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REPORT OF THE GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE

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LAW OFFICES OF
GEORGE W. LIEBMANN, P. A.
THE KEYSER BUILDING
207 EAST REDWOOD STREET
BALTIMORE, MARYLAND 21202

(301) 752-5887

January 25, 1984

Governor Harry R. Hughes
State House
Annapolis, Maryland 21404

Dear Governor Hughes:

I am pleased to transmit herewith the Final Report of the Governor's Commission on Health Care Providers' Professional Liability Insurance together with the Exhibits to the report and the minutes of the Commission's meetings.

Since the Commission's appointment in September, 1983, the Commission has held no fewer than twelve meetings. In addition to receiving presentations and reports from its members and staff, the Commission has heard oral presentations by no fewer than 41 persons with an interest in its subject matter including physicians, attorneys representing both claimants and defendants, representatives of the insurance industry, claimants, and others with an interest in the Commission's work.

I am pleased to report that the Commission has arrived at an unexpectedly high degree of agreement with respect to many of its recommendations. Put briefly, the Commission's Report recommends, without notation of dissent, a series of measures designed to foster the early disposition of frivolous claims including requirements of notice of filing of actions, requirements that a certificate of merit of a qualified expert be filed within 90 days of institution of an action, and provisions for summary judgment procedures. The Commission also recommends, without dissent, a series of measures designed to improve the functioning of the arbitration process if it is retained including provisions for waiver of the arbitration process, for clearer definition of applicable rules of evidence and procedure, for improvement in the qualifications of members of arbitration panels, and for the elimination of duplicative and redundant testimony and

pleadings. The Commission also recommends, without notation of dissent, measures designed to render the damage determination process more rational by requiring itemization of elements of damage and restricting prejudice in connection with the presentation of punitive damage claims. The Commission also recommends improvement in reporting requirements imposed on insurance companies to make certain that licensing boards are apprised of malpractice claims when claims are initiated rather than when they are closed so as to improve professional discipline.

The Commission also makes two other recommendations as to which it is divided. With four members dissenting, the Commission recommends prospective abolition of the arbitration process and the return of malpractice cases to the courts, the abolition to be accompanied by restriction of the Collateral Benefits Rule so as to deny claimants double recovery of health insurance and similar benefits.

Irrespective of the fate of the arbitration system, the Commission recommends, with two dissenting votes, that the Collateral Benefits Rule be altered in the manner described so as to eliminate double recovery of health insurance benefits. The Commission is unanimous in the view that such double recovery should be eliminated although some of its members would prefer the elimination to be achieved by mandatory subrogation rather than alteration of the Collateral Benefits Rule.

The Commission has considered and rejected various more arbitrary means of impairing the rights of claimants in the interests of controlling insurance premiums including such measures as arbitrary caps on awards or awards for pain and suffering, shortening of the statute of limitations and modification of doctrines relating to qualifications of expert witnesses and relating to counsel fees. The Commission believes that implementation of its recommendations will bring greater speed and economy to the process of adjudicating claims against health care providers, will raise the qualifications of persons adjudicating such claims, and will significantly protect providers against the assertion of unfounded claims while rendering more rational the damage determination process and curbing awards that are duplicative and hence extravagant.

I would be remiss were I not to pay tribute to the exemplary cooperation of the members of the Commission who have attended twelve meetings in a period of less than four months. I wish also to pay special tribute to the work of the Commission's Recording Secretary, Ms. Doris A. Tippett of the Department of Licensing and Regulation as well as to the cooperation of Dr. Laura Morlock of Johns Hopkins University and Walter Tabler, Esquire, Director of the Health Claims Arbitration Office in making available to the Commission the large amounts of statistical information requested by it.

Respectfully yours,

George W. Liebmann

GWL/ir

REPORT OF THE GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS' PROFESSIONAL LIABILITY INSURANCE

Introduction

The Commission was appointed by the Governor in September, 1983 pursuant to a Joint Resolution of the 1983 General Assembly sponsored by Senator Abrams. The Joint Resolution which, together with the Governor's charge letter to the Commission is set forth as Appendices A and B to this report, contained a number of recitals relating to the escalation in premiums for medical malpractice insurance, the effect of this escalation on the cost of health care generally, and particular problems which the level of premiums is said to cause for younger physicians and for physicians approaching retirement. In the course of its passage through the General Assembly, the Joint Resolution was amended to also require the Commission to review the present functioning of the Health Claims Arbitration Office established by the General Assembly in 1976.

As originally appointed, the Commission included a Chairman and two additional public members, the Insurance Commissioner of Maryland, the Executive Director of the Health Services Cost Review Commission, two physicians, two representatives of hospital boards, and two representatives of insurance companies, including the Executive Vice President and Chief Operating Officer of Medical Mutual Liability Insurance Society of Maryland, as well as two members of the Senate and two members of the House of Delegates. At the suggestion of the Maryland Trial Lawyers' Association and with the support of the Chairman, two attorneys with long experience in the representation of claimants were added to the Commission in order to provide more adequate representation of the interests of claimants.

Subsequent to its appointment, the Commission, meeting at approximately weekly intervals, conducted approximately ten advertised public meetings, including a public hearing addressed by approximately twenty interested persons. At its public meetings, the Commission received a large amount of additional testimony, both from various of its members and from invited speakers, including the Director of the Health Claims Arbitration Office,

Walter Tabler; the Chairman of the Commission on Medical Discipline, Dr. Karl Mech; the former Chairman of a legislative Joint Committee reporting to the 1983 session, Senator Harry McGuirk; and a large number of lawyers representing both claimants and insurers in malpractice cases, as well as a number of medical specialists and some persons involved with the arbitration process as claimants and invited representatives of the Medical and Chirugical Faculty of Maryland and the Maryland Hospital Association. The Commission also conducted a detailed review of a statistical study of the Health Claims Arbitration Office conducted by Dr. Laura Morlock of Johns Hopkins University and others under the auspices of the Medical and Chirugical Faculty and other sponsoring organizations. In addition, a large quantity of legal and statistical studies aggregating several thousand pages were gathered by various members of the Commission and by staff supplied by the Department of Licensing and Regulation and were circulated to the Commission members.

On the basis of its consideration and discussion of the data made available to it, the Commission reaches the following conclusions and recommendations with respect to the matters dealt with in its charge.

The Effect of Malpractice Premiums on Health Care Costs

The Commission finds that the language of the Joint Resolution creating it as to the effect of malpractice premiums on health care costs to be significantly overstated. The facts as they exist in Maryland do not warrant ascribing 15% of recent increases in health care costs to malpractice premiums, nor do they justify a conclusion that there has been a ten-fold increase in premiums in the course of the last decade. Rather, the Commission finds that the impact of malpractice premiums on total health care costs is quite modest and that the overall rate of increase in premium levels has at most paralleled and not exceeded increases in the cost of health care, though exceeding the general rate of inflation. The Commission finds, however, that

in a number of other jurisdictions the level of premiums has been such as to justify some of the concerns expressed in the Joint Resolution, and that the present premium levels and rates of increase in Maryland have had a significant impact, not on health costs generally, but on the costs of the services of a number of high-risk medical specialties, notably neurosurgery, orthopedic surgery, obstetrics, thoracic surgery, and plastic surgery.

With respect to the impact of malpractice premiums on hospital costs, the Commission finds, on the basis of submissions by Maryland hospitals to the Health Services Cost Review Commission, that the cost of malpractice premiums aggregates somewhat less than 1% of the total operating expenses of Maryland hospitals when the premiums ascribable to basic malpractice coverage and umbrella liability coverage covering also non-malpractice risks are combined. Specifically, the available statistics record total hospital costs approximating $1.6 billion in 1982 and malpractice and umbrella liability costs aggregating $15.9 million, of which $11.2 million was for malpractice insurance and $4.7 million for umbrella liability insurance. The rate of increase in malpractice premiums paid by Maryland hospitals was -4.74% in 1980-81 and 4.96% in 1981-82. See Appendix C to this report.

In assessing these figures, it must be borne in mind that the primary burden of malpractice insurance and of the liability claims giving rise to it falls on physicians and not on hospitals, even with respect to instances of malpractice that are hospital-based, as some 70% of all instances of malpractice are said to be. Evans, et al, A Survey of Professional Liability Incidence in Maryland (1971), Table reports that 69.3% of the claims reported to the Med-Chi insurance program with the St. Paul companies involved hospital-related incidents, including 54.2% involving hospital in-patients, .7% involving hospital out-patients, and 14.4% involving hospital emergency rooms.

Dr. Morlock's study, undertaken twelve years later, found that 47% of the incidents involved hospital in-patients, 2% hospital out-patients, 12% hospital emergency rooms, and 5% hospital physician's offices, for a total of 66% (Appendix D). Dr. Morlock's study encompassed a larger universe of claims against health care providers including not merely Med-Chi members but dentists, who accounted for approximately 12% of the claims reported in the study. The national closed claims study of the National Association of Insurance Commissioners for the period 1975-1978 reported that 78% of the incidents resulting in paid claims took place in hospitals. In general, liability is imposed on hospitals only for the negligence of their para-professional personnel not separately insured and no Maryland hospitals assume responsibility for the malpractice insurance costs of their attending staff physicians who are not employees. In addition, there are a number of less significant factors operating to reduce the insurance costs of hospitals, including, as to non-profit hospitals, the availability of the doctrine of partial charitable immunity which operates to render insurance coverage beyond the first $100,000, voluntary in nature. This factor is said to be of limited significance, since full coverage is said to be the almost universal practice of Maryland hospitals, although the charitable immunity doctrine may operate to discourage an undefinable but limited number of claims against hospitals. Nationally, the 1975-1978 National Association of Insurance Commissioners closed claims study reported that 60% of all paid claims involved doctors and 31% hospitals, and that physicians accounted for 71% of all reported indemnity payments and hospitals for only 25% of them in consequence of factors such as those enumerated above.

With respect to the proportion of physicians' costs accounted for malpractice premiums, the absence of a rate regulatory agency akin to the Health Services Cost Review Commission (HSCRC) makes precise data difficult to derive. (The relevant insurance costs are not broken out separately

in Blue Shield rate filings with the Insurance Commissioner). Some notion as to the applicable percentage may be derived by reference to the gross premium income of Medical Mutual, which is estimated at present to write approximately 70% of the physicians' liability isnurance currently written in Maryland. The gross premiums of Medical Mutual amounted to $18.8 million in 1982. The aggregate income of practicing Maryland physicians can only be estimated. There were in 1982 approximately 5,000 practicing physicians in the State, and their gross income is estimated as not exceeding $500 million in that year. On the basis of these figures, malpractice premiums paid by physicians would appear to aggregate to something on the order of 5 to 6% of the cost of physidans' care. When the insurance costs and gross costs of physicians and hospitals are combined, it would appear that malpractice premiums account for something in excess of 2% of the total costs of health care. There are also less direct and measurablecosts of the malpractice system, including the costs in time associated with physicians' defense of malpractice actions and with their service as members of arbitration panels. (The costs of services as expert witnesses is already partially accounted for by inclusion of the compensation of the insurer's experts in premium rates). In addition there are the costs of so-called defensive medicine, which are difficult to quantify or even estimate. In mitigation of these alleged costs, it has been pointed out that the number of tests per patient directed by physicians has increased at an almost constant rate of 4% per annum over the course of the last years, and that this rate of increase has not fluctuated or varied in periods of sharp upsurge in malpractice claims or insurance premiums.

