or any other average, of insurance is to optometrists?

MR. HAGGART: The average in the State of New

Jersey is about $80.

SENATOR GREENBERG: What kind of increase have you seen in the last five years?

MR. HAGGART: It has increased from about $35 in 1970 to $80 presently.

SENATOR GREENBERG: Thank you very much.

Philip Angeloni.

P H I L I P A N G E L O N I: By profession, I am an engineer, but I am here as an injured patient, and I believe it was malpractice. I am Philip Angeloni, and I live at 832 Green Avenue, Mount Ephraim, New Jersey, outside of Camden.

First, I want to read from an article that appeared in the Camden Courier-Post on June 2, 1975: "Dr. Roger O. Egeberg, the U.S. Department of Health, Education and Welfare's top malpractice expert, charged, . . ." The article went on to say, "About 20,000 malpractice claims are filed each year, although Egeberg estimates that as many as 700,000 injuries occur each year because of medical negligence." Twenty thousand is only 3 percent of 700,000 injuries each year due to medical negligence. That is hardly a frivolous thing when patients sue.

The next thing I want to read is from an article in the Philadelphia Inquirer of May 11, 1975: "'Many of the doctors who are practicing good medicine are picking up the tab for the 2 percent who get sued each year,' says Dr. Sidney M. Wolfe of Public Citizen's Health Research Group in Washington," Ralph Nader's group.

The next thing is from the book, Law for Everyone, by Howard L. Oleck, Distinguished Professor of Law, Cleveland State University, College of Law, copyright 1971. On page 165 he tells of a woman who went into a hospital for a hemorrhoid operation and came out a vegetable. I'll read: "The surprising feature of the case, to lawyers,

was the relative success of this woman's sttorney in obtaining physicians willing to testify against other physicians or a hospital. The 'conspiracy of silence' of physicians (absolute refusal of many doctors to testify against each other . . ."

Next I will read from Louis Nizer's book, My Life in Court.

SENATOR GREENBERG: Excuse me, Mr. Angeloni. We will read any material you wish to submit to us, and I want to assure you we will do that. That being the case, and due to the lateness of the hour, would you please submit the material and just summarize it at this time?

MR. ANGELONI: The point is that, rather than being frivolous, according to Dr. Egeberg, only 3 percent of the cases out of 700,000 injuries each year are filed.

I will conclude with the suggestion that you adopt something like that which was just adopted by the State of Pennsylvania: a panel consisting of two doctors, two lawyers, and three consumers. If you do that, the number of law suits might go way up because right now only 3 percent ever come to court, and there are actually 33 times as many injuries due to medical negligence according to Dr. Egeberg. This is something that has to be faced.

Another suggestion is that you let the physician watchdog in each medical center be paid by the State, and let him have the power to check on things.

Thank you. (Material on file with committee.)

SENATOR GREENBERG: Thank you, Mr. Angeloni. We appreciate your remaining here throughout the day, and you may be assured we will read the material you have submitted.

SENATOR MC GAHN: For the record, I would like to say that I am familiar with the statement of Dr. Egeberg,

and let me say here that it is incorrect that 700,000 injuries occur each year because of medical negligence. The statement should be that "700,000 injuries occur each year, and of those, only 20,000 malpractice claims are filed." The words "because of medical negligence" are not those of Dr. Egeberg.

SENATOR GREENBERG: Thank you.

Andrew Clark.

(No response.)

Dr. Maurer, President-Elect of the New Jersey Association of Osteopathic Physicians and Surgeons.

D R. R O B E R T S. M A U R E R: I am Dr. Robert S. Maurer, D.O., President-Elect of the New Jersey Association of Osteopathic Physicians and Surgeons, and Chairman of its Insurance Committee for the past six years, and very actively involved with the professional liability problem for the past ten years. I represent 900 physicians in the State of New Jersey, primarily general practitioners, about 80 percent of us.

The American medical liability program at present is arcaic, unjust, expensive, and inefficient. The physician is constantly hounded with the specter of professional liability and the dreaded word "malpractice" hanging over his every move, resulting in overcautiousness, overutilization of laboratory, x-ray, and hospital facilities, and increased costs down the line for the patient.

SENATOR GREENBERG: Excuse me, Dr. Maurer. Perhaps you were not here earlier when I indicated we would read all documents submitted to us. I have asked the witnesses to capsulate their positions with the assumption that we will be familiar with what has been submitted, and I see that you are reading your statement. The statement will be incorporated in the record of the hearing. Based on that, would you please run through

your recommendations briefly so that the people here will know what you are talking about?

DR. MAURER: There are eight recommendations. I will list them and will not embellish on them.

1. Statute of limitations shall be two years from the alleged event. In pediatric cases, the statute shall begin at age six.

2. A mediation or arbitration panel shall be created and utilized for immediate review of all malpractice claims.

3. The limitation of awards shall be $100,000 maximum with an additional $400,000 provided by a state catastrophic fund for medical payments only.

4. Lawyers shall be compensated on a "fee for service" basis exactly as doctors are. Court awards shall be in four areas: 1) compensation to the patient, 2) medical bills, 3) legal fees, and 4) court costs.

5. A collateral source law should be included to prevent duplication of medical payments.

6. This is the most important for us. There shall be no discrimination between insurance premiums for M.D.s and for D.O.s. Physicians shall be rated on their type of practice and not by their degree designation, since the State of New Jersey makes no distinction between the two in awarding a license to practice medicine in the State.

7. All finders fees of any kind shall be outlawed.

8. This is extremely important. The Commissioner of Insurance shall be requested to review the actuarial and accounting procedures of casualty underwriters to be assured that reserves for pending claims and for claims incurred but not reported are not unnecessarily large.

We have other suggestions. The Medical Society and Dental Society have stated their positions, and we feel very strongly that some relief should be given in

this entire area. (See 75 X for complete statement.)

SENATOR GREENBERG: In effect, you propose a $500,000 maximum.

DR. MAURER: In effect, we propose a $100,000 maximum for so-called "pain, suffering, and injury" with the additional to be provided for additional medical bills, such as long-standing medical treatment.

SENATOR GREENBERG: Can you tell me the average premium paid by members of your Association?

DR. MAURER: The average premium charged for general practitioners - and a rate increase has been proposed - is approximately $2,000 and anywhere up to $15,000 for anesthetists and neurosurgeons.

SENATOR GREENBERG: What kind of an increase does that represent over the last five years?

DR. MAURER: I'll state this in the best way I can. I started my practice in 1963, and I paid $100 a year malpractice premium. That went up to $300, and in 1970, Chubb, which testified here, raised our rates somewhere between 300 and 500 percent. So to me it was an increase from $100 in 1963 to $2,000 today. In addition, there is a new conspiracy that has been created against the medical field in the last two months. This is the field of professional liability umbrella insurance. We formerly were provided umbrella insurance at approximately $100 to $200 a year over the $100,000 maximum liability. Suddenly, the insurance companies are only providing insurance up to one hundred - three hundred. The umbrella carriers are not accepting umbrella - only from two hundred - six hundred. There is a gap between these two areas. So a new premium was just offered to us at over $1,000 to cover that gap. In other words, the premium for the second hundred thousand is almost more than the premium for the first hundred thousand.

SENATOR GREENBERG: In one of your points, you asked

the Commissioner to review actuarial and accounting procedures, etc. Do you have any information in that area, or are you requesting that because you do not have information?

DR. MAURER: We have been trying for years and years to get figures from insurance companies. They talk about a "conspiracy of silence" among doctors. We feel there is a tremendous "conspiracy of silence" among insurance companies. The figures are almost impossible to obtain. As Chubb testified before, they are working on figures that are almost ten years old.

SENATOR GREENBERG: What carriers does your organization use?

DR. MAURER: Chubb through the outfit that was mentioned, Pacific Indemnity Company, through a national organization.

SENATOR GREENBERG: Do you have any figures as to how many claims have been brought against members of your Association in this State over any period of time and the results?

DR. MAURER: We do not have any official figures beyond 1970. They were the last figures Chubb offered to us - from 1960 to and including 1970. They have not given us any recent figures. They will not provide figures to the State Association of New Jersey because they deal with us on a national basis. Because of the fact that we do not approve of their current premium policies, they will not offer us any information on a local basis.

SENATOR GREENBERG: Thank you. Senator McGahn.

SENATOR MC GAHN: I have only one comment. Very frankly, I am extremely distressed at hearing members of the medical profession, the hospitals, as well as the osteopaths, come up with what they consider solutions to

the problem without ever attempting to hit what is basically the root cause and the root source, that is, if we are talking about injuries, we should hear what should be compensable. Some of these are negligence, but the majority are not, but the majority of these are preventable. I have yet to hear any witness testify as to the best way in which these can be prevented. This eventually is the bottom line insofar as reducing the number of claims and consequently reducing the premium cost.

SENATOR GREENBERG: Thank you, Dr. Maurer.

Leon Wilson of the New Jersey Psychological Association.

L E O N S. W I L S O N: Senators, my name is Leon Wilson, and I am the General Counsel for the New Jersey Psychological Association. With me today is Dr. Robert Garber, the Executive Officer of that Association. You have received copies of our prepared statement, and rather than recite the matters covered in it, I would like to address those points that Senator Greenberg has expressed to several of the previous witnesses. I would like to address them from the point of view of professional psychology in this State.

First and foremost, psychology appears today as relatively tangential to the issues before you. While the profession does in fact provide care services, and while a good number of its practitioners do secure malpractice insurance and require it for their livelihood, a bulk do not.

The New Jersey Psychological Association, specifically, numbers some 1200 licensed psychologists. Of that unumber, a relatively small percentage are in so-called "private practice." The premium rates that they pay for insurance today is of interest. The cost

for $500,000 - $1 million is $40 a year. I understand that figure has remained relatively constant, at least over the past seven or eight years. There are several reasons why that cost is low. Since, however, I have no hard data, I am not going to speculate other than to say that I am familiar with the intensive efforts of the profession to establish and maintain high standards of practice.

This particular profession deals in a somewhat difficult area, and it is surprising to learn that there are so few claims against psychologists for injuries or damages. Principally, of course, there is no physical involvement with the patient, and thus the likelihood of unintended damages is reduced. Nevertheless, there are many fragile areas with which the psychologist does deal, and damage that results there is measurable if not tangible.

With regard to some of the suggestions that have been advanced, I would make this observation from the point of view of a profession that is involved with malpractice but not necessarily injured by its tremendous costs. We acknowledge that there is a certain percentage of negligent acts which will be committed in the performance of any profession. This is to be anticipated and not to be ignored. Suggestions such as have come before this committee to reduce the statute of limitations, to place a ceiling on the amount of recovery, and to reduce attendant costs for work before malpractice claims all aim at one-half of the formula, that is, the costs of restoring the injured patient to the situation in which he would have found himself if he had not been injured. I would call the committee's attention, rather than reducing the cost, to providing funds to meet that cost if it is indeed legitimate and to observing where we can seek those funds.

An earlier bill introduced in this Legislature to meet the problem - I think it was Senate 1552 - proposed that malpractice rates be fixed upon a pool of providers including all health care providers in the State. Incidentally, that bill is what principally prompts our interest in these hearings. We feel that to do that is grossly unjust and inequitable - to impose upon the low-risk health care specialists an aliquot portion of the costs imposed upon the public by so-called "high-risk" specialists. Rather, we feel there should be a defined pool, a risk pool, against which the rates should be measured.

If the neurosurgeons and anesthetists cannot financially meet the cost that the risks in their own pool produce, then if those services are necessary to the public, as we believe they are, they should be spread throughout the public.

I make reference in our statement to the no-fault principle established first through workmen's compensation and laterally in the automobile field and to a second possibility of surcharge on health insurance generally, not necessarily liability health insurance. These suggestions and others like them would have the effect of not denying to the injured patient recompense for his injury, but rather of alleviating what may well be an injustice by imposing the cost of those injuries on a very limited group of professionals.

One particular suggestion I would also like to address myself to is the so-called "review panel." I am sure the committee is familiar with the court rules of New Jersey which do in fact provide a review panel of physicians to review malpractice claims. This, however, is voluntary, and in my personal experience, I have yet to encounter a respondent's attorney willing to submit a claimed malpractice allegation to that review panel, though

again in my experience, I have requested it expressly to be met with an absolute refusal to even consider it. I do not know what kind of experience that panel has. I suggest it is a worthwhile area for investigation by the committee. (Statement may be found at 77 X.)

Dr. Garber, as I mentioned earlier, is with me, and if there are any questions for us, between the two of us, I hope we can respond.

SENATOR GREENBERG: From whom do you presently obtain your coverage?

MR. WILSON: An agency in Champagne, Illinois, Haggett and Dawson. They apparently coinsure through any number of other insurance companies, and Haggett and Dawson insures all psychologists throughout the country.

SENATOR GREENBERG: Do you obtain that through the Association or individually?

MR. WILSON: The information comes through the Association, but it is an individual policy.

SENATOR GREENBERG: Is it a master policy?

MR. WILSON: They are individual policies.

SENATOR GREENBERG: I assume you have absolutely no availability problem.

MR. WILSON: None at all, not at those rates.

SENATOR GREENBERG: And you have no particular financial problem at the moment, although you are concerned with the ultimate spreading of the costs throughout the field which would adversely affect your group economically.

MR. WILSON: That is correct.

SENATOR GREENBERG: That is the thrust of your testimony and the statement you submitted.

MR. WILSON: That is correct.

SENATOR GREENBERG: I have no questions for you, but I do thank you for bringing this to our attention.

SENATOR MC GAHN: I have one comment to make concerning certain statements I have heard here today. For the record, a physician cannot, across the board, pass on the increased cost of medical malpractice insurance to all his patients. Medicaid and Medicare will not simply accept this, and therefore if it is going to be done, it must be done through the third-party carrier or private patients who do not have any insurance whatsoever, or the physician himself m u s t absorb the loss.

SENATOR GREENBERG: Thank you, gentlemen.

Gary Turndorf of the New Jersey State Society of Anesthesiologists.

G A R Y O. T U R N D O R F: Thank you, Senator. With me today is Dr. A. L. Lucas, President of the New Jersey State Society of Anesthesiologists. In view of the lateness of the hour and the fact that we will be submitting a statement subsequently, I will truncate the remarks I had planned to make in an effort to highlight the problem from the anesthesiologists' standpoint, and I address myself to some of the issues that were raised during the day.

SENATOR GREENBERG: What is the problem the anesthesiologists have aside from the high cost of insurance?

MR. TURNDORF: In the first place, you have to understand that the anesthesiologist is a high-risk specialist. He is classified as a high-risk specialist by the insurance company, and it is for good reason because the anesthesiologist is dealing with a crisis situation all the time. He is literally dealing with life and death every moment of his practice. I am sure that to know what the specialty is, is enough to make that self-evident.

The anesthesiologist has another peculiarity in

his practice, and that is that there is a physical limitation in the course of a year on the number of cases that he can do. Therefore there is a limitation, as a practical matter, on the amount of his income in relation to other high-risk specialties. We have information that leads us to believe that the anesthesiologist spends a higher fraction of his gross income for malpractice insurance than any other comparable specialty.

I testified at the United States Congressional hearings on this same question, and I had the privilege of hearing Dr. Bennett who was the Dean of New York University Medical School on the question of the practice of defensive medicine. I heard him say that he did a survey of three voluntary hospitals in Manhatten with respect to procedures that were performed in their laboratories and diagnostic x-ray procedures that were carried out in the hospitals. In the last four years, he found out that there was a steady increase in the number of these procedures performed, and they increased each year by significant percentages. He said that the increase could not be attributed to increase in hospital occupancy or in medical sophistication, but he ascribed it as probably due to the practice of defensive medicine. He is associated with University Hospital which is an acute general hospital. They have 635 beds, and he said that at the present time, they have 103 malpractice suits pending which is almost one for every six beds in the hospital. It is because they are practicing at the forefront of the advances in medical knowledge. The same thing is true of the anesthesiologists.

The enabling resolution that created your committee alludes to the adverse consequences of the malpractice crisis. In the case of the anesthesiologists, this is particularly evident because what is happening is this:

The medical student, recognizing that it is a high-risk specialty, and that the anesthesiologist is encountering a limitation on his income, coupled with an increase in cost for malpractice insurance, is opting to not go into anesthesia. As a result, the anesthesiologist is forced to call upon the use of trained technical assistants such as medical nurse anesthetists. Although they are qualified to practice in a limited way, they must practice under the supervision of an anesthesiologist.

It is also true - and the statistics can be supplied to the committee - that 50 percent of all the residents in this country in anesthesia today are foreign medical graduates which is evidence of the trend I am alluding to - that people are being driven out of this specialty.

It is also true that people who go into this specialty are tending to move into areas where the awards have been lower, or the risk of malpractice litigation has been lower. So you wind up with an adverse geographical distribution of specialists.

In fact, in New Jersey, almost 100 percent of all the residents are foreign medical graduates. I think this is something that the committee should take special note of because it is a risk that a failure to address this problem promptly is going to cause long-term, profound problems for us.

Another area that I did not hear referred to is the area of the teaching anesthesiologist. A teaching anesthesiologist may only do 200 cases a year. Yet he pays the same premium as a full-time practitioner. It is also true that the teacher is right out at the forefront of the practice of anesthesia, doing the highest-risk procedures, and has the highest risk of a malpractice proceeding being brought against him. If he suffers an adverse result, then, in New Jersey at any

rate, we have a structure where his premium can be surcharged. This would have a tendency to drive him out of teaching because in order to teach effectively, he must practice. The consequence would be that he could only practice and not teach.

In the malpractice umbrella insurance crisis that we went through last July, which I know, Senator Greenberg, you are very familiar with, we saw another facet of the problem. Just before July 1, it appeared as though none of the doctors in New Jersey would be able to get umbrella insurance from an admitted carrier. As a result, a contact was made by the agent for the Medical Society with a nonadmitted carrier, what we might call "the excess market," and it would have cost perhaps four or five times the premium to get umbrella coverage as compared with the one that was ultimately approved just about July 1. But the important thing to note is that the anesthesiologists were singled out in that period of time by the nonadmitted carrier which refused to write anesthesiologists except on an ad hoc basis. The anesthesiologists were told that each anesthesiologist must apply for coverage and a determination would be made as to whether he would be insured or not, and this is clearly an unacceptable solution with respect to what you might call the "life's blood" of the operating room. You need the anesthesiologist and he needs the protection.

With respect to the solutions, of course, anesthesiologists are high-risk specialists, but on the other hand, they are not specialists in what the root causes are or what the solutions are to this problem. However, they have given a great deal of thought to this question, and they have spent a great of time meeting on it, studying it, and talking about it. I think it is fair to say, from my conferences with them and the

discussions we have had, that the doctors are not looking for a solution which would deprive people of compensation in a justified case. But on the other hand, they must cry out against the system which allows a significant number of perhaps unjustified claims to be brought and a system which provides a set of laws and doctrines which create the possibility for a bad result to be equated with malpractice and for an award to be made under those circumstances.

I think that the proposals that are pending for state-sponsored or doctor-sponsored insurance companies leave the doctor to bear the brunt of the problem in an inequitable way.

I read remarks by Clyde Schlater who is President of Employer's of Warsaw in addresses made in April. He said , "People can't get along without doctors, doctors can't get along without insurance, and the insurance company can't get along without premiums equal to the losses and expenses produced by the insured exposure, and this is just as true of pooling plans or state or federal agencies or funds as it is of any single private carrier. The price tag travels around that circle as far as it can go, which is back to the people." I know that Mr. Schlater said it travels around back to the people, but Senator McGahn aptly observed that it doesn't always travel around back to the people because in the case of Medicaid and Medicare, as a matter of law, we cannot pass it on to the people. And in the case of Blue Shield-Blue Cross subscribers, where the doctor is a participating doctor, he cannot pass it on either because Blue Cross-Blue Shield will not pay it. The argument that you need not be a subscribing doctor, as a practical matter, is an unfair answer because a doctor is at a terrible disadvanta

in those circumstances. The carrier will then refuse to take an assignment of the claim, pays the claim directly to the patient, and the doctor then has the problem of pursuing the patient to collect what may be a $120 fee, and many times it gets spent on some household commodity, and he doesn't get the fee.

There are solutions possible which don't produce great inequity. We have heard all of them alluded to today: shortened but fair limitations statutes, reasonable limitations on recovery for pain and suffering, compulsory nonbinding arbitration, perhaps with results evidentiary in subsequent proceedings. I didn't hear anyone mention this, but it might be useful to perhaps pursue consideration of compulsory bifurcation of trials where they occur so that the issues of liability and damages are separated. Some modification of the "res ipsa loquitur" doctrine, the informed consent doctrine, and the collateral source doctrine are all viable avenues that could be pursued.

There was some discussion this morning with Mr. Greenstone about the narrow scope of the "res ipsa loquitur" doctrine. I believe a comment was made that the doctrine is rarely, if ever, invoked in New Jersey. I call to your attention the case of Anderson v. Somberg, which is recorded at 67 NJ: 291. It was decided by the Supreme Court in April of this year. That was the case involving an unconscious patient, and I think the tip of a forcep broke off during a back operation, and a sliver was left in the patient's tissue, and further procedure was required. The court said that under those circumstances, each participant is a custodian of that patient and has an obligation to come forward with an explantion, or he may be left holding the bag and be liable. The court said it is not a traditional application

of the "res ipsa loquitur" doctrine, but it certainly is an extention of the same type of notion operating there.

I also heard some discussion about the unconstitutionality of an approach that would lead to a limitation of recovery. I think that that is not correct. I think it isn't correct particularly if you separate the recovery for economic loss as opposed to the recovery for, let us say, pain and suffering. There was a long and learned debate in the literature at the time of the adoption of the no-fault in auto with respect to the limitation of pain and suffering and the constitutionality of it. Professor Keaton has written on this subject, one of the national proponents of no-fault. In that regard, I know that the Supreme Court in Massachusetts has specifically ruled that there is no constitutional right to recover for pain and suffering, and we have precedent in New Jersey where classical common law causes of action have been abolished; the Hart, Molmack, in particular, comes to mind. I don't have the citation with me, but if the committee is interested, I could supply that. In that particular case, the cause of action that existed at common law was abolished by the Legislature, and the court specifically held that that abolition was constitutional. I am not suggesting by that remark that r i g ht of recovery in appropriate cases should be abolished, but when you consider you have, let us say, one in ten thousand instances, as Dr. Todd said this morning, where a doctor may make a mistake, not a willful one, not a wanton one--- But it is inevitable, with the huge number of procedures performed every year, that there will be some untoward occurrences. Some of them may even be the product of carelessness. If a haggard man is called out at 3:00 in the morning and he has someone in a life-threatened position, he can make a mistake.

In the case of no-fault with automobile, society finally determined that with millions and millions of automobiles on the highway, accidents are inevitable, and a system should be found to take this constant harangue out of the court forum, and I think the same thing is true here.

Unfortunately, Assemblyman Salkind is not here this afternoon, but he was repeatedly questionning witnesses concerning the propriety of imposing a requirement for all doctors to carry malpractice insurance as a condition of licensure. I don't think that question is strictly related to the question that is before your committee, Senator Greenberg. But if it is considered that it is appropriate, I think that you should also give consideration to other approaches, such as making insurance available to any private patient who chooses to have it, much the same as a transit insurance policy is available when you fly or when you move your household possessions. The patient is in the best position to determine the scope of the economic loss which he might suffer. If, for example, as part of the hospital admission procedure, he were offered the opportunity of purchasing a policy to protect him against economic loss, if he disclosed the limits he thought were desirable in his circumstances, and if it were made available to him at some moderate premium, this would be a direct way of passing the cost on to the person who is exposed to that risk of loss rather than making the doctor bear it for everyone.

The only other solution that we have discussed among ourselves which I did not hear discussed today - perhaps it was and I missed it - has to do with the creation of some type of reinsurance program - it might take a national program to do this - to deal with the rare and calamitous occurrence where there is some massive

recovery. I don't think it is appropriate for the doctor who has a momentary lapse rather than being a real incompetent to be excoriated or have his career ruined because of the fact that he made an error.

The only other thing is that the practitioners of anesthesia, who by reason of the nature of their practice are exposed to high-risk procedures all the time and the risk of life and death, pay a high percentage of their incomes for malpractice insurance, and it is higher than that that other doctors pay for protection. I think there should be some way of leveling out the premium load that the anesthesiologist bears to make it distributed in a more equitable way. After all, everyone is potentially the beneficiary of the skill of the high-risk specialist, and I think that society has an obligation to find some way of making it equitable and desirable to maintain these high-risk specialists at a good level of competence and effectiveness.

SENATOR GREENBERG: One of the ways that society does that is by providing those individuals with a higher income than others receive. Could you tell this committee, for the record, whether you can provide us with statistics with regard to both mean average premium and income attained by the members of your Society.

MR. TURNDORF: A suit was filed by the Justice Department against the American Society, and in that suit, it is alleged that the average gross income of anesthesiologists is $56,000. At the present time, the basic coverage - Dr. Lucas can correct me if I'm wrong - I think costs $6,600, but we have that compounded by the fact that--- Dr. Moss, who is Chairman of our Economics Committee, is here and can explain this a little better. He came in today and told me that he has just learned that he is now going to be required to get umbrella insurance for

the nurse anesthetists who work under his supervision, who characteristically carry a $100,000 policy, and that that will cost him an additional $5,700 per nurse anesthetist. I have heard it estimated that the average anesthesiologist - and we are talking averages now - bears 20 percent of his gross income as the expenses of protection against the malpractice crisis.

SENATOR GREENBERG: Do you have figures on that, Mr. Turndorf?

MR. TURNDORF: I can supply those to the committee, and I will do that as part of my written presentation.

SENATOR GREENBERG: Thank you very much.

Senator McGahn.

SENATOR MC GAHN: Mr. Chairman, may I have Dr. Moss correct that statement?

SENATOR GREENBERG: What is the correction, Doctor?

DR. ERVIN MOSS: It is not a form of umbrella coverage. A letter was received in the last few days from Britain Agency, through Chubb and Co., that unless--- The nurses carry their own insurance. They carry a policy through a company in the midwest called Marsh, MacClellan. The maximum they can obtain through this company is $100,000 - $300,000. They used to pay $200 a year; now they want $800 for a claims-made policy which, as you know, in a five-year period represents the cheapest the first year, according to the hearings on St. Paul that I attended. Right? Now we received a letter saying that if you are incorporated - and many anesthesiologists in the State are incorporated, professional corporations - and if you employ a nurse, she must carry a half million - a million and a half.

I called Chicago today and they don't sell more than $100,000. Therefore, if you are incorporated and have a nurse in your employ, you cannot obtain insurance unless you pay for her a full doctor's premium, minimum of a half a million - a million and a half, which is an additional $5,700 a year.

I would like also to simply make a statement about incomes. Traditionally, anesthesiologists' fees, going back to 1946 when they became a specialty, according to the Blue Shield of New Jersey, are 20 percent of the surgeon's fee. And if you wish to have copies of Blue Shield 500 or 750 program, you will find that anesthesia fees are 20 percent. We are classified in the same category as surgeons, urologists and specialists like this. Therefore, the problem is that we are paying on an income that is 20 percent of a surgeon's income.

SENATOR GREENBERG: Okay. Thank you very much. Senator.

SENATOR MC GAHN: Doctor, I think yours was a very articulate presentation. I think, however, possibly there are a few things that should be brought out.

You made a comment concerning foreign medical graduates in the State of New Jersey. I think you are fully cognizant of the fact that, generally speaking, it is impossible since we have only one medical school - we have only one, should I say, medical center, that of course being Newark, Piscataway as well - that most of the community hospitals and most medical centers are forced to go with foreign medical graduates.

MR. TURNDORF: Let me clarify that, Senator. When I said foreign medical graduates, I didn't mean graduates of medical schools outside the State of New Jersey.

SENATOR MC GAHN: I am talking about individuals that come from foreign countries who are doing their

residiency programs here and who, after they come here, stay, and actually then are taking surgical anesthesiology, pathology or medical residency, as the case may be.

I would like a little clarification on this. I think it is well worthwhile to recognize the fact that an anesthesiologist like a pathologist basically may be on a salary, as far as the hospital is concerned, or on a fee-for-service basis. I think the book that was published, "Bureaucratic Malpractice," put out by Princeton Resources for Public Services, I think it was, that created such a hurrah about a year and a half ago, showed - they did not have surgeons-- but they showed that anesthesiologists and pathologists in this state in a number of areas were receiving over $250,000.

Just a moment, please. Now we are getting back to one thing. Fees may be 20 percent of what the surgeon does. But don't forget one thing: if you have an anesthesiology group in a hospital, you are responsible for every anesthetic that is given. You may find yourself having one, two or three anesthesiologists. You may have four or five anesthetists. And if you are a teaching anesthesiologist, you are having students that under the doctrine of respondeat superior are actually carrying out this and they are not getting paid and they are not getting any salary.

I do not know because this is not true at Atlantic City. In Atlantic City the anesthesiologist in charge of the department pays malpractice insurance for the nurse anesthetist, as the case may be.

So that what you are talking about here - and I can't argue your figures - but, by the same token, this does not necessarily turn out the way that this thing basically sounds.

You may be having a group of eight or ten people operating five ORs from eight o'clock in the morning until

four o'clock in the afternoon and emergency surgery throughout where, even if you have a surgical group of four, the most they may be doing is ten or twelve procedures a day. And, if you have a busy OR, you may be doing forty or fifty procedures.

Let me finish, and then, if the Chairman so desires, you may respond.

I am not decrying this. It is an extremely important service and I think that the impact of this is even beyond what the doctor here has stated, because you are responsible for pre-operative as well as the operative care, the immediate post-operative and post-operative care beyond that point. Let us not kid ourselves, I think it would be very imformative if possibly this Committee could actually see - and we haven't even talked about informed consent yet - the informed consent list the California Society of Anesthesiologist has come out with. Very frankly, after reading that, anybody would be out of his mind to even sign an anesthesia permit because they have everything in there that can possibly happen. But this is carrying informed consent procedure absolutely to the nth degree. That was a comment.

I may be a little wrong on my figures on this, but I would like to ask you how you feel about informed consent from the standpoint of an anesthesiologist?

MR. TURNDORF: May I have Dr. Lucas address himself to that?

SENATOR MC GAHN: Yes.

DR. A. L. LUCAS, JR.: Dr. McGahn, if we told a patient every possible thing that could happen to that patient during an operative procedure, I would be quoting exactly what you just said about the California Society.

I feel each case is an individual case. There is a certain amount that you can tell one patient that you

can't tell the patient in the next room. We attempt to be as honest as we can. We attempt to protect ourselves as much as we can. But we also feel we must give a service to that patient and, if that patient has indicated surgery and we are going to scare that patient away from the operating room, we may have to keep some things back.

However, in the process of trying to be humane and keep these things back, we sometimes get our faces washed in court by the statement, "You did see the patient and you didn't mention the possibility of . . ." "Well, sir, I felt that if I did the patient would become afraid." Isn't that a judgment? Yes, it is a judgment. But if we do it this way, we feel we are being fair, but yet we have been having our faces washed by not saying everything.

SEN. MC GAHN: Prior to anesthesia, at the time you go around for a pre-anesthetic examination of the patient, you note everything on the chart is done: electrolytes, EKG, and everything. If you do not find the patient in suitable condition for anesthesia, you will so inform the surgeon and in essence refuse to give anesthesia.

DR. LUCAS: That is correct, sir.

SEN.MC GAHN: Fine. Also during the operative procedure itself, is it not true that that patient is fully monitored at all times?

DR. LUCAS: I can speak for my hospital alone, but that is correct. That is good practice.

SENATOR MC GAHN: Thank you.

SENATOR GREENBERG: Thank you, gentlemen. We appreciate it.

Our next witness is Mr. Czech.

G R O V E R C Z E C H: Mr. Chairman and Senator McGahn, I appreciate your letting me appear at this late hour.

My name is Grover Czech. I am Mid-Atlantic Regional Manager for the American Insurance Association. Our membership consists of 138 of the nation's large, stockholder-owned property-casualty insurance companies doing business in all 50 states. Included among that membership are seven of the approximately ten remaining companies that write any medical malpractice insurance in the country today, including Federal-Chubb, St. Paul, Aetna, Hartford and Travelers. As a result, we have been very active in this issue all over the country during this past year, in an effort to come to grips with this problem.

I have a very large statement with three substantial attachments to it. I am not going to go through it due to the lateness of the hour.

But basically our purpose in giving you this statement is to provide the Committee with some background with regard to the history of the problem, the development of the problem and the present situation in the country. I have gone through and broken down the problem in three areas: availability, tort reforms, regulation and quality of medical care; and a fourth area of procedural efforts, such as the establishment of study commissions and development of statistical-gathering efforts. I have gone through each of these categories and listed them for your information and assistance in reaching your conclusions.

I can run through quickly what each one is just by naming the captioned item. And, if you have any questions on a particular item that we perhaps haven't discussed today, you can either stop me or we can talk about it after I run through them.

Joint Underwriting Association - 23 states have established these so far.

Physicians Mutuals - Legislation has been passed in four states.

State funds have been established in three states.

Reinsurance facilities have been adopted by two states.

Other Insurance Mechanisms. Here I have really only listed one. Some states have enacted legislation limiting insurance companies' liability to 100 thousand dollars, while establishing a patients compensation fund to cover the liability in excess of 100 thousand dollars.

One other item I didn't list for no other reason than I just forgot is claims made, which could be included under this category as well.

Reforms to the Tort System. Many states - I have here 19 states and there may be more than that now - have enacted some tort reform legislation. Again running through these, I think most of them have been talked about today. There are a few in here I don't think have and I will point them out as we go through:

The Ad Dammum Clause we have touched on. Eight states have taken some action there.

Advanced Payments. Five states have taken action in this area. I think that has been discussed today.

Pretrial Panels. This includes arbitration as well. Nine states have done something in this regard.

Attorneys' Fees. Eight states have taken action in this area, although I understand New Jersey already has the sliding fee schedule, due to the Supreme Court Rule. So that shouldn't be a problem here.

Collateral Source Rule. Six states have done something.

Informed Consent. Eight states have taken action here.

Limitation of Liability and Limitation on Recovery. Nine states, according to my research, have acted in this regard. Someone before, a prior witness, indicated that some 24 states had done something here. I don't believe

that is correct.

Standards of Care or the Locality Rule. Five states have done something in this regard.

Statute of Limitations. Fourteen states have taken some action.

Good Samaritan Laws. I think 25 states have either clarified or enacted Good Samaritan Laws.

Periodic Payment of Awards. I know of one state, that is California -- no, I'm sorry. It is Wisconsin that has just recently done something in that regard. I am not sure this would require legislation in all states. This was talked about this morning, where you would set up a trust fund in which the lump-sum award would go and then you make periodic payments out of it; and in the event the plaintiff dies, perhaps some of the award can be not paid to the estate and would go back to the insurance company.

Workmen's Compensation and No-Fault Systems. No states to my knowledge at this time have done anything seriously in this regard and it hasn't been discussed seriously by any state for some time.

Burden of Proof. Three states have dealt with this issue.

Notice of Intent to File Suit. I don't think that was discussed today. California recently adopted this provision as part of a comprehensive law. They required that prior to filing any medical malpractice law suit, the plaintiff's attorney give the insurance company 90 days' notice prior to this time, the idea being to give the company, the insurer, time to preserve evidence, to gather evidence, to prepare their case, and also time to try to settle and negotiate the dispute without going to trial.

The last one I have here is Channeling of Liability. I don't believe it has been discussed and I think it is

an interesting concept. I might just take a minute to explain it. It is being developed in a few jurisdictions and I think Michigan has a bill on it. This goes along the line of recognizing the fact that you have a very small base of insurers that you are dealing with, namely, the physicians, who are bearing the brunt of these large premiums, over which to spread the payment. The concept here is based on the HEW Medical Malpractice Report of 1973, that indicated that at least 75 percent of all medical malpractice incidences arose out of a hospital situation. Assuming this to be true, the idea would be to make the hospital the sole party defendant in a medical malpractice case. In other words, when a medical malpractice law suit is brought, the hospital would be the only one that could be named as a defendant in that law suit, the idea being that they are in a better position to spread the cost across a wider base of people, basically. They can charge all those who use the hospital, which would further be spread across health insurance premiums.

Some of the benefits here in terms of reduction of cost would be: now when a medical malpractice case is brought, several parties are named as defendants. Here you would only name the hospital. So right away you are reducing the defense cost, which is significant.

SENATOR GREENBERG: I have been following you through your report. Incidentally, let me ask you a question.

MR. CZECH: I was trying to develop this one last idea.

SENATOR GREENBERG: Go ahead.

MR. CZECH: Do you want to ask me a question?

SENATOR GREENBERG: Go ahead.

MR. CZECH: Basically, the benefit of it is: one, reduced defense cost; two, to place the hospital as the sole party defendant where the cost of insurance can

be better spread. You can also spread the premiums over the classes of physicians through the hospital. That is another supposed benefit. Also, if the hospital is solely liable, the insurance company and the hospital can better work together on a loss prevention control program, getting at the basic malpractice incidence, itself.

As I said, this proposal is relatively new in terms of being discussed across the country. A few states are discussing it now. But it seems to hold promise among those who have been observers of this problem.

SENATOR GREENBERG: What page are you on?

MR. CZECH: I am on page 14 and 15.

SENATOR GREENBERG: Was this document put together for your testimony here today?

MR. CZECH: Yes.

SENATOR GREENBERG: Has it been used as a basis for testimony anyplace else in the country?

MR. CZECH: No, I just put it together last week.

SENATOR GREENBERG: I think it is very well done and I want to congratulate you on it. Unfortunately, we just are running out of time.

MR. CZECH: I know. I am not going to go through it all. I just want to make one more point.

SENATOR GREENBERG: The point I wanted to make to you - then I will come back to you -- it is really a question so that people reading this could understand. This association of yours represents or has as members most of the carriers of malpractice in the United States?

MR. CZECH: Right.

SENATOR GREENBERG: You have an interesting line in here in your conclusions which indicates that the real impact of any change in the system, regardless of what is done at this time, will very likely not be realized for several years. Even then its impact may be difficult

to measure.

Can you tell us this: Does it really make any difference what we do because I get the feeling that it doesn't from what I read in your statement, at least for the foreseeable future? I think what you are saying in here is that many companies have bailed out, haven't keep records to begin with, and have bailed out because it has been a side issue with them, the exposure is too great and it will take a while to get them back in, if they want to, in fact, come in; regardless of what you do, it is not going to make a whole lot of difference in that area. Is that true? Is that what you are saying?

MR. CZECH: Well, of course, a lot of this is judgment and opinion. What I am doing, I think, is trying to express some caution that no matter what is done in terms of tort reform or in terms of any of the reforms or changes that we are all talking about today -- in terms of those actions reflecting themselves in either cost reductions in terms of premiums or in terms of reduced frequency in the number of law suits that are broughtor in terms of the size of jury awards, none of this, I don't think,and again other people who have observed this scene across the country for the past several months are not of the opinion it is going to have any immediate impact. In other words, it is probably going to take two or three years before you are going to begin to know whether it has an impact or not, before you can get some statistically adequate information to be able to judge the impact that it has had. That is basically what we are saying.

We are working in a kind of an unknown situation. We are saying we think these things make sense, we are moving in the right direction, and common sense would indicate that they will have some either cost-reduction or, at least, cost-stabilization impact. But we can't

say for certain whether they will have an impact or what that impact will be. We hope they will have an impact, but we just don't know at this point, and we are not sure anyone can know.

I didn't mention in my statement, but it is very difficult to cost these various proposals that are being put forth; in other words, if you reduce the statute of limitations or you enact a collateral source, direct offset, how can you tell dollar for dollar what impact this will have on premiums? You really can't. If you can, it is going to be a terribly rough estimate. An effort was made recently in California to cost five or six of these tort reform proposals. They did it, but no one knows whether what they did has any meaning or not. So I guess what I am saying is that it is not a hopeless situation, but it is certainly not one that you can bet on with any kind of certainty.

I don't know whether I have answered your question or not, but it is a very uncertain area.

SENATOR GREENBERG: Is your association the recipient of statistical information from its members in this area?

MR. CZECH: No, we are not. We are three-fold basically. We do legislative representation in the state legislatures through local counsel and we have property claims service activities which assist in loss-prevention control in fire and property insurance. But we don't gather statistics,per se, in terms of setting premiums.

SENATOR GREENBERG: Can you tell us why it is as we look around the country we find different carriers writing different states and not find the situation where those carriers are competing against one another in those states?

MR. CZECH: I think at this point in time -- at one time, maybe 20 years ago, there probably was a lot of

competition between carriers. There were a lot more carriers at that time too writing medical malpractice insurance. But even as far back as the '40's, I believe, from the research I have done, there were companies in and out of this business. In other words, a company would come in the business --- It was a constantly increasing frequency in the number of law suits and the size of the awards even then, but it was a much slower increase and it was more subtle than it is today. But companies would get into it for a period of time, either a short or a long period of time. They would start to develop some unfavorable loss experience. They would try to protect themselves by either getting rate increases or some other protective devices. But there was enough competition at that time where another carrier would come along and say to the medical society, "we would like to be the sponsored carrier and we will give you x premium," which was lower than the existing carrier or than what the existing carrier was asking for. So the medical society would say, "all right - we will go with you." So they would go with a new company. The old company would drop out of the market perhaps altogether or for a time, and a lot of them dropped out altogether.

So gradually we ended up as we are now in the '70's with about ten companies writing medical malpractice insurance, with all the time a constantly increasing frequency of the number of claims, the number of law suits being filed, and larger and larger jury awards. This is statistically demonstrable. The HEW report, I think, documents this and there have been many other research activities which would document that as well.

There just isn't any competition in the market today because companies see this as a very, very difficult line of insurance to make any money out of, which, of course is what they are in business for - to make money.

So they are very reluctant to get into it. In fact, it is very obvious from what we have heard here today and what I have heard all over the country that a lot of the companies that are in it are trying to get out.

I have heard a lot of talk, particularly here in New Jersey, about the word "monopoly", that the insurance industry has a monopoly on the medical malpractice field here in New Jersey. I was going to get a dictionary and look up the definition of "monopoly." When you talk about a monopoly, that usually connotes a field where there is one company that has all the business and is fighting off all the competitors who are trying to get it away from them, and finally driving them out of the market. That is not what has happened here. Here everyone wants to get out of the market.

SENATOR GREENBERG: I know. The question that has been raised in this State has to do with an agreement of some sort that only one or two companies should operate within the State. The right word is "conspiracy" and that word has been used from time to time in describing what people think exists. Monopoly is not the correct word.

MR. CZECH: I would categorically state, as far as I know, there is absolutely no conspiracy between medical malpractice insurers to divide the market; if anything, they all, or most of them, want to either curtail their writings and maintain only what they have or get out altogether.

SENATOR GREENBERG: I cut you off. Is there another point you wanted to make?

MR. CZECH: I just wanted to make one more point.

Attached to my statement are seven draft statutes: Informed Consent, Burden of Proof, Statute of Limitations, Hearing Panels, Limitation on Damages, Advanced Payments, and Notice of Intent.

Our law department has prepared these. The three property-casualty trade associations have tentatively agreed on the form of those statutes, which basically means that the property-casualty industry would support them.

We are making them available to you simply from the point of view of information. We are not strongly advocating them at this point because again we can't promise that if you do pass them you are going to have any cost savings; and, if you do, we can't tell you what they are going to be. We are making them available and we think they move in the right direction. We will work with you on these and on any other information that we can make available to you.

(Complete statement submitted by Mr. Czech can be found beginning on page 84X.)

SENATOR GOLDBERG: That is the problem we are having. All of the suggestions are well motivated, I am sure; but when you ask whether or not there will be any cost savings, the answer is, "I don't know."

MR. CZECH: That's right.

SENATOR GOLDBERG: And when you want to know how much, the answer is, "I don't know."

MR. CZECH: It is a terrible position for us to be in as well as you, because it is hard for us to come forward and offer these things when we can't tell you any definitive answer.

There are two other attachments here as well: a chart put out by ISO showing nationwide experience in terms of premiums paid versus losses paid, from '68 through '73; and the report done by the California Auditor General's Office, dealing with seven insurance companies in California over a period, I think, of '60 to '74, showing that they are going to suffer some $183 million

in losses on malpractice premiums for that period of time. This is just to give you some idea of what the national experience has been.

SENATOR GREENBERG: I appreciate it. I thank you very much for this statement. It looks to be very helpful.

Senator McGahn.

SENATOR MC GAHN: Senator Greenberg, I share your pessimism concerning the issue that you just brought up here, that unfortunately the medical profession which is most intimately involved with this cost, despite what might be passed, is certainly not going to reap the benefit of this within the next year or two or three or four, for that matter.

As I have been reiterating today, I think, given the present malpractice climate, with the consumer movement, with the increasing number of successful claims that are awarded or simply settled, with an increase of 10 to 15 percent of malpractice claims per year, certainly there can be no bottom line or tail to this thing until such a time as the number of claims and the number of injuries that are occurring are cut back and cut down on.

Are the companies that you are representing here - and again I will ask you this because I have yet to get a good answer - basically carrying out any loss-prevention programs and are they making these known to the physicians and to the hospitals and cooperating with them, in order to analyze general and specific types of situations or incidents which either the hospital or the physican should be aware of and should pay due care to, in order to cut down on the incidents that could possibly lead to a claim?

MR. CZECH: I know that generally insurance companies do make available loss-prevention control programs, but

I don't know specifically what ones are doing it where. From what I understand, the problem is, in a lot of hospitals and within the medical profession itself - and this is true of lawyers as well - the physician as an individual working within a hospital environment who has privileges at that hospital does not want the hospital to have any or some control over his activities They resist the hospital and the insurance company working together with loss-prevention control programs. I understand in some hospitals they don't have them at all because of this.

I think that is something that perhaps should be addressed and looked into. I don't know the extent of it, but I do know there is a great deal of resistence. I think that is at the heart of the matter because it is crucial to getting at the reduction of the incidence of medial malpractice itself.

SENATOR MC GAHN: I agree with you and I think because of this,possibly,it may be the medical profession is going to have to take a second hard look at itself and make a determination that we are going to have to go into some type of loss-prevention control.

By the same token, you talked about the liability being placed upon the hospital rather than the physician. The first thought that occurred to me is that basically in any hospital the physician is a private contractor of medical service. He is not responsible to a hospital except that he must abide by the rules and regulations and the bylaws. Why should the hospital be responsible for an individual who is a private practitioner and is simply being granted the privilege of the facilities of the hospital?

MR. CZECH: That is one of the problems in the concept. I think what this is is a very practical concept aimed at making the problem more manageable; it doesn't

really do anything to solve the problem. It simply makes it more manageable by spreading the premium over a larger base, and making the premiums more manageable per physician. But there are several problems, whether you would call them political problems or technical problems,that are there. One is that it would cause an increase in the premiums to hospitals, to which I am sure the hospitals would object. This problem that you pointed out would be another one. The third problem is: if you make the hospital the sole party defendant, you would still have to bring the individual physicians in somehow to point the finger and say, "you were negligent in this case." That is another one of the problems.

I think it is a concept worth looking at anyway from the point of view of spreading the cost over a broader base. As I see it, personally, the basic problem is that you have only approximately 250 thousand or 350 thousand, depending on which statistic you look at, physicians in the entire country. When you talk about the insurance concept and the law of large numbers, it is a very small base over which to spread an extremely large premium. Look at the automobile insurance situation where I think you have 100 million people who are paying automobile insurance premiums. It is a much larger base. So from a purely technical insurance standpoint, enlarging the base would be not an answer but a way to make it more manageable. That's all it is really.

But you hit the nail on the head before when you said that the real basic problem is people's attitude. People are litigants. They are suing more and more today than they ever have before for various reasons. Until that changes, our frequency and cost situation is not going to change.

SENATOR MC GAHN: The solution might be something

like trip travel insurance. Once you go in, you simply deposit a buck and get $100,000 worth of insurance.

ASSEMBLYMAN GREENBERG: Thank you, Mr. Czech.

Now our final witness -

F R A N K C I E S L A: My name is Frank Ciesla. I am with the law firm of Giordano and Halleran in Middletown, New Jersey. We have been retained by six of the seven hospitals in Monmouth and Ocean Counties, their medical staffs, and the Monmouth Medical Society, to analyze the medical malpractice situation and to present the problems to this Committee as well as to, hopefully, work on some legislation that will solve it.

Our basic capacity prior to that was as general counsel to some of these hospitals, so we have some familiarity with the malpractice situation in the hospital setting.

I think the first thing underlying what we would like to see done is that the solution to the malpractice situation be a statutory solution; and, that is, that we try to stabilize the floating concepts. The doctrine of malpractice - what is malpractice - is now in the hands of the courts and it keeps getting broader and broader, and that makes it difficult to estimate now what malpractice is going to be ten years from now, as with some of the other doctrines.

An example of the use of resources that the present system causes is: First of all, I think one of the congressional committees has estimated that we are spending about $7 billion a year right now in defensive medicine. With the rate-making that we are doing in the State of New Jersey, we can't afford to spend our portion of it on defensive medicine; it has to be used for care needed by the patients to cure illness.

The second problem we are having now is the malpractice premium itself; while it is actually going up

by pheonomenal percentages, it has now reached ridiculous proportions as to the coverage. An example of that is Monmouth Medical Center where one million dollars of coverage costs over $300,000 in premium a year. They are paying about one-third a year for the first million of coverage. We are not the only hospital that is in that circumstance. Other hospitals in the State -- I think one in Morris County, for three million dollars of coverage, is paying $750,000 a year in premium.

SENATOR GREENBERG: You mean per incident.

MR. CIESLA: Yes, one million per incident; but the premium for that is $300,000. A couple of years ago - and by a "couple," I mean three or four - it was like $50,000. It is not just that the percentage increase is phenomenal; it is the amount of the premium that is also phenomenal.

SENATOR GREENBERG: Bear with us a minute. We are familiar with that problem. I would like you to get into the heart of what you have to say.

MR. CIESLA: What I'd like to say is that I feel we should zero in and segregate out negligence from non-negligence. I would like us to zero right in on negligence; define statutorily what is malpractice, what is negligence; define what is informed consent and what the physicians have to do to get informed consent and, if they comply with the statute, then they don't get sued - that would be a change from what we have today; adopt an arbitration procedure that is effective; do not adopt a screening or an arbitration procedure that is going to result in many cases going to a jury trial. I am not saying eliminate jury trials. But I am saying, adopt an arbitration procedure that gives people confidence in the hearing and then they are not going to take their cases to court.

If we do adopt an arbitration procedure that doesn't dispose of many of the cases, then we are just adding another administrative cost to the situation.

With reference to damages, we feel that we should eliminate front-end awards completely. We should pay the actual cost of medicals whenever they are incurred. We should pay a set figure for economic loss, maybe with a ceiling of $1,000 a week or some other figure, but no front-end awards. They would be paid over the life of the patient so the patient would be assured during his life of getting compensated, but we wouldn't have any speculative damages and should the patient get a front-end award, he would not become a burden on society after having spent it.

We also think we should require medical malpractice insurance of all health care providers - hospitals and licensed physicians - coextensive with the liability created under the statute, so whatever liability we create under the statute, the malpractice insurance that should be required is coextensive with that liability. And any carrier who wants to write insurance in the State must write insurance coextensive with the liability created under the statute.

The next thing we feel that has to be done is that statutorily hospitals be required to review the credentials of all physicians before they admit them to practice and that they review the credentials at least on some periodic basis, be it annual or biannual; and that the members who participate on the credentials board or any other boards, as well as the witnesses who appear before them, be given immunity for what they do, except if they do it with malice, so that they feel protected; and that this same type of immunity for a witness or a member be extended to appearance before the State Licensure Board, before PSRO boards, before utilization

review boards, before any boards that are created for the purpose of controlling quality of care, so that they become effective and physicians don't fear suit because they have appeared before them or they participate in them by the physician who is, I don't want to say necessari accused, but being reviewed.

In our experience as general counsel we have found many physicians reluctant to appear or participate in hospital boards because of fear of being sued. And that is one of the ways you have to get at malpractice, getting at one of the sources, and that is getting at the bad physician and eliminating him.

I think the thing we want to underline though is that we want statutory resolutions to stablize the law so it is predictable and we don't have to sit back today and say negligence five years from now is going to be this when law suit is brought.

We also don't want to get caught in a situation in which many physicians are now caught; and, that is, five years ago one hundred, three hundred or five hundred, a million was great coverage, but when suits are brought now or will be brought five years from now, that is rotten coverage. It is nowhere near adequate to cover the awards that will come down at that point in time. So the physicians are getting themselves in a bind and now they don't know what kind of coverage to buy or how much to buy because they don't know when the suits are going to be brought and what damages can be expected at the time the suits aregoing to be brought.

The other situation which we don't want to get into is the situation where we are on a claims-made and not an occurrence basis. Premiums are being paid out of the dollars when the event occurs and not being paid out of dollars five years from now. So we don't want to get in

the situation where the carriers are writing claims-made policies and not occurrence policies.

We also do not feel that a dollar limitation is in the best interest of either the health care provider or the patient. While we do think maybe eliminating some of the speculative elements, such as pain and suffering, and maybe limiting the award for economic loss to a thousand dollars a week or some other figure, might be reasonable, putting a $200,000 limitation or a $500,000 limitation or $1,000,000 limitation is not reasonable. There may be certain circumstances where actual costs are over $1,000,000 and, if it is due to malpractice, that should be paid and the patient should not be limited by statute.

We further feel that the no-fault concept - because we spent a lot of time looking at no-fault - is not workable. There are nowhere near enough figures to come up with the resources necessary or even to estimate what the resources are for either a no-fault or a result-oriented type insurance. If the injury is due to negligence, that is one thing, and it should be paid for. If the injury is not due to negligence, if it is just a risk of this operation or the operation cannot cure the patient, the figures with which we were supplied by various groups - and they were very tentative and not reliable at all - are so high we don't think the State of New Jersey could afford to pick up bad results. And the profession certainly can't afford to pick up bad results.

That gets me back to why we are here: Both the doctors and the hospitals feel that too much of our resources are going to the problems created by malpractice, both in premiums and in defensive medicine and they should be going to something else in this era when we have decided only a certain amount can go to medical care. More of it has got to go to care and less of it to

malpractice. Thank you.

(Statement submitted by Mr. Ciesla can be found beginning on page 144X.)

SENATOR GREENBERG: That is what we are here for. That is what we are trying to do. I appreciate very much your coming down and giving us the benefit of those thoughts.

What do you do at that hospital with regard to doctors who have been adjudicated guilty of malpractice, if anything?

MR. CIESLA: We review the case and we review the physician's record. We do not suspend a doctor for one case of malpractice.

SENATOR GREENBERG: You do have a system?

MR. CIESLA: Yes, we do.

SENATOR GREENBERG: Is that system formalized in writing?

MR. CIESLA: No, it is not formalized -- it is formalized in the sense it is in the bylaws, but it doesn't say malpractice should go before anybody. He is automatically brought up, but it is not in writing anyplace. But we do have a hearing procedure, etc., under our bylaws.

The problem with that is - and I have to tell you honestly it is a very bad problem - that we have no subpoena power, physicians are afraid of being sued for appearing and testifying or participating. We have had to give indemnity agreements to any physician who has appeared, any physician who has participated. We have been unable to get a carrier to write insurance for this. What we really need is a statute that says, if you participate as a witness or as a member of a hospital board, you can't be sued.

I think the Point Pleasant case is an example where Merritt Lane threw out the action of Point Pleasant and

has now gotten them back into a hearing. I may also point out here that the cost to the hospital is phenomenal to run these hearings. We do them, but there is a large cost to the facility in time, in attorneys' fees and in gathering evidence to put a cause forward.

SENATOR MC GAHN: Sir, I think we recognize the fact that immunity is needed for the medical boards who want to restrict the privileges of a physician, for whatever the reason may be, in a hospital. We have discussed this previously.

I can make one comment concerning the attempt to define malpractice. I think Senator Greenberg and I at the present time are trying to define death and trying to define life. I think it is going to be an extremely difficult thing to do this. I think if you want to do something, let's prove proximate cause as a cause for action, as against some other type of thing.

I think you realize also that they have had difficulty legally in coming up and defining what a compensable event is.

Let me make one observation as far as hospitals are concerned. I think this is possibly something that would be beneficial. I know a number of hospitals do have grievance procedures and grievance commissions and panels as far as the patients are concerned. This is a rather haphazard type of situation. It is certainly not a mandatory thing. I think this type of situation, whether it should be mandatory or tried on a voluntary basis, with an ombudsman who would attempt to resolve any adverse effects that happen in a hospital that might result in a future claim, would be worthwhile trying, at least on a trial basis, in an attempt to cut down on the number of claims.

Furthermore, as I have mentioned before, I believe it was to Mr. Owens, I do think despite the fact the experience may not have been the greatest, it doesn't mean that it should not be tried; and arbitration,

with the patient coming in the hospital with the right to withdraw from this arbitration in case anything happens within a 30-day period of time, might be something that would be worthwhile from the standpoint of hospitals.

MR. CIESLA: Can I comment on that?

SENATOR MC GAHN: Surely.

MR. CIESLA: Let me tell you that at Monmouth Medical Center for about eight months now, we have a patients' services section, in which, I think, every patient in every room is seen once every three days by a person who reports directly to the administrator. He hears whatever the patient wants to tell him about the doctor, the nurses or anything else. We don't know whether in the long run it is going to have a great effect or not, but at least it gets whatever is bothering the patient off his chest and, if it is anything critical, it gets to our attention immediately. That is one approach that we take.

The problem when we get to untoward results or non-negligent injury is that it is almost indefinable. We found that out. And it is almost impossible to put a cost figure on it. I am not talking about negligent injury where there should be compensation; I am talking about where we failed to provide a cure. I think it is necessary though to define malpractice, I really do, because the uncertainty is one of the reasons our costs keep going up.

SENATOR GREENBERG: Thank you, Mr. Ciesla. Thank you for participating in this hearing.

This hearing will now be adjourned. The Committee will meet when the transcript is available, digest what has been presented, and schedule a new date for an additional hearing, of which you will be notified. Thank you very much.

(Hearing Adjourned)

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TESTIMONY OF

JOANNE E. FINLEY, M.D., M.P.H.

NEW JERSEY STATE COMMISSIONER OF HEALTH

BEFORE THE

SPECIAL LEGISLATIVE COMMITTEE

TO INVESTIGATE AND STUDY

MEDICAL MALPRACTICE INSURANCE

OCTOBER 24, 1975

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Mr. Chairman, Members of the Committee, Ladies and Gentlemen:

I am Dr. Joanne E. Finley, Commissioner of Health of the State of New Jersey. I appear before you today to offer my observations--both as a physician and as a public health official--on the continuing crisis our nation and our state face in the area of medical malpractice insurance.