Although the present level of malpractice costs as a proportion of total health care costs would not seem of itself to be cause for great concern, it is plain that a doubling or tripling of their present level would significantly impact overall health care costs and the rate of their increase. A condition in which a system which annually compensates not more than several

hundred injured persons came to account for 6% to 10% of the health care costs of some four million Marylanders might not long be regarded as acceptable, particularly where the costs of operation of the system in the form of fees of counsel on both sides approximately equal the indemnities paid to the limited number of successful claimants. The number of claims closed with payment by Medical Mutual, which is said to write approximately 70% of the physicians' coverage and 43% of the total health care malpractice coverage written in Maryland was 13 in 1978, 13 in 1979, 3 in 1980, 52 in 1981, 103 in 1982 and 151 in the first nine months of 1983. (Appendix E) Although the number of claims paid in the earlier of these years were limited by Medical Mutual's recent origin, the later figures suggest that the number of persons compensated annually by the system is not in excess of two to three hundred. The Health Claims Arbitration Office records the number of claims initiated and since closed in 1981 at 276, in 1982 as 358 and in 1983 as 451. Dr. Morlock's study of the 774 claims closed by the Health Claims Arbitration Office prior to January 31, 1983 indicates that 272 were dismissed without hearing and without settlement (Appendix G) and that 102 of the 178 panel determinations were in favor of the defendant (Appendix H) (some of these cases are the subject of judicial appeal). Although the latter figure is subject to adjustment in accordance with the results of appeals taken, there being 27 defendant's appeals, 67 claimant's appeals and 14 appeals by both parties, it would appear accurate to state that approximately 45% of the 300 to 500 cases disposed of annually and passing through the arbitration office result either in a dismissal or a judgment for the defendant. In addition to the claims resolved after institution of claim through the arbitration office, there are a significant number of claims in which indemnities are paid without or prior to such filing. Medical Mutual records 42 such claims with indemnities of $706,900 in 1982 and 56 such claims with indemnities of $1,147,700 in the first nine months of 1983 (Appendix I). Although the total number of claimants paid each year is not large, the malpractice system does assure

all persons receiving medical care of a right of redress against serious negligently inflicted injury and does operate in some measure to induce caution and maintain appropriate medical standards. In our recommendations we have thus been concerned not with a "rolling back" of existing levels of overall costs, which we regard as socially acceptable, but in guarding against the possibility of a future spiralling of them inspired by excessive verdicts or excessively enhanced claims consciousness.

We also find it difficult to overlook the especially heavy burden present premiums impose upon practitioners in a limited number of "high risk" medical specialties. Although by reason of competition between Medical Mutual and commercial insurers, including mutuals sponsored by professional associations in some medical specialties, the average level of premiums paid by Maryland practitioners in a given specialty cannot be divined by inspecting the rate schedules of Medical Mutual or any other particular company, and although insurers sometimes discount the rates submitted by them to the Insurance Commissioner, the rates found by him to be actuarially justified are at least suggestive as to the present magnitude of the burden on particular medical specialties. The current Medical Mutual rate and the current Insurance Services Office (a private rating bureau), rate and the lowest filed rate for $1 million in occurrence coverage with respect to particular high risk specialties are set out below. (More detailed statistics appear as Appendices D and K hereto).

Specialty	Medical Mutual*	I.S.O
Anesthesiology	$15,190	$11,615
Neurosurgery	21,164	36,508
Obstetrics	22,658	19,914

*For Baltimore City and Baltimore, Howard and Anne Arundel counties; includes 16% rate stabilization reserve fund surcharge which is reduced by 1% per year for the first seven years of prior coverage with the company; does not include surcharges of 3% to 5% for partnerships and of $1,901 for physicians administering shock therapy, $2,642 for employed nurse anesthetists for vicarious liability of the physician only, and $317 for each employee (vicarious liability only). Rates for Montgomery and

Prince George's counties are approximately 10% less than those given and for balance of state approximately 20% less than those given.

Although the medical specialties in question are, in general, not merely high risk specialties but well-rewarded specialties, the burden of the existing level of premiums on the income of practitioners is more than ordinarily significant. The crude figures available as to the incomes of particular classes of Maryland medical practitioner suggest that the cost of occurrence coverage in a number of specialties is on the order of 10 to 15% of the income of particular classes of practitioners, and the burden upon practitioners below the specialty's average in income may be considerably higher. In the absence of occurrence coverage, practitioners must purchase a 'tail' policy on retirement. See Appendix L as to the available data on income of practitioners.* Although economists may differ as to the extent to which increments in insurance costs can be successfully 'passed on' to patients and their insurers, there can be little doubt that the premiums for certain specialties both heavily burden at least some practitioners and account for a significant portion of their professional fees and increases in them.

This burden on the high-risk specialties is one which we believe requires attention, if only to insure that it is not significantly further enhanced. We find little reason to believe that the enhanced premiums of recent years as to the high-risk groups reflect either a deterioration in professional competence or one in bedside manner. Dr. Morlock's study indicates that 49% of the claims filed with the Arbitration Office are filed against physicians with whom the claimant has had no previous contact, and this limited prior contact is almost by definition an attribute of the high risk specialties (Appendix M). It is also evident that with respect to some of the specialties--neurosurgery and obstetrics for example--advances in medical knowledge provided by such developments as CAT scans and amniocentesis have made

*Nationally the average net income of medical specialists ranges from $69,020 for general practitioners to $142,500 for neurosurgeons.

possible the assertion of claims which once would have failed for want of proof. The increases in premiums allowed Medical Mutual by the Insurance Commissioner with respect to obstetrics have been especially dramatic. Premiums for $1 million in coverage, exclusive of the 16% or other rate stabilization surcharge for obstetrics in Baltimore City and Baltimore, Howard, and Anne Arundel counties increased from $6,002 in 1975 to $7,202 in 1979, $7,591 in 1980, $10,240 in 1981, $13,703 in 1982, and $19,703 in 1983 (Appendix J).

Thus, although we regard many of the premises of the Joint Resolution as both overstated and simply mistaken, we believe that there are both present conditions and future dangers which warrant us in making recommendations for limited changes in tort doctrines as well as in the procedures by which claims are processed.

The Problem of the Younger Physician

The Joint Resolution makes reference to the problems which the existing high level of premiums in specialties present for physicians starting practice. We believe this concern to be in some respects overstated. The present Medical Mutual schedules contain provisions for a 50% discount for physicians in their first year of private practice and a 25% discount for physicians in their second year of private practice. The high-risk specialties are generally practiced in close association either with other physicians or with hospitals. To the extent that a genuine problem of physicians availability is presented by high premiums in early years, it will frequently be addressed by appropriate economic arrangements between the physician and his colleagues and/or hospital, or by borrowing against future earning power, or by the existing provisions for discounts for beginning or part-time practice. To the extent that further provisions are needed, we believe that they are appropriately left, at least for the time being, to insurers and professional institutions.

The Problem of the Retiring Physician

Although insurers provide discounts similar to those provided neophyte physicians to physicians limiting their practice

to 20 or fewer hours a week, these discounts are characteristically not available to physicians practicing surgery and engaged in the high-risk specialties. The high level of premiums for members of this group thus renders practice on a reduced schedule difficult, and assertedly promotes early retirement of physicians who would otherwise continue to serve and who would be, in some instances, mentors for their colleagues.

We believe this problem to be a real one, although we note that the prevalence of claims-made insurance means that retirement no longer totally eliminates the burden of malpractice coverage. The failure of insurers to offer discounts for reduced practice in the surgical specialties appears to be founded on the difficulty of ascertaining with respect to surgical practice whether a reduced schedule is in fact being followed; it may also derive from perceptions as to enhanced risk. We believe that Medical Mutual and other insurers would do well to explore, possibly in cooperation with hospitals in which practitioners enjoy staff privileges, the issuance of policies providing for discounts for reduced practice limited to and certified by a particular hospital. We do not believe that legislation addressed to this problem is appropriate, although our more general recommendations are designed to prevent it from getting worse.

The Arbitration Process

Since 1976, Maryland has had a mandated arbitration procedure requiring health care malpractice claims involving in excess of $5,000 to be submitted to an arbitration panel consisting of a health care provider, a lawyer, and a layman. Appeals to the courts are available from panel determinations, and may be tried to a jury de novo, the jury, however, being instructed that the panel determination as to liability and damages enjoys a presumption of correctness.

Because of early legal challenges, the procedure has been fully effective only since 1978-79, many claims being withheld from it until the legal challenges were resolved. It also seems

generally agreed that the administration of the Arbitration Office in its early years was in need of significant improvement from the standpoint of such matters as the maintenance of adequate dockets and efficiency in the scheduling of hearings. Many of the purely administrative problems encountered by the Office appear to have been resolved by its present Director. In addition, by amendment of the statute effective in 1982, the Director was accorded authority, thus far largely unexercised, to promulgate regulations as to procedure. A Special Committee of the Maryland State Bar Association is presently engaged in formulating recommendations as to improvements in arbitration procedures as well as a handbook for arbitration panel chairmen designed to promote greater uniformity in the disposition of procedural and evidentiary questions. These developments promise significant improvement in arbitration panel functioning.

Nonetheless, a majority of the Commission is constrained to recommend, provided that appropriate steps described below are taken to prevent a further large escalation of unjustified malpractice cases and excessive awards, that the arbitration procedure be abolished. Even sweeping changes of a statutory nature in its composition and functioning will, in our view, be insufficient to remedy its inherent defects. We have detected almost unanimous dissatisfaction with the functioning of the procedure on the part of counsel who must practice before the arbitration office, and substantial dissatisfaction on the part of health care providers and malpractice insurers. The Medical and Chirugical Faculty, which originally enthusiastically supported adoption of the procedure now has adopted a position of more tempered support of its maintenance. A Special Committee of the Maryland State Bar Association composed of six attorneys representing claimants and six representing defendants has unanimously recommended its abolition.

Although much of the dissatisfaction of counsel rests on the unfamiliarity of informal procedures and the limited scope for forensic talent afforded by a three-member tribunal at least

two of whose members are professionals, some of the criticism rests on weightier grounds. The principal concerns may be summarized as follows.

1. The arbitration procedure constitutes an exception to the untrammeled procedure of jury trial that society makes available for the weightiest of its legal controversies involving money judgments. The interests involved in arbitration cases are not slight. On the plaintiff's side, there are frequently damage claims eclipsed in few if any other areas of legal controversy. On the defendant's side there are weighty interests of professional reputation ordinarily not lightly dealt with by the law; witness the multi-layered review provided for disciplinary complaints against legal and medical professionals. A second rate procedure is not acceptable.

2. The procedure has not operated to limit delay; the time for processing of cases has frequently been unduly long, although direct comparisons with the court system are difficult and the operation of the arbitration office and its ratio of claims disposed to claims instituted have recently improved. According to Dr. Morlock's study of the 774 claims closed by the arbitration office as of January 31, 1983, the mean length of time elapsing from initiation of the claim to its disposition was 16.84 months and the median period 15.50 months (Appendix N). With respect to the 204 claims not dismissed and settled and actually proceeding to hearing, the mean elapsed time prior to disposition by the arbitration office was 19.79 months and the median time 17.72 months (Appendix O). While these figures may be somewhat skewed by adverse experience of the office prior to the advent of its present Director, and while statistics for the most recent month available, November, 1983, indicate that 40 new cases were opened and 44 closed, suggesting that the office as now functioning is not accumulating a large further backlog, it nonetheless is fair to state that it requires close to a year and a half to process a case through the arbitration office. While the statistics published by the Administrative Office of the Maryland Courts suggest that a comparable or longer

time is required to process the average negligence case through jury trial, a procedure allowing claims to be initiated in court does not entail the delays attendant upon a duplicative de novo hearing on appeal. These delays are significant in relation to the total functioning of the system, since a high proportion of the cases proceeding to panel determination are appealed. According to Dr. Morlock's study, 108 of the 182 cases in which hearings were completed by the arbitration office prior to January 31, 1983 were appealed, data being lacking on 4 cases (Appendix H). The Health Claims Arbitration Office statistics indicate that 455 cases were closed by panel determination as of December 11, 1983, presumably including at least 74 cases which Dr. Morlock records as involuntary dismissals by panels or their chairmen prior to January 31, 1983, and that 160 appeals were taken (Appendix F). Although the arbitration office figures suggest a slackening in the rate of appeals in the last two years, only 20 of the 74 cases instituted in 1982 and closed by panel determinations having been appealed, these statistics may not yet be definitive, since complex cases have not yet closed.

3. There is reason to believe that one effect of the procedure has been to enhance the amount of awards beyond those that would be rendered by juries, particularly in rural areas of the state. As of January 31, 1983, there had been four awards of in excess of $1 million (Appendix P), and since that date there have been, among other large awards, two awards of $5 million each, both rendered in rural counties. Although it is understood that these cases may well have justified very high awards, and that lesser indemnities were paid upon settlement or appeal of these cases, it seems to be commonly agreed that jury verdicts in these very high amounts would be unlikely. The significance of the limited number of cases in which very high awards are made can scarcely be overstated. According to the Morlock study, 76 claimants received awards in cases litigated before panels prior to January 31, 1983, the awards totalling $17,302,749. Nine claims

involving awards in excess of $500,000 accounted for 72% of the dollar amount of all awards. Statistics compiled by Medical Mutual relating to incidents closed for accident years 1975 through 1980 and reflecting actual amounts paid as distinct from amounts awarded and including settlements as well as litigated claims reflect a total of 1,498 incidents of which 320 resulted in indemnity payments totalling $31,995,887 (Appendix Q). Fourteen incidents involving indemnity payments of over $500,000 accounted for 37.1% of all indemnity payments. When indemnity payments for the 320 incidents between 1975 and 1980 for which indemnities were paid are converted to 1983 dollars assuming an inflation rate of 10.5%, the 33 incidents in which indemnities of over $500,000 in 1983 dollars were paid accounted for 60.2% of all indemnities converted to 1983 dollars (Appendix R).

There is some reason to believe that the arbitration system because of its present lack of uniformity in approach and procedure may be more prone than the court system to produce excessive verdicts: highly publicized large awards which, whether or not ultimately paid, foster claims consciousness on the part of the public and bar and greater resistance to reasonable settlements.

4. There is reason to believe that the arbitration process has given rise to a greater number of frivolous claims presented by lawyers inexperienced in medical malpractice than the pre-existing court system for adjudication of claims. The 1971 Survey of Professional Liability Incidence in Maryland indicated that during the years 1960 to 1970 the maximum number of occurrences in any one year upon which suit was filed was 59 (Appendix S), the data base including the physicians embraced by Med-Chi's then insurance program with the St. Paul companies, which was said to embrace 96% of the practicing physicians in Maryland (3,166 physicians). The number of cases instituted was stated by the legislative committee recommending the 1976 arbitration statute to have been 50 in 1973 and 61 in 1974. The number of cases initiated before the arbitration panel has continuously increased, from 93 in 1978 to 269 in 1979, 326 in 1980, 428 in 1981, 462 in 1982, and 558 through December 11, 1983

(Appendix F). Although the statistics for the first two years may have been depressed by the pendence of litigation relating to the constitutionality of the panel and those for the immediately following years somewhat enhanced by the cases whose filing was thus delayed, there can be little doubt that the arbitration system has facilitated the filing of claims. According to Dr. Morlock's study, 35% of the claims filed before the arbitration panel through January, 1983 and closed have been dismissed without settlement, 194 by the claimant, 11 on jurisdictional grounds, and 63 by the chairperson (Appendix G). An additional 102 cases, about 14% of the total, have been litigated before the arbitration panel and have resulted in verdicts for the defendant (Appendix H). According to Medical Mutual, slightly more than half the defense costs incurred by it with respect to cases filed before the arbitration panel were incurred with respect to claims not resulting in indemnity payments, such defense costs amounting to $496,800 during the first nine months of 1982, or approximately 12% of the $4,017,000 paid in indemnities, total defense costs amounting to $948,000 with respect to arbitration cases or about 22% of indemnities (Appendix T). Of the 257 nonjurisdictional dismissals recorded in the Morlock study, 118 did not take place until after the prehearing conference, by which time substantial costs would be incurred.

There also seems reason to believe that the success ratio of claimants in litigated arbitration cases--about 42%-- is substantially higher than that previously characteristic of court proceedings. The 1978 NAIC closed claims study recorded that defendants won 8 of every 10 court cases tried in 1975 and 9 of every 10 in 1978. The 1970 Med-Chi study and the 1976 legislative committee report each suggest that the number of cases annually litigated to final judgments in favor of claimants prior to 1974 did not exceed about three cases per year. It is doubtful, therefore, that the arbitration process has lowered insurance costs, and it may have operated to multiply the number of claims. As observed in Danzon and Lillard, Settlement Out of Court: The Disposition of Medical Malpractice Claims, 12 J. of Legal Studies 345, 374

(1983) "procedural reform intended to reduce total expenditure on litigation may be counterproductive because of the "freeway principle" at work: adding more lanes does not simply move the current flow of traffic faster, because when the cost per trip falls, more traffic enters the system."

5. In addition, the process is open to criticism because of the duplication it engenders: duplicative pleadings, document requests, interrogatories, and the need to call expert and other witnesses twice in cases where an appeal is taken. While this duplication results only in the limited number of cases that are appealed, these cases are characteristically the most serious cases with the largest verdicts that are the most intensively litigated.

Against these considerations, there are some which speak against abolition of the arbitration system. These include the following.

1. The system has arguably made possible the presentation of smaller claims which lawyers would hesitate to file in court, and, where these claims are resolved without appeal, has lowered costs of litigation. According to the Morlock study, 28 of the 47 arbitration panel awards of less than $100,000 have not been appeals (Appendix U). The most recent State of the Judiciary Message of the Chief Judge of the Court of Appeals notes that the average time between filing and trial of an average civil action in the law courts is 15 months, a time comparable to the elapsed time between filing and trial of arbitration cases, but in malpractice cases, which are of more than average complexity and which are concentrated in the more congested jurisdictions, it may be assumed that the elapsed time before trial would be greater in the courts than in the arbitration process.

2. If the arbitration system were abolished, the arbitration office would need to be preserved for a period of four or five years so as not to flood the courts with the 935 cases in the system as of December 11, 1983; abolition would need to be

prospective only, at least in the sense of being applicable only to cases filed after the effective date of an amendatory act. There would thus be no immediate savings to the general fund, while the court system would be burdened, commencing about a year after the amendatory act, with a burden of new filings and new trial. If the same number of cases were filed in the courts as in arbitration, this would result in approximately 600 filings per year, and in 50 to 100 additional jury trials, each estimated to be a minimum of 5 trial days in duration. (During the period August 24, 1980 through January 31, 1983, the Morlock study reveals that costs of medical and public members were assessed in 175 and 180 cases respectively, this being suggestive of the number of cases in which trial commenced before the panel during this period). The additional burden on the courts would be ultimately reduced somewhat by elimination of the need to hear appeals. The maximum number of cases filed in a given year to have been appealed is thus far 46 as to the year 1981; accurate statistics are unavailable as to the number of these cases resolving prior to trial of the appeal; the Director of the Health Claims Arbitration Office has estimated that fewer than 20 appeal cases annually are tried before the courts. Abolition thus would appear likely to result in an increased burden of between 20 and 80 jury cases annually on the courts, requiring from 100 to 500 additional trial days in addition to the burden of pre-trial processing of approximately 500 new cases annually. This burden would appear likely to generate a demand for at least two or three additional trial judges and supporting staff, particularly since the pending cases are concentrated in five jurisdictions. As of December 11, 1983, the Director of the Health Claims Arbitration Office listed 401 open cases originating in Baltimore City, 250 in Baltimore County, 149 in Montgomery County, 139 in Prince George's County and 111 in Harford County, the remaining 19 subdivisions having only 189 cases among them (Appendix V). In the short run, the costs of providing additional judgeships would burden the general fund; in the long run, they

would be offset by the savings from abolition of the arbitration office, which presently accounts for approximately $400,000 annually in general funds, and whose costs may increase by a like factor if in pending litigation a decision holding it not entitled to award costs against physicians not found liable for damages is upheld.

3. The system has been only administered efficiently for the last three years and only recently has gained control of its caseload and been empowered to promulgate procedural rules. This consideration led the Medical Malpractice Task Force of 1983 General Assembly to conclude that abolition "is a bad idea at the present time".