I would like to commend the State Legislature for authorizing the formation of this Special Committee to investigate and study the many aspects of this critical issue. Too often, problems of this sort -- perceived to be national in origin and national in scope -- are ignored or carelessly put aside by state and local governments. By addressing itself directly to this problem, I believe that the State Legislature is saying that no matter how complex or how controversial this problem may be, it is time for the State of New Jersey to take action.

Certainly, the charge to this Committee reflects that sense. I believe that there is no question that the cost of medical malpractice insurance has risen "at an alarming rate;" similarly, there is no question that as the cost has increased, the availability of this insurance has decreased. Above all, there is no question that both the increase in cost and the decrease in availability of such insurance has had a direct impact on the health care costs borne by our citizens.

I am sure that everyone in this chamber today is aware of the statistics -- documented in newspapers and magazines and periodicals throughout the country in recent months -- attesting to the rising cost and decreasing availability of medical malpractice insurance. These statistics indicate that we face a problem of staggering proportions.

While it is difficult to assess the consequences of the
:uation in all areas of the health care delivery system in New
'sey, it is readily apparent that the cost of hospitalization in
State has increased due to the higher medical malpractice
urance rates.

Based upon information drawn from the Health Department's
pital rate-setting program I would offer the following examples
cost increases. Hunterdon Medical Center experienced a 763%
rease in its malpractice insurance premium from 1974 to 1975.
ristown Memorial Hospital showed an increase of 806% and St.
zabeth Hospital suffered an increase of 1560%. West Hudson Hospital,
mall general hospital not performing the more sophiticated services
vided at large medical centers and with a very good record of claims
erience, incurred a premium increase of 336%.

And at the teaching hospitals of the College of Medicine and
:istry of New Jersey, malpractice insurance premiums, paid directly
State Government, increased by 241% in the same period.

The costs to hospital facilities such as these, due to mal-
:tice insurance premiums alone, can amount to over five dollars
patient per day. In addition, the cost is further escalated
:e the physicians under contract to the hospitals are also
:riencing premium increases which are then, in turn, reflected in
:er compensation rates for their services. Ultimately, as you may
lise. the costs are passed on to the consumer in the form of
:er medical insurance premiums.

The State Department of Health exercises very limited authority
the private practice of medicine in our State. Therefore, we are
nearly as well acquainted with the impact of rising malpractice
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:r the private practice of medicine in our State. Therefore, we are
: nearly as well acquainted with the impact of rising malpractice
surance rates on the finances of the private physician as we are

with those of health care facilities. Nevertheless, I think one can safely conclude that physicians' costs have gone up dramatically as medical malpractice insurance premiums have risen and the consequence is felt, again, by the consumer.

The increases in the cost of medical malpractice insurance to our health care facilities come at a particularly inopportune time for the citizens of New Jersey--a time when the State Departments of Health and Insurance are intensifying their efforts to control the spiraling increases in the cost of health care in our State. Clearly, if the upward trend in malpractice insurance costs is allowed to continue unchecked, our cost containment efforts -- which have shown significant results in a relatively short period of time -- will be seriously jeopardized.

Therefore, I agree with the State Legislature that the time has come for the State of New Jersey to take action -- action that not only protects the consumer against unreasonable increases in the cost of health care but also protects the competent physician and the efficient hospital against exorbitant increases in the cost of malpractice insurance coverage.

In order to establish a rational and comprehensive approach toward solving this extremely complex problem, I believe we must first identify those elements that affect the cost and availability of medical malpractice insurance. The learned commentaries which have been advanced in print to explain the issue at hand indicate that there are several contributory components. The groups which have influenced and will continue to influence the magnitude and scope of the medical malpractice insurance problem are: the insurance companies; physicians; lawyers; and the consumer in the role of patient.

t a time when medical technology and science places increasingly
ticated and complex tools in the hands of physicians, and when
neral publicity of medical advances heightens the awareness
pectations of the consumer, it is not difficult to understand
ything less than the display of superior medical skill and
mance is met with suspicion, distrust extending to outrage,
ably proceeding to litigation. The success of other
ctice suits lures both patient and lawyer into the pursuit
estionable claims. Realistically, also, the performance (or
erformance) of some physicians warrants a proper redress for
atient. Those doctors who chronically do not exercise
nable care in diagnosis and treatment, or who do not have the
r respect and understanding of the complex arsenal of
umentation at their command, or those who knowingly attempt
icated procedures beyond their capabilities, should incur the
pline of their peers and society, as well as afford the patient
fiable compensation. And so it is that we must recognize that
is no simple nor single step that can be taken to rectify a
em with many facets.

In my opinion, however, the one element more responsible than
ther for our present medical malpractice insurance crisis is the
olistic practice of those insurance companies writing malpractice
ies. The arbitrary decision of insurance underwriters to
terally increase premium rates to whatever level the market
bear have thrust the medical community into turmoil.

Until steps are taken to restore a competitive marketplace
e writing of malpractice insurance policies -- or, at the very

least, to restore some sense of reasonableness through government mandate, to the rates that are being charged -- little else can be done to solve our medical malpractice insurance woes. No amount of public monitoring or control over the activities of lawyers, doctors or pateients will achieve effective results until and unless the activities of insurance companies are brought under stricter control.

To that end, I strongly support the legislation proposed by Insurance Commissioner Sheeran. This legislation could break the existing monopoly which currently assures that exorbitant rates can be charged. When there is only one seller of a product, the buyer has no choice but to pay the price being asked, and that is the situation today in New Jersey for doctors, hospitals, and every other purchaser of malpractice insurance. As I understand the proposed legislation, it would encourage an insurance company that is already selling malpractice insurance anywhere in the United States, and selling any other form of insurance in New Jersey, to voluntarily sell malpractice insurance in New Jersey as well. If the insurance company would not be willing to write malpractice policies in New Jersey it could then be prohibited from selling any insurance whatsoever in the State. Another feature of the legislation is to establish a reinsurance facility for accommodating the high-risk customer and would guarantee that insurance coverage would be available to everyone.

If the State Senate were to act favorably on this proposal, it would be taking a strong forward step toward bringing the cost and availability of medical malpractice insurance under control. In addition to this necessary action, government can take other steps to further control the excesses of our present system of dealing with

the malpractice issue. Such action should consider the interests of the patient, the lawyer and the physician.

It is indeed unfortunate that many members of the medical profession -- an honorable and noble profession of which I am proud to call myself a member -- are now suffering for the indiscretions, excesses and misjudgments of a fraction of their number.

Even the strongest defender of the medical profession would be forced to admit that, unfortunately, there remain a small number of physicians practicing medicine in this country who should not be permitted to do so. And as long as this continues, medical malpractice claims will be filed . . . and unfortunately, in some cases, they will be filed with justification.

In a similar vein, even the strongest defender of the legal profession would be forced to admit that there remain a small number of attorneys practicing law in this country who continue to bring frivolous medical malpractice claims into our courts, not only wasting the valuable and expensive time of our court system but also contributing to the steady increase in malpractice insurance rates.

And even the strongest defender of the consumer would be forced to admit that there remain a small number of ill-informed, ill-advised patients in this country who continue to initiate unsubstantiated litigation.

I am not suggesting that the incompetent or mistake-prone physician should be granted undue protection against liability for malpractice. Nor am I suggesting that the honorable attorney or the justified patient should be denied access to legal remedies for substantive malpractice claims.

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There is a step we can take (which has not yet been considered legislation in this State) to protect physicians, attorneys, :ients and our courts with equity. Legislation authorizing e creation of a Board of Inquiry, to conduct pre-litigation view with the public sector, could lead to a reduced incidence th of medical malpractice claims and of huge medical malpractice ards. As I envision it, the Board should be set up within the alth Department and have a small administrative staff including :rhaps, a part-time investigator. Its modest budget should permit :penditures for expert consultants fees, so that technical opinions :om specialists not connected with the case under consideration,)uld be sought when necessary. The Board might be composed of a awyer, a physician and a public member who neither belongs to the edical or legal profession, nor shall be associated with the nsurance industry. The lawyer would be chosen on a rotation basis rom a panel roster supplied by the New Jersey Bar Association. imilarly, the physician would be chosen on a rotation basis from a)anel roster supplied by the New Jersey State Medical Society. The)ublic member of the Board would be chosen on rotation from a panel :oster supplied by the State Commissioner of Health and approved by :he Governor.

Legislation which sets forth the responsibilities of the Board and its relationship to the courts should specify that when a complaint is filed with the court of competent jurisdiction either the court or the plaintiff would thereupon institute a request to

the Board to review the case. The sole function of the Board of Inquiry would be to determine whether a finding of "probable cause" exists. Board recommendations on all cases would be forwarded to the court and no plaintiff would be denied the opportunity to pursue the case. However, a recommendation by the Board of "no probable cause" would, I think, deter some litigation or at least affect the outcome of the case as to the size of the award.

The Board, through its staff, should also be required to maintain a complete record to cases reviewed so that an annual statistical report can be compiled. This report would allow the professions, the State, and the general public to know exactly the pattern of malpractice allegations in New Jersey, the costs involved and the disposition of cases.

The findings and recommendation of the Board, whether positive or negative as to probable cause, should also be forwarded to the agency which licenses health facilities and the body which licenses and, therefore, can discipline physicians. In this regard, consideration should be given to legislation that would mandate appropriate sanctions that the disciplinary body could impose upon the chronic offender, or against the licensing body if it fails to carry out its responsibilities.

In summary, I believe that this two-fisted approach to the medical malpractice insurance crisis -- stricter controls over insurance providers and pre-litigation review of malpractice claims -- would provide greater protection for all of those involved in malpractice cases without encroaching unduly upon their respective practices or civil liberties. I believe that legislation to this

effect would represent a responsible approach to a problem which demands early and firm action.

Thank you again for affording me the opportunity to present this testimony. I have the utmost confidence that the Special Committee will exhibit both prudence and courage in formulating its legislative recommendations.

STATEMENT

by Assemblywoman Rosemarie Totaro

to the

Special Committee to Investigate and Study
Medical Malpractice Insurance

Mr. Chairman and members of the Committee, I would like to thank you for affording me the opportunity of sharing with you my views on medical malpractice. For the record, I am Rosemarie Totaro, Assemblywoman from District 23, which encompasses a part of Morris County, and I have been deeply concerned with the problem of medical malpractice for some time.

In speaking here today about malpractice and malpractice premiums we must not suppose that these rates are affecting only the doctors they are charged to and the insurance companies providing the insurance. High malpractice premiums affect every man, woman and child in this state. Every citizen at one time or another finds himself a patient. Increased medical fees do not discriminate between rich and poor, black and white, male and female, or young and old. We all see the increases in malpractice insurance premiums reflected in the higher medical fees we are paying our physicians. We are sadly mistaken if we do not recognize that physicians are not themselves absorbing the increased costs, we the people of New Jersey are, in fact paying these increases. Middle class, impoverished and unemployed citizens of New Jersey alike, at this time of economic strife, have enough of a financial burden without watching their medical bills climb along with their mortgage payments, and food and fuel bills.

We legislators must realize the magnitude of the problem
ıd the scope of the implications it has for the people of our
:ate. It is one special case where we must constantly keep
ı mind the welfare of our citizens, because any decisions made
ere or as a result of what we say here will bear directly and
eavily on the lives of all the people we represent.

May I also remind the people in attendance here today that
alpractice insurance is unlike any other kind of insurance. It
annot be discussed as if it is car insurance. The reasons, I
ıink, are obvious, but when we hear the word insurance, we tend
ɔ think consumers. I cannot emphasize enough the fact that a
atient is not a consumer and cannot be placed in the consumer's
ɔle. The circumstances surrounding malpractice insurance differ
rom those surrounding any other sort of insurance.

High malpractice premiums also affect the public in less
irect ways other than simple increased costs but which are prob-
bly in the long run just as detrimental to the public health of
he state.

New Jersey is in great danger of losing its specialists
ecause we are no longer offering them an atmosphere in which
hey can practice in comfort. High risk doctors, the specialists,
re required to pay higher premiums, and constant large increases
f these premiums are a discouragement to doctors who we in the
tate cannot afford to lose. Doctors in these special categories
ay find it easier to practice in other states. We have in fact
lready lost a few neurosurgeons. In a state where we only have
bout 50 neurosurgeons we should be doing what we can to make it
asier for them to stay, rather than induce them to leave because

of boosting rates with no controls in sight. This state has been building up a fine community of cardio-vascular surgeons and we should be fighting to keep them, by making it clear that this problem of boosting rates will not be allowed to prevail.

It is possible that fewer of our young doctors and students considering high risk areas of medicine as possible careers will be discouraged. We are faced with specialist shortages in the future if we cannot make these professions attractive to our young people. Already young doctors feel the pinch of impending malpractice premiums. They cannot set up the traditional individual family practices, and they find that after years of medical schooling they still face further financial insecurity at the onset of their practices.

According to many people examining the crisis of malpractice there is a problem of malpractice insurance availability. I want to stress to you that the real crisis of availability is that the high price of insurance limits its availability. This is the problem we must deal with here. It is the problem which is affecting patients and doctors alike.

The problem of high malpractice insurance rates, cannot be attributed singularly to insurance companies, and it cannot be blamed on a few incompetent and negligent physicians. It is due primarily to the present structure of portions of our legal system that affect the way malpractice is handled and our lack of official channels for regulating doctors effectively.

At the present time, the statute of limitations that applies to malpractice cases is two years from the time of the discovery of injury supposedly due to the negligence of a physician. Since there is no definite limit to the time during which a case can be brought to court, doctors must be prepared to defend themselves

in cases brought to court by patients treated for an ailment many years before. This means that insurance companies must be prepared to fund court cases and pay damages for almost every patient that any physician has ever seen. For this they must maintain giant reserves that are funded by skyrocketing insurance premiums. When setting up their reserves, they must take into consideration the price of legal costs and damages, whose prices are continually rising and the toll of inflation and time on the reserves. If there was a more definite statute of limitations, insurance companies would only have to be prepared to deal with cases that related to treatment of patients during a smaller period of time. The need for giant reserves would be wiped out and insurance companies would not have to charge such exorbitant malpractice insurance premiums. The people of New Jersey, so burdened with financial problems, might not have to deal with rising medical costs as well. Commissioner Jay Jackson, Insurance Commissioner for the State of Connecticut, has said that his State's definite statute of limitations of three years, has been a factor in holding malpractice premiums down. This law has been in effect for at least five years. Now other states are following Connecticut's example. California has just voted into law the same type of legislation with a statute of limitations of three years.

In order to bring the benefits of this experience from our sister states to New Jersey, I have introduced in the Assembly a bill to establish a separate, definite statute of limitations for medical malpractice cases. It would require that a malpractice case be instituted within three years from the date of the medical treatment or procedure upon which the claim is based, or else it would be barred by the statute. For minors, the statute of limita-

medical treatment or procedure. Under existing law, a minor has two years from the date he reaches the age of majority, 18, to file an action. Adding the discovery rule to this potentially long period and the liability of a doctor or hospital could continue for a life time. The time periods provided in the bill should be more than sufficient to allow negligence related injuries to surface and be recognized. Patients would have sufficient protection against the untoward results of negligent medical treatment. The people of New Jersey would be spared from another rapidly rising cost factor related to their medical bills which are already too high.

Another problem faced by insurance companies, doctors and patients alike is that too often a patient will bring a case to court which has little or no merit. Too often much money is wasted on these cases as well as the time and energy of all the parties involved. Insurance companies must be prepared financially to handle all cases even if they have no merit. If we could screen all cases, and perhaps weed out the invalid cases before they reach the courts, the legal costs involved with such claims might be reduced. This could lead to a reduction in premiums.

To provide for such screening, I have also introduced legislation which would provide for the screening of medical malpractice claims by a medical malpractice review panel. A permanent panel of attorneys, doctors and public representatives would be appointed by the Governor. For each case, an attorney, doctor and public member from the permanent panel, and one doctor selected by each side in the case, would serve as the review panel.

panel would review the claim and make a recommendation with pect to both liability and damages. The recommendation of panel would be admissible in a subsequent court action if the rt found that the panel's findings were not clearly erroneous, decision was in accord with applicable law, and procedural uirements were met. A party would still be able to bring ourt action on his claim after review by the panel, but he be required to pay the additional legal cost of the other ty if he receives 25% less in damages in the court action n he would have received under the panel's recommendation.

We need in this State an agency capable of allowing tors to police themselves, and to seek out and take action alleviate the problem of incompetence in the profession. State licensing board should have the power and means to pend licenses, put doctors on probation and investigate tors who the public and the profession feel are incompetent. can see by the number of cases with little merit that are ught to court that patients feel they have little recourse er than to bring suit when they fear they are being treated ompetently.

I have introduced legislation which spells out more arly and expands the powers and options of the State Board Medical Examiners to deal with incompetence in the practice nedicine and surgery. In addition to their power to suspend revoke licenses, the Board would be given the authority suspend judgement in any case, to place a licensee on probation, place practice limitations upon a licensee, and to take such

other disciplinary action which the Board, in its dicretion, deems appropriate. It would be authorized to investigate any evidence of incompetence by any licensee, to order mental, physical or medical competency examinations, and to require a licensee to participate in informal interviews related to his competency. Members of the profession, hospitals and insurers would be required to report to the Board evidence of incompetence and malpractice claims. Licensees would be required to inform the Board of any disciplinary activities against them in other jurisdictions, by professional associations or health care facilities. Licensees would also be required to have 150 hours of continuing medical education activities to their credit every three years in order to maintain their licenses. Hopefully this approach will provide a better means for dealing with incompetence in the medical profession than the hit-or-miss approach of medical malpractice court actions. It could lead to stopping much malpractice before it can occur.

Other measures may be needed but I feel this legislation is a real start and lays a foundation upon which we can build more malpractice protection policy. It is not a patch-up job on a system that cannot sustain its own costs. We can get down to the roots of these most damaging high costs by acting upon this legislation and by investigating fully every proposed rate increase by insurance carriers. And never while we look at this or any other malpractice proposal may we allow ourselves to forget that in this instance, the words citizen and patient are one and the same.

In New Jersey medical care is rapidly becoming a luxury many people may soon be unable to afford. We as legislators government officials must not allow this to happen. Good h should not be the right of only the rich. All people d be able to get health care and there is no reason why e should pay exorbitant medical fees when we can alleviate and now the pressures of rising costs.

THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA

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STATEMENT OF HERBERT E. GREENSTONE
MEMBER, BOARD OF GOVERNORS
ASSOCIATION OF TRIAL LAWYERS OF AMERICA
PRESENTED AT A HEARING BEFORE THE SPECIAL COMMITTEE
TO INVESTIGATE AND STUDY MEDICAL MALPRACTICE INSURANCE
FRIDAY, OCTOBER 24, 1975

As a representative of the Board of Governors of the Association of Trial Lawyers of America, consisting of 25,000 trial lawyers throughout the country, with over 700 members in New Jersey, I appreciate this opportunity to appear before you, in a sincere effort to assist in resolving the medical malpractice problem in New Jersey.

We all recognize that the primary concern in a discussion of this nature is not what is best for doctors or lawyers, but what is best for the public.

Doctors and lawyers owe their right to practice to the State of New Jersey, which grants licenses. Accordingly, the State has the power to regulate both professions. As a corollary to our right to practice, we must adhere to the standards of conduct defined by statute and the law of New Jersey.

In the Report of the Secretary's Commission on Medical Malpractice conducted by the Department of Health, Education and Welfare released in 1973 it was determined that the quality of medical care in the United States was the cause of medical malpractice law suits. Accordingly, any attempt to eliminate the legal practice will not eliminate medical malpractice.

Senator Edward M. Kennedy is reported as stating in the Boston Globe of May 18, 1975, "The malpractice insurance crisis will not be relieved until the medical profession improves the quality of health care."

The fact that medical malpractice exists, and victims are entitled to recover, can be gleaned from only a few illustrations which have recently been reported in the press.

In Sacramento, California, in the case of Gonzales v. Nork, ecovery was allowed against a doctor who performed unnecessary negligent operations on 38 patients to support a drug habit. its opinion the Court stated:

> "The beneficial effect of malpractice litigation in improving medical performance has been established by evidence in this case."

The New York Times carried an editorial on August 16, 1975 ncerning two doctors who were on the staff of a hospital, who w patients and even operated on them under the influence of ugs. The Times stated, "The Marcus case is an extreme example the conditions that have under mined public confidence in the actice of medicine and thus contributed to the multiplicity of tions against doctors."

Dr. John H. Knowles, former head of the Massachusetts eneral Hospital and currently president of the Rockefeller oundation, is reported as stating in the Reader's Digest, in ecember, 1974, "An incredible amount of unnecessary surgery is oing on and perhaps 20 to 30 percent of all physicians gain financially through excessive charges for the use of hospital facilties and by performing uncalled for surgery."

It is not my intent to provoke a name-calling confrontation etween the legal and medical professions. The time is now ripe or both professions to combine their efforts and resources and ooperate in a sincere attempt to prevent medical malpractice, nd when it does occur, to provide for proper remedies for the ictims of malpractice.

THE PROBLEM

If physicians cannot obtain reasonable insurance coverage, atients actually injured by a medical accident or by negligence ight be unable to receive any financial retribution.

We have witnessed the spectacle in New York of the Argonaut Insurance Company. After Argonaut took over the malpractice insurance of the Medical Society of the State of New York, it claimed that it was suffering tremendous losses, and it was necessary to increase premium rates. It has been reported in financial circles that the losses sustained by Argonaut were due to bad investments rather than the payment of losses arising out of medical malpractice suits. Doctors, faced with an increase in insurance rates or with the alternative of losing their sole insurance carrier, threatened to go on strike.

In New Jersey the Chubb Insurance Group, which presently insures the State Medical Society, likewise asked for and was granted an increase in its premium rates.

It is obvious that doctors and hospitals are in a bind if one insurance company has a monopoly in writing medical malpractice insurance. Such a condition should not be permitted to exist. I agree with the position of State Insurance Commissioner James J. Sheeran, recorded in the Newark Star Ledger on March 11, 1972, pointing out the dangers of a monopoly in malpractice insurance.

Assembly Bill No. 3094 would remedy this situation by requiring all insurance companies offering liability insurance in New Jersey to write malpractice insurance.

Senate Bill No. 3232 would provide the State Insurance Commissioner with the responsibility to provide medical malpractice insurance coverage for all doctors and medical facilities in New Jersey.

Both bills warrant consideration to assure the medical profession and hospitals that there will be adequate insurance coverage for liability at reasonable rates. Public interest requires that these health care providers should be able to obtain professional liability insurance.

Rates should be allocated in accordance with the doctor's gross income so as not to burden the new physician who has not yet developed a full practice, or the retired physician who wants to maintain a part time practice.

In the case of high risk doctors, such as neurosurgeons, orthopedists, anesthesiologists, etc., an assigned risk program should be set up which authorizes the State Insurance Department to distribute among existing insurers coverage for doctors who might otherwise have difficulty in obtaining it.

The cost of medical malpractice insurance, and this can better be described by insurance actuaries, can be considerably reduced by a reinsurance program. There is a need for backup excess coverage. If private insurance companies cannot furnish this reinsurance market, then the responsibility should be assumed by the State Medical Society or the American Medical Association. If both of these professional groups fail to assume this responsibility, then it is necessary for the State to provide reinsurance through a source other than the doctor or the medical society.

A reinsurance program can enable a doctor to afford basic r primary insurance coverage for a sum up to $250,000.00. Any laims in excess of the primary coverage should be borne by a atastrophe Loss Fund to pay medical professional losses in ex- ess of the primary coverage. Such a fund could be supported by pportionment among all casualty insurers in the State, or from State Reinsurance Fund. This would permit health care providers o have less apprehension about the catastrophe loss and less ex- ense in buying liability insurance.

In order to properly evaluate the reasonableness of premiums charged by insurance companies writing medical malpractice insurance, a study should be made which would include the following:

Direct and indirect costs of medical malpractice claims;
General categories and specific types of adverse incidents causing injuries to patients, indicating specialty involved as well as types of injuries;
Experience in paying out claims;
Comparison of premiums and payments;
An analysis of reserves;
An analysis of investments and returns on premiums;
A survey of claims made, settlements entered into before and after trial, results of jury verdicts, costs of litigation.

Only after such a survey has been made can our Insurance Department pass upon applications for rate increases.

Litigation arising out of medical malpractice has given rise to many legal problems.

THE MEDICAL EXPERT

In order to prevail in a case involving medical malpractice it is necessary for the plaintiff to produce a medical expert who can testify concerning the standards of conduct. It is understandable that doctors are reluctant to testify against fellow members of the medical profession in their particular community; and the courts in New Jersey and elsewhere have rejected the locality rule so that doctors who are not licensed in the State where they testify on behalf of the plaintiff may nevertheless give their opinions as to standards throughout the profession, and are not limited to the locality where the defendant physician practices.

Accordingly, plaintiffs have relied on the testimony of experts out of the state in presenting their claims. Many of these experts are well qualified, have the courage of their convictions, and are willing to render opinions against other physicians.

It is unfortunate that the medical profession does not make available doctors in the local community to pass judgment upon their professional colleagues who do not adhere to the standards of their profession. If all doctors are insured by the same insurance company in the state, this makes it even more difficult to get one doctor to testify against another doctor when they are both covered for liability insurance by the same company.

It is recommended that organized medicine establish an official policy to encourage members of their profession to cooperate fully in medical malpractice actions so that justice will be assured for all parties.

SCREENING PANELS

Medical malpractice litigation is costly from both the plaintiff's and defendant's viewpoint. Very often it cannot be determined whether or not the plaintiff has a justified malpractice case until suit is started and the defendant is compelled to produce his records and be questioned concerning his procedures and treatment.

The New Jersey Supreme Court Rule 4:21 provides for Screening Panels. A study should be made of the claims which have been presented to the Supreme Court Panels, to determine what has been the experience of the claims handled by these Panels. Have they been successful in disposing of any claims? What recommendations have been made by the Panels, and how have they been acted upon? It is recommended that this Committee make a study of the operations of the Supreme Court Panels to determine their success or failure. Screening Panels, if properly constituted, may help to weed out non-meritorious claims and encourage the settlement of justified claims. This will serve to cut down the cost of malpractice litigation.

THE RIGHT TO A JURY TRIAL

ATLA takes the position that both the patient and the physician are entitled to assert their respective rights in a full judicial proceeding unless the cost of such a proceeding makes it practically unsuitable to the resolution of that dispute. Where the dispute involves a very substantial sum of money the expenses incurred in a full judicial proceeding are certainly justifiable. However, where

dispute concerns a smaller sum the expense of a full judicial
ermination may be excessive. For these reasons, ATLA recom-
ds that consideration be given to a mandatory arbitration of
professional liability dispute involving less than $25,000.00.
such a recommendation were adopted it would curtail the costs
expensive litigation.

LEGAL DOCTRINES

Unjustified criticism has been made of the development of
al doctrines in medical malpractice cases. For example, the
s ipsa loquitur" doctrine (the thing speaks for itself) enables
laintiff to shift the burden of proof to the defendant to come
with an explanation as to the untoward result. This doctrine
been utilized where a foreign body or surgical instrument is
t in the patient's body after surgery. This doctrine is sound
justified, and is restricted to specific types of cases that
peak negligence on the face of the facts presented.

Another doctrine which has been criticized involves informed
ısent rules, which oblige a doctor to advise a patient of the po-
ıtial consequences of treatment or surgical procedures. The
;al philosophy in back of this doctrine is that the patient has
'ight to know what risks are involved in the nature of the treat-
ıt or surgery being furnished to him so that he may make a choice
to whether or not to proceed with the recommended treatment or
'gery. Self-determination is a basic right of free men.

STATUTE OF LIMITATIONS

Criticism has been directed against the statute of limita-
)ns which enables a plaintiff to bring an action within two
ırs after he discovers the injury, or obtains his majority.
:ordingly, claims may be brought some time after the treatment
; terminated. Physicians who complain about long statutes of
ıitation fail to realize that the significance of a short stat-
: of limitations forces counsel to sue everyone within the range
possible involvement to prevent the defense from later arguing
ıt the responsible party was omitted.

In the case of infants, quite often the true nature of the
ury does not become manifest until the child has matured. This
particularly true of brain damage following birth.

The position of ATLA is that patients who are plaintiffs in
.practice cases are entitled to the constitutional guarantees
equal protection under the law, and that legal doctrines and
.nciples should be applied in medical malpractice cases in the
ıe fashion as they are applied in other cases.

CONTINGENT FEES

The lawyer's contingent fee, whereby he receives a percentage of an award, but no compensation if he loses the case, assures a negligently injured person of competent counsel. It has been called the poor man's key to the court house door.

Medical malpractice cases are long, complicated and expensive.. so much so that many lawyers are reluctant to accept them. The overwhelming majority of injured patients would be unable to retain expert counsel if they were obliged to pay for legal services on an hourly basis.

Critics who assert that the lawyers' contingent fees encourage medical professional liability litigation and provide excessive compensation to attorneys are patently uninformed. Most attorneys who agree to handle a medical malpractice action are competent, knowledgeable and honorable. The amount of research, both medical and legal, that goes into the preparation of a malpractice case, far exceeds any other type of personal injury litigation. Substantial expenses are incurred in the preparation and presentation of these cases, involving pretrial discovery as well as the cost of medical expert opinion. When the attorney is successful in obtaining compensation for a victim of medical malpractice, he earns every cent of the fee which is allowed to him under the law.