4. Abolition would be to some extent a leap in the dark. Both malpractice cases and large jury awards are more prevalent and accepted phenomena than they were in 1976 and it cannot be predicted with certainty that a return of cases to the courts would result in stability in or a reduction of the level of awards and indemnity payments; conceivably, in view of the publicity given to several recent very large awards, there could be a sharp escalation and a return of a crisis situation in terms of rates if not of availability.

On balance, the Commission recommends:

THAT ABOLITION OF THE ARBITRATION SYSTEM AS TO CASES FILED AFTER THE EFFECTIVE DATE OF AN AMENDATORY ACT BE IMPLEMENTED IF, AND ONLY IF, THERE IS SUBSTANTIAL RESTRICTION OF THE COLLATERAL BENEFITS RULE AS TO HEALTH BENEFITS SO AS TO REDUCE THE LEVEL OF AWARDS FOR ECONOMIC LOSSES THAT WOULD OBTAIN UPON A RETURN OF CASES TO THE COURTS, SUCH RESTRICTION TO TAKE THE FORM OF MANDATORY DEDUCTION BY THE COURT AFTER VERDICT OF HEALTH BENEFITS COLLATERAL COMPENSATION RECEIVED BY THE PLAINTIFF AFTER CREDITING THE PLAINTIFF WITH PREMIUMS PAID FOR INSURANCE RESULTING IN SUCH COMPENSATION.

In reaching this recommendation, the Commission has considered other possible means of limiting the level of awards. It has noted the conclusion of the recent comprehensive study of The Frequency and Severity of Malpractice Claims undertaken by the Institute for Civil Justice of the Rand Corporation pursuant to a contract with the Health Care Financing Administration of the U.S. Department of Health and Human Services, which concluded

that "Of the post-1975 tort reforms, caps on awards and mandatory offset of collateral compensation appear to have had the greatest effects. States enacting a cap are estimated to have had 19 percent lower average severity within two years. Mandatory collateral source offset in effect for two years is estimated to result in a 50 percent reduction in severity." The Commission does not look with favor on arbitrary caps on awards or on pain and suffering awards, which cause the costs of control of rates to be imposed on a limited number of the most seriously injured claimants. It finds suggestions that statutory limits be placed on attorneys' fees to be of no demonstrated effectiveness in controlling rates and to be inconsistent with the approach to civil litigation taken in the United States, which in general refrains from imposing legal costs on claimants because of its reliance on a private insurance system and private civil actions in place of a more highly elaborated social security and public welfare system and the burdens of taxation accompanying it. If controls beyond those now existing are to be placed on the contingent fee system, malpractice cases, which require a high degree of professional effort and skill and which also frequently require counsel to advance thousands of dollars in expert witness and other costs are not self-evidently the logical place to begin in imposing them. Similarly suggestions that statutes of limitations be shortened, that doctrines relating to res ipsa loquitur be modified, and that rules of liability or of evidence be altered so as to evict from the courts claims of concededly injured persons suffer from the twin vices of arbitrariness and ineffectiveness.

Restriction of the collateral source rule, by contrast, appears neither arbitrary nor ineffective. The rule permits tort claimants two recoveries for the same damages: the first from their own insurance, public or private and the second from the defendant's insurance. Recognitition of it has long been recognized as conferring a windfall on claimants, a result traditionally justified by the explanation that the wrongdoer should not be permitted, by the circumstance that the plaintiff is insured, to

avoid the consequences of his wrong. In the medical malpractice field, this policy has limited force. As pointed out in Abraham, Medical Malpractice Reform, 36 University of Maryland L. Rev. 489, 505 (1977): "The plaintiff is not truly penalized for having purchased insurance; rather he gets just what he bargained for--certainty of payment. Nor is the purchase of insurance likely to be discouraged [by abolition]. Most first party insurance coverage that compensates for medical malpractice injuries covers a much wider range of events than those for which recovery could be obtained in a tort action (e.g. health, life, and disability insurance). Therefore, such insurance will probably be purchased regardless of the status of the collateral source rule. In addition the elimination of the rule will probably have little effect on the deterrence of medical negligence. Since in many instances payments from collateral sources will constitute much less than half the damages suffered by a plaintiff, a financial threat will still exist. Furthermore, the other forces which encourage physicians to exercise care and skill, such as the adverse publicity accompanying litigation and the possibility of peer group disciplinary action, will continue to be at work even if the rule is eliminated."

The Commission is not unanimous in this recommendation. Messrs. Hughes, Shadoan and Dr. Cohen favor abolition of the arbitration process irrespective of whether there is any change in the collateral source rule and also favor elimination of duplicative recovery by expansion of subrogation rather than curtailment of the collateral source rule. Commissioner Muhl and Messrs. Carter, Czech and Spinella are opposed to abolition of arbitration at this time but favor curtailment of the collateral source rule.

Any abolition of the arbitration process should, in the Commission's view, be prospective only, so as to avoid the problems which would be created by the sudden return to the courts of the 935 cases pending in the system as of December 11, 1983, more than 400 of which originate in Baltimore City and 250 of which originate in Baltimore County (Appendix V). The prospectivity need not

relate to the date of the incident sued upon, an approach which would cause substantial numbers of cases to continue to enter the arbitration system during the three years following the effective date of a new act. Rather it should relate to cases instituted after the effective date of the new act. The arbitration system should be preserved to process cases now in the system with a gradually decreasing support staff and budget. When three years have passed from the date of an amending act, the number of cases remaining will probably be sufficiently small to warrant the transfer of the remaining functions of the arbitration office for the disposition of the few protracted cases remaining to the office of the Insurance Commissioner so as to avoid the costs associated with an independent office.

RECOMMENDATIONS DESIGNED TO ENCOURAGE THE EARLY RESOLUTION OF INSUBSTANTIAL CLAIMS

As previously noted, the Commission is impressed by the substantial number of unwarranted claims filed at the present time, and by the costs incurred in their disposition. As previously noted, no less than 272 of the 774 claims filed prior to January, 1983 were terminated by voluntary dismissals or dismissals by the chairperson without monetary payment of any kind (Appendix G). Only 114 of the voluntary dismissals took place prior to the first pre-hearing conference, an event which occurs after a median elapsed time according to the Morlock study of approximately 10 months from filing (Appendix N). In addition more than half the arbitrated claims result in defendants' verdicts. The proportion of claims of temporary or purely emotional injury that are tried and result in awards seems especially low. Of the 301 cases arising prior to January, 1983 in which the injury alleged was temporary or emotional, only 12 concluded in arbitration verdicts exceeding the jurisdictional amount of $5,000 and only one was tried to a verdict exceeding $50,000 (Appendix W). By contrast, the 146 claims of alleged grave permanent injury or death gave rise to 29 verdicts exceeding the jurisdictional amount and to 22 exceeding $50,000 and the 327 claims of lesser permanent injury

resulted in 27 verdicts exceeding the jurisdictional amount and in 22 exceeding $50,000.

According to figures presented by Medical Mutual, in the years 1979 through 1982 inclusive, defense costs on claims closed without indemnity payments accounted for nearly one-third of total defense costs (Appendix X). For incidents in the years 1975-1980 inclusive, nearly 45% of total costs of defense were incurred with respect to cases in which no indemnity or an indemnity of less than $5,000 was paid. Total defense costs characteristically aggregate in excess of 15% of indemnities paid, and when added to the characteristic one-third contingent fee of successful plaintiffs' counsel operate to produce a result in which the costs of litigation or investigation approximately equal the net indemnities accruing to claimants.

Examination of representative cases tried to arbitration panels after a characteristic year or year and a half of preliminary proceedings discloses many which are found at that stage to be frivolous. Three examples will suffice:

In Case 82-159, summary judgment was granted in favor of a provider on August 17, 1983 where the claimant alleging eye injuries failed to comply with a February 1, 1983 deadline to designate expert witnesses, and the claimant's only designated expert gave deposition testimony indicating no breach of the standard of care. This judgment was reached only after a pre-hearing conference, the taking of depositions, the filing of memoranda, and a separate hearing on summary judgment.

In Case 82-24, the panel granted a motion to dismiss at the close of a plaintiff's case. The plaintiff alleged dizziness, pain and embarrassment associated with the removal from her vagina, two weeks after giving birth, of a hard odiferous dark brown object which she alleged to be gauze negligently left by a physician attending the birth. No evidence was adduced to show that the object removed was gauze, no hospital records were introduced, the attending nurse, the only available third party witness, was not called to testify, and there was no evidence of either physical injury or external manifestation of emotional injury. Judgment was entered on June 29, 1983, the incident

occurring on March 25, 1979.

In Case 81-428, the panel on November 4, 1983 dismissed a complaint brought by an incarcerated claimant against four health care providers. The claimant failed to timely answer interrogatories, his original counsel striking his appearance after the expiration of the original deadline for completion of discovery by the claimant. After the entry of new counsel into the case, new deadlines were set and the case was set for trial. On the new deadline date for responding to interrogatories, the second counsel indicated an intention to withdraw his appearance, and no answers were filed. Dismissal took place some 23 months after initiation of the case in December, 1981, after entry of a scheduling order, the filing of memoranda and discovery papers and two motion hearings.

The medical and legal professions and the public all have an interest in the swift and early disposition of cases such as these. The Commission accordingly,

RECOMMENDS:

1. THAT, AS A MEASURE TO AFFORD PROVIDERS AND THEIR COUNSEL AN OPPORTUNITY TO DEMONSTRATE TO CLAIMANTS THAT THEIR CLAIMS ARE UNWARRANTED, CLAIMANTS BE REQUIRED TO GIVE SIXTY DAYS ADVANCE NOTICE OF FILING OF SUIT, THE EXPIRATION OF THE STATUTE OF LIMITATIONS TO BE TOLLED DURING THE NOTICE PERIOD AND THAT RECOURSE TO ARBITRATION BE DEEMED WAIVED IF THE CLAIMANT OR PROVIDER FAILS TO FILE A REQUEST FOR ARBITRATION WITHIN SUCH PERIOD.

Measures similar to this have been adopted with respect to claims against municipalities in Maryland, and, with respect to medical malpractice, in several other states. The measure also permits time for investigation to plaintiff's counsel retained immediately prior to the running of the statute of limitations. The provision for waiver where there is no demand is derived from Rule 2 of the Virginia Malpractice Rules.

2. THAT FILING OF A CERTIFICATE OF A QUALIFIED EXPERT ATTESTING TO DEPARTURE FROM STANDARDS OF CARE OR OF INFORMED CONSENT BE REQUIRED AS A CONDITION OF CONTINUANCE OF A CLAIM, SUCH A CERTIFICATE NOT TO BE REQUIRED UNTIL 90 DAYS AFTER FILING OF THE COMPLAINT, SUCH TIME TO BE EXTENDABLE FOR GOOD CAUSE SHOWN.

Measures of this type have been adopted in several other jurisdictions.

The Commission, however, rejects the suggestion that such certificates be required as a condition of suit, since in many instances discovery of records or of the defendant will be required to provide facts upon which an expert will be justified in submitting an opinion. Since expert testimony is required as a matter of law to sustain all cases except a limited class of informed consent and res ipsa loquitur cases, and is as a practical matter required to make out a case in these areas also, the requirement should not impose a serious additional financial burden with respect to meritorious claims.

3. THAT THE MINIMUM JURISDICTIONAL LIMIT FOR ARBITRATION BE RAISED FROM $5,000 TO THE MAXIMUM JURISDICTIONAL LIMIT OF THE DISTRICT COURT AS IT FROM TIME TO TIME MAY BE AMENDED.

This recommendation would not eliminate a substantial number of claims from the system. Of the 76 cases in which damages were awarded by panels, 10 involved awards between $5,000 and $9,999 according to the Morlock study (Appendix U). The change is consistent with the judgment made when the arbitration act is passed, and may operate to discourage frivolous and burdensome claims based on emotional or temporary injury. The speedy and inexpensive procedures of the District Court remain available for meritorious small claims which enjoy support of expert testimony.

4. THAT THE SUMMARY JUDGMENT RULE BE EXPRESSLY MADE APPLICABLE TO ARBITRATION PROCEEDINGS, THE JUDGMENT TO BE THAT OF THE CHAIRMAN AND NOT OF THE PANEL AND THAT ON APPEAL THE JUDGMENT, IF UPHELD, ACTIVATE THE PRESUMPTION AND IF NOT UPHELD SHOULD RESULT NOT IN REMAND BUT IN JUDGMENT BY THE COURT WITHOUT REFERENCE TO THE PRESUMPTION.

Although, as noted above, some panel chairmen have applied the summary judgment rule, the arbitration statute expressly adopts only the discovery rules. It is also desirable that the authority of the Chairman to rule be clearly established, and that the effect of an erroneous ruling on the presumption attaching to panel judgments be clarified, in the fashion recommended by the Committee on Health Claims Arbitration of the Maryland State Bar Association.

RECOMMENDATIONS DESIGNED TO IMPROVE THE FUNCTIONING OF THE ARBITRATION PROCESS IF IT IS RETAINED

The functioning of the arbitration process has recently undergone intensive review by a committee of the Maryland State Bar Association composed of equal numbers of plaintiffs' and defendants' malpractice attorneys. The Commission does not fully endorse all the recommendations of the Bar Association Committee, since these in some measure reflect the bias of trial lawyers in favor of formality and regularity of procedure, in some instances at the cost of speed and efficiency in the arbitration process. Thus the Commission has not been able to join the Bar Association Committee in recommending without further qualification that the present provisions of statute providing that technical rules of evidence shall not apply be eliminated, thus restoring normal rules of evidence. Particularly as respects admissibility of medical reports, the Commission was of the view that the interests of economy, speed, and conformity to what has largely become established practice before arbitration panels demanded more liberal rules favoring admissibility. Similarly, although the Commission shares the desire of the Bar Association Committee that panel members be drawn from a wider base, it believes that use of random selection of

the lawyer chairman from Client Security Fund lists would be productive of administrative inefficiency and would also not improve the quality or consistency of arbitration decisions. Many of the other recommendations of the Bar Association Committee, however, are included in the Commission's recommendations, as are recommendations concerning some matters not considered by the Committee. Specifically, the Commission,

RECOMMENDS:

1. THAT THERE BE PROVISION FOR MUTUAL WAIVER OF THE ARBITRATION PROCESS AT ANY TIME UP TO THIRTY DAYS BEFORE A SCHEDULED HEARING.

A provision of this nature was recommended by the Bar Association Committee and is included in the Virginia

arbitration statute. As framed this recommendation contemplates mutual waiver; the Commission does not intend to disturb the holding in Bailey v. Woel, No. 1669, October Term, 1982 in the Court of Special Appeals to the effect that a party who unilaterally fails to put on a case before the arbitration panel waives the right to appeal its decision.

2. THAT THE RULES OF EVIDENCE APPLICABLE TO ARBITRATION HEARINGS BE DECLARED TO BE THE RULES AS COMMONLY APPLIED BY JUDGES SITTING WITHOUT A JURY IN CIVIL CASES, INCLUDING RULES OF PRIVILEGE RECOGNIZED BY LAW, SUBJECT TO THE EXCEPTIONS SET FORTH IN THE THREE FOLLOWING RECOMMENDATIONS.

This recommendation contemplates that with the exception of the reports and depositions specifically made admissible by the succeeding recommendations the hearsay rule and other rules of evidence should be applicable in arbitration hearings. At the present time, there is great inconsistency among panel chairmen in rulings on evidence. Some apply the rules with strictness. Others take the view that hearsay should be freely admissible. Some admit medical reports, including those of non-treating physicians not called to testify, whenever offered; others demand live testimony in all instances. The Commission believes that the overriding need in this area is for consistency and certainty. Accordingly, it provides for explicit and fairly liberal rules relating to reports and depositions, the issues generating the lion's share of disputed evidentiary questions. In other areas, the Commission opts for the normal rules of evidence rather than the vaguer standards of the Administrative Procedure Act. Cases before panels frequently involve large sums of money and the professional reputations of providers which should not be put at hazard upon hearsay. The reference in the above recommendation to the rules of evidence as commonly applied by courts sitting without a jury is intended to permit panels, while recognizing the rules, to receive testimony subject to connection, or to the laying of a foundation, or to a motion to strike, in recognition of the fact that the professionals and selected laymen on panels

are apt to be better able than juries to understand and honor grant of motions striking testimony. The Commission also recommends below a procedure for allowing motions in limine involving potentially highly prejudicial testimony to be ruled on in advance by the chairman of the panel.

3. THAT HOSPITAL RECORDS AND THE RECORDS OF TREATING PHYSICIANS BE MADE ADMISSIBLE WITHOUT THE NECESSITY OF CALLING THE PHYSICIAN, SUBJECT TO THE OPPOSING PARTY'S RIGHT TO DEPOSE.

4. THAT DEPOSITIONS OF PHYSICIANS BE MADE ADMISSIBLE.

5. THAT THE REPORTS OF NON-TREATING PHYSICIANS, NOT GOING TO THE ULTIMATE ISSUE, BE MADE ADMISSIBLE, WHERE THE PARTY OFFERING THE REPORT GIVES TEN DAYS NOTICE OF HIS INTENTION TO OFFER IT, OR SUCH LESSER NOTICE AS IS ALLOWED BY THE PANEL UPON GOOD CAUSE SHOWN, HAS COMPLIED WITH THE RULES OF DISCOVERY, AND AGREES NOT TO CALL THE MAKER OF THE REPORT AT THE ARBITRATION HEARING.

6. THAT THE CHAIRMAN OF THE PANEL BE REQUIRED TO RULE IN CAMERA ON ANY MOTIONS IN LIMINE.

With respect to these matters it is the view of the Commission that the records of treating physicians generally are made in the ordinary course of treatment and ought appropriately to be admissible as a hearsay exception even where they contain language going to the ultimate issue, subject of course to the protection afforded by the right to depose. Where the records are those of the defendant, he will usually be deposed as of course. The reports of non-treating physicians are made admissible as a means of reducing cost and inconvenience to physicians. The adverse party is protected by advance disclosure of the report, by his right to depose its maker and have the fruits of his cross-examination admitted in evidence, and by the assurance that where he elects not to depose, he will not be surprised by the calling of the maker of the report as a live witness at trial.

The Commission believes that the chairman should be accorded the power, on application of a party, to grant a motion in limine in order to shield the physician and lay panel members from highly prejudicial matters.

7. THAT THE DIRECTOR OF THE ARBITRATION OFFICE BE EMPOWERED TO RULE ON ALL MATTERS ARISING PRIOR TO HEARING WHERE A PANEL CHAIRMAN IS NOT SERVING.

This recommendation, corresponding to one of the Bar Association Committee, is designed to eliminate a frequent source of delay.

8. THAT THE PROVISIONS OF STATUTE IMPOSING A RIGID DEADLINE ON FILING OF THIRD PARTY CLAIMS BE ALTERED IN FAVOR OF A PROVISION REQUIRING SUCH CLAIMS, IN THE ABSENCE OF CONSENT TO THEIR FILING, TO BE FILED 15 DAYS FROM THE DATE OF ANSWER OR AT A LATER TIME UPON GOOD CAUSE SHOWN.

This is also a recommendation of the Bar Association Committee and is intended to recognize that in some instances discovery is needed prior to filing of third party claims.

9. THAT THE STATUTE EMPOWER THE DIRECTOR TO IMPANEL ALTERNATE MEMBERS OF PANELS IN PARTICULAR CASES.

This recommendation is intended to give the Director the ability to deal with problems presented by last-minute unavailability of the provider member, by allowing him to seek the advance agreement of the parties to use of a qualified alternate (e.g. a retired physician) whose availability is more assured.

10. THAT THERE BE A MINIMUM EXPERIENCE REQUIREMENT OF THREE YEARS SINCE ADMISSION TO THE BAR FOR PANEL CHAIRMEN.

The Commission heard complaints from at least a dozen of the witnesses before it with respect to the youth and extreme inexperience of some panel chairmen (Appendix Y). While the study conducted by Dr. Morlock found no significant statistical difference in results reached as between less experienced and more experienced chairmen, the Commission believes that even one case in which a party believes his cause has been prejudiced by extreme inexperience is one case too many, particularly in a class of cases involving grave personal injuries and the professional reputations of providers who have undergone long and expensive courses of training. The Morlock study reveals that of 639 panel chairmen for whom data was available, 43 had less than three years' experience at the Bar, and an additional 42 had just three years' experience (Appendix Z). The legislative Task Force on Medical Malpractice of the 1982 Session under the

chairmanship of Senator McGuirk likewise recommended that an experience requirement be imposed.

11. THAT SERVICE OF PROFESSIONALS ON PANELS BE DECLARED TO BE A RESPONSIBILITY OF LICENSURE ENFORCEABLE BY THE APPROPRIATE LICENSING BOARDS, SUBJECT TO THE LIMITATION THAT NO PERSON BE REQUIRED TO SERVE MORE OFTEN THAN ONCE EVERY TWO YEARS AND THAT THE LAY MEMBER BE SELECTED AT RANDOM FROM JURY PANELS.