PREVENTION OF MEDICAL MALPRACTICE

Medical malpractice litigation has a therapeutic effect. It has been stated that immunity from liability breeds neglect while liability for torts encourages care. Medical malpractice litigation has made doctors more aware of the necessity to treat all patients with the degree of care that is recognized in their profession.

Professional Standards Review Organizations (known as PSRO) should be expanded to establish peer review proceedings to inform doctors as to what constitutes standard medical care and practice for a particular medical specialty.

Patients should have a right to receive from physicians, on demand, copies of medical reports, including the doctor's office records, just as the law provides for the right of a patient to obtain a copy of his hospital chart.

Many cases of medical malpractice arise as a result of inadequate hospital care. By statute, liability against hospitals is limited to the sum of $10,000.00 (N.J.S.A. 2A;53A-8). However, the statute does not preclude the claimant from suing individual members of the hospital staff including nurses and residents.

This has resulted in adding to the number of litigants in a malpractice case. It is recommended that the limitation of liability that presently exists in the statute be eliminated, so that hospitals, as institutions, may be liable, as any other responsible party. The salutary effect of elimination of the $10,000.00 limitation of liability as applies to hospitals is that it will encourage greater supervision by hospitals over their medical staff and other personnel.

Hospital and health care institutions should develop programs to prevent patient injury. Eli P. Bernzweig, Executive Director of HEW's Commission on Medical Malpractice, has recommended that a national clearing house be set up to monitor the information that is gathered and used to reduce malpractice. At present we have an organization known as NEISS (National Electronics Injury Surveillance System) which discloses to the Consumer Product Safety Commission injuries from consumer products that are reported in the emergency rooms of hospitals throughout the country.

Such a program can be set up in New Jersey, so that hospitals can report claims of medical malpractice that have been uncovered by their medical staffs.

In addition, plaintiffs, their legal representatives, insurance companies and doctors, should report specific claims of medical malpractice to a central clearing house within the State. This information can be computerized and examined to determine what particular areas have resulted in claims of medical malpractice, and make necessary recommendations for procedures to prevent such medical malpractice in the future.

* * *

It is fortuitous that the medical malpractice problem has been brought out into the open, so that we can examine it, determine the causes, consider appropriate preventive measures, and, as always, insure that the rights of the public are fully protected.

STATEMENT OF JOHN J. NANGLE
WASHINGTON COUNSEL
NATIONAL ASSOCIATION OF INDEPENDENT INSURERS
BEFORE THE
SPECIAL COMMITTEE TO INVESTIGATE AND STUDY
MEDICAL MALPRACTICE INSURANCE
CONCURRENT RESOLUTION 3001
TRENTON, NEW JERSEY
OCTOBER 24, 1975

NAII is a voluntary national trade association of some 533 insurers of all types, both stock and non-stock, whose membership provides a representative cross-section of the casualty and fire insurance business in America. Our companies range in size from the smallest one-state entrepreneurs to the very largest national writers; they reflect all forms of merchandising -- independent agency, exclusive agency, and direct writer -- and they include companies serving not only the general market but also those specializing in serving particular consumer groups such as farmers, teachers, government employee and military personal. We estimate that our members write approximately 50% of the insured vehicles in the State of New Jersey. They generally do not write medical malpractice insurance.

Within the past year or so, a considerable amount of nationwide publicity has focused on the subject of medical malpractice, sprinkled liberally with half truths, erroneous statistics and accusations of blame, but essentially devoid of critical analysis. Perhaps this is understandable to some degree since the subject is, after all, not a single indentifiable problem but a complex of interrelated problems which seem to be changing dynamically almost daily. Yet most discussion of the subject today continues to focus on symptoms rather than the causes.

What has disturbed us in the past year are the hasty and ill-conceived proposals to paper over the problems that have not come to grips with what really are the basic issues. A common characteristic of these band-aid reponses is the plan to distribute medical malpractice losses by assessing all companies writing liability coverages, regardless of whether they have ever written malpractice insurance.

The NAII does not believe that a Joint Underwriting Authority or a similar pooling mechanism can possibly solve the malpractice problem. The effect of such an authority or pooling mechanism is not to reduce the cost of malpractice insurance but simply to distribute medical malpractice losses by assessing companies writing other types of liability coverage regardless of whether they have ever written malpractice insurance. Needless to say, the cost of such distribution will eventually be passed on to the policyholders. It seems grossly inequitable that a homeowner, businessman or automobile owner pay an increased insurance premium in order to cover medical malpractice losses. Why should these consumers be compelled to subsidize the medical profession? Such a system obviously does not come to grips with the real problem of medical malpractice. In no way would such a system reduce overall costs of medical practice. Admittedly, it would reduce the premiums charged to the doctors purchasing the insurance but would spread the actual cost to the purchasers of other types of insurance. Such a procedure may alleviate the symptom temporarily, but it does not cure the illness.

For a study of the long-range solution, it is necessary to look to the roots and primary causes of the crisis and attempt corrective measures. NAII feels that some of the main causes of the malpractice claims crisis are the following:

... At present the policies cover malpractice on an "occurrence" basis. This means that on a policy written for this year the company agrees to insure the medical

provider for any malpractice claim presented in which it is alleged the malpractice was committed in the policy year. Very few of the total claims that will eventually be presented are presented within the policy year. Only a fraction over 50% of the claims which will eventually be presented will be known after five years, and many cases will not be know for ten to fifteen years. This as known as the "long tail;" and its effect on the actuarial premium charged for this year is disastrous when one considers the spiral in the inflationary costs of medical care and jury awards, coupled with the ever-increasing sophistication to sue on the part of patients and plaintiff attorneys.

The two year statute of limitation in New Jersey on personal injury claims should be an excellent one. However, the very liberal interpretation upon discovery and the minor exception make it much less than so. We would suggest a two year limit on discovery which would provide an outside limitation of four years.

Meanwhile, the cost and availability of medical malpractice insurance could be eased for the shortterm by insurance department approval of a "claims made" policy. This would insure a provider for all claims filed against him the year in which the policy is in effect, regardless of when the alleged malpractice occurred. "Claims made" would reflect a current loss picture and permit insurers to determine an adequate rate with more certainty, thus allowing more insurers to participate in a competitive atmosphere.

... Increasing numbers of plaintiffs' lawyers are becoming more proficient in the handling of medical malpractice lawsuits. They are winning more damage verdicts of jumbo size and commanding contingent fees amounting to as much as 50% of the jury award. The contingent fee arrangement has worked well for plaintiffs in automobile liability and malpractice suits because it permits the rich and poor to obtain a lawyer, win or lose. It would be very unpopular to bar the contingent fee arrangement; but to

such fees to hit such astronomical heights as jury awards have trended, makes intiff's attorney a copartner in the result.

A uniform, graduated scale of contingent fees as established in New Jersey istic and has our continued support here as well as elsewhere.

... Advances in medicine and specialization have given patients a total and te "recovery syndrome" for any and all maladies which might befall them. s consider the medical facilities and profession available to them as near ss; and anything less than full expeditious recovery, no matter what the personal al circumstance of the patient, produce a malpractice claim. Frequently patients ued providers for malpractice based upon oral guarantees of successful outcome tment. No proof of negligence on the part of the provider is required. At the ast these guarantees should be required to be in writing or held void in law.

... In many jurisdictions a provider's negligence is assumed unless proven ise. When it is, the burden of proving the provider was negligent is not required he claimant. The jurisdiction provides a prima facie case of negligence against vider, and it is up to the provider to prove he is not negligent.

Negligence on the part of the provider should have to be proved by medical ony, not presumed. A provider should be responsible for following only his own nity's standards of medical practice, and not subject to the spectacle of a sional witness who travels country wide to testify in medical malpractice cases.

... I understand that New Jersey recognizes that arbitration agreements are ution and enforceable. Providers should be permitted to require as a condition of ent that the patient agree to arbitrate any claim he might wish to make for medical ctice. Virtually all union contracts are arbitrated, as well as many business ents. As one plaintiff's attorney has put it, "why should a state force upon

claimants and doctors alike a decision by randomly selected jurors, each of whom would be horrified at the thought of having to deliver a baby, but who is obliged by law to decided whether a neurosurgeon was careless in removing a brain tumor?" This committee may wish to consider the requirement that all malpractice incidents are to be arbitrated.

... Medical techniques have become more sophisticated and in many areas more effective, but they have also become more complex. New operations are sometimes risky. New drugs may have unexpected side effects. Larger numbers of medical and paramedical personnel in the handling of a case may mean increased opportunities for error. Each provider has more and more to keep up with; and, a result, his competency may fall short of the standards demanded.

The medical profession must rise to the occasion and set up standards and enforce them, which would weed out those providers who fall below the necessary standards expected in each provider's specialty.

... Another concept gaining popularity is limits on the size of the awards in medical malpractice cases. This, of course, is the result of the recent legislation enacted in Illinois, Indiana and Idaho. While there are grave questions of constitutional inherent in this concept, it should be pointed out that a statutory limit could result in great savings in the malpractice situation. This is confirmed by a study recently done by the Cook County Jury Reporter and Illinois Jury Verdict Reporter which consisted of a five-year summary of malpractice trials, 1970-1974 inclusive. This involved all completed trials in Cook County and five adjoining counties. The highest malpractice award record has been broken six times since it stood at $117,000 as of May 29, 1970. This includes the record now of 2.5 million dollars on October 31, 1974. Three verdicts out of fourteen in 1974 accounted for almost 5 million dollars. In 1970 the total awards

e $637,000 and in 1974 this had grown to almost 6 million dollars. If the proposed
),000 limitation of malpractice damages had been effect during this period, the
rds would have been reduced by an aggregate of $3,748,000 or more than 37% of
entire five-year total. These figures would seem to indicate that a cap on liability
rds should be seriously considered by this committee.

... A final alternative is the so-called no-fault approach or the medical
lpractice injury compensation system. The overwhelming question in either of
se two systems would be the question of how is one to determine if an event merits
ment on behalf of the physician, unless we are to assume that every injury, every
oward result, every physical manifestation which increases a pre-existing condition
owing consultation and treatment by the physician, should be deemed to automatically
uire the physician to respond to damages. I would visualize a courtroom being replaced
h an administrative board or arbitration panel before whom causal issues would
lace the fault issues being litigated.

While such approaches should not be discredited completely they obviously
uire intense study before adoption. Some of the problems that we would visualize are:
such a system is bound to be more costly than the present one to the extent that it
pensates injured persons whom the present system excludes either because injuries
e not due to negligence or because they were unable to prove negligence; and
the extreme difficulty of defining the type of injury which would be compensable
er such a new system. A medical injury compensation system which is not fault-
ented presumably would authorize compensation for an injury which may be termed
edical accident, untoward results, therapeutic misadventure or some similar concept.

There is the problem of a delicate balance between the rights of the individual
h a legitimate claim versus the rights of society to have continued medical care at

reasonable cost.

Many feel that the expansion of no-fault doctrine to professional services removes the concept that culpable parties are and will be held accountable for their conduct. To some degree we know that this serves as an incentive to exercise greater care in one's activities.

To arrive at a designated equitable schedule of benefits to cover every conceivable malpractice injury would border on the impossible. There remains again constitutional questions as there is no quid pro quo in this area, we are asking an individual to surrender a right in return for a limited recovery. Additionally, to place such restrictions on a person's right in the medical malpractice field only while other personal injuries have no such corresponding limitation would be an injustice. Such a restriction would conceivably conflict with the equal protection clause of State and Federal Constitutions.

There are no easy answers to the malpractice problem. The National Association of Independent Insurers, however, submits that the Joint Underwriting Authority approach does not solve the problem but simply passes on to the consuming public in the form of premiums they pay for the other insurance the cost of malpractice insurance. The public is already complaining about the high cost of other types of insurance.

In conclusion, we would urge caution. We should not leap headlong from a system that works even with many faults into an untested one that may cause even more severe problems. The true solution may be some combination of the alternatives mentioned. These various proposals must be developed, tested and demonstrated through both public and private initiatives.

We of course offer any assistance we can to this endeavor.

Thank you.

SUBMITTED BY JAMES S. TODD, M.D., Chairman Board of Trustees
The Medical Society of New Jersey:

I am James S. Todd, M.D., Chairman of the Board of The Medical ociety of New Jersey, and a practicing surgeon. I appreciate this pportunity to present the position of our more than 8,000 members, nd the 7,200 doctors insured under our Society's professional liability rogram. The Committee should be immediately aware that the vigor ith which a physician speaks about professional liability has a irect relationship to how closely the problem presses upon him. ltimately, however, without some alteration in our current procedures, ot only the physician, but the public as well will feel the pinch f unrestrained escalation in liability cases, and its resultant ffect on medical progress and care. The magnitude of our potential roblem is speculative, but if we assume all suits filed are legitiate and that in 1975 there will be approximately 1.5 billion hysician-patient contacts, and assuming doctors do the right thing 99 times out of 1,000, we will still have 1,500,000 potential malpractice cases a year. But come closer to the truth, assume a mistake only once every 10,000 contacts and there are still about 150,000 potential suits annually. Contrast this with the estimated 40,000 cases that will be filed in 1975. This figure represents an increase of 225% in the past five years. Add to this, the prospect of further inflation, it becomes clear that physicians' incomes, and consequently patient payments cannot long support the load of malpractice costs.

Slowly, but surely, the public will take interest in the problem. A recent Gallup poll showed 9 out of 10 Americans have heard or read about malpractice difficulties, and the majority of those questioned support limits on awards, use of out of court settlements, limiting time in which suits may be filed, advance determination of attorney fees, and increased policing of the medical profession.

The public's views on this issue are important since it is they who eventually will have to pay the costs of increased medical insurance through higher fees. Federal estimates are that, because of the higher rates doctors and hospitals must pay, each visit to a doctor's office now costs a patient an additional $1.50 to $2.00, and a hospital bed an additional $10.00 - $15.00 a day. Furthermore, there is no question that the rash of malpractice lawsuits are leading doctors to practice "defensive medicine". This necessary practice may well cost the public an additional 3 billion a year in health costs.

The reasons for the increase in malpractice claims are not ıediately obvious. Ironically, one major reason may be the fact ıt physicians are better trained than ever before, and use vastly ›roved technology in caring for patients. Utilizing such technology ves lives, but results in greater risks.

The great advances in medicine in recent years have led to rising ›ectations on the part of the public. Perhaps oversold on the so-lled wonders of modern medicine, patients are not infrequently ıry and resentful when medical results are less than perfect. No ysician can be expected to be perfect; nor can he ensure a good ıult in every instance. Yet patients expect and demand more and e of him.

These same wonderful advances in medicine have of necessity le it more scientific, more specialized, and less personal. No ıger can the physician know all the idiosyncrasies of his patient, l no longer can the patient receive unlimited attention. This ›ersonality makes consideration of litigation less distasteful, fits directly into the evolving trends of society.

The increase in medical malpractice litigation to a large sure parallels that in other areas. No-fault auto insurance was response to the great increase in auto liability suits. Personal bility, legal liability, and compensation suits are all rising at increasingly rapid rate. Indeed, litigation appears to be re-cing baseball as our national pastime.

Insurance companies have come in for their share of criticism and implication as a cause for increasing costs. Paradoxically while being charged with monopolistic profit making practices, they drop from the market unable to sustain their losses which, by the nature of the liability lag, often are not measurable for some years after the occurrence. For example in New Jersey, for the carrier of record 1960 to 1968, the losses to date are 250% of the available premium. For the company insuring our Society 1968 to 1971, the losses to date are 228% of the available premium. Calculate the investment income at any reasonable level you may choose, and still there is no profit to be seen.

Incompetent physician performance receives great attention as a ource of malpractice claims, but the simple demonstrable fact is hat the poorer physicians are not those most often sued. Rather, it s the progressive, pioneering, and inventive physician who is willing hrough greater knowledge to assume greater risk to preserve life. enator Lombardi of New York was startled to learn that the distinguished edical school professor testifying on professional liability had eleven utstanding suits against him!

And finally, and perhaps most significantly, some patients, articularly those presenting a complex array of medical problems, ill suffer adverse results or will fail to respond to all known ethods of treatment, despite a physician's best efforts. Society, hich once limited awards to patients who could prove negligence, now s inclined to reimburse every patient for any adverse result or un- voidable accident that occurs in the course of medical treatment. ndeed, in a recent case, the Supreme Court of New Jersey held that njury even without negligence should be compensated. The burden of his new social philosophy currently falls upon those insurance companies nderwriting professional liability policies, and upon the physicians ho must pay for coverage.

Public attitudes, professional development and inflation as well as many other intangible factors have rapidly produced a problem of great magnitude and implications for the whole future of medical care and its financing. Hopefully, there is a stable middle ground between today's increasingly intolerable malpractice premiums, and the solution of full government control and operation of the American medical system. If anything is certain, however, it is that no matter how acute the situation, we cannot allow ourselves to be stampeded into ill advised short term remedies, we cannot attempt to abridge the rights of anyone, and we can no longer ignore the obvious inequities in the existing system.

New Jersey, while not spared from the malpractice mess, nonetheless some undeniable assets which need to be emphasized, and more importly preserved intact.

The Medical Society of New Jersey has developed a unique program insuring professional liability. In many states, this program envied and being imitated. Through its loss control program mained by its agent, the Society has amassed information concerning niums, losses, and operating expenses which guages the need for ging carriers. Since 1960, three different companies have written liability insurance. The most recent carrier beginning in 1971 increases of 10-20% and this year an average of 49.8%, which e it sounds high, compares favorably with the 200-400% cipated elsewhere.

Furthermore, this loss control program eliminates the costly nse of bonafide malpractice suits, while at the same time giving ce that the frivolous suits or those not representing malpractice be defended. The result being that in the last 274 cases going rial, there were 246 verdicts of dismissal, 19 defendant verdicts ther issues, and only 9 plaintiff's recovery. During the same od, 338 cases were settled as non-defensible. This record suggests, nearly half of the suits filed have no validity in terms of maltice. At $30,000 - $40,000 defense costs per case, the defense of stified suits is a real factor in premium costs.

The data currently being generated by the Society's loss control program will be of great value in determining future directions and decisions. We know of no other program so dedicated to the equitable settlement of professional liability disputes.

Another area of pride for New Jersey is the sliding scale contingency fee schedule established as a rule of court by the New Jersey Supreme Court, and to which liability lawyers must adhere. While one may still argue the figures, the concept is a bold and foreward looking action now being copied by other states. The United States is the only country where the contingency fee is allowed, and also is the only country with a liability crises. Cause and effect while not proved, certainly have to be suspect. It has been estimated that the contingency fee scale alone reduces losses in this state by 20%, a not inconsiderable figure.

A less utilized, but equally valuable tool in liability actions is the voluntary screening panel, again established by the State Supreme Court in an attempt to cull out the valid from non-valid liability suits. Unfortunately, it fails of its goal because the proceedings are voluntary, and findings of the panel are inadmissable in any subsequent court hearing. The Medical Society and Supreme Court maintain a unique liaison committee to address and solve mutual concerns. At its last meeting, this committee decided to ask for a Court Rule which would make pre-trial screening mandatory in all cases alleging professional liability. The value of this approach can only

estimated, but would go a long way toward preventing unjust or ivolous suits with their taxing effects on both plaintiff and fendant, all the while protecting the rights of all.

An additional accomplishment of the New Jersey liability program its over all efficiency of operation. A widely quoted figure is at only 16 cents of the premium dollar goes to the plaintiff. Our atistics indicate that 82% of the premium dollar here goes to aintiff and his attorney, and only 17% (more recently reduced to 14½%) retained by the company for commissions, legal defenses and profit. s admirable figure has been reached through the utilization of in- ance experts working on behalf of the Society to find legitimate panies willing to negotiate on all aspects of liability coverage benefits.

Finally, should be mentioned the matter of availability of insur- e. Nationwide, 10 states have a critical problem with either no urance available, or the premiums beyond support. Fifteen (15) tes see a coverage problem developing. So severe is the situation some states that anywhere from 25-100% of physicians may be without insurance by the year's end. Overall premium jumps have been 540%, of the 44 states for which accurate data are available, only 7 e lower rate hikes than those recently approved in New Jersey. eed, New Jersey had the 18th lowest rates in the country.

Despite public statements by some officials, our conversations osteopathic physicians, podiatrists, optometrists, and nurses eal no evidence of unavailability of insurance. Consequently,

the Medical Society has opposed the concept of a joint underwriting association as envisioned by Assembly Bill No. 1552.

State managed underwriting associations are calculated to do only one thing, guarantee that insurance is available. There can be no long term control on rates, there is no guarantee of actuarial soundness since they are a new creation, and most importantly they beg the basic issue of how to reorganize an already long intolerable situation. Indeed, the concept of Joint Underwriting Associations may be counterproductive. For example, Travelers, one of the largest medical liability carriers in the country has indicated it may have to pull out of several of its group programs because of the additional exposure and reserves retained by the Joint Underwriting Associations springing up in so many states. We have reason to believe that our previous umbrella liability carrier pulled out because of the fear of being included in a J.U.A. program. For these reasons, and many others, we feel the record of liability coverage in New Jersey does not warrant the imposition of a new, cumbersome, unproven, and ultimately self-defeating bureaucracy.

Everything I have said so far only strengthens the conviction of the medical profession that fundamental change in three areas must occur if any control over the runaway liability expense is to occur.

First: Remedial legislation is required to eliminate the inequities and abuse of the present system.

Second: Remedial legislation is required to foster, achieve, and control professional competence and responsibility.

Third: New solutions must be found for old problems. Let me elaborate briefly on each of these areas.

There can be no substitute for case law in defining malpractice or professional liability, but there has to be circumspection in accumulating that case law. Increasingly, the courts have liberalized traditional concepts until now effectively in New Jersey there is no statute of limitations as seen through the loophole of the discovery rule. Res Ipsa Loquitor now applies to any untoward event that is visible. The influence of inflation and progress with time is ignored as physician's actions of a decade ago are judged by the entirely different standards of today. There is no intent, as some charge, to erode the traditions of Tort Law, but rather the medical profession has a strong desire to return to the strict interpretation of Tort Law.

We therefore would recommend the following:

1. A strict statute of limitation which would allow adequate time in which to act upon alleged negligence, but not so long as to maintain the current indeterminate length of liability which has made actuarial prediction of liability premiums almost impossible. Actuarial predictability is essential to insurability.

2. Res Ipsa Loquitar was originally intended to expedite cases when professional negligence was obvious, but this doctrine has been so broadened and distorted by the courts as to now be useless. Strict application of this principle is essential for the equitable settlement of liability cases.

3. Awards to patients for professional negligence, especially in the category of pain and suffering, have in recent years skyrocketed. Such awards and their publication have a dramatic effect on increasing professional liability suits, insurance premiums, and hence on health care costs. Everyone should have the right to adequate, but not excessive compensation for medical negligence. A maximal allowable settlement should be adopted.

4. An increasing number of cases include an assertion that the patient failed to receive adequate information for the procurement of informed consent. It is imperative that the health professional have some flexibility in the interest of the patient's welfare and therefore disclosure should be based upon the standard of practice within the profession, and the plaintiff should have the burden of proof that such standard was violated.

. Under present rules of evidence, a jury may not be informed a plaintiff's collateral sources of benefits. This situation ıfrequently results in the plaintiff obtaining reimbursement for .ts that already have been paid through other public sources. .practice cases, the plaintiff's public reimbursements should be ıable as evidence to the jury, but should not include private ınce benefits purchased by the plaintiff's own funds.

ı. Often lump sum settlements do not take into account changing of injured parties regarding dependency, rehabilitation and ıity. Therefore, structured payments taking these factors consideration should be provided for, under court supervision, ıally in cases of permanent disability.

'. The ability to respond to an emergency without reservation ıallmark of good medical care. Good Samaritan laws apply to : places, but as yet are not accepted as covering a physician ı the hospital responding to an emergency on other than his ıt. It is imperative that the Good Samaritan principle be ılly applied.

ı. The mandatory pre-trial screening panel concept has been ɔned, and if the Supreme Court does not implement it by rule, :he legislature should.

ıll of these concepts have been or soon will be prepared for luction into the legislature.

A little known impediment to medical discipline and requirements for excellence is the current judicial posture that maintains due process must be available to all physicians, and that membership in a medical society as a requirement to practice medicine is unconstitutional. The consequence is that hospitals are forced to accept incompetent physicians on their staffs as the result of court decisions. Medical societies have no clout over doctors who would rather resign than face regulations. The State Board of Medical Examiners as currently constituted under the control of an understaffed attorney general's office has all it can do to handle obvious infractions of the medical practice act, let alone deal with the ethical and competence aspects of the profession.

The medical profession needs a mechanism whereby it can exert meaningful control over the performance, continuing medical education, competence, ethics, physical and mental wellbeing of its members. Equally importantly, there needs to be developed a mechanism whereby the public may easily and anonymously bring to our attention the deviant physician with expectation of prompt action. The Medical Society is preparing proposals in this regard.

Lastly, by now it should be eminently clear that no solution thus far advanced is adequate to the problem of malpractice and professional liability. As mentioned earlier, it appears that the American public - rightly or wrongly - has decided that it should be compensated for all untoward or unexpected results of medical

eatment whether or not negligence was involved. If this is so, then longer, if the American people also want progressive first class dical care, can 360,000 physicians underwrite the liability for 0 million Americans. It just can't be done, and the public and gislatures will have to recognize it.

Consequently, a new financing mechanism for compensating the toward and unexpected results of medical treatment as distinguished om medical negligence must be developed. The concept of injury thout negligence has been enunciated by the Supreme Court of New rsey, and is best demonstrated by the patient who gets hepatitis om a carefully tested unit of blood. There is no reason this case ould ever go to court, but perhaps should fit into a medical mpensation program supported by public funds. Elimination of this rge group of cases from the malpractice roster will serve the best terests of society and the profession equally well.

Ultimately, medical liability originates from the professional rvice required by the sick or injured patient. Both parties part- ipate, and therefore may contribute to the ultimate result, good or l, and since neither the providers nor receivers of health services perfect and since health care is not an exact science, a per- ntage of end results will be unsatisfactory. From antibiotics to rt transplants, or immunization to chemotherapy, individual response variable. As more and more people receive increasingly sophisticated lth management, serious unexpected consequences are inevitable.

This is as much a societal problem as it is a health profession problem.

Since sickness and accident insurance is in force for the vast majority of people, it seems reasonable to include in it protection against the occasion of adverse results of health services whether arising from nursing, hospital, physician or other aspects of health care. A part of the premium would be allocated for this purpose. Physicians, of course, would still carry protection against true malpractice. Practically, this would maintain a protective arrangement based on the fundamental principle of all insurance, a large number of people sharing the losses produced by inherent risks on an equitable basis. This new concept requires further investigation.

In all adversity, there is opportunity. We in New Jersey, while feeling pressure, still have time to rationally and objectively survey our problems. We have the opportunity to develop a new system addressing the needs of both society and the profession without abridging the rights of either. The Medical Society is currently developing a comprehensive integrated program which will be acted upon at a special meeting of our House of Delegates in December. We have every expectation it will be adopted, and serve as a model for others to follow.

We as physicians stand ready to participate in any program calculated to improve the health - both physical and economic - of the people we serve. We do not stand ready, however, to be swallowed in a convulsive revolution of health care and its financing which sacrifices quality and individuality for expediency.

It is with a keen sense of responsibility and desire to cooperate

at we present our views today.

MORRIS COUNTY MEDICAL SOCIETY

executive office: 51 ELM STREET MORRISTOWN, N.J. 07960 • telephone: (201) 539-8

MEDICAL MALPRACTICE INSURANCE COVERAGE IN NEW JERSEY: EFFECT ON THE DELIVERY AND COST OF MEDICAL CARE SERVICES

Testimony Submitted by

Dr. Donald P. Burt, President
Morris County Medical Society

To The

Special Committee to Investigate and Study Medical Malpractice Insurance

October 17, 1975

Left unchecked, the diminishing availability and increasing cost of professional liability (medical malpractice) insurance will seriously affect the availability, comprehensiveness and cost of medical care available to residents of New Jersey.

Indications that New Jersey's health care delivery system has been adversely affected by the medical malpractice issue already exist.

Medical practitioners, many of them representing essential areas of specialization, are considering the abandonment of their practices due to the weight of legal and economic uncertainties clouding the issue. In Morris County, nearly 400,000 citizens may be deprived of the essential services of medical specialists who could take early retirement or seek other work as a result of the malpractice issue.

They, like many present medical students, are attempting to avoid the questions surrounding professional liability in New Jersey by seeking other areas of activity.

For them, like many of their colleagues who continue to provide health care under the burden of existing New Jersey law, the questions go well beyond the simplistic economic equations so often applied to the issue.

At the outset, physicians recognize that as long as the art of medicine is practiced by humans, the results of medical practice are subject to human error. In the event such error can be attributed to a proven act of negligence, equitable avenues of recourse and compensation must be established and maintained.

That existing avenues provide such recourse is of primary concern to members of the Morris County Medical Society. Operating under vague statutes and subject to the "popular" opinion of a non-professional panel of jurors, the system ostensibly designed to protect the aggrieved health care consumer acts as a penalty against all health care consumers.

To them and their physicians, concern over the availability of comprehensive health care in New Jersey has been coupled with growing awareness of the increasing cost of such care -- a cost which is adding millions of dollars annually to the medical bills and insurance premiums of New Jersey residents.

Should New Jersey's seven million health care consumers be subjected to the inflationary impact of what many believe to be a fundamentally inequitable process? Members of the medical profession think not. Yet existing State law and departmental practice permits the <u>full</u> cost of hospital malpractice insurance to be <u>automatically</u> passed on to the consumer.

Should members of the medical profession, as many critics have suggested, assume the cost of their own professional liability insurance? Statistics suggest not. Given a 1972 median income of less than $40,000 before taxes, New Jersey physicians simply cannot afford to absorb increases in malpractice insurance premiums ranging as high as $4,700.00 annually.

Should the insurance industry be asked to face an uncertain future without adequate reserves to settle totally unpredictable malpractice claims? The number of insurance companies refusing to write professional liability insurance at any price has provided an abrupt -- and unsatisfactory -- answer.

These problems, together with concern over additional health care costs incurred through the practice of "defensive" medicine, have created a series of malpractice "crisis" throughout the nation. It is our hope that this Special Committee can permanently avert a similar health care crisis in New Jersey.

To do so without compromising the interests of your many constituents, be they consumer, physician, hospital trustee, or insurance executive, will require a concerted and cooperative effort toward the creation of equitable and lasting legislative reform.

Toward that end, we respectfully submit the following points for your deliberation and action:

1. Court records in New Jersey suggest an increasing number of malpractice suits are being dismissed for insufficient cause. Permitted to continue, such a trend can only add to that percentage of insurance costs invested in legal defense.

Members of the medical, legal and insurance professions believe the cost and time involved in such cases could be minimized, we believe, through the creation of a panel composed of medical experts, lawyers and a hearing judge to rule on all medical malpractice charges before they enter the formal judicial process.

2. Another significant portion of the malpractice premium dollar presently is held in "reserve" by insurance companies as protection against unpredictable future settlements. Contributing to this practice of "defensive insurance funding" are existing New Jersey statutes which fail to properly establish a statute of limitations on malpractice litigation.

The necessity for such cash reserves could be substantially minimized, we believe, by establishing a realistic limitation on the time in which a patient may formally file a medical malpractice charge.

3. Under existing law, medical malpractice settlements have been awarded on the grounds that results of medical care and treatment did not meet the patient's expectations.

We believe vagarities surrounding this question could be eliminated through a statutory definition which limits medical malpractice to any proven act not in conformity with accepted standards of care.

4. While the intent of malpractice legislation is above reproach, recent malpractice settlements in New Jersey suggest existing law does not preclude the possibility of "windfall" profits to the successful plaintiffs.

Assuming malpractice settlements are designed only to compensate a plaintiff for expenses, loss of income and punative damages, we believe consideration should be given to the plaintiff's collateral sources of income, including insurance or employment benefits, before the final value of a malpractice claim is set.

5. The possibility of "windfall" profits could be reduced further by establishing a maximum level on all liability claims, including medical malpractice, which do not result from proven criminal action, gross negligence or willful and wanton misconduct.

Although these points are considred major by members of the Morris County Medical Society and many of their patients, they by no means exhaust the constructive possibilities for reform in New Jersey malpractice legislation.

Aware that the issues facing this Special Committee will be complex, and perhaps controversial, the Society I represent today stands ready to be of any future assistance the Committee may require.

On behalf of our 460 members and, most importantly, the 400,000 patients we serve, please accept my gratitude for the interest you have taken in an issue of critical importance to us all.

# # #

New Jersey Hospital Association

RESEARCH PARK, 1101 STATE ROAD • PRINCETON, NEW JERSEY 08540

N. Owen, President

Telephone (609) 924-4124

Statement Before
Special Committee to Investigate and Study
Medical Malpractice Insurance--October 24, 1975

My name is Jack W. Owen and I am President of the New Jersey Hospital Association which represents all of the general hospitals in the State of New Jersey. I appreciate the opportunity to appear before this Special Committee to Investigate and Study Medical Malpractice Insurance.

In view of the lack of medical liability carriers and with the increasing cost of medical liability insurance, it appears that this study and resultant legislation should concern itself with two major problems. The first problem is the availability of medical liability insurance. It is important for the benefit of patients being treated by providers in the State of New Jersey that physicians, hospitals and other health care providers have an opportunity to purchase medical liability insurance which will protect the provider and the patient when the provision of medical care results in a claim for damages. Although hospitals in New Jersey have some immunity by legislation, this immunity does not carry onto hospital employees. Therefore, the hospital in order to protect its agents, must provide for insurance in the same manner as if there were no immunity. If legislation which provides limited liability to the hospital corporation only had been extended to all of its agents, the availability of insurance in New Jersey would undoubtedly not be a problem. The problem with such legislation would then be whether or not it gave protection to the public using the hospital facility.

There has been legislation proposed which would improve availability of insurance by requiring all insurance companies who write liability to participate in a joint underwriting fund in our state. To just solve the problem of providing availability is not the answer since we must also be concerned with the cost of premiums. Insurance coverage at an astronomical premium is of no benefit to the citizens of New Jersey. The medical care providers are forced to pass this high cost of insurance premiums on to the patient and health care costs will continue to soar without any of the increase accruing to the benefit of the public.

The second problem is obviously one of cost. Whatever legislation is enacted in the State of New Jersey, it must take into consideration the cost of providing such insurance as well as making sure that it is available. We have seen medical liability premium costs increase as much as one thousand per cent in the past year. To continue to allow this escalation in premium costs to go unchecked will drive up premium rates for health care insurance to a point where few families or individuals could afford coverage.

It appears to us that there are several things happening in New Jersey which limit the availability of insurance coverage and continue to drive premium costs up. The first issue has to do with the statute of limitations. At the present time there is no limit on this statute and a patient can go any number of years before discovering that an incident took place on which he wants to bring a claim. He is allowed two years after discovery of such an incident and this can conceivably be twenty or thirty years after such an incident took place. By that time

the physician may have left the scene, the records will no longer be fresh in anyone's mind. Neither the health care provider nor the patient benefits from this delay.

The insurance companies, on the other hand, must start to reserve funds once an incident is reported--even informally--on the basis that something might be brought to court many years after the incident has taken place. The tie-up of dollars in reserves has reached a staggering amount. In addition the insurance companies are faced with the impossible situation of trying to determine what the economics will be twenty years from today. If inflation continues, the dollar's value decreases and much more money is required in reserve to hedge against the future.

Secondly we have seen in other states dramatic increases in jury awards above the actual cost incurred by the patient because of a claim for damages. With the delay in any action taken by a claimant and with the increasing amounts awarded by juries, it is almost impossible for an actuary to truly judge how much premium to charge to cover future awards.

Thirdly, there is to date in New Jersey no collateral source legislation for patients who have received compensation for medical expenses incurred and are awarded duplicate monies by juries. This duplicate payment for the same service cannot help but increase medical liability premiums.

This is by no means an exhaustive list of what is creating our lack of ability to find insurance coverage nor that which is driving up premium costs. It does serve to point out those major areas where something can and should be done to control the situation that now exists.

We believe that the problems dealing with availability and escalating costs of medical liability insurance can be corrected with some legislation which will protect the public, the providers and the insurance companies.

First, we believe that a statute of limitations should be enacted in which no claim may be brought against a health care provider unless filed within two years from the date of the alleged act. We believe that most damages can be readily ascertained in a short period of time and that requiring prompt action by a claimant will allow insurance company actuaries to more accurately predict costs of his claims. We also think that there should be no limit on awards for the claimant when action is brought within the two-year statute of limitations.

There must also be a method of protecting the patient who could not reasonably expect to discover an act within a two-year period of time, such as discovery of a foreign body left in a patient and not discovered until x-rayed at some future time. When discovery is so difficult to ascertain, it also seems reasonable to expect that damages are not nearly so severe since discovery is so delayed.

Therefore, we recommend secondly that a reserve pool be established with a restriction on awards of $500,000. This reserve pool would be funded by a

special assessment on the providers of health care and not part of the insurance premium. This pool shall not become a part of the general fund of the state or any private insurance corporation. The fund should be created by an annual surcharge determined by the Commissioner of Insurance and should not exceed 10 per cent of the cost of the policy for providers purchasing medical liability insurance. A limit of fifteen million dollars should be established for the fund after which no surcharge should be made to the providers of health care.

In order for a patient to avail himself of the reserve fund, it would require a decision by a judge that there was no way that this patient could have discovered the incident within the two-year statute of limitations. The patient would then bring an action in court, and should he win his case, an award would be made to the patient from the reserve fund not to exceed $500,000. In order for a claimant to utilize the reserve fund he must do it within ten years from the incident.

Third, in order to fairly treat minors the statute of limitations should again be two years from time of incident for any action which would produce an unlimited award. In order to protect the minor from the ten-year late discovery limitation, it is recommended that they be permitted to bring an action where there is justifiable late discovery within five years after attaining majority (age twenty-three), in which case any resulting award would be paid out of the special reserve fund and subject to the $500,000 limitation.

Fourth, in order to facilitate action on negligence claims it appears to us that a medical review panel should be established which would hear all claims against health care providers. This panel should consist of an attorney and three physicians. All physicians licensed to practice medicine in New Jersey should be available for selection to the panel. Each party should have the right to select one physician and these two physicians should select a third panelist. The attorney should serve as chairman of the medical review panel, and should be drawn by lot from a list of attorneys qualified to practice law in the State of New Jersey. Any report of the expert opinion reached by the medical review panel should be admissable as evidence in court on the action filed by the claimant and any member of the panel may be called by either party to appear and testify. The panelists should have absolute immunity from civil liability from any findings and opinions and considerations made in the course and scope of this activity.

Fifth, legislation should tackle the problem of duplication of medical payments. In other words, the issue of collateral source must be addressed. We believe that claimants who have been paid for medical services provided should have these payments deducted from an award when such an award includes costs of medical services. Medical liability insurance should be designed as a protection for the patient and not as a method of double payment for services which he has already received.

summary we believe that the problem of availability and cost of medical li-
bility insurance can and should be addressed and corrected by the legislature.
e are prepared to submit draft legislation which will cover the points I have
ised in this testimony. We think that this legislation must protect the public
s well as the provider and the insurance companies who underwrite such pro-
ction. Medicine is not a science; it is an art. As long as there exists differ-
nt judgments of the best way to provide medical care, there will be questions
aised as to whether it was done properly. Such questions will sometimes lead
o claims and there must be a mechanism for protecting and equitably balancing
he interests of all involved.

TESTIMONY BEFORE THE

SPECIAL COMMITTEE TO INVESTIGATE AND STUDY MALPRACTICE INSURANCE

OCTOBER 24, 1975

Assembly Chamber, State House Trenton, New Jersey

by Dr. Frederick Harvey, President

NEW JERSEY DENTAL ASSOCIATION

For further information contact:
Gary Shenfeld, Director
Communications/Dental Care
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201-821-9400

THANK YOU SENATOR GREENBERG FOR INVITING THE NEW JERSEY DENTAL ASSOCIATION TO TESITFY BEFORE YOUR SPECIAL COMMITTEE

FIRST. . . BY INTRODUCTION. . MY NAME IS FREDERICK HARVEY AND I HAVE BEEN PRACTICING DENTISTRY FOR 27 years. . 20 of those years in Ridgewood, Bergen County. I am president of the New Jersey Dental Association, representing most of the 5,000 practicing dentists in this state.

I will attempt to quickly answer the questions posed by the legislation establishing your committee, offer some suggestions and observations, and then take a look into the future.

Dentistry, when we speak of professional liability insurance is a low risk profession. The cost of this Dental insurance, however, has doubled in the last year. It costs the average dentist in this state approximately $200 / year for insurance. The price for oral surgeons is about $100 higher. There is no insurance availability problem for dentists in this state. Because we are a low risk profession, we resist efforts to lump us into a pool with other professionals, resulting in a drastic increase in our premiums, which will inevitably affect the cost of dental care to the consumer.

American dental health is the best in the world. In Great Britain, for example, the percentage of adults who have lost all their teeth is double that in the United States.

We are here today because organized dentistry has a history of supporting constructive and beneficial legislation beginning in 1939, when the American Dental Association first proposed a national children's dental program.

The reason we are here, too, is because utilization of our services is increasing now that more and more workers are being covered by Dental Insurance. Just 10 years ago, fewer than 2 million Americans received dental insurance. By 1980, we estimate 60 million Americans, workers and dependents will be covered. A national health insurance act might push that number to 100 million.

In other words, we are here in the public interest, the consumer interest, to suggest what we feel should be a comprehensive professional liability bill.

First, we should look to other states and learn by what they have done in this field. As of October 1, 39 states, including NJ, have established malpractice study commissions, and 23 states have established joint underwriting associations, with authority to give the state insurance commissioner the right to establish JUA's if insurance becomes unavailable. Sixteen states are moving to revise the powers of their State Boards. Thirteen states, including most recently Pa., allow for malpractice review panels. These include pre-screening of cases and various forms of arbitration panels. Many states have revised downward the statute of limitations.

Now. . what do we propose should be included in comprehensive professional

liability bill?

First. . .a good definition of malpractice.

Next, a limit of recoveries. The legal counsel of the American Dental Association reports that more than 25 states now put a maximum of $500,000 on awards.

We suggest a reduction of the Statute of Limitations. Where is it now 8 or 9 years, many states have reduced it to five years and some are trying to make it two or three years.

We like the idea of review panels. Before a patient can sue, we suggest a 90-day notification period. Then a review by a panel. We feel this is necessary because there is a great deal of waste of money, time and effort in bringing suit.

For example, Attorney William O. Morris, Prof. of Law at West Virginia University, a recognized malpractice authority, and author, says "dentists are winning 90 percent of their malpractice cases. The patient has only a 10 percent chance of winning." Obviously, review panels would substantially reduce the number of arbitrary, capricious, frivolous, and whimsical cases.

Perhaps a catastrophic fund can be set up to pay for claims exceeding $100,000. Pennsylvania's new malpractice bill sets up such a fund, financed by a 10 percent surcharge on the insurance costs of health care professionals, including physicians, dentists, hospitals and other health care providers.

We are faced with what I would like to call the Marcus Welby syndrome. In real life health care practitioners do a good job, but compared with the perfect record of their TV counterparts, we look less than good.

Informed consent must be labeled. Any health care professional who is about to undertake a procedure involving possible danger should tell the patient what the situation is, so the patient is aware of the risk.

What we want to do is to bring the cost of professional liability insurance down because, in fact, that cost is passed on to the consumer. Therefore, any new professional liability insurance act must have a reporting and review of claims provision. By discovering what causes malpractice, perhaps we can bring the incidence and cost of insurance down. Right now the reporting procedures are so shoddy we do not know what the major causes of malpractice are and therefore cannot take steps to correct them.

Malpractice means bad practice, but most of the malpractice cases filed are filed by patients who are "disappointed with the results," consider it a "breach of contract," and seek reparations, windfall payments from their health care practitioner.

Let's look into the future. . .

Perhaps the answer is a no fault system. This would change the method of payment from the small pool of health care professionals to the patient. The patient, not the professional, would be assessed 50 cent

one dollar per visit and that money would go into a pool to pay for professional liability claims. Since most of the money in such ts goes for finding fault, this would cut down on those costs, and rease the award to the plaintiff, if justified.

t we are suggesting is that the risk be spread across the large l of health care consumers. The base of health care professionals is t too small to absorb the rising cost of this risk especially with exceptionally high jury judgements being awarded. Dr. William H.L. nette, a physician and a lawyer, made this proposal in the first ue of the Journal of Legal Medicine.

at would immediately stimulate more action in the area of professional ability in this state would be the passage of S-3163. This bill, troduced by Senators Hirkala and Feldman, grants liability immunity physicians dentists, podiatrists, optometrists and pharmacists in lation to certain peer review functions. This bill introduced in ril, and reported on second reading in May, deserves your immediate tention in the public interest.

offer no easy solutions to the professional liability problem, we only fer suggestions. Time and reason are on your side. Let us not rush push through any special interest legislation, but let us work gether to get a meaningful professional liability bill enacted into w.

Thank you

TESIMONY CONCERNING MALPRACTICE
INSURANCE OCTOBER 24, 1975

I am Dr. Edward Campell, Chairman of the Insurance Committee of the New Jersey Optometric Association, representing 80 percent of all optometrists liscensed to practice in the State Of New Jersey

I appreciate the opportunity to speak on behalf of the Optometric Association before the Special Committee to Investigate and study Medical Malpractice Insurance.

Each of you is undoubtedly aware of the immense problem facing the Health care provider--physicians, hospitals, dentists, nurses, optometrists, podiatrists, chiropractors, physical therapists and psychologists, in the medical malpractice area.

The great attention given to malpractice insurance in the recent past has given rise to unwieldly mechanisms, generally instituted without adequate provision to protect, to the greatest extent possible, the practitioner himself. The lack of proper provisions against abuse were of less concern at the beginning of the malpractice insurance debate. Legislatures were compelled to act quickly and decisively on what appeared to be comprehensive laws for the protection of public welfare. Legislation did not take into account the welfare of the providers as well to cushion against the great financial and professional burdens placed on them with mind-boggling speed. But the result of original legislation passed in many states is now beginning to show disturbing signs of overburdening practitioners.

Data available since 1960 shows rapid increases in three areas: (1) the number of malpractice claims (2) the amount

paid to the insured patients and their legal representatives and (3) the medical malpractice insurance premiums which various providers must pay.

Between 1960 and 1970, malpractice insurance premiums for dentists rose 115%; for hospitals, 262%; for physicians other than surgeons, 540%; for surgeons 949%.

The basic concern of health care providers today is the threat that they will be unable to purchase medical malpractice insurance because carriers will no longer be willing to offer it. Medical malpractice and claims that result from alleged malpractice create additional problems regarding the delivery of services. Practitioners, because of their great concern for avoiding malpractice suits, frequently practice defensive medicine.

The state, now aware of the great problems facing health providers in the malpractice area, has an obligation to the many practitioners in all areas of the health field to insure that malpractice insurance is available at a reasonable cost and on reasonable terms.

We would now like to make serveral suggestions which may aid in putting malpractice insurance back into proper perspective and on a more reasonable basis.

First, Limitations should be placed on the amounts recoverable by patients in various malpractice suits. The health-care provider should not be liable for any amount over $100,000 for a claim of malpractice. The total amount recoverable for injury or death should not exceed $500,000. The patient's claim should not be assignable.

Second, Clear statutes of limitation should be formulated, making any claim filed after two years of an alleged occurance invalid.

Third, Attorney fees should be limited to a small percentage (perhaps 15%) of any claim awarded.

Fourth, A medical review panel should be set up sufficiently representing all classed of health care practitioners in the state. This panel will have the duty to express its expert opinion on the substance of any case brought before it, to determine the defendant's liability in those cases.

Fifth, Payment of awards should be payable not necessarily in one lump sum but spread over a period of time.

We feel that these basic measures, easily insituted, would remove a great deal of pressure from those who are licensed to provide services which are basic to individual and community welfare.

Thank you

Statement of Dr. Robert S. Maurer, D.O., President-Elect of the
Jersey Association of Osteopathic Physicians and Surgeons and
irman of its Insurance Committee for the past six years.

tlemen:

The American medical liability program at present is archaic, unjust,
ensive and inefficient. The physician is constantly hounded with the
cter of professional liability and the dreaded word "malpractice" hanging
r his every move, resulting in overcautiousness, over-utilization of
oratory, x-ray and hospital facilities, and increased costs down the
e for the patient.

Even in the event of a successful suit, for due cause, the injured
son receives only a small percentage of the award and costs involved,
y times long years after the original injury had occurred. These
layed settlements make them more costly for the insurance company due
inflation, thereby adding to the overall expense of premiums and
ttlement fees.

Higher and higher insurance costs eventually mean higher costs of
dical care to the general public, and in turn to the insurance carriers,
vernmental agencies, and other third party agents.

Because of the many inadequacies of the present system, we propose
e following as several suggestions to help improve the system for the
nefit of the greatest good to the largest number of people.

1. Statute of limitations should be two years from the alleged event.
pediatric cases, the statute shall begin at age six.
This would allow adequate time to file suit for alleged professional
iability while allowing the insurance companies to greatly reduce the
normous amount of reserves previously required to be maintained for
laims incurred but not reported.

2. A Mediation or arbitration panel shall be created and utilized for
mmediate review of all malpractice claims. The panel shall consist of
hree physicians selected at random from a roster of physicians experienced
n the field in question. The panel shall attempt to reach a fair and
quitable decision, which should be binding on the parties involved. If
his is not possible, then the findings of this special committee should be
dmissible at any further court proceedings.

3. Any awards in a medical liability case shall be limited to the sum
of $100,000 against the physician and his insurance company. If a court
lecision is greater than this, an additional $400,000 may be awarded for
nedical expenses only from a catastrophic fund created by the State Insurance
Department. This dollar limit proposal will go a long way to place the
awards made at realistic figures, limit the insurance companies' reserves,
and reduce the overall costs of the entire liability program.

4. Lawyers shall be compensated on a "fee for service" basis exactly
as doctors are. These fees shall be consistent with the amount of work
done in each case. There shall be no contingency fees. The lawyer's fee
shall be presented to the court and open for scrutiny exactly as a physician's

fee. If an award is made, it shall be given in four categories: 1) compensation to the patient, 2) medical bills, 3) legal fees, and 4) court costs.

5. A collateral source law should be included. Evidence shall be admissible to determine the amount and sources of any insurance benefits available to the claimant. There shall be no duplication of compensation.

6. There shall be no discrimination between insurance premiums for M.D.'s and for D.O.'s. Physicians shall be rated on their type of practice and not by their degree designation, since the state of New Jersey makes no distinction between the two professions in awarding a license to practice medicine within the state.

7. Finders fees of any kind should be outlawed in every aspect of medical liability cases, including fees to lawyers, hospital employees, ambulance drivers, ambulance chasers, and others.

8. The Commissioner of Insurance shall be requested to review the actuarial and accounting procedures of casualty underwriters to be assured that reserves for pending claims and for claims incurred but not reported, two major factors in the high rates today, are adequate but not unnecessarily large. If some of our previous proposals are adopted, this reserve figure can be decreased by as much as 50%.

We would be happy to discuss further embellishment of these and other proposed solutions at any time. In an attempt to keep this report brief, we have touched on only some of the highlights in this problem of great concern to physicians, lawyers, legislators, and consumers alike. We strongly feel that with adequate legislation based upon input from us all, we can help solve this problem that has created a tremendous burden for all concerned.

10/16/75

SPECIAL LEGISLATIVE COMMITTEE TO INVESTIGATE and
STUDY MEDICAL MALPRACTICE INSURANCE

Established Pursuant to SCR3001

In public hearing, Friday, October 24, the Senate Chambers, State House, Trenton, New Jersey

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Statement on Behalf of the
NEW JERSEY PSYCHOLOGICAL ASSOCIATION

Mr. Chairman, members of the Special Legislative Committee, ladies and gentlemen:

On behalf of the New Jersey Psychological Association, I wish to express my appreciation for this opportunity to set before you our views of the current crisis in medical malpractice insurance and of an appropriate legislative response to it.

My name is Leon S. Wilson. I serve as general counsel to the New Jersey Psychological Association; I am also its registered legislative agent. Appearing with me today is Dr. Robert Garber, Executive Officer of the New Jersey Psychological Association and a licensed practicing psychologist of this state.

By way of introduction, the New Jersey Psychological Association represents approximately 12 hundred professional psychologists

in New Jersey. About 1000 psychologists are currently licensed to practice in New Jersey. Some of these reside outside the state. All practicing members of the Association are licensed by the Board of Psychological Examiners in the Department of Law and Public Safety. The Association includes, in addition to those engaged in private practice (commonly referred to as "therapists"), industrial psychologists, school psychologists, counselling psychologists and academic-research psychologists. With few exceptions, every licensed psychologist in New Jersey is the holder of a Ph.D. degree awarded by an approved institution.

The profession is concerned with health and malpractice insurance through its licensed practicing psychologists who render non-medical health care services. By law an individual licensed only to practice psychology may not engage in the practice of medicine or surgery. Conversely, however, physicians and surgeons are exempted from the restrictions of the Practicing Psychology Licensing Act. They can and do practice psychology.

For many years, psychologists have had available to them a program of malpractice insurance in which, we believe, most independent practitioners participate. Current rates for coverage limits of five hundred thousand and one million dollars are approximately forty dollars a year. This profession is thus concerned with such legislation as this committee may recommend and, potentially at least, will be affected by it.

I need not review the history of the problem that brings us here, except to assert unequivocally that this Association urges an effective and early legislative response to the crisis in medical malpractice insurance. Specifically, legislation is needed to assure the continued availability of medical malpractice liability insurance to those engaged in the several high-risk health specialities. We suspect these are principally the specialities of neurosurgery, plastic surgery and anaesthesiology. The drastic escalation in premium costs to these specialists, to amounts exceeding ten thousand dollars a year, threatens the interruption of insurance protection to the practitioner and indirectly the avaliability of their services to the public. It is, of course, the proper province of this Legislature to intervene directly to prevent this interruption and to assure that the interests of all involved are equitably balanced.

These include not only the patients (or "consumers") and the providers of high risk health services, but all other providers of health care and the general tax-paying public as well.

We believe that those licensed physicians engaged in the high-risk specialities commit errors no more frequently than do other physicians or nonmedical health providers generally. The consequences of error, however, are frequently drastic in the

case of a neurosurgeon or anaesthesiolgist. Thus, substantial damages awarded by juries on claims for redress by injured patients should not be viewed as an indictment of the skill or concern of the high-risk specialists. It is merely an extreme example of the proper application of tort law.

The underlying concept of damages for private wrongs is both a valid expression of our common law heritage and an appropriate instrument in the securing of justic. Our society believes with good reason that an individual injured by the fault of another is entitled to be made whole again to the extent that money damages can restore him to the position in which he would have been but for the offense of the wrongdoer. In terms of medical malpractice, wrongdoing is properly defined as the failure to adhere to those standards of performance common to the reasonable practitioner in the field. That the alleged offender may be a respected and even needed medical specialist should not detract from the clear right of the injured patient to compensation for injuries sustained due to such failure. We urge that the right to seek damages remain undisturbed.

We recognize, of course, that error and negligence in any field are phenomena reasonably to be anticipated. These hearings may well demonstrate that it is unconscionable to visit the burden of loss resulting from these defaults solely on those practitioners

ngaged in the high-risk specialities. Where then should this urden rest?

Little more than half a centry ago, this legislature accepted s public policy the proposition that industrial accidents and the njuries resulting from them were unfortunate but perhaps necessary y-products of commerce. The Workmen's Compensation Act of 1911 was an embodiment, however, of the proposition that the loss or burden of that by-product should fall ultimately not upon the injured worker, but upon industry first, and through it, society at large. Thus, was born the no-fault insurance concept. Most recently, this concept has been applied to spread the loss arising from predictable automobile accidents. We believe the concept has applicability here.

Our principal concern is with the selection of those among whom the predictable losses should be spread. To inflict a per-capita share of these losses arising from the few high-risk health care specialities upon all those who render health care services regardless of loss experience constitutes an extremely discriminatory half measure. If the high-risk specialities themselves cannot carry the burden and if society at large requires the provision of those services, then it is to that society that this Committee should look to equalize the burden.

The low loss experience of professional psychology in New Jersey comes about not by accident. It is the result of a careful and long term process of the improvement and maintenance of high

standards among practitioners regardless of speciality. We believe there are other medical and nonmedical health providers with equally admirable loss experiences. To require all such practitioners, as a condition of licensure, to purchase malpractice insurance the rates for which reflect the losses of professions in which they have no more interest than the general public, would constitute a punitive and thus unconstitutional imposition on these groups.

We propose instead either of two alternatives to the present situation. Although I personally, by profession and inclination, am a partisan of an adversary system, circumstances may compel the introduction of a no-fault concept embodying reduced compensation in exchange for the certainty of recovery. The measure of recovery in such a system should depend upon the extent of loss rather than the degree of culpability.

More preferable from my personal point of view and equally palatable to the health care industry at large would be a system whereby a major loss fund is established under the auspices of the state to which would contribute the public at large either through equitable assessments upon all health insurance policies or through direct taxation. This committee must fix a value in terms both of dollars and of public interest on the continued availability of high-risk medical services. If that value is

insufficient, we must then be prepared to do without such services or to see them available only to those able to pay the exorbitant costs the current system invites. If the value is sufficient, however, and if the community at large understands and accepts that value, then it must share that burden.

Two bills earlier introduced in this legislature, A 1552 (OCR) and A 3094, do not represent equitable solutions to the problem. The New Jersey Psychological Association urgently protests the gross inequity of imposing the burdens associated with the few high-risk medical specialties upon the limited community of health providers practicing in New Jersey. The state, of course, has a legitimate public interest in assuring the continued availability of liability protection to those specialists (and thus to the public at large); we nevertheless condemn as unconstitutionally discriminatory any attempt to impose this burden, as a condition precedent to the right to practice one's profession, upon a selected group of individuals who make no contribution to the loss to be relieved. Whatever response this legislature provides to the critical issue facing it, we implore it to abandon such narrow and inequitable solutions.

Thank you.

STATEMENT OF

GROVER E. CZECH
MID-ATLANTIC REGIONAL MANAGER
AMERICAN INSURANCE ASSOCIATION

before

NEW JERSEY SPECIAL COMMITTEE
TO INVESTIGATE AND STUDY MEDICAL MALPRACTICE INSURANCE

OCTOBER 24, 1975

SENATE CHAMBER
TRENTON, NEW JERSEY

My name is Grover Czech and I am Mid Atlantic Regional Manager for the American Insurance Association. We appreciate this opportunity to appear here before you today to discuss this most vexing problem. The American Insurance Association is a national trade association whose membership consists of 138 stockholder owned property and casualty insurance companies doing business throughout the country. With a few exceptions the majority of the ten or so companies that continue to write medical malpractice insurance are members of AIA, including Federal Insurance Co., St. Paul Fire & Marine, Aetna Life & Casualty, the Hartford and Travelers. As a result, AIA has been very active during this past year, throughout the country, assisting in efforts to come to grips with this problem.