The Commission declined to follow the suggestion of the Bar Association Committee that lawyers be selected at random from the Client Security Fund list, which includes many non-practicing lawyers, title searchers, trust officers, and others without significant litigation experience. It believes, however, that measures are necessary to enlarge the available pool of lawyers, and particularly of more experienced lawyers. Of 639 chairmen serving through January, 1983 for whom data were available, only 278 had more than ten years experience at the Bar (Appendix Z). As of August 31, 1983, 1,424 attorneys of approximately 12,000 in the State had volunteered to serve if asked as panel chairmen. In three counties, there were three or fewer lawyers volunteering; in Somerset County only one lawyer volunteered (Appendix AA). With respect to providers, of whom there were 1,990 volunteers statewide, a similar situation existed in two counties where two or fewer providers volunteered. There is also a shortage of available panelists in certain high-risk specialties. No less than 12% of provider panelists serving were dentists (Appendix BB).

The difficulty of recruiting qualified panelists for extended proceedings at limited compensation has been enhanced by the position taken by a number of large law firms which, out of concern for relations with insurance company clients, have flatly prohibited their members or associates from volunteering for service on arbitration panels. The Commission believes that this action misconceives applicable canons relating to conflicts of interest and a lawyer's public obligations (see, e.g. EC 2-27 of the Code of Professional

Responsibility) and believes that the Director of the Arbitration Office should seek an opinion from the appropriate Bar Association Committee as to the propriety of such blanket refusals. The recommendation that a duty to serve be imposed by statute is designed to assist the Director in broadening the pool of experienced panel members.

Many persons testifying before the Commission expressed the opinion that there was need for some expansion of voir dire so as to ensure full disclosure of the involvement of medical panelists in pending cases and of the relationship of panelists to the doctors and lawyers involved in a case. The Commission believes that existing law accords the Director adequate authority to make provision for the submission of voir dire questions through him, and that this is the preferable procedure for dealing with this problem.

12. THAT DEPOSITIONS TAKEN IN THE ARBITRATION PROCESS BE AS FULLY USEABLE AS IF NOTICED IN COURT PROCEEDINGS; THAT INTERROGATORIES AND REQUESTS FOR ADMISSION AND PRODUCTION OF DOCUMENTS UNDERTAKEN IN THE ARBITRATION PROCESS REMAIN BINDING IN THE COURT PROCEEDINGS, SUBJECT TO A DUTY OF SUPPLEMENTATION; AND THAT ADDITIONAL REQUESTS FOR SUCH DISCOVERY IN THE COURT PROCEEDINGS BE LIMITED TO DISCOVERY RELATING TO NEW CLAIMS OF INJURY.

This recommendation is designed to eliminate unnecessary expense and duplication when an appeal is taken from an arbitration award.

13. THAT NO PARTY SHALL BE PERMITTED TO PRESENT TESTIMONY FROM MORE THAN TWO EXPERTS IN A DESIGNATED SPECIALTY BEFORE A HEALTH CLAIMS ARBITRATION PANEL, PROVIDED THAT THE PANEL CHAIRMAN FOR GOOD CAUSE SHOWN MAY PERMIT ADDITIONAL EXPERTS.

This recommendation is designed to limit costs and delays.

RECOMMENDATIONS DESIGNED TO ELIMINATE EXCESSIVE DAMAGES

Although most of the controversy surrounding the law of medical malpractice has surrounded efforts to directly reduce premiums by controlling damage awards, the Commission believes that in the first instance premium reductions are best sought by measures designed to swiftly eliminate frivolous cases from

the system, to limit the costs of litigation, and, where possible, to improve the quality of medical practice and medical discipline. In view of the fact that a relatively small number of cases account for a high percentage of indemnities awarded and paid, safeguards against excessive verdicts are desirable; in the Commission's view, its recommendations designed to upgrade the quality of the pool of arbitrators and promote greater consistency in the admission of evidence will contribute to limiting eccentric verdicts.

Because the level of premiums for some medical specialties is a matter of appropriate public concern and because of indications that the number of claims and amount of indemnities is accelerating, the Commission believes that some 'tort reform' measures designed to prevent verdicts from providing excess compensation to claimants are in order. The Commission notes that the number of cases filed in 1983 as of December 11th of that year was 558, as compared with 462 in 1982 and 428 in 1981, an increase approximating 25% over the previous year (Appendix F), and that indemnities and defense costs paid by Medical Mutual during the first nine months of 1982 amounted to a total of $7,342,000 as compared with a total of $6,288,000 in the entire previous year (Appendix X). The Maryland Hospital Association Insurance Program Annual Report for 1982 reports an increase in number of claims per 100 exposure units from 3.1 in 1977 to 4.7 in 1980 and 4.2 in 1981, the data for later years being incomplete because of the only partial running of the statute of limitations (Appendix CC). There have also been several highly publicized verdicts of several million dollars which have not yet been reflected in reported statistics relating to indemnity payments or awards or in insurance rates. These data suggest that a period of relatively gradual increases in premium rates may be nearing its end.

The Commission therefore believes that its recommendation should address appropriate measures of damage. It has rejected, however, a number of approaches which have been popular elsewhere

on grounds of their arbitrariness and unfairness to seriously injured claimants. Thus the Commission expressly declines to recommend either a general ceiling on awards or a ceiling on that portion of them representing pain and suffering. It also declines to recommend regulation of contingent attorneys' fees, a further shortening of the statute of limitations, an ad hoc power of remittur in the appellate courts, mandatory structured settlements, or the elimination of survivors'actions for pain and suffering of a decedent. Rather the Commission favors measures to improve the rationality of the damage-determination process and to eliminate the clearest examples of non-compensatory recoveries. The Commission,

RECOMMENDS:

1. THAT THE TRIER OF FACT BE REQUIRED TO ENUMERATE ON VERDICT FORMS SIMILAR TO THOSE CONTAINED IN THE MARYLAND PATTERN JURY INSTRUCTIONS THE ELEMENTS OF GENERAL AND SPECIAL DAMAGE AWARDED.

There have been two recent instances of totally unexplicated awards of $5 million by arbitration panels totally unaccompanied by any explanation of the breakdown of the award. Although this is consistent with the long tradition permitting general jury verdicts, the courts in large cases are empowered by rule to require special verdicts on elements of damage and do so with increasing frequency. Particularly inasmuch as a presumption of validity is attached to panel awards, the Commission believes that the reviewing court and jury should be apprised by a rudimentary breakdown of the panel's allocation between elements of damage. Such an allocation will also foster greater rationality and consistency in the making of awards, and will more clearly reveal the nature of the costs imposed by medical injuries.

2. THAT THE CAUSE OF ACTION FOR PUNITIVE DAMAGES BE RESTRICTED BY PROVIDING THAT EVIDENCE OF A DEFENDANT'S MEANS MAY NOT BE ADMITTED BEFORE A JURY OR ARBITRATION PANEL UNTIL THERE HAS BEEN A FINDING OF LIABILITY.

This recommendation contemplates bifurcation of the damage hearing where punitive damages are claimed, as they appear to be in about 20% of initiated cases. Although punitive damages are rarely awarded in medical malpractice actions, the Court of Special Appeals in the recent case of Bishop v. Holy Cross Hospital has established that they are allowable. Given the means of many doctors, this decision gives rise to the prospect that such damages may be claimed as of course in order to place the defendant's financial statement before the trier of fact as a device to attempt to inflame the trier of fact and inflate the compensatory damage award. The Commission believes that this collateral issue does not belong in a case unless and until the jury has found that liability for punitive damages exists.

The Commission has considered the alternative course of recommending abolition of the cause of action for punitive damages. Because punitive damages may be appropriate in very egregious cases as a means of expressing the trier of fact's perception of the case to disciplinary authorities, as a means of punishing derelictions motivated by pecuniary gain, and as a means of insuring that those guilty of especially heinous conduct are rendered unable to transfer an entire award against them to their insurers, the Commission has concluded to retain the cause of action with the restriction above mentioned.

3. THAT THE COLLATERAL BENEFITS RULE BE MODIFIED TO ALLOW INTRODUCTION OF EVIDENCE OF REMARRIAGE WHERE SUPPORT OR CONSORTIUM ARE AT ISSUE.

The Commission believes that whatever general conclusion is reached with respect to the collateral benefits rule that it should at least be modified in the respect above stated in order to insure that awards are not made for damages which are essentially fictitious or imaginary. Since the support obligations and consortium rights of a spouse of an uninjured person cease on that person's remarriage, the spouse of an injured person should not be placed in a more favorable position

by the imposition upon the trier of fact of a blindfold derived from the collateral benefits rule. Numerous states have enacted this limitation.

4. THAT THE COLLATERAL BENEFITS RULE BE RESTRICTED BY REQUIRING HEALTH INSURANCE, HEALTH BENEFITS PAID UNDER AUTOMOBILE ACCIDENT INSURANCE AND THE PROCEEDS OF ANY AGREEMENT TO PROVIDE, PAY FOR, OR REIMBURSE MEDICAL, DENTAL, HOSPITAL OR HEALTH CARE COSTS TO BE SUBTRACTED FROM MALPRACTICE AWARDS AFTER THEIR RENDITION.

The Commission believes that some restriction of the collateral source rule is in order as a means of curtailing duplicative and excessive insurance recoveries. Restriction of the collateral source rule is one of only two methods (the other being arbitrary caps on awards) which the recent Rand Corporation study above-cited has found significantly impacts the level of premiums. As already noted, the deterrent function of the collateral source rule is limited as applied to defendants who are independently subject to professional discipline as well as to liability for pain and suffering and other damage awards, and deterrence is the principal social justification advanced in support of the rule.

The Commission, however, declines to go so far as to recommend complete abolition of the collateral source doctrine. Complete abolition would require the offset against awards of such things as life insurance payments generated by payment of substantial premiums, disability insurance payments replacing, after the fact, income actually lost by injured persons, social security disability payments not received or determined until after the malpractice judgment has been returned, and a myriad of other possible reimbursements. Total abolition would be administratively difficult, and would encourage delay in applying for other benefits. The fact that claimants enjoy some windfall recoveries is not in itself deplorable, since such recoveries generally occur only in cases which have been fully and expensively litigated and are reduced by litigation costs and plaintiff's counsel fees.