Our purposes here today are threefold. First, we would like to supply you with some history and background with regard to medical malpractice insurance in general; second, to give you a broad overview of what medical malpractice legislation is being proposed and enacted throughout the country and third, to provide your committee with copies of AIA's malpractice legislation charts and several model legislative proposals dealing with various tort reforms. We are not here to strongly advocate one proposal verses another but only to provide your committee with what we hope is information that will be useful in your efforts to develop a sound long term answer to the problem.

HISTORY OF THE PROBLEM - Most of the furor about malpractice insurance has occurred in the last year or two, and because of this one might conclude that this line of insurance did not present problems until very recent years. This is incorrect. Many companies who wrote substantial amounts of malpractice insurance as long as 20 years ago correctly foresaw what was developing in terms of increasing claims frequency and larger awards and gradually phased out of the business. The problem did not become acute however, until more recent times when the number of writers has rapidly declined.

The present situation developed something like this. When the existing writer under contract with a state medical society began to develop unacceptable losses and sought rate increases and various other protective devices, the society's generally preferred to go with a new company that offered lower premiums. Obviously, at an earlier time the medical society's had no reason to be concerned about stability of the market. There were enough companies competing who were willing to come in with very competitive proposals in order to secure the position of being the sponsored carrier. Gradually however, many companies learned the hard way that optimistic pricing lead to serious losses particularly in view of what developed to be a constantly increasing rate of claims frequency and a constantly increasing cost per case. In the 50's and 60's there were a number of companies that went through this learning process and retired from the malpractice area altogether.

In the late 60's and 70's problems excellerated at a more
id pace. There became greater awareness on the part of patients
the legal profession, of the possibility of recovering for med-
l injury whether real or imagined. This was apart from insurance,
hough the very existence of liability insurance does appear to
courage larger and more frequent claims. By the time we reached
mid 70's the problem of ever rising consumer expectations, in-
ased litigation, consumerism, increased complexity of medical
e, specialization, the growing impersonalization of medical care
l all of the other intangible factors, resulted in skyrocketing
ims frequency and claims cost, much difficulty in securing adequate
e increases, and a drastic decline in the number of companies writ-
medical malpractice insurance. As of this time there are less
an ten companies with substantial books of medical malpractice
surance. Many of these companies have stopped accepting new busi-
ss except on a very limited basis and some are pulling out of the
rket altogether.

The problem then has been developing for a long time and as I
ve indicated has been brought about by many subtle and not so
btle, intertwining and complex reasons. It has suddenly come to
head reflecting itself both in declining availability and rapid
d significant increases in price. In essence, in this line of
surance the insurance mechanism can no longer function properly.

This very basic insurance concept operates as follows. The small contributions of many individuals form a pool of dollars from which the larger losses of a few individuals are paid. Most significantly today there are only 250,000 practicing physicians in the entire nation over which payment of the necessary premiums must be spread. Obviously the rapidly increasing frequency and severity of claims have excascerbated this basic problem of too small of a base thereby substantial increasing premiums to each individual physician. In contrast the automobile injury reparations system is supported by more than one hundred million individual motorists over which to spread premiums. In addition the size of this group allows for a predictable statistical experience upon which to base rates.

The actual dollars and cents numbers of the medical malpractice situation is startling and I have attached to my statement a bar chart showing countrywide experience comparing premiums verses losses and expenses for all companies reporting to (ISO) Insurance Services Office, a nationwide statistical gathering and rate making organization. You will note that during the period shown, 1968 through 1973 losses and expenses have continuously exceeded premiums collected. Not all companies report their statistics to ISO however, but their figures do reflect the experience of at least 50% of the malpractice premiums written countrywide. I have also attached to my statement a summary of a report prepared by the California State Auditor General showing that several major medical malpractice insurance companies operating in California ultimately will pay out 183 million dollars more than they collected in premiums on policies written in California from 1960 through 1974.

These figures emphasize the fact that there is a problem not nly in increasing frequency and cost but there is a problem in ccurately pricing the product. As you have probably heard many imes, claims that arise from medical malpractice occurrences in a iven year take years and years before they are reported and paid. his is the so called long tail problem. A substantial percentage f claims do not emerge or are not discovered until 3, 4, or 5 ears after treatment. For example, this means that an insurer has o price its product in 1970 by trying to estimate what claims cost ill be five or more years hence. In a time of repaid inflation nd quickly changing social attidtudes, such efforts to develop dequate pricing have understandably been on the low side. Generally hen, this is a thumbnail history of the problem and an indication ›f the situtation today.

AN OVERVIEW OF NATIONAL MEDICAL MALPRACTICE ACTIVITY - In iewing this problem from the point of view of the various proposed olutions it is useful to divide them into four categories as follows: 1) Mechanisms to maintain the availability of insurance, (2) modfications of the tort system, (3) regulation and quality of medical are, and (4) procedural efforts such as the establishment of study ommissions and the creation of medical malpractice statistical reorting systems. Of the 52 United states jurisdictions each state nd territory, with the possible exception of Mississippi, had some

recent activity addressed at the medical malpractice situation either in the form of study commissions convened, bills introduced, and/or laws enacted. 34 States have enacted some form of substantive legislation and at least 39 states are studying the malpractice problem through committees or commissions.

AVAILABILITY MECHANISMS

1. Joint Underwriting Associations (JUA).

23 States have established joint underwriting associations at this time. Generally, authority is granted to the Insurance Commissioner to implement the JUA if insurance becomes substantially unavailable in the jurisdiction. They are either exclusive or serve as residual market mechanisms. Generally the JUA's require mandatory participation of all insurance carriers writing liability insurance in the state, they have a defined period of existence (usually 2 to 6 years), they have stated maximum coverages and they operate on either a claims-made or occurrence basis. Many are structured to be self supporting, preventing any subsidization of physicians medical malpractice premiums.

2. Physicians Mutuals.

Physicians Mutual insurance company legislation has been passed in 4 states. This is simply an insurance company owned and operated by the physicians themselves for purposes of providing their own medical malpractice coverage.

State Funds.

State funds have been established in 3 states and are insurance
panies operated and funded by the state specifically for purposes
providing medical malpractice insurance.

Reinsurance Facilities.

Reinsurance facilities have been adopted by 2 states. Rein-
ance facilities differ from JUA's in that all companies who are
luded in the plan (generally all those companies writing liability
rance in the state regardless of whether they write malpractice
rance) are required to write the policies on an individual com-
y basis, and then ceed the policies to a reinsurance pool funded
its members. In contrast the Joint Underwriting Association
tes medical malpractice insurance policies as a separate entity
le receiving financial support from its member companies.

Other Insurance Mechanisms.

Several States have enacted legislation limiting insurance
panies liability to 100 thousand dollars and have created a
cial patients compensation fund contributed to by all health
e providers to take care of claims in excess of 100 thousand
lars. These plans generally encompass compulsory liability
urance schemes.

REFORMS TO THE TORT SYSTEM

At least 19 states have enacted some tort reform legislation
ging from the enactment of a single bill dealing with only a

single subject all the way to enactment of a package of several bills dealing with several subjects. I have listed below in no order of priority or emphasis the various areas of tort reform that have been considered and enacted as of September 1, 1975.

1. The Ad Dammum Clause. 8 States have taken some action in this regard. It is contended that by eliminating a statement in the suit papers of a specific amount for damages which may often be far in excess of what the claim is actually worth, will have a positive intangible effect on the public thereby possibly reducing claims frequency and cost in the long run and will result in more realistic awards for damages which should soon reflect itself in claims cost. We are advised this is not a problem in New Jersey.

2. Advanced Payments. 5 States have taken action in this area. These statutes generally state that any advanced payments cannot be considered as evidence of liability but that they shall or may be offset against any final judgement awarded to the plaintiff. The idea being to prevent duplicate recovery and to reduce claims cost.

3. Pretrial Panels. 9 States have taken action in this regard. This heading can include either hearing panels or arbitration panels and may entail various combinations of mandatory vs voluntary and binding vs non-binding requirements. The argument in favor of this concept is that a non-jury determination of negligence will be more objective both in terms of liability, and in terms of

netary damages awarded, thereby reducing cost and providing fairer
d faster treatment to all concerned. Generally if the parties to
ıe proceeding are not satisfied an appeal or a trial de Novo is
ermitted with introduction into evidence the findings of the hear-
ıg panel; although generally not including the amount of damages
warded, if any.

4. Attorneys Fees. 8 States have taken action with regard to
ıis proposal. The argument is that attorney's fees are excessive in
alpractice cases and by lowering them to a reasonable amount premium
ost can be stabilized or reduced. In addition it is contended that
uccessful plaintiffs will retain more of the award. We realize that in
iew of the sliding fee schedule presently in use in New Jersey this
s not a major problem.

5. Collateral Source Rule. 6 States have taken action in
:his regard. The argument in favor of changing this rule is that
duplicate sources of recovery should be offset against any award
to the plaintiff or at least introduced into evidence so that the
jury will know they exist when determining monetary damages. It is
thought by some that this proposal may result in meaningful premium
reductions or at least premium stabilization.

6. Informed Consent. 8 States have taken action on this issue.
Generally these statutes clarify just what informed consent is.
Some require written agreements and apply local standard of care.
The argument here is that physicians should be given some protection
against suit where the claim arises not out of malpractice but out of a
misunderstanding between a patient and a physician as to the nature

and results of the treatment. The concept being that if the patient was properly informed as to the consequences of the treatment the patient may have not undergone treatment at all and not suffered as alleged.

7. Limitation of Liability/Limitation on Recovery. 9 States have acted in this regard. This is both a tort reform and an insurance availability mechanism and encompasses two aspects. First, some of the states have limited the insurance companies liability to a sum certain, for example $100,000. Beyond this amount a patients compensation fund is created, contributed to by all health care providers, and will pay claims in excess of $100,000. Some states have placed maximum limits on the amount of recovery that can be had. Some states have limited general damages to a sum certain and eliminated or limited punitive damages to a sum certain and to certain defined circumstances. There are various proposals in the several states as to whether the insurer, the patients compensation fund, or the individual physician pays all or a part of the award. The idea behind these concepts is that if awards are limited to a sum certain cost will at least become predictable and perhaps stabilized, making it easier to set premiums and perhaps attracting or keeping insurers in the market.

8. Peer Review. 13 States have acted with regard to this issue. It has been contended that peer review mechanisms for physicians have been ineffective. Physicians would often refuse to report a colleague to the medical review board or the board would not follow through with a complaint regarding a physicians alleged incompetence. In addition

sicians would often refuse to testify against one another in a practice case for fear of legal action and other repercussions. se statutes create certain immunity's against lawsuit and provide ıer protections to encourage physicians to both strengthen and im- ove peer review systems and to testify in medical malpractice cases. ıs proposal in essence, goes toward the improvement of the medical re system by focusing on the actual occurrence of malpractice.

9. Standards of Care or Better Known as the Locality Rule. States have taken some action in this regard. For many years ate court evidentiary rules prohibited outside medical experts om testifying in a local medical malpractice case. The theory ing that it would be unfair to apply a standard of care practiced r example, in a New York City medical center to a small upstate actitioners office. Today by court decision many of these evi- ntiary rules have been struck down permitting expert testimony outside experts even in small rural towns where the standard of are may be somewhat less. These statutes would reinstate some emblance of the locality rule and are based on a concept of equity nd the possibility that this will result in a lower or stabilized laims frequency.

10. Statute of Limitations. 14 States have taken action hanging their statutes of limitations. Because of the uniqueness f medical malpractice occurrences courts have interpreted statutes f limitation in many states as not beginning to run until the injury s discovered. This of course, may be many years after treatment

and has added to the long tail problems and resulted in some well publicized cases. Many states have tried to balance the equities by shortening the various statutes of limitations and placing maximum time periods on the discovery rule. The idea of course, is to both reduce claims frequency and make pricing malpractice insurance more predictable by shortening the tail.

11. Good Samaritan Laws. There has been legislation in 25 states clarifying and extending good samaritan laws.

12. Periodic Payment of Awards. I know of only one state where this has been enacted at this time although I am not sure it would require legislation in all states. The idea is to permit insurers to pay successful plaintiffs on a periodic basis rather than in one lump sum giving the insurer the right to cease payments upon the death of the plaintiff with certain exceptions. The argument is that the plaintiffs estate should not fall heir to a windfall award. This proposal would seem to have an impact on cost reduction.

13. Workmen's Compensation and No-Fault Systems. No states to my knowledge have enacted either of these systems at this time and none have seriously been proposed for several months in any state. The two primary concerns with these proposals are the great difficulty in determining what constitutes compensable injury and most significantly there is great difficulty of determining the cost of either system. There is also great concern with what the effects would be of doing away with the negligence concept with regard to the incidence of medical malpractice.

14. Burden of Proof. At least three states have dealt with is issue directly by placing the burden of proving negligence on e plaintiff. This is in contrast to the long standing doctrine Res Ipsa Loquitor, (the thing speaks for itself) whereby the fendant in certain cases has the burden of disproving his neg- gence. It is argued this doctrine should not be applied in ises where causation of the injury involves questions of medical cience.

15. Notice of Intent to File Suit. California has recently dopted this provision as part of a comprehensive law.

These statutes provides that no action based on medical mal- ractice may be commenced unless the health care provider has been iven a certain number of days (usually 60 to 90) prior notice of the intention to commence the action.

The purpose is to provide an early notice to the health care provider so that the facts and evidence necessary to an effective defense may be more easily obtained or preserved for trial. In addition, prior notice provides an opportunity to re- solve a complaint before both parties become involved in the expensive process of litigation.

16. Channeling of Liability. One final proposal that is being only recently advanced in a few jurisdictions is the concept of channeling liability through a single party defendant. The concept would work like this. According to the HEW Medical Malpractice report of 1973, at least 75% of all malpractice incidences arise out of a hospital situation. Based on this statistic, legislation would place upon the hospital the responsibility of defending all suits for all malpractice committed in the hospital. The theory here is that hospitals are in a better position than individual physicians to spread the cost of medical malpractice insurance premiums to users of the health care system, namely all patients who use the hospital and ultimately purchasers of health insurance. Indirectly then the concept attacks the very basic problem of a too narrow base by broadening the base which the premium costs can be spread. An additional benefit is that defense costs could be considerably reduced. Today when a malpractice suit is filed the claimants attorney invaribly names as a defendant the hospital and any other parties who may have the most remote involvement, including physicians, nurses and others. Generally they are insured by more than one company and each company incurres duplicate investigative and defense cost which escalate before the real merits of the case can be considered. Under the single party defendant concept the

hospital would be the only defendant and only one set of investigative and defense cost would be incurred. In addition, it is argued it would be easier and appropriate under this system to spread the premium cost more evenly among the various classes of physicians that use the hospital. Another significant side effect would be that loss prevention programs could be more readily focused within individual hospitals thereby reducing the incidence of malpractice occurrences. Individual physicians who retain exposure outside of the hospital situation would continue to require liability insurance protection. It is argued however, that this reduced exposure would make the premium more manageable.

Attached to my statement are drafts of several model tort reform proposals that have been prepared by the AIA law department regarding several of the above mentioned tort reform proposals. We are pleased to make them available to your committee. They are:

1. Informed Consent
2. Burden of Proof
3. Statute of Limitations
4. Medical malpractice Hearing Panels
5. Limitation on Damages
6. Advanced Payments
7. Notice of Intent to File Suit

A precautionary note is in order at this point. We urge you not to attempt to put price tags on any of these proposals. There is a temptation, for example, to try to get a definitive answer to the question "how much will this reduce insurance costs?" or "how much will this reduce total recovery?" before a particular measure is recommended or advanced. At this time it would seem impossible to accurately cost these measures. If the entire insurance industry has been unable to accurately price the package constituting the known malpractice environment, how can anyone be expected to price a proposal that has never been tested and is likely to be changed before enactment. We can say, however, that common sense indicates these proposals if enacted, would move in the direction of at least stabilizing costs and perhaps in the long run reducing them. However, without a statistically adequate period of time over which to develop experience with regard to each proposal, no accurate cost estimate is likely to be made.

Regulation and Quality of Medical Care

Several of the omnibus legislative packages aimed at this problem have also contained some provision intended to improve professional competency. Most of the changes deal with granting expanded authority to medical review boards; giving the boards wider range of sanctions and disciplinary powers, including mandatory periodic

-examination and limiting the scope of practice.

Study Commissions and Statistical Gathering Mechanisms have
eived much attention. As I indicated earlier some 39 states have
ated study commissions of one sort or another to look into the
blem and attempt to develop long term solutions. Many have been
ated as part of comprehensive tort reform and availability pack-
s with the purpose of monitoring results of a new law and making
itional recommendations for change as experience and necessity
ld dictate. With or without legislation dealing with substantive
orm we believe that continuing study commissions such as yours
h regard to this very complex issue are absolutely necessary.

There are several ongoing efforts concerning statistical
hering mechanisms. Most significantly, the National Association
Insurance Commissioners, (NAIC) in cooperation with the insurance
ustry, has brought about change in the annual and quarterly re-
ting statements that individual companies must provide to the
te Insurance Departments. Because of this every company is now
orting the same information in the same form to every state. This
ormation will be forewarded to the NAIC beginning in 1976. In
ition, most companies have agreed that beginning in 1976 they will
ort statistical information to ISO. Both of these efforts are
ed at creating central statistical gathering entities making it
sible to develop meaningful up-to-date data. It is generally
ed however, that such data will not be statistically meaningful
about 3 years.

A few states have attempted to establish their own systems although we don't encourage this for it could become an impossible burden for insurance companies to have to respond separately to 50 jurisdictions in the detail that is necessary. Finally some states are now requiring physicians to report claims against them to their medical review board.

The major problem in this area is that medical malpractice insurance was not a major line of business for most companies and they did not keep separate detailed statistical information beyond what they felt was necessary for their day to day operations. Much of the detailed information required today in order to properly construct solutions was either lumped into miscellaneous categories or was not kept at all. As a result, the gathering of much of this information entails going back to closed claims files and completing some very expensive and time consuming analysis of those files in order to develop the necessary information.

Before I close I feel a final word of caution is in order. The real impact of any change in the system regardless of what is done at this time, will very likely not be realized for several years. Even then its impact may be difficult to measure. If coupled with inflation, claims frequency and severity continues to increase, the impact of any changes may be minimal. Recognizing this, all parties concerned, including the legislature, the bar, health care providers and the insurance industry must continue to work hard in a cooperative effort to seek realistic and workable solutions.

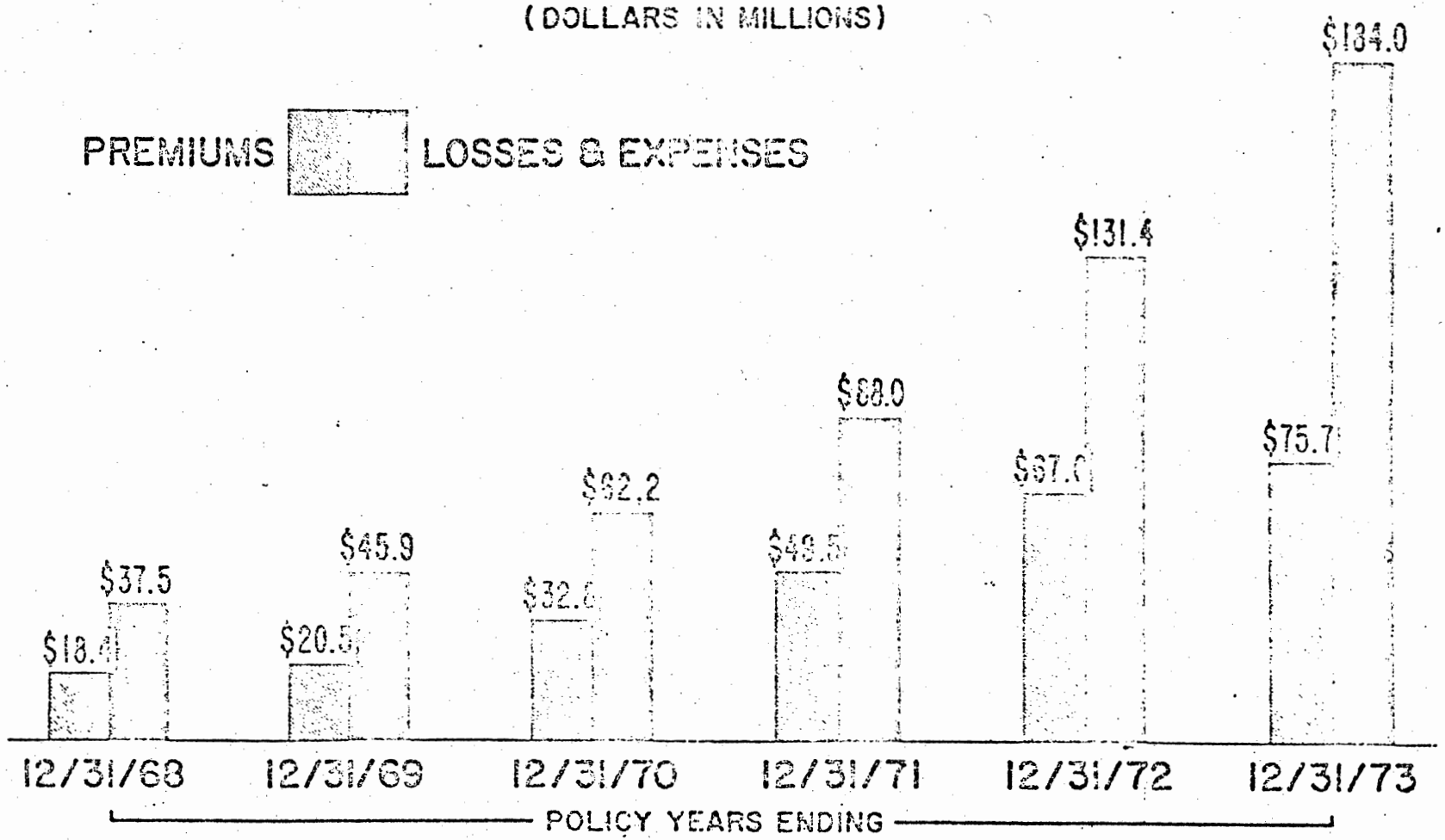
We appreciate this opportunity to appear here today and we pe that some of the information we have provided will be of lue in your deliberations. If the AIA can be of continued assis-nce with regard to your efforts, please call on us.

Respectfully submitted,

Grover E. Czech
Mid Atlantic Regional Manager
American Insurance Association

UNDERWRITING RESULTS* FOR PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

(DOLLARS IN MILLIONS)



*BASED ON TOTAL LIMITS EARNED PREMIUMS, INCURRED LOSSES AND EXPENSES FOR ALL COMPANIES REPORTING TO INSURANCE SERVICES OFFICE

104 x

Insurance Facts from Insurance Information Institute
110 William St., New York, N.Y. 10038 (212) 233-7650

September, 1975

Summary of Findings,

California Medical Malpractice Study

Seven major medical malpractice insurance companies ultimately will pay out $183 million more than they collected in premiums on insurance written in California from 1960 through 1974, according to an interim report filed by the California State Auditor General with the state legislature.

According to the report, the seven companies collected $262 million in physicians' malpractice insurance premiums in California during that period and eventually will pay out an estimated $445 million. The projected loss does not take into account insurers' indirect expenses, investment earnings on premiums held, inflationary factors or increases in the frequency of claims.

(more)

EDITOR: A copy of the full report may be obtained from the Auditor General, 925 L Street, Room 750, Sacramento, Calif. 95814

The report is critical of the medical profession for the ineffective use of policing procedures, the Insurance Information Institute pointed out, and maintains that insurers have not raised rates often enough to meet steadily rising claims and costs.

Of the total paid claims costs, the legislature was told, claimants received approximately 56 per cent, attorneys received about 40 per cent and direct costs other than legal accounted for the remaining 4 per cent.

Presented verbatim below are 14 conclusions contained in the body of the auditor general's report, and five conclusions contained in an appendix by Booz-Allen Consulting Actuaries.

Auditor General's Conclusions

1. "The seven insurance companies we reviewed collected $262 million in physicians' malpractice insurance premiums in California during the 15 year period 1960 through 1974 and paid out approximately $115 million in claims and claim expenses from this revenue through December 31, 1974."

2. "On the basis of our review of the payments made by the companies we reviewed and the trend of these payments, we estimate that these carriers will ultimately pay out $183 million more than they collected in premiums for physicians' malpractice insurance coverage for the years 1960 through 1974. This projected loss does not include any provision for insurance companies' indirect expenses, investment earnings on premiums held, inflationary factors in the amounts of physician malpractice claims, or increases in claims frequency.".

3. "Of the total paid claims costs of the insurance companies our review, the claimants received approximately 56 per cent or 4 million, attorneys received approximately 40 per cent or $45.3 illion, and direct costs other than legal, were approximately four r cent or $4.3 million of the total payments."

4. "Our preliminary evaluation of seven malpractice insurance arriers in California indicates their financial condition has undergone erious erosion over the last five years and they currently face insolvency."

5. "The carriers reviewed have, over the last five years, shown composite loss of -1.8 per cent from underwriting operations for all ines of liability insurance."

6. "The liability insurance carriers must increase premiums in order to improve their underwriting results. However, any increases in premiums without the injection of new capital will, on a temporary basis, increase risks to policyholders and further erode the financial condition of these carriers."

7. "The availability of physician malpractice insurance is being affected because the California Insurance Commissioner issued cease and desist orders effective September 10, 1975 precluding two companies which we have reviewed from writing any new policies or renewing any current policies due to insolvency and has advised another company we reviewed to restrict the writing of high risk lines of insurance, such as physician malpractice insurance."

(more)

8. "If the cost of malpractice insurance for physicians is passed on to the patient, the cost per physician-patient contact at present insurance rates is estimated at between $.35 per contact for general practitioners and $1.54 per contact for anesthesiologists."

9. "The Board of Medical Examiners has not promptly investigated and resolved alleged violations of the Medical Practice Act by physicians. In most cases the physicians had an unrestricted license to practice medicine until the effective date of the board's final order."

10. "The board has not made full and prompt use of malpractice insurance reports to identify physicians who may be practicing in an incompetent or grossly negligent manner."

11. "The board has not issued regulations requiring reports from state-licensed hospitals on physicians whose hospital privileges have been limited or terminated."

12. "Up to 48 per cent, or $192 million, of the projected ultimate losses which insurance companies will sustain on physicians' malpractice insurance coverage for the period 1960 through 1974 may be recouped by the companies through provisions of the Internal Revenue Code which allow net operating losses to be offset against taxable income earned by the carrier."

13. "Under California's method of taxing insurance companies, increases in premium rates result in greater tax revenues even if the companies experienced losses because the state tax is based upon a percentage of gross premiums earned."

14. "The results of a survey of physicians, conducted as a part of this review, indicate that most doctors would submit malpractice claims to binding arbitration, would join a mutual insurance group formed by doctors, and have not reclassified their practice because of high insurance costs."

Additional Conclusions from Appendix

"Premiums paid by California doctors for medical malpractice insurance have increased dramatically over the past 15 years, but have not kept pace with increasing claim costs."

"The current malpractice crisis has been caused in part by poor pricing by the insurance industry, for premiums have increased erratically while claim cost increases have been relatively steady."

"The insurance industry has collected more premium than it has paid in claims for medical malpractice insurance written in California over the past 15 years, but future claim payments on past coverage will ultimately result in a severe net loss to the industry."

"Income on invested premium funds will alleviate the situation to some extent for the industry, but the net loss will remain severe."

"The medical profession in California over the past 15 years has paid an inadequate amount for its medical malpractice insurance coverage."

PROPOSED MODEL LEGISLATION FOR TORT LAW REVISION

WITH RESPECT TO ACTIONS BASED ON MEDICAL MALPRACTICE

Prepared and Tentatively Agreed To By:

American Insurance Association
American Mutual Insurance Alliance
National Association of Independent In

This statute seeks to limit those situations in which an action for lack
informed consent may be brought, to provide for a presumption in favor of
health care provider where consent is in writing and to establish three
irmative defenses to any malpractice action based on an informed consent theory.

Historically, the doctrine of informed consent makes a health care provider
ble even though he properly administered the treatment intended, because he
led to thoroughly advise the patient of all the alternatives available and
risks or benefits of each, and the patient, who would not have otherwise
lergone treatment, suffered some adverse condition as a direct result of such
ck of disclosure.

By limiting the doctrine only to those procedures involving either non-
ergency treatment or surgery or diagnostic procedures involving invasion or
sruption of the integrity of the body and by requiring the plaintiff to prove
a preponderance of the evidence that the health care provider did not supply
nformation to the patient in obtaining his informed consent in accordance
ith the recognized standards of acceptable professional practice, it is hoped
nat spurious actions resulting from a mere failure of the procedure to meet the
laintiff's expectations will be curtailed.