The Commission believes, however, that abolition of the collateral benefits rule in the special area of health insurance is appropriate, for several reasons: 1) health care costs compensated by health insurance generally do not involve any loss of funds, however brief, to claimants in view of the frequency that benefits are assigned; the collateral benefits rule in this sphere allows claimants to be compensated for losses they have never sustained, unlike the situation with respect to disability payments for lost wages 2) health insurance payments and duplicative malpractice insurance payments for the same injuries both operate to feed the spiraling costs of medical care, a matter of grave national concern, and the costs of duplication are ultimately borne by consumers of health care as such, a result that does not obtain where the overlap is with life or disability coverage 3) the extent of health insurance coverage is readily determinable at the time of trial, unlike the situation with respect to some disability payments 4) at present, there is an insupportable distinction between Medicaid recipients who are denied the duplicative recovery by reason of statutorily mandated subrogation (see §15-120 of the Health-General Article) and the recipients of Medicare and private health insurance, whose malpractice recoveries are not reduced by exercise of subrogation rights.

Acceptance of this recommendation will materially reduce the portion of malpractice awards accounted for by medical expenses. According to Table 23 of the Morlock study, in 443 arbitration cases in which data was available, Blue Cross/Blue Shield or other private insurance provided the costs of medical care in 50% of cases, Medicare in 5%, Medicaid in 6%, various combinations of these payors in 3%, unknown sources in 9%, and self-payment in only 27% of cases (Appendix DD). Under present law, the 27% of claimants who self-pay recover their medical costs only once, as is true also of the 6% of claimants under Medicaid whose recoveries are reduced by mandated subrogation. By contrast,

the remaining claimants recover twice: their actual costs are borne by an insurer and in addition they receive a windfall amount equal to these costs upon settlement of the malpractice claim. Although this discrepancy could be addressed by mandating subrogation with respect to all private insurers and facilitating subrogation by Medicare, the processing of subrogation cases imposes costs of its own and curtailment of the collateral benefits rule is a more efficient means of limiting duplication. Mandated subrogation would marginally reduce health insurance costs, whereas the approach of curtailing collateral benefits would significantly reduce malpractice insurance costs and appears preferable.

Messrs. Hughes and Shadoan dissent from this recommendation. Dr. Cohen would favor mandated subrogation as an alternate approach.

Any adoption of this recommendation should, in fairness to claimants, be accompanied by a prohibition on subrogation by health insurers, and a repeal of the present statute relating to subrogation by Medicaid.

5. THAT IF THE PRECEDING RECOMMENDATION IS NOT ADOPTED BY STATUTE, THAT CONTRACTUAL SUBROGATION BE FACILITATED BY REQUIRING THE DIRECTOR TO MAKE AVAILABLE A NOTICE OF ALL JUDGMENTS AND SETTLEMENTS TO INTERESTED INSURERS PRIOR TO THEIR FINALITY.

This recommendation appears desirable as a means of reducing the costs and increasing the efficiency of the subrogation process. Arrangements of this nature already exist with respect to the Medicaid program.

RECOMMENDATIONS DESIGNED TO IMPROVE MEDICAL DISCIPLINE AND PRACTICE

The least controversial means of reducing malpractice premiums is by reducing the occasion for malpractice suits. A significant part of the malpractice problem arises from the slow speed of professional discipline and from multiple claims against the same doctors. The Med-Chi study undertaken in 1971 revealed

that of 381 claims, 105 were accounted for by 46 physicians with more than one claim, or approximately 28% of all claims (Appendix EE). The Morlock study in 1983 revealed that of 1,124 claims against individual defendants, 215 were accounted for by 97 providers with more than one claim, or approximately 20% of all claims (Appendix FF). While many claims are baseless and the fact of multiple claims does not of itself provide an occasion for discipline, the Commission has been advised that the Commission on Medical Discipline actively monitors malpractice claims and along with other licensing agencies would welcome an improvement in reporting provisions.

In addition, the doctrine of informed consent, though it generates few verdicts standing on that ground alone, generates a substantial amount of uncertainty among physicians as to what is required of them. Although the contours of the doctrine are clearly defined in Maryland by case law not requiring the statutory elaboration recently undertaken in some other states, provision for early disposition of frivolous claims would be helpful.

Accordingly, the Commission,

RECOMMENDS:

1. THAT THERE BE A CHANGE IN REPORTING REQUIREMENTS TO REQUIRE INSURANCE COMPANIES TO REPORT CLAIMS TO THE COMMISSION ON MEDICAL DISCIPLINE WHEN A CLAIM IS OPENED OR WHEN NOTICE OF SUIT IS GIVEN RATHER THAN WHEN A CLAIM IS CLOSED AS AT PRESENT.

2. THAT INSURERS BE REQUIRED TO REPORT CLAIMS AFFECTING HEALTH CARE PROVIDERS OTHER THAN PHYSICIANS TO THE RESPECTIVE LICENSING BOARDS RATHER THAN TO THE INSURANCE COMMISSIONER.

3. THAT PLAINTIFFS IN INFORMED CONSENT CASES BE REQUIRED TO ESTABLISH BY EXPERT TESTIMONY THE APPROPRIATENESS OF THE DISCLOSURES WHICH WERE ALLEGED TO HAVE BEEN WRONGFULLY OMITTED, AND TO SUPPLY A CERTIFICATE THEREOF WITHIN 90 DAYS OF CLAIM.

These recommendations are in large measure self-explanatory. The proposed changes in reporting requirements involve no innovations in principle, since insurers are presently required to report to the Commission on Medical Discipline the closing of all claim files, including those closed without any indemnity payment. These reports would obviously be of greater value to the Commission if made several years earlier, when a file is opened rather than when it is closed. Similarly, reports as to other providers should be required to be directed to the appropriate licensing board rather than to the Insurance Commissioner.

The recommendations as to informed consent are designed to foster the early disposition of frivolous cases. Although informed consent cases do not significantly impact premiums, their effect on medical practice, for both good and ill, is profound and exposure of physicians to unjustified claims may be generative of forms of defensive medicine and over-disclosure in the interests of neither physicians nor patients.

George W. Liebmann, Esquire,
Chairman
W. Minor Carter, Esquire
Honorable Joel Chasnoff
Harold A. Cohen, Ph.D.
Honorable Jerome F. Connell, Sr.
Honorable Gene W. Counihan
Grover E. Czech, Esquire
James P. Durkan, M.D.
Leo A. Hughes, Esquire
Honorable Francis X. Kelly
Edward J. Muhl, Insurance
Commissioner
George W. Shadoan, Esquire
J. John Spinella
Israel H. Weiner, M.D.

TABLE OF APPENDICES

TABLE OF APPENDICES
(continued)

HARRY HUGHES
GOVERNOR

STATE OF MARYLAND
EXECUTIVE DEPARTMENT
ANNAPOLIS, MARYLAND 21404

September 23, 1983

George W. Liebmann, Esquire
Keyser Building
Suite 703
207 East Redwood Street
Baltimore, Maryland 21202

Dear Mr. Liebmann:

Pursuant to Resolution 9 of the 1983 session of the General Assembly, I am appointing a Commission on Health Care Providers Professional Liability Insurance to examine the impact of such insurance on the costs of health care including increased cost in medical insurance and patients' bills. The Commission is also asked to study the role and function of the Health Claims Arbitration Office.

Thank you for agreeing to serve as Chairman. I would appreciate you contacting the members of the Commission to set the time and place for the first meeting.

As Chairman, you will be contacted by Kathleen J. Fay, Administrator of the State Publications Depository and Distribution Program, with regard to the requirements stipulated in Section 23-2A-04 of the Education Article of the Annotated Code of Maryland.

Your Commission and a copy of the membership list are enclosed. Thank you again for agreeing to serve as Chairman.

Sincerely,

Harry Hughes

Governor

SENATE JOINT RESOLUTION No. 14

31r2514 25

By: Senator Abrams
Introduced and read first time: February 10, 1983
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 29, 1983

RESOLUTION NO. _____

SENATE JOINT RESOLUTION

A Senate Joint Resolution concerning

Governor's Commission on Health Care Providers Professional Liability Insurance

FOR the purpose of requesting the Governor to establish a Commission on Health Care Providers' Professional Liability Insurance to study the impact of Health Care Providers' Professional liability insurance, including the role and function of the Health Claims Arbitration Office, on the costs of health care and to make recommendations for reform.

WHEREAS, The cost of Physicians and Hospitals professional liability insurance has increased tenfold since the crisis of availability in 1975; and

WHEREAS, It is estimated that 15 percent of the cost of physician services go towards the payment of these premiums, reflecting an increased cost in medical insurance and patients' bills; and

WHEREAS, In 1976, the General Assembly created the Health Claims Arbitration Office, requiring all alleged cases of professional liability to go to arbitration, rather than through the courts; and

WHEREAS, Government, industry, and the general public are concerned over the increases in health care costs; and

WHEREAS, These increasing costs make it difficult for new physicians to establish themselves in practice because of the cost of professional liability insurance; and

WHEREAS, The older physician who would like to reduce his workload and continue to make his expertise and knowledge

EXPLANATION:
Underlining indicates amendments to bill.
~~Strike--out~~ indicates matter stricken by amendment.

available to the public and new physicians, cannot continue to practice because premiums may be higher than the income received; and

WHEREAS, Younger physicians migrate to areas where the costs of such professional liability insurance are lower; and

WHEREAS, Physicians are, in many cases, practicing defensive medicine increasing the total costs of health care; now, therefore, be it

RESOLVED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Governor is requested to appoint a Commission on Health Care Professional Liability Insurance to examine the problem in its entirety and make recommendations to the 1984 General Assembly; and be it further

RESOLVED, That representatives from the House of Delegates, the Senate of Maryland, and representatives of the public, the insurance industry, health professions and other related groups be included as members of this Commission; and be it further

RESOLVED, That the Governor designate the chairman of the Commission; and be it further

RESOLVED, That the Commission be appointed by June 1, 1983 and provide its final report and recommendations to the Governor and the General Assembly by November 1, 1983; and be it further

RESOLVED, That the staff for the Commission be provided by the Department of Legislative Reference; and be it further

RESOLVED, That copies of this Resolution be forwarded to the Honorable Harry Hughes, Governor of Maryland, the Honorable Melvin Steinberg, President of the Senate of Maryland, and the Honorable Benjamin Cardin, Speaker of the House of Delegates.