Currently, the prevailing view is that an action based on a lack of
nformed consent is, in reality, one for negligence in failing to conform to the
cceptable professional practice of health care providers in the community in
hich the defendant practices or in a similar community. The factors to be
onsidered by the health care provider in making the required disclosures in-
lude the likelihood and seriousness of the bad result, the feasibility of

alternative methods, the interest of the patient, knowledge of the patient's past history, the patient's emotional stability and the necessity of treatment. Consequently, whether a particular health care provider fully informed his patient of the risks involved can only be determined on the basis of expert testimony as to what disclosures should have been made. Section 4 of the statute adopts this conclusion and provides that a cause of action based on a lack of informed consent must be supported by expert medical testimony concerning the alleged qualitative insufficiency of the consent.

The statute also creates a presumption in favor of written consent although this is not in any way intended to dilute the sufficiency of oral consent which will still, upon proof, overcome any allegation that the patient was not fully informed of the risks involved. No specific suggestion has been included as to the type of written form to be used for obtaining consent as it was felt that any writing would have to be specifically tailored to the procedure involved.

In Section 3 of the statute three defenses are codified and are not intended to be the exclusive defenses available to a health care provider in actions based on a lack of informed consent. These defenses are based on the presumption that a patient can be denied the opportunity to weigh the risks involved in treatment where disclosure would be injurious, as in the case of a patient who is not emotionally capable of coping with unpleasant information, and where the surgery or treatment is a common procedure and it is common knowledge what the inherent risks are.

A BILL FOR AN ACT RELATING TO INFORMED CONSENT

ection 1. As used in this Act, "health care provider" means any person, ition, facility or institution licensed by this state to provide health professional services including but not limited to a physician, al, dentist, registered or licensed practical nurse, optometrist, rist, chiropractor, physical therapist or psychologist, or an officer, ee or agent thereof acting in the course and scope of his employment.

ection 2. No recovery of damages based upon a lack of informed consent be allowed in any action, based on tort, contract law or otherwise to re- damages for injury or death against a health care provider, which alleges ealth care provider was negligent or in breach of an agreement in ing, examining or otherwise rendering professional care to an injured without the informed consent of said injured party unless:

(a) The alleged injury to the injured party involved either (1) a non-emergency treatment, procedure or surgery, or (2) a diagnostic procedure involving invasion or disruption of the integrity of the body; and

(b) The plaintiff proves by a preponderance of evidence that the health care provider did not supply that type of information regarding such treatment, procedure or surgery as was customarily given to patients, or other persons authorized to give consent for patients, by other licensed health care providers with similar training and experience in the same or similar medical community as the defendant at the time of the treatment, procedure or surgery.

Section 3. In any action based on tort, contract law, or otherwise, to recover damages for injury or death against a health care provider, in addition to other defenses provided by law, it shall be a defense to any allegation that such health care provider treated, examined or otherwise rendered professional care to an injured party without his informed consent that:

(a) A person of ordinary intelligence and awareness in a position similar to that of the injured party could reasonably be expected to know of the risks and hazards inherent in such treatment; or

(b) The injured party assured the health care provider he would undergo the treatment regardless of the risk involved or that he did not want to be informed of the matters to which he would otherwise be entitled; or

(c) It was reasonable for the health care provider to limit the extent of his disclosures of the risks of the treatment, procedure or surgery to the injured party because further disclosure could be expected to adversely and substantially affect the injured party's condition.

Section 4. No person shall be competent to testify to establish any of the facts required to be established by Sections 2 and 3 of this Act unless such person is licensed to practice the profession practiced by the health care provider in this state or contiguous bordering states and has

:ticed such profession in one of such states during the year preceding the
: on which he commences to testify.

Section 5. Any writing signed by the injured party or a person authorized
consent for such injured party which consents to the rendering of professional
e by a health care provider in any action which alleges such health care
vider was negligent or in breach of an agreement in furnishing such pro-
sional care to the injured party shall, in the absence of convincing proof
it it was secured maliciously or by fraud, create a presumption that the treat-
it was given with the informed consent of the injured party.

This statute is designed to eliminate the doctrine of res ipsa loquitur ("the thing speaks for itself") in all medical malpractice actions. There is no presumption or inference of negligence on the part of the defendant health care provider and further, medical testimony is required to establish the standard of acceptable practice. In effect, by eliminating this doctrine in actions based on medical malpractice, the trier of fact is precluded from concluding that a health care provider was negligent based on the showing of injury alone.

The complaining party in all medical malpractice cases will have the burden of proving that the health care provider was negligent. This statute eliminates those certain conditions that previously gave rise to a shifting of that burden. The doctrine of res ipsa loquitur is an evidentiary rule that is permitted to be invoked when (1) an injury occurs which is of a type that ordinarily does not occur except for someone's negligence, (2) the conduct or mechanism which caused the injury was within the exclusive control of the person from whom damages are sought, and (3) the complaining party was free of any contributory negligence given these circumstances. The law as it now exists permits an inference of negligence on the part of the health care provider and liability will accrue unless the health care provider, to whom the burden is shifted, proves he was not negligent.

The doctrine of res ipsa loquitur should not be applied to medical malpractice actions. Rather than facilitating a more precise judgment, the application of res ipsa loquitur in medical malpractice actions has resulted in legal uncertainties. In matters of causation in medicine, there is no logical basis for a judgment based on the general experience of mankind. In short, the doctrine of res ipsa loquitur should not be applied in circumstances in which the causation of the injury involves questions of medical science.

n drafting this statute, the question of limiting the doctrine of
sa loquitur to certain medical malpractice actions was discussed but
ed. The doctrine of res ipsa loquitur has been applied to a wide
y of situations, and its range is as broad as the possible events which
y such a conclusion. By stating specific instances in which the
ne is to apply might have the effect of giving the various courts a carte
ie to broadly interpret the scope of these exceptions. Such a broad
ial interpretation might undermine the bill's effectiveness. Only the
mony of medical experts should be used to establish both the question of
tion and the standard of care to which the defendant should be held.
on 3 allows the use of expert testimony only from licensed health care
ders practicing in the state or in contiguous bordering states.
The statute provides that as a necessary element of his burden of proof
plaintiff must affirmatively show through the use of medical experts the
gnized standard of care to which the defendant health care provider should
eld and further that the defendant's failure to meet this standard was
proximate cause of an injury which he would not have otherwise suffered.

A BILL FOR AN ACT
RELATING TO THE BURDEN OF PROOF
IN CERTAIN ACTIONS

Section 1. As used in this Act, "health care provider" means any person, corporation, facility or institution licensed by this state to provide health care or professional services including but not limited to a physician, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment.

Section 2. In any action based on tort, contract law, or otherwise, to recover damages for injury or death against a health care provider for alleged professional negligence, or for performance of professional services without consent, or upon any error or omission in the practice of the health care provider's profession, the plaintiff shall have the burden of proving by affirmative evidence consisting of the expert testimony of competent witnesses:

(1) The recognized standard of acceptable professional practice in the profession or the speciality thereof, if any, that the health care provider practices in the community in which he practices or in a similar community;

(2) The health care provider failed to act in accordance with such standard; and

(3) As a proximate result thereof the injured party suffered injuries which would not otherwise have occurred.

Section 3. No person shall be competent to give the expert testimony
red to be established by Section 2 unless such person is licensed to
ice the profession practiced by the health care provider in the state
ntiguous bordering states and has practiced such profession in one of
states during the year preceding the date on which such person commenced
stify.

Section 4. In an action of the type described in Section 2 of this
here shall be no presumption or inference of negligence on the part of
ealth care provider and the jury shall be instructed that the plaintiff
the burden of proving, by a preponderance of the evidence, the negligence
he health care provder. The jury shall be further instructed that injury
e does not raise a presumption or inference of the health care provider's
igence.

STATUTE OF LIMITATIONS

This statute provides for a two-year statute of limitations for all malpractice actions, whether based on tort or contract, the period commences on the date of the alleged act, omission or failure. The only exceptions provided are (a) for the discovery of a foreign object which was not, nor could have reasonably been, discovered within the initial two-year period, in which case the injured party will have one year from the date of discovery of the object (or from the date that facts would have reasonably led him to discover it) to commence his action, and (b) for a minor under the age of six years, in which case such minor will have until his eighth birthday in which to commence his action.

One of the most important factors contributing to the rise of the cost of medical malpractice insurance has been the large reserves of so-called "tail" which must be maintained to cover claims which could arise in the very remote future in states that have adopted an open-ended discovery rule. To avoid this problem, this statute places a four-year outside limit on the length of time from the act which gave rise to the cause of action in which actions involving foreign objects can be brought.

Inasmuch as this statute is intended to be applicable to all persons, including those under any kind of legal disability, special amendment clauses may also be necessary when any exceptions (for example, for minors or those with mental disability) are located in separate statutes dealing with exceptions under the existing statute of limitations.

It should be noted that in many states, a new statute alone is not

h. Usually, it will also be necessary to amend the presently applicable
ite to eliminate its reference or application to claims against health
providers. One should also carefully examine a particular state's
:ing statute of limitations that is applicable to actions against health
providers to make certain that this model statute does not extend the
within which an injured party may institute his action.

Section 1. As used in this Act, "health care provider" means any person, corporation, facility or institution licensed by this state to provide health care or professional services including but not limited to a physician, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment.

Section 2. An action based on tort, contract law, or otherwise, to recover damages for injury or death against a health care provider for alleged professional negligence, or for the performance of professional services without consent, or for error or omission in the practice of the health care provider's profession shall be commenced within two years of the act, omission or failure complained of except that a minor under the full age of six (6) years shall have until his eighth birthday in which to file. Where the action is based upon the discovery of a foreign object in the patient's body, which is not discovered and could not have reasonably been discovered within such two year period, the action may be commenced within one year of the date of such discovery or of the date of discovery of facts which would reasonably lead to such discovery, whichever is earlier. The time within which an action must be commenced shall not be extended by any of the provisions of this section including those relating to the discovery of foreign objects beyond four years after the date of the act, omission or failure giving rise to such action. This section applies to all persons regardless of minority or other legal disability.

Section 3. Notwithstanding any other provision of law, any claim whether in tort, contract law, or otherwise, by a minor or other person under a legal

ity for damages for injury or death against a health care provider for professional negligence, or for the performance of professional s without consent, or upon any error or omission in the practice of lth care provider's profession, based on an alleged act, omission or which occurred prior to the effective date of this Act, shall be within the longer of:

(a) Two (2) years of the effective date of this Act, or

(b) The period described in Section 2 of this Act.

Section 4. For the purpose of this Act, the term "foreign object" not include a chemical compound, fixation device or prosthetic aid or

This statute requires all parties to certain medical malpractice actions to appear, together with counsel, before a medical malpractice hearing panel before proceeding to trial. Such panel consists of a judge, an attorney and a medical specialist. Following presentation and discussion between the panel and counsel, the panel shall prepare a formal statement of its opinion based on its findings. If no disposition is arrived at between the parties at the conclusion of such hearing, the hearing panel's recommendations are not binding on the parties to the action. Although no statement or expression of opinion made at the hearing is admissible in evidence at a subsequent trial, the panel's written statement of its opinion is admissible in evidence upon the request of either party to the action or upon the determination of the justice presiding at the trial. In this way, the hearing panel's opinion may provide a catalyst for settlement. In addition, many of the costs and delays of litigation can be reduced substantially.

The reference in the statute to the "appropriate court or courts" will allow each state to apply this hearing panel concept either to all medical malpractice actions or to only those that are within the jurisdictional amount of a particular court or courts. For sake of uniformity, the former approach is more desirable.

A requirement for the posting of a cost bond by the plaintiff prior to his proceeding to trial after an adverse decision by the hearing panel has been included to reduce frivolous post-hearing litigation. Provision has been made for a waiver or reduction of this requirement where the plaintiff is found to be indigent.

is the intention of this statute that the cost of any such hearing
e absorbed by the state as an administrative court cost. An
lual state will benefit from this type of legislation in that a re-
ı of court calendars and a resultant easing of delay and congestion at
ial level will be a direct result of instituting these panels.
ompensation for the health care provider and attorney members of the
has not been specifically suggested; instead it is recommended that
›e paid an hourly sum for time actually spent at the hearings. It had
›roposed that any such compensation be limited to $25.00 per day but that
was rejected as it might tend to discourage qualified persons from making
elves available to serve on the panels.

Section 7 of the statute provides that all parties shall be represented
›unsel before any such hearing panel. However, if the health care provider
s to retain an attorney for an appearance before the panel, the health care
ider's insurer must be represented. The intent of this provision is to
ect the interests of both the health care provider and his liability insurer.

A BILL TO ESTABLISH MEDICAL MALPRACTICE HEARING PANELS

Section 1. As used in this Act, "health care provider" means any person, corporation, facility or institution licensed by this state to provide health care or professional services including but not limited to a physician, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment.

Section 2. The (appropriate court or courts) shall establish within (its or their respective) jurisdiction(s) a medical malpractice panel or panels to facilitate the disposition of medical malpractice actions. The number and locations of such panels and the rules governing the operation thereof shall be determined by the respective court.

Section 3. Any claim or action based on tort, contract law, or otherwise, to recover damages for injury or death against a health care provider for alleged professional negligence, or for performance of professional services without consent, or upon any error or omission in the practice of the health care provider's profession, other than those claims and actions validly agreed for submission to a lawfully binding arbitration procedure, shall be referred to the appropriate medical malpractice panel established in accordance with Section 2 for hearing and disposition as required by this (Chapter, title, etc.)

Section 4. All hearings shall be before a panel of three consisting of a justice of the (appropriate court or courts), a physician of the same medical specialty as the health care provider involved and an attorney-at-law, the latter two to be designated in accord with the following provisions:

(a) A list of health care providers regularly admitted to practice medicine in the state shall be prepared by each (presiding justice) of the (respective court or courts) with the assistance of (state medical society) and (the appropriate county medical society). Said list shall be divided into lists of health care providers according to the particular specialty of each.

(b) The (presiding justice) shall prepare a list of attorneys with trial experience, not confined, however, to the field of medical malpractice.

(c) Names of health care providers and attorneys may be added to or taken off the list at any time by the (presiding justice) at his discretion.

(d) Any party prior to the date set for the hearing may file a written objection to the designation of a health care provider or attorney which objection shall be decided by the justice presiding as a member of the panel.

Section 5. (a) The rules of the (respective court or courts) shall rovide that prior to the date set for hearing the parties shall submit to he court all written material, including pleadings, bill of particulars, edical and hospital reports (or authorization to obtain the same), said ritten material to be submitted in triplicate except as to hospital records nd X-rays, and that these materials shall be made available to any panel ember desiring to see the same in advance of the hearing.

(b) The rules of the (respective court or courts) shall provide the (appropriate state medical society) and the (appropriate county medical society) shall review the said submitted material and designate the medical specialty involved and notify the court as to such designation.

Section 6. The hearing shall be informal and without a stenographic record. Except as otherwise provided, no statement or expression of opinion made in the course of the hearing shall be admissible in evidence either as an admission or otherwise in any trial of the action, provided, however, that the panel shall prepare a formal statement of its findings which statement shall include one or more of the following opinions:

(a) The evidence supports the conclusion that the health care provider failed to comply with the appropriate standard of care as charged in the complaint.

(b) The evidence does not support the conclusion that the health care provider failed to meet the applicable standard of care as charged in the complaint.

(c) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury.

(d) The conduct complained of was or was not a cause of the resultant damages. If so, whether the injured party suffered: (1) any disability and the extent and duration of the disability, and (2) any permanent impairment and the percentage of the impairment.

The findings of the panel shall be admissible in evidence at any sub-
at trial upon the request of either party to the action or upon the
mination of the justice presiding at the trial. Such statement shall
e binding upon the jury but shall be accorded such weight as the jury
es to ascribe to it. The justice presiding at the hearing shall not
ide at the trial or hear any application in the case not connected with
earing itself. No other panel member shall participate in the trial
er as counsel or witness except if a panel's findings are admitted into
ence at trial, the health care provider member or the attorney member of the
l, or both of them, may be called as a witness by any party to present the
dings of the panel only. The party calling such witness or witnesses shall
their reasonable fees and expenses.

Section 7. All parties shall be represented at the hearing by counsel
horized to act for their respective clients. If authority is not conferred,
plaintiff and a representative of the carrier so authorized must attend.
iling an appearance, the justice presiding may order an inquest, strike the
se from the calendar, or make such direction as justice requires.

Section 8. The health care provider member and the attorney member of any
medical malpractice panel shall be compensated at the rate of $_____ per
our by the (STATE, COUNTY, ETC.) for time actually spent at hearings of the
anel. If a finding is made for the defendant, the plaintiff may pursue the
ction through a subsequent trial only upon filing bond in the amount of $2,000
ecured by cash or its equivalent with the (clerk) of the court in which the
ase is pending, payable to the defendant for costs assessed, including witness

and attorneys' fees, if the plaintiff does not prevail in the final judgment of the court. If said bond is not posted within 30 days of the panel's finding, the action shall be (dismissed with prejudice). Upon motion filed by the plaintiff, a justice of the court may find the plaintiff is indigent and reduce or waive the bond required.

LIMITATION OF DAMAGES

These statutes place a maximum limit on the amount that may be recovered
y one person as a result of a claim for medical malpractice regardless of
otal number of health care providers involved. The amount of this
um limit is left blank in each of these two statutes so that each
idual state can tailor the maximum amounts to the need of their residents.
mportance of establishing such a limitation, in states where it is
itutionally permissible, lies in the unfortunate tendency of juries to
n award for general damages as a basis for either punishing the defendant
idirectly providing for the plaintiff's counsel fees. If any significant
id is to be made in the overall reduction of the cost of medical services
isonable limitation must be placed on these awards.

It is also significant to note that portion of each of the statutes
n treats a multiplicity of claims arising out of continuous treatment as
ngle claim.

A STATUTE RELATING TO
LIMITATION OF DAMAGES IN ACTIONS
BASED ON MEDICAL MALPRACTICE

Section 1. As used in this Act, "health care provider" means any person, corporation, facility or institution licensed by this state to provide health care or professional services including but not limited to a physician, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment.

Section 2. In any claim or action based on tort, contract law, or otherwise, for damages for injury or death against a health care provider for alleged professional negligence, or for performance of professional services without consent, or upon any error or omission in the practice of the health care provider's profession, the compensation and benefits recoverable shall be subject to the following maximum limitations:

(a) For death of a minor without dependents, the compensation recoverable shall be the reasonable value of the minor's services to its parents or legal guardian, less the reasonable cost of the maintenance of said minor, which compensation shall enure to the exclusive benefit of said parent or guardian, plus any and all reasonable medical, hospital, funeral, burial or related expense, all not to exceed $_____. The sole right to institute the claim or claims provided for in this paragraph shall be in the personal representative of the deceased, for the exclusive benefit of: (1) such parent or parents, or legal guardian and (2) the persons incurring such medical, hospital, funeral, burial and related expense.

(b) For death of an adult without dependents, the compensation recoverable shall be the reasonable value of the hospital, medical or other related expense plus the reasonable cost of funeral and burial, not to exceed, however, the sum of $_____. The sole right to institute a claim under this paragraph shall be the personal representative of the deceased for the exclusive benefit of those incurring such expense.

(c) For the death of a minor or adult with dependents, the compensation recoverable may include the actual or prospective loss of earnings for the working life expectancy of such deceased (during the dependency of the claimant) less the reasonable cost of the maintenance of such deceased, plus the reasonable cost of the deceased's medical, hospital, funeral and burial expense, all not to exceed $_____. The sole right to institute the claim provided for in this paragraph shall be in the personal representative of the deceased for the exclusive benefit of the deceased dependents and for those incurring such expense.

(d) For bodily injury to an adult or minor not resulting in death it shall be the duty of the court to determine the percentage of permanent impairment of the body of the injured person as a whole, if any, for which the Board shall allow an amount not to exceed $_____ for 100% permanent impairment. For a lesser percent of permanent impairment, the court shall allow a proportionate lesser amount. In addition to the allowance for

permanent impairment, the court may allow for any and all other injury or damage, general or special, including temporary total disability, temporary partial disability, loss of earnings, past, present and future, the reasonable medical, hospital and related expense, past, present and future, pain and suffering, past, present and future, a sum not to exceed $_____. The sole right to institute, maintain and recover a claim for the compensation and benefits provided in this paragraph shall be in the injured party, or in the event of his legal disability, his parent, legal guardian, trustee, or other representative.

Section 3. In no event shall the total amount of damages recoverable for such injury or death for any claim arising out of the rendering of such professional services to any one person by one or more health care providers exceed $_____. Any claim or action brought against a health care provider that involves continuous treatment or care made on one or more occassions shall be treated as one claim.

ALTERNATE STATUTE RELATING TO
LIMITATION OF DAMAGES; SPECIFICATION OF
ELEMENTS OF AN AWARD

Section 1. As used in this Act, "health care provider" means any person, corporation, facility or institution licensed by this state to provide health care or professional services including but not limited to a physician, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment.

Section 2. Any award of damages in any action based on tort, contract law, or otherwise, for damages for injury or death against a health care provider for alleged professional negligence, or for performance of professional services without consent, or upon any error or omission in the practice of the health care provider's profession, shall separately state the elements of damages upon which the award is based and the amount assigned to each element.

Section 3. In no event shall the total amount of damages recoverable for such injury or death for any claim arising out of the rendering of such professional services to any one person by one or more health care providers exceed $_____. Any claim or action brought against a health care provider that involves continuous treatment or care made on one or more occassions shall be treated as one claim.

This statute disallows any award for punitive damages in actions based on medical malpractice.

The rationale behind this statute is simple: the awarding of punitive damages in medical malpractice cases should be taken out of the tort law system so that the amount of damages an injured person receives is such an amount as will constitute a just and reasonable compensation for the loss sustained, and nothing more. From the viewpoint of a health care provider, a pleading containing a prayer for punitive damages is most disturbing. In addition, most malpractice liability policies do not purport to indemnify the health care provider for punitive damages because of the public interest factors involved.

Also enclosed is an alternative statute relating to punitive damages which would allow punitive damages to be awarded only in those instances where the harm was maliciously intended by the health care provider. This statute is meant to be utilized in those states where there is considerable legislative opposition to a "blanket" disallowance of punitive damages in actions based on medical malpractice.

In drafting these statutes several alternative approaches to the awarding of punitive damages were considered. Two of these alternatives were: (1) the paying of any punitive damage award by the health care provider directly to the state or some other third party other than the plaintiff, which award is made by the court in a separate proceeding, and (2) the referral of all incidents involving injury that was maliciously intended or proximately cause by a health

provider's reckless disregard for the welfare of a patient to the state's
al (or other appropriate) society for their review and disposition. In
er of these two alternatives should the injured party be the recipient of
unitive damage assessment. It should be noted that these alternatives
erely suggested. They were not incorporated into these statutes because of
remoteness to the medical malpractice crisis at hand.

ELIMINATION OF PUNITIVE DAMAGES IN ACTIONS BASED ON MEDICAL MALPRACTICE

Section 1. As used in this Act, "health care provider" means any person, corporation, facility or institution licensed by this state to provide health care or professional services including but not limited to a physician, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment.

Section 2. In any action based on tort, contract law, or otherwise to recover damages for injury or death against a health care provider for alleged professional negligence, or for performance of professional services without consent, or upon any error or omission in the practice of the health care provider's profession, no pleading shall contain a demand for punitive damages nor shall there be an award for such damages.

ALTERNATE STATUTE RELATING TO
PUNITIVE DAMAGES IN ACTIONS
BASED ON MEDICAL MALPRACTICE

Section 1. As used in this Act, "health care provider" means any person, ›ration, facility or institution licensed by this state to provide health or professional services including but not limited to a physician, ital, dentist, registered or licensed practical nurse, optometrist, atrist, chiropractor, physical therapist or psychologist, or an officer, oyee or agent thereof acting in the course and scope of his employment.

Section 2. No damages may be awarded in any action based on tort, contract or otherwise to recover damages for injury or death against a health care ›ider for alleged professional negligence, or for performance of professional ›ices without consent, or upon any error or omission in the practice of health care provider's profession, other than compensatory damages except t punitive damages may be awarded by the trier of fact only if the harm maliciously intended by the health care provider; harm is not considered iciously intended in instances in which unintended damage or injury results ›m intended medication, manipulation, surgery, treatment, or the intended ission thereof, or if the intended treatment is applied or omitted by stake to or for the wrong patient or wrong organ.

Section 3. Where punitive damages are awarded pursuant to Section 2 this Act, the trier of fact shall separately state the amount of punitive mages awarded.

ADVANCED PAYMENTS

The intent of this proposal is to allow defendants or their liability insurers to make advanced payments for economic loss to claimants without incurring the possibility that the claimant would then be allowed to introduce evidence of that payment on the issue of liability during subsequent litigation. The statute also provides that the insurer is allowed to credit such advanced payments against any judgment awarded the plaintiff at a later date.

The concept of advance payment is an answer to criticisms that the tort liability reparations system inevitably delays payments for economic loss to persons who are in need of such payments. By encouraging the continued and expanded use of advance payments, particularly in the area of remedial medical care, it is hoped that the claimant's injuries may be minimized and his out-of-pocket losses reimbursed quickly.

OPTIONS OF PAYMENT

Section 1. An advance payment or partial payment or an offer thereof, by a person or his insurer as an accommodation to an injured person or behalf to others or to the heirs of law or dependents of a deceased made because of an injury or death claim or potential claim against rson thereunder shall not be construed as an admission of liability by rson claimed against, or of the insurer's recognition of the liability, espect to the injured or deceased person or with respect to any other arising from the same accident or event.

Section 2. Evidence of an advance or partial payment is not admissible proceeding relating to the injury, death, claim or potential claim there is a final judgment in favor of the plaintiff, in which event the shall reduce the judgment to the plaintiff to the extent of the advance t. The advance payment shall inure to the exclusive benefit of the de- t or the insurer making the payment.

Section 3. In the event the advance payment exceeds the liability of efendant or the insurer making it, the court shall order any adjustment sary to equalize the amount which each defendant is obligated to pay, sive of costs. In no case shall an advance payment in excess of an award payable by the person receiving it.

This statute provides that no action based on medical malpractice may be commenced unless the health care provider has been given 60 days' prior notice of the intention to commence the action. If such notice is served within 60 days of the expiration of the applicable statute of limitations, the time within which the action must be commenced is extended 60 days from the service of the notice.

The purpose of the notice of intent is to provide an early notice to the health care provider so that the facts and evidence necessary to an effective defense may be more easily obtained or preserved for trial. In addition, prior notice provides an opportunity to resolve a complaint before both parties become involved in the expensive process of litigation.

A BILL FOR AN ACT RELATING TO
NOTICE OF INTENT TO FILE SUIT IN CERTAIN ACTIONS

Section 1. As used in this Act, "health care provider" means any person, oration, facility or institution licensed by this state to provide health or professional services including but not limited to a physician, ital, dentist, registered or licensed practical nurse, optometrist, atrist, chiropractor, physical therapist or psychologist, or an officer, oyee or agent thereof acting in the course and scope of his employment.

Section 2. Notwithstanding any other provision of law, no action based on , contract law, or otherwise, to recover damages for injury or death against alth care provider for alleged professional negligence, or for performance of essional services without consent, or upon any error or omission in the practice he health care provider's profession, shall be commenced until at least sixty days after valid written notice of claim setting forth under oath the nature circumstances of the injuries and damages alleged is served personally or by stered or certified mail upon the person or persons who are allegedly liable for alleged injuries and damages. If the notice is served within 60 days of the ration of the applicable statute of limitations the time for the commencement he action shall be extended 60 days from the service of the notice.

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JOHN C GIORDANO
OF COUNSEL

FILE NO.

October 20, 1975

Senator Martin L. Greenberg, Chairman
Special Committee to Investigate Medical
Malpractice Insurance
c/o Legislative Services Agency
State House
Trenton, New Jersey 08625

Dear Senator Greenberg:

In my capacity as the legislative representative for six of the hospitals in Ocean and Monmouth counties, their medical staffs, and the Monmouth County Medical Society, I respectfully request that the Special Committee to Investigate Medical Malpractice Insurance, in reviewing the medical malpractice situation as it exists in New Jersey, pursue its investigation with an eye towards developing a statutory solution to the malpractice insurance problem. A statutory solution should assure the patient adequate compensation and coverage for injuries suffered due to the negligence of a health care provider and, at the same time, assure that the costs of such coverage are reasonable in relation to the benefits provided to the public and do not consume a disproportionate share of the resources allocated to health care.

In reviewing the malpractice situation, I am sure that the Committee has become aware of the following problems:

1. Malpractice insurance premiums for physicians as well as hospitals in the State of New Jersey have increased significantly in the past few years, and it appears that such increases will continue in the foreseeable future unless major changes in the malpractice law are made.

2. The availability of malpractice insurance and the number of insurance carriers providing malpractice insurance have decreased.

3. In addition to the aforementioned problems, the practice of defensive medicine has increased to the point where the Congress of the United States now estimates

t it consumes in excess of Seven Billion ($7,000,000,000) lars of scarce medical resources.

On the whole, the uncertainties which surround the practice problem have resulted in the increased cost of practice coverage without any attending increase of efits to the public. With respect to non-profit hospitals, is clear that any increase in malpractice premiums as l as the costs of defensive medicine must be passed on to patient. With respect to the private practitioner, practice premiums and requests for additional tests, ., are a cost of doing business which will be included in fees charged to the patient just as increases in operating enses experienced by businessmen are passed on to consumers. party ultimately bearing the expense of increased malpractice miums and defensive medicine is the patient or a public ncy on behalf of the patient. It is apparent that the reased cost of malpractice insurance is one of the elements sponsible for the significant rise in the cost of medical e.

In light of the existing problems, it is suggested that lical malpractice should be controlled by a statutory eme and no longer left to common law development. Such a atutory scheme, at a minimum, should cover the following eas:

A. A definition of malpractice based upon negligence ich would operate to eliminate recoveries for unsuccessful sults. The malpractice system is not designed to and is nancially unable to carry the financial burden for unsuccessful esults" which are not due to negligence. Any expansion of e system to cover such payments would impose a significant nancial burden upon health care providers which, in turn, uld be passed on to the consumer. There is insufficient ta available at this time to allow the exact financial rden to be determined; however, the recovery by a patient r failure to obtain a cure represents a significant extension the present basis of recovery.

B. A clear definition of informed consent, the eps which must be followed to obtain informed consent, as ll as the damages which would flow from the lack of formed consent.

C. A system of compensation to be paid to the jured patient or to his survivors which would assure that

the funds paid actually cover the expenses incurred as a result of malpractice as well as compensate the reasonable economic loss experienced by the injured patient or his survivors as a result of malpractice. Such an award should be paid in a manner which assures that the funds are used for the purposes set forth above in order that the injured patient does not ultimately become a burden upon society, demanding support out of general revenue funds.

D. The disposition by a professional panel of most malpractice allegations in an efficient and economical manner. This can be accomplished by arbitration, professional screening or any other system which would provide a hearing and be acceptable to most patients and health care providers. The system should not be designed so as to completely deny a jury trial in the rare case in which the patient or health care provider is not satisfied with the system.

E. A revision of the statute of limitations to provide a shorter period in which suit can be brought. In addition, the discovery rule should be eliminated and replaced with the occurence rule. This will make it possible, by providing a reasonable time frame, to project losses.

F. A statutorily required standard regarding proof that must be offered to recover for malpractice.

G. A requirement that all health care providers carry insurance covering the liabilities created under the statutory scheme as well as a requirement that any policies issued by insurance carriers be co-extensive with the liability created under a statute. This would assure to those individuals who suffer injury as a result of malpractice or lack of informed consent, recovery pursuant to the statutory scheme, minimizing the probability of obtaining a judgment which is not collectible.

H. The creation of an alternative insurance carrier to operate in the event that there is no private insurance carrier willing to write malpractice coverage. It is clearly an untenable position for both the health care providers and the public for malpractice insurance not to exist. Surely, very few physicians have sufficient assets to cover a significant malpractice injury. Thus, in developing a statutory scheme based upon insurance, we, as a society, have elected to look to insurance as the method of compensation and not to the individual tort-feasor.

I. The requirement that hospitals should review he privileges of licensed physicians and dentists of such nstitution and that those physicians and dentists and other mployees of hospitals who participate in this review process hould be protected from suit if their participation is in ood faith, either as witnesses or members of a reviewing anel. This protection to the individual employee or physician hould assist in controlling malpractice and increase the uality of health care.

Any statutory scheme that is adopted by the legislature ust be a scheme which provides adequate compensation to the ndividual who suffers from malpractice; however, at the ame time, such a scheme must be limited to malpractice njuries and developed in a manner which controls the rising ost of both malpractice premiums and defensive medicine.

Thank you for your consideration of this matter.

Respectfully submitted,

GIORDANO & HALLERAN

RC/kmb

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STATEMENT OF THE NEW JERSEY PODIATRY SOCIETY RE MEDICAL MALPRACTICE INSURANCE

October 24, 1975

Senator Greenberg and Members of the Committee to Investigate & Study Medical Malpractice Insurance:

The New Jersey Podiatry Society appreciates this opportunity to comment on the serious problem of medical malpractice insurance which affects New Jersey's podiatrists as seriously as it does any other medical practitioners in the State. It has been, and continues to be, increasingly difficult for medical practitioners to obtain professional liability insurance coverage at a reasonable premium cost.

The podiatrist is a physician practicing within a limited area of the human body, similar to the dental practitioner, and he shares the same concerns as any other physician regarding professional liability insurance, premiums for which have escalated in the last few years as much as 500% in the State of New Jersey.

We recognize the fact that insurance carriers intend to operate their business for a profit. When claims, a substantial number of which could be labeled opportunistic, result in defense costs and awards of such magnitudes that the carrier is hardput to cover them adequately, we can understand their difficulty.

(con't.)

When the length of time permitted to elapse from the date he alleged occurence, past the time of discovery, is so nsive that many years pass before a claim surfaces, and more s before the claim is tried, we can understand the problem of carrier in trying to amass sufficient reserves to cover the nse and possible award of almost limitless amounts. The ier then insists that he must continually stockpile reserve s to cover almost unpredictable future costs.

It is our opinion that opportunistic claims, unlimited awards, an overly long statute of limitations concerning such cases the primary factors which have caused the cost of professional bility insurance to rise to the point where many carriers are lling to sell it and the practitioner who must buy it is ced to pass this exorbitant expense on to his patients.

The New Jersey Podiatry Society offers the following proposals the Committee's consideration with the hope that they will vide bases for development by the Committee, and subsequently legislature, into solutions to this very serious problem ch affects practitioners and patients alike and which con- butes to the high cost of medical care at a time when most ple can ill-afford the high cost for anything, let alone high t for the mainteance of health:

(1) The statute of limitations governing claims of alleged practice should be reduced to a more reasonable period and uld begin with the date of the alleged cause rather than the e of discovery. In pediatric cases the statute of limitations ght be somewhat more liberal.

(con't.)

(2) Screening panels should be established to explore the merits of any proposed claim prior to its acceptance by a court. Such panels could consist of 3 doctors, a representative of the court and a representative of the consumer sector. The doctors should be expert in the subject area of the claim and should be selected from a panel offered by the recognized state professional society of the same medical discipline as the defendent. Such peer group representation would provide the sharply defined expertise required for specialty areas. The representative of the court could be appointed by the court and the consumer representative appointed by a legitimate and recognized consumer advocacy agency.

(3) There should be a legal limit placed upon the size of awards. Excessive awards, sometimes amounting to millions of dollars, have no apparent basis in logic and seem often to be expressions of retribution rather than compensation for actual damage.

(4) Attorneys fees should be either awarded by the court or strictly limited to percentages of the award on a schedule established by the legislature. This would eliminate many of the opportunistic and non-meritorious cases encouraged by the possibility of contingency fee which frequently leave the plaintiff disadvantaged after settlement.

(5) In cases where it is ruled that a claim is without foundation, invalid or non-meritorious, the plaintiff should be obligated to pay court costs and fees.

(6) Awards should be reduced in cases where compensation for expenses and/or damages are already being paid by other insurance coverage.

(con't.)

(7) Payment by attorneys of finders' fees and kickbacks for formation from hospital employees and others should lead to ofessional liability action and disciplinary measures.

(8) Professional liability insurance coverage should be ailable to all licensed podiatrists in New Jersey on the same sis as any other physician. Likewise, any conditions, veloped by legislation or administrative regulation, governing e area of medical malpractice insurance should apply to pod- trists on the same basis as any other physician.

(9) The Commissioner of the New Jersey State Department of surance should review the accounting policies and records of sualty carriers to determine the propriety of the amounts set ide as reserves for actual claims and anticipated claims as ll as their financial responsibility and resources.

We do not at all believe that these proposals in any way ny the public its right to sue. We do believe that these oposals will discourage the frivolous, opportunistic and non- eritorious claim. We do believe that these proposals suggest ne and practical perameters for medical malpractice actions d will do much to encourage professional liability insurance rriers to provide such coverage to medical practitioners at mpetitive rates, encouraging medical practitioners to remain active public practice and, ultimately, reducing the cost of alth care to the patient.

Representatives of the New Jersey Podiatry Society stand ady and would welcome the opportunity to confer with members of e Committee, or any other body involved with solutions to this oblem, to discuss in greater detail and more specifically the oposals herein submitted.

LEONARD HYMES, D.P.M.
PRESIDENT

gt

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David C Hayman M.D

I am here to answer questions and to explain how the present liability situation affects anesthesiologist, particularly those at small, community hospitals.

Because I believe I am fairly typical among anesthesiologists; I would like to tell you something about myself and the way I work. At the age of 33, I began to practise anesthesiology at a small hospital in Southern New Jersey; and I have now been there for 9 1/2 years. Prior to that time, I completed medical school, a one-year internship, spent two years as a doctor in the Navy, and more than one year as a general physician at a Miners Hospital in Kentucky. Next, I spent two years training and qualifying in the specialty of anesthesiology.

For the 9 1/2 years that I have been in our state, I have been on 24-hour "call" every third day, and every third weekend-this is besides the regular daily schedule during the week. When one of my two associates is away, I take "call" every other day and every other weekend. Like other physicians, I am used to my profession interrupting my private life, but I am happy to do my professional duties to the best of my ability. We provide coverage for our hospital in the same manner that a Fire Department does, that is, someone must be readily available at all times. Like many other hospitals, ours is expanding; and we have been looking forward to increasing the number of doctors in our group. This would spread out the number of nights I am on "call", and provide better quality and availability.

Until two years ago, the major consideration for enlarging our group would have been salary; that is, if we were earning enough money, we could add another doctor, But today, we must also seriously consider the cost of insuring another doctor. I feel that the present system is a reverse incentive for quality care. For, as strange as it seems, the more highly qualified doctors we have in our group, the higher our professional liability insurance is. Now, we cannot increase the number of patients who need operations;we also need to have extra hands available in operating rooms, and to provide help during emergencies, such as cardiac arrests outside the operating room, or coverage when somebody is ill. Returning to the Fire Department analogy, this means we must pay salaries to people who may not work and who do not create income, but who are simply ready.

In the past we have hired Certified Registered Nurse Anesthetists to help us fill this gap. Now, a Certified Registered Nurse Anesthetist is a Registered Nurse, who has received training in the techniques of administering anesthesia for two years, and has passed a qualifying examination.

We try to maintain the quality of anesthesia care by strict supervision of the nurse anesthetists. As an aside, I wish to state my belief, that quality in any field of medicine, is best maintained by supervision. Nowadays, enlarging a group with nurse anesthetists is not economical from an insurance point of view either. I believe we are expecting to pay over $5.000 insurance premuim for

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David C. Heyman M.D.

ich of our nurses next year. So, it remains desirable to keep a group small, ren though all of us must work harder-and many times do a job requiring traordinary vigilance, when we are most tired.

his year our group can pay our insurance bill. Next year, I cannot say. If ir bill rises to that paid by neurosurgeons this year, we will be "out of Business". one of us feels that it would be proper to work three or four months to pay his bill. Can we practise without insurance? Our hospital Board of Governors ys, "No". We find that the high limits we carry for professional liability surance make us targets for dubious claims. Most of us are insured to well er the value of our personal assets. The insurance which was originally signed to protect our homes, our automobiles, etc;has taken on a new function. are financing the entire compensation system with our premium payments.

would be logical for you to ask why we do not pass these charges on to patients? cannot. In my practise, 75% of patients pay us fixed fees through Medicare, ue Shield, and Medicaid. It is also logical for you to ask why we do not rminate our participation in Blue Shield, and then increase our fees? Because has been our experience, that when Blue Shield sends checks to patients;a good rcentage don't bother to pass the checks on to us.

me final statements about the compensation system, as it effects us. I'm ing to call this "the Fraud of Insincerity of Blanket Suits". That is, when e patient's lawyer sues everyone involved in his case, including the man who eaned the floor after the operation.

ile I have been here, talking to you, some incident may have occurred which ll cause me to be named in a suit. Why? That have I done? Nothing, of course. t one of my associates could have become involved in a problem;or one of the rgeons on our staff;or some nurse who works for the hospital could have done mething. But the patient's lawyer has included me in the suit, in case I may found guilty later. But did the attorney do his homework and really investigate e case? Of course not! Two years from now, during the first dispositions, he ll study his files in earnest. In the meantime, the insurance company has ened a file in my name, and have hired people to defend me. This is ludicrous d costly. It would be better to limit the suit to a fixed number of people osely associated with the problem.

also want to say that the adversary system is not a fit place to determine leged cases of malpractise. I know of one case in progress, where a client's torney has offered to drop charges against the surgeon, if he will testify ainst the hospital. Now, this technique may be useful in prosecuting alleged iminals;but is this the proper system we must follow for a patient, who has uly suffered, to achieve just compensation?

mming up;I have spoken to you about what an anesthesiologist is;how he works,

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and why the present system is a reverse incentive for quality care. We are now, watching the annual premium increases closely, as they threaten our availability. And finally, I tried to show how disheartening it is to become not just a physician doing his job-but a target.

STATEMENT TO THE COMMITTEE

EDICAL MALPRACTICE SITUATION IN THE STATE OF NEW JERSEY

GERALD B. O'CONNOR, ESQ.

This office has been involved in the handling of personal y litigation and, specifically, medical malpractice claims, for ximately 20 years and longer. My former senior partner, ur B. Jacobs, now deceased, had been one of the leading pioneers is field and is responsible for most of the present law dealing malpractice cases. We have seen many advancements and changes is area of tort law, some dealing with the Statute of Limitations, s, the doctrine of res ipsa loquitor, and also the recognition e 'conspiracy of silence."

Though we have noticed these advancements in this area of law, there has still been no great noticeable change in the ance companies' position relative to the defense or payment of claims or the ready availability of medical experts. These actice cases are still vigorously defended and still the great ity of physicians refuse to cooperate because of their professional iation with the potential defendants. Further the costs of rial preparation in medical negligence cases are greater than tort cases.

This malpractice situation has blossomed to the forefront tional legal problems because of a dramatic and alarming rise in ost of malpractice insurance. It is at the point now where many surgeons in this area pay as high as $21,000.00-$28,000.00 for a lity policy, though they have never had any claims against them. high policy premiums are also being paid by what has been called "high risk" specialists. The interesting thing to note, however, at the Medical Society is one that sets the premium levels for igh risk specialists, and not the insurance companies. In words, the Medical Society of the State of New Jersey enters into tract with the liability carrier for a set premium. The society, rn, sets the premium for the various specialists. A recent study lifornia points out that, if the risk of liability was spread ly among all physicians in California, the premiums would not d $1,000.00 per doctor. In New Jersey, because of the smaller

number of physicians, the similar type of premium would be approximately $3,000.00. However, the society argues that, why should the majority of its physicians, who are not in the very high risk specialties, bear the cost of providing the insurance coverage for those specialists.

There are a number of areas which your committee is going to be concerned with, but the three basic areas will be the legal profession, the medical profession and the insurance industry. All three have arguments concerning their self-interest and are growing polarized in their arguments. However, it would seem that in all three areas, compromise would have to be effectuated if the rights of the citizens of this state are to be protected.

The New York Times, on Sunday, June 1, 1975, published the claim experience of Employers Insurance of Wausau for its coverage of the Medical Society of New York from 1966 to 1973. This study revealed that during that period of time Employers of Wausau had collected $159,679,162.00 in premiums, and paid out $55,141,656.00, in claims, showing a gross profit for this period of approximately $104,000,000.00. Unavailable, interestingly enough, from these statistics were the operating expenses and legal expenses incurred in defense of claims by this insurance company during that period of time. Apparently, New York State has the same problems faced by the Insurance Commissioner in New Jersey, namely, the refusal of the insurance industry to supply complete records concerning its risk of loss for doing business in the state.

During the year of 1974 in the New York State area, of more than 2,000 claims brought against physicians, no money was paid on 1,467 of these claims, for a figure of 70% claim close-out with no payment. It would appear, based upon the statistics, that 75% of all claims settled are settled for an amount below $10,000.00.

The present medical malpractice insurance carrier in this state is the Chubb Insurance Group, through one of their subsidiary insurance companies. They have just been granted a 48% rate increase on malpractice policies. However, the figures published by the Chubb Grou show that in the year preceding this request, they had collected approximately $12,000,000.00- $15,000,000.00 in premiums and paid out approximately $300,000.00 in claims This loss record, if it can be called that, was followed up by the rate increase request of 48%.

The Insurance Commissioner, Mr. Sheeran, spoke about this problem at the Bar Convention in September, wherein he indicated that one of the great problems he faces in dealing with these requests is th

of legislation requiring the companies to open up their books inspection prior to the granting of these increases. Apparently, nsurance company may at any time, if it does not like the rate eases that are allowed, give a 30 day notice to the Medical Society he termination of their coverage. The Commissioner expressed ern as to why there seems to be a de facto monopoly by insurance anies in this country concerning the writing of malpractice insurance. ther words, an insurance company might be writing malpractice in part of this country, and yet not bid for the right to write the erage in another section. The Commissioner was concerned that there ns to be an unwritten agreement concerning the making available of practice liability insurance coverage.

One of the areas of concern of this committee, and an ropriate area for legislation, would seem to be the requirement support and substantiation for rate increases. In conversations ave had with the Chubb Insurance Group and the attorneys representing t organization, they indicate that the greatest majority of practice cases in this state are settled within the range of ,000.00-$9,000.00, the exact same loss experience shown by the gures furnished by Insurance Company of Wausau for their coverage the New York State Medical Society.

The Medical Society, in its publications concerning the handling malpractice claims, seeks to revise the Statute of Limitations, iminate the jury system for deciding malpractice cases, and establish limit of liability for physicians when damages are awarded. Their lutions are to completely take away the rights of their victims or materially restrict or reduce those rights. It should be understood dealing with the issue of medical malpractice that a malpractice aim is founded on the alleged actions of physicians and has never en based on the actions of the patient or lawyer or his insurance mpany. In short, medical malpractice is caused by and committed by ctors. The doctor must recognize the malpractice insurance premium oblem is primarily rooted in the substantial number of injuries and her adverse results sustained by patients during the course of spital and medical treatment. The Medical Society must now move to e forefront in establishing better medical care and establishing ocedures to eliminate those who are incompetent and unfit to practice dicine. There are many cases in this state where doctors have been peatedly sued and their patients awarded substantial amounts, and with action taken by the society to review the competency or qualifi-tions of the offending physicians.

Seminars on safety techniques, drug use, adequate peer review and periodic mandatory examinations to insure continued competency will go far towards reducing medical malpractice claims.

One of the claims by the medical profession is that the open-ended Statute of Limitations is a substantial cause in the high premiums they are paying. This committee should keep in mind that the State of New Jersey has always had an open-ended Statute of Limitations, not only in the area of malpractice, but in all other areas of tort law. Namely, this state has granted to minors the right to have their claims open without the running of the Statute of Limitations until two years after they have attained their majority. No other group has complained about this longstanding statutory right in the State of New Jersey. The only question, therefore, is whether there has been a substantial increase in the number of claims filed by adults because of the changing standards of the Statute of Limitations. I understand that the Chubb Insurance Group has statistics on this and that there is a surprisingly small amount of claims that are filed by adults that deal with the Statute of Limitations. Is this legislative committee going to take the position that a person who has had surgical instrument left in his abdomen does not have a cause of action if that surgical instrument is not discovered within a two year period of time?

It is this area, however; namely, the Statute of Limitations, that is used by the actuarial experts of insurance companies to justify these premiums. It would seem that the insurance companies should be required to produce their figures and their statistics to show whether or not there has been any substantial increase of adult claims based upon our "discovery rule."

Another area of concern by the physicians seems to be " the million dollar claim." Most of the members of this committee, who are attorneys, would readily recognize that juries of this state have been historically conservative in their awards. We can count on our fingers the amount of jury awards in any type of litigation in excess of $1,000,000.00. I don't know anyone, however, who would want to have the type of injuries necessary to substantiate a jury verdict in an amount in excess of $1,000,000.00. And it should be born in mind that any jury verdict in this state that is unconscionable, is subject to being set aside by the trial judge or the Appellate Tribunal.

As far as the lawyers of this state are concerned, they must carefully screen medical malpractice cases before they are filed. While most lawyers who specialize in medical malpractice follow this procedure, all lawyers must make every effort to file only cases which are legitimate in every respect. This office, based on its experience,

ects approximately 18 out of 20 cases reviewed. Of those rejected, ever, a considerable number still find their way into the courtrooms this state. Under our present policy, you can always find a lawyer handle your case. This committee might entertain the suggestion requiring all medical malpractice cases, once they are in litigation, be screened by a committee to insure that they are valid and stantial claims and not nuisance claims. In fact, where those cases filed, penalties may be considered against the attorneys or ties filing such claims.

As a practicing attorney dealing primarily with medical practice cases, I would not and do not object to a strengthening the Statute of Limitations. However, before this is undertaken, ould strongly suggest very, very few of the cases that I have dealt h have been made viable because of the alleged length of the tute of Limitations. Of the few that I have seen, and here I'm ling with an adult case, one involved the leaving of a surgical trument in the abdomen of a patient, which was not discovered until years after the original surgery; the others with conditions that eloped because of improper treatment.

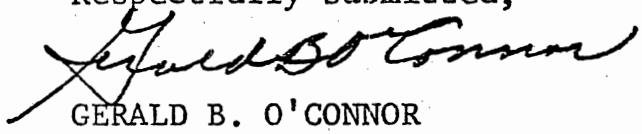
As far as dimunition of jury awards in medical malpractice es is concerned, I cannot understand how any constitutional islation could be enacted which would limit jury awards only in one a of tort law. Is a quadraplegic's injuries which are caused by lical malpractice any less severe or debilitating or expensive than compared to those caused by an automobile accident? One of the atest expenses incurred in that type of injury is the future medical l hospital expenses. I recently completed a malpractice case in which 3 year old woman was rendered quadraplegic. The future projected lical and hospital expenses for the care of this woman were over 0,000.00. Would you seriously entertain limiting her jury award to 0,000.00 without taking the necessary steps to insure protection for s person for future medical and hospital care? Any entertaining of limitations of jury verdicts should be limited to the area of pain l suffering, and adequate and appropriate legislation would have to adopted, which would provide for the medical or hospital care for se catastrophic injuries, or permit juries to return awards for those jected expenses plus pain and suffering.

As you can see, much of what I have said has been random thoughts reflections concerning the various professional groups involved in s subject. I do not have any ready solutions for the problems and now none are available. I would only caution this committee that should move cautiously; that any legislation adopted should only be pted after full disclosure of the issues from all of the respective

parties involved. It might even be that interim studies would have to be conducted to find the full reasons why malpractice premiums have sky-rocketed. Should legislation be adopted limiting patient's rights when there has not been a full investigation of the insurance industry concerning the premiums they have set? Should there be a limitation of patient's rights without a full study of the cases that make up the malpractice claims in this state? And, if the majority of claims being filed are legitimate and are substantial and, in fact, do reveal deviations from the accepted standards of medical practice, then the medical profession should bear the brunt of the costs of their liability insurance. Why should the injured party, the one injured by the medical practitioner, bear not only the physical but the financial brunt of his doctor's negligence?

In conclusion, let me say that most attorneys that I know are willing to discuss and support reasonable approaches to finding solutions for the problem of medical liability insurance, but most attorneys I know oppose and reject being called the cause of the malpractice situation in this state. Attached I have listed some of the cases I've dealt with and describe the areas of negligence so this committee can be aware of the type of medical negligence involved and the injuries sustained.

Respectfully submitted,



GERALD B. O'CONNOR

ATTACHMENT

MEDICAL NEGLIGENCE CASES

ee cases in which separate orthopedic surgeons over prescribed
called "butazolidin" and failed to monitor the patient while
drug. Patients developed a disease called aplastic anemia of
wo died by bleeding from most of the orifices of their bodies.

ieurosurgeon cut the aorta and vena cava during surgery and was
l of abdominal blood build up by vascular surgeon, but discharged
:. Patient's left leg paralyzed.

ie neurosurgeon operated on wrong patient or wrong part of the
)atient and conducted surgery against advice of the anesthesiologist
endance. (Doctor had altered the hospital records after suit
stituted) Patient died on operating table.

:ient with history of prior heart attack returns to same hospital,
)riginally treated, with complaints of chest pains. Emergency
nysician after taking E.K.G refused admission. This happens
patient's E.K.G was improperly interpreted on both occasions.
t went into cardiac arrest. He lived but was totally disabled.

year old woman complains of lump on breast over a 12 month
of time to her physician. He refuses to do biopsy. Woman died
etastatic lung disease. She had had cancer of the breast.

man went to hospital for x-rays. While nurse was moving x-ray
e they cut off her finger.

rgeon operates on patient unnecessarily; complications arise and
to call in consultation. Re-operates on five separate occasions.
t moved to another hospital by family where he recovered-totally
ed.

thopedic surgeon fails to treat condition of patient, compensation
r recognizes the problem, sends patient to vascular surgeon who
amputate left leg.

tient stabbed, surgeon delays surgery. Patient died.

ntist drops instrument down throat of patient. Surgery required
ove same.

11) Orthopedic surgeon orders blood studies on patient prior to surgery; doesn't wait for results which show liver disease. At second surgery does not order blood studies and never read the results from the original tests. Anesthestic used contra-indicated in liver abnormality- Patient died from destruction of liver.

12) Neurosurgeon manipulated spinal cord during surgery, though aware cord under pressure from bony ridge in neck. Patient quadriplegi

13) Neurosurgeon fails to read pre-op x-rays of patient, diagnosed condition on myelogram film though contradicted by radiologist, no informed consent made for the surgery, condition which was the basis for myelogram not found at the time of surgery. Patient quadriplegic.

These are just a few of the cases I've worked on in the past few years. All of these cases have been settled and all cases were the subject matter of suits filed in the Superior Court.

The names of patients, doctors, or amounts cannot be disclosed because the Insurance Companies' insist as terms of the settlement that there be no disclosure of the terms of the settlement.

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JOSEPH D EPSTEIN
(1934-1973)

October 27, 1975

nator Martin L. Greenberg
0 Evergreen Place
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Re: Public Hearing Before The Special Committee To Investigate and Study Medical Malpractice Insurance

ar Senator Greenberg:

ring the course of the hearing before the Special Committee, ere was some discussion of the constitutionality of a law which uld limit recovery in tort actions. I understand that Senator Gahn, and perhaps others, have serious doubts about the nstitutionality of such a limitation. In my testimony, I dicated that authority exists for the proposition that common w rights may be modified to meet changing conditions in society d that, in particular, compensation for pain and suffering ising out of a tort may be denied. I am writing to supply the thorities to which I referred and trust that if I can be of rther assistance with regard to this question you will contact .

ny state constitutions guarantee every person a remedy by due urse of law for injury done him in person or property. This ovision derives from Chapter 40 of the Magna Charta which provides:

> "We will sell to no man, we will not deny to any man, either justice or right."

is generally considered that this guaranty which runs through e common law is designed to protect procedural rights and does t prohibit alteration of common law rights, as suggested. The w Jersey Constitution provides that the common law may be perseded, altered or repealed. N.J.S.A. Const. Art. XI, Sec. par. 3. This principle was utlized in sustaining the legis- ature's abolition of actions for alienation of affections by .J.S.A. 2A:23-1 et seq.. In Magierowski v. Buckley, 39 N.J. per. 534 (App. Div. 1956) it was held that the legislature may lidly abolish a common law right or remedy, prospectively, thout furnishing an adequate substitute. Beginning at page 558, e Appellate Division held:

"A state has the constitutional and legislative power to change or modify the common law; the Constitution does not forbid the creation of rights or the abolition of old ones recognized by the common law if the purpose is to attain a permissable legislative object. (Citation omitted). There can be no vested right in the continued existence of a statute or rule of the common law which precludes its change or repeal. (Citation omitted). New Jersey followed these principles in upholding the Workmen's Compensation Act....

No constitutional objection may be raised to the abolition of the common law action where such abolition was for the public good....

The framers of our Constitution realized that time inevitably brings changes. New situations arise; existing rules are found inadequate; sometimes the old rules become obsolete, cause oppression and result in injustice so that they have to be abandoned. Our State Constitution provides for all this, for it clearly reveals that future legislatures have the right to enact laws of prospective application and which would meet new conditions as they evolve.

***

A traditional and recognized function of the Legislature is to inquire into facts dealing with the protection of the health, morals, safety and general welfare of the people, so that adequate remedial legislation may properly be prepared. The findings of the Legislature may be set forth by way of declaration of policy, and...(o)rdinarily a legislative declaration of policy is final and binding upon the courts; only when the declaration is illusory and intended, under the cloak of police power, to mask some unreasonable or illegal purpose, may the court strike it down...."

Assuming that the legislature were to determine that recovery for pain and suffering should be limited or eliminated, this would be consistent with the approach utilized in the Workmen's Compensation Act and in the no-fault law. Massachusetts was the first state to adopt a no-fault statute. In that state, general damage recovery is allowed where negligence causes certain classes of injury or where reasonable medical expenses in excess of $500 are incurred. If the $500 threshhold is not crossed then compensation for pain and suffering is denied. In Pinnick v. Cleary, 271 N.E. 2d 592 (1971) the Massachusetts Supreme

licial Court upheld the constitutionality of the no-fault
ıtute. The plaintiff in that case had incurred medical ex-
ıses of $115 and was denied compensation for pain and suffer-
ı. The court rejected the argument that a tort action was a
.xed property right". It also rejected the argument that the
'pose of a tort action was to protect "the fundamental right
personal security and bodily integrity" delineated by Justice
dberg in Griswold v. Connecticut 381 U.S. 479 (1965). The
rt, in Pinnick, went on to find that the no-fault statute bore
easonable relation to proper legislative objectives and that the
islature had the power of creating rational methods of allevi-
ng problems of court congestion, high premium costs and com-
sation delays.

espectfully submit that the same considerations which are
lined above operate in the present medical malpractice crisis
that the legislature is free to modify the common law to cure
existing problems.

Very truly yours,

Gary O. Turndorf

:mlw
19-004
Senator Joseph L. McGahn
New Jersey State Society of Anesthesiologists