Approved:

_____
Governor.

_____
President of the Senate.

_____
Speaker of the House of Delegates.

10/05/83

HSCRC SCHEDULE UA (FISCAL YEAR 1980)
MALPRACTICE INSURANCE EXPENSES ETC..
PREPARED BY Yihshyong WENG

FISCAL YR-1980

HOSPNAME	MALPRACTICE INSURANCE	OTHER INSURANCE	MED-CARE REVIEW	SUB-TOT
ANNE ARUNDEL	139,900	85,700	54,500	280,100
BALTIMORE CITY	251,700	8,600	2,700	263,000
BALTO. COUNTY GENERAL	203,100	62,100	41,700	306,900
BON SECOURS	209,000	78,300	35,300	322,600
CALVERT COUNTY	80,800	16,500		97,300
CARROLL COUNTY	89,400	47,700		137,100
CHILDRENS	62,600	27,700	2,900	93,200
CHURCH HOSPITAL	261,000	56,500	94,300	411,800
CLINTON COMMUNITY	62,700	3,400		66,100
DORCHESTER GENERAL	59,400	26,500	2,200	88,100
FALLSTON	149,700	27,500	75,000	252,200
FRANKLIN SQUARE		484,000	48,000	532,000
FREDERICK MEMORIAL	88,700	60,200	20,100	169,000
FROSTBURG COMMUNNTIY	23,400	5,800		29,200
GARRETT COUNTY	39,900	33,500	10,800	84,200
GOOD SAMARITAN	160,300	49,100	88,300	297,700
GTR.BALTO. MED. CNTR.	67,800	488,700	109,900	666,400
GTR.LAUREL/BELTSVILLE	162,200	23,700	12,400	198,300
HARFORD MEMORIAL	146,200	46,700	39,800	232,700
HOLY CROSS	648,400	41,000	72,500	761,900
JOHNS HOPKINS	682,800	331,200	244,000	1,258,000
KENT & QUEEN ANNES	39,600	8,300	7,900	55,800
KERNAN	94,400	43,500		137,900
LELAND MEMORIAL	103,300	32,300		135,600
LUTHERAN	178,200	44,900	73,300	296,400
MARYLAND GENERAL	422,000	31,800	60,300	514,100
MCCREADY	15,300	17,100	600	33,000
MEMORIAL AT EASTON	168,500	28,100	79,100	275,700
MEMORIAL CUMBERLAND	207,600	118,200	2,800	328,600
MERCY	326,200	80,300	171,900	578,400
MONTGOMERY GENERAL	99,000	104,800	41,600	245,400
NORTH ARUNDEL	100,900	73,800	39,800	214,500
NORTH CHARLES	115,400	22,000	47,300	184,700
PENINSULA GENERAL	239,600	60,600	40,000	340,200
PHYSICIANS MEMORIAL	90,700	37,700	42,100	170,500
PRINCE GEORGES	673,500	30,200	159,800	863,500
PROVIDENT	295,700	143,600	43,600	482,900
SACRED HEART	155,700	31,400		187,100
SAINT AGNES	328,500	353,900	6,800	689,200
SAINT JOSEPHS	259,000	179,100	108,000	546,100
SAINT MARYS	51,500	10,900		62,400
SHADY GROVE ADVENTIST	38,300	37,100	22,100	97,500
SINAI	393,400	73,300	94,700	561,400
SOUTH BALTIMORE	306,800	160,600	33,200	500,600
SOUTHERN MARYLAND	436,600	136,000	44,200	616,800
SUBURBAN	452,500	58,600		511,100
UNION MEMORIAL	66,000	461,400	132,800	660,200
UNION OF CECIL COUNTY	56,500	59,300	5,100	120,900
UNIVERSITY MARYLAND	896,100		52,900	949,000
WASHINGTON ADVENTIST	193,400	68,500	26,800	288,700
WASHINGTON COUNTY	172,400	165,800	63,500	401,700
YEAR TOTAL	10,565,600	4,677,500	2,354,600	17,597,700

10/05/83

HSCRC SCHEDULE UA (FISCAL YEAR 1981)
MALPRACTICE INSURANCE EXPENSES ETC..
PREPARED BY Yihshyong WENG

FISCAL YR-1981

HOSPNAME	MALPRACTICE INSURANCE	OTHER INSURANCE	MED-CARE REVIEW	SUB-TOT
ANNE ARUNDEL	129,500	81,200	66,800	277,500
BALTO. COUNTY GENERAL	210,300	71,300	48,000	329,600
BON SECOURS	197,200	64,000	79,800	341,000
CALVERT COUNTY	45,700	26,900	10,700	83,300
CARROLL COUNTY	76,200	60,300		136,500
CHILDRENS	67,300	44,300	6,400	118,000
CHURCH HOSPITAL	260,800	62,600	143,300	466,700
CLINTON COMMUNITY	53,500	3,000		56,500
DORCHESTER GENERAL	79,800	29,400	2,200	111,400
DRS OF PRINCE GEORGES	416,600	50,800		467,400
FALLSTON	176,900	28,300	113,400	318,600
FRANKLIN SQUARE		534,900	72,600	607,500
FREDERICK MEMORIAL	104,600	77,400	23,000	205,000
FROSTBURG COMMUNNTIY	19,300	9,600	8,600	37,500
GARRETT COUNTY	39,100	23,300	10,200	72,600
GOOD SAMARITAN	180,300	59,900	111,700	351,900
GTR.BALTO. MED. CNTR.	69,400	519,400	120,900	709,700
GTR.LAUREL/BELTSVILLE	222,000	20,200	24,200	266,400
HARFORD MEMORIAL	146,900	53,500	27,300	227,700
HOLY CROSS	668,800	42,400	60,500	771,700
HOWARD COUNTY GENERAL	142,700	46,300	37,800	226,800
JOHNS HOPKINS	620,300	308,900	210,500	1,139,700
KENT & QUEEN ANNES	39,000	24,900	2,400	66,300
KERNAN	100,200	50,800	2,900	153,900
LELAND MEMORIAL	64,400	37,100		101,500
LUTHERAN	178,300	66,400	113,700	358,400
MARYLAND GENERAL	399,800	108,500	62,000	570,300
MCCREADY	8,600	19,300		27,900
MEMORIAL AT EASTON	163,800	50,300	84,900	299,000
MEMORIAL CUMBERLAND	325,400	114,900	2,700	443,000
MERCY	338,900	74,000	211,900	624,800
MONTGOMERY GENERAL	105,200	74,800	46,100	226,100
NORTH ARUNDEL	109,100	73,900	39,900	222,900
NORTH CHARLES	119,000	33,300	62,600	214,900
PENINSULA GENERAL	252,300	68,200	39,300	359,800
PHYSICIANS MEMORIAL	86,300	31,100	79,800	197,200
PRINCE GEORGES	789,700	28,500	147,500	965,700
PROVIDENT	297,900	121,100	65,700	484,700
SACRED HEART	149,300	31,100		180,400
SAINT AGNES	313,200	455,600	7,000	775,800
SAINT JOSEPHS	214,300	220,400	199,500	634,200
SAINT MARYS	59,400	12,600	14,000	86,000
SHADY GROVE ADVENTIST	47,900	64,700	43,100	155,700
SINAI	430,600	223,600	127,000	781,200
SOUTH BALTIMORE	330,800	124,000	57,500	512,300
SOUTHERN MARYLAND	291,600	58,400	67,900	417,900
SUBURBAN	272,400	283,300	10,600	566,300
UNION MEMORIAL		473,300	150,700	624,000
UNION OF CECIL COUNTY	81,200	59,200	3,800	144,200
UNIVERSITY MARYLAND	587,100		39,700	626,800
WASHINGTON ADVENTIST	121,100	224,400	43,300	388,800
WASHINGTON COUNTY	173,700	117,300	79,800	370,800
YEAR 81 TOTAL	10,377,700	5,542,900	2,983,200	18,903,800

10/05/83

HSCRC SCHEDULE UA (FISCAL YEAR 1982)
MALPRACTICE INSURANCE EXPENSES ETC..
PREPARED BY Yihshyong WENG

SCAL YR-1982

HOSPNAME	MALPRACTICE INSURANCE	OTHER INSURANCE	MED-CARE REVIEW	SUB-TOT
ANNE ARUNDEL	166,800	120,800	74,900	362,500
BALTIMORE CITY	450,000	14,300	67,700	532,000
BALTO. COUNTY GENERAL	217,800	50,300	59,700	327,800
BON SECOURS	241,700	55,700	75,400	372,800
CALVERT COUNTY	36,600	24,700	24,100	85,400
CARROLL COUNTY	87,500	44,100		131,600
CHILDRENS	88,300	44,000	26,100	158,400
CHURCH HOSPITAL	290,400	53,100	211,500	555,000
DORCHESTER GENERAL	91,600	22,800	15,200	129,600
DRS OF PRINCE GEORGES	351,800	45,200		397,000
FALLSTON	133,400	33,000	134,100	300,500
FRANKLIN SQUARE		523,000	107,400	630,400
FREDERICK MEMORIAL	142,000	71,900	26,800	240,700
FROSTBURG COMMUNNTIY	22,200	6,500	9,200	37,900
GARRETT COUNTY	48,200	28,800	12,000	89,000
GOOD SAMARITAN	177,400	62,200	126,900	366,500
GTR.BALTO. MED. CNTR.	379,200	183,300	130,400	692,900
GTR.LAUREL/BELTSVILLE	126,300	38,500	19,100	183,900
HARFORD MEMORIAL	157,400	17,000	58,600	233,000
HOLY CROSS	606,900	37,800	83,600	728,300
HOWARD COUNTY GENERAL	162,600	36,600	53,300	252,500
JOHNS HOPKINS	762,400	320,400	220,000	1,302,800
KENT & QUEEN ANNES	37,200	24,200	1,400	62,800
KERNAN	93,100	85,500	3,600	182,200
LELAND MEMORIAL	-400	21,300	8,000	28,900
LUTHERAN	157,600	60,600	121,400	339,600
MARYLAND GENERAL	395,900	162,600	81,000	639,500
MCCREADY	7,700	17,400	1,500	26,600
MEMORIAL AT EASTON	139,100	42,600	94,400	276,100
MEMORIAL CUMBERLAND	95,700	140,900	51,400	288,000
MERCY	346,000	85,100	253,400	684,500
MONTGOMERY GENERAL	140,300	87,500	61,400	289,200
NORTH ARUNDEL	80,000	99,500	67,000	246,500
NORTH CHARLES	146,600	25,200	76,700	248,500
PENINSULA GENERAL	266,500	67,600	49,900	384,000
PHYSICIANS MEMORIAL	95,400	10,400	72,700	178,500
PRINCE GEORGES	576,800	44,100	177,300	798,200
PROVIDENT	262,400	106,600	169,800	538,800
SACRED HEART	134,700	23,100		157,800
SAINT AGNES	334,400	368,300	5,600	708,300
SAINT JOSEPHS	244,600	210,200	214,100	668,900
SAINT MARYS	19,800	14,400	14,100	48,300
SHADY GROVE ADVENTIST	82,700	300	66,600	149,600
SINAI	454,200	236,400	131,100	821,700
SOUTH BALTIMORE	300,700	138,200	53,900	492,800
SOUTHERN MARYLAND	420,400	36,800	77,800	535,000
SUBURBAN	324,000	83,300	27,200	434,500
UNION MEMORIAL	52,200	408,400	184,700	645,300
UNION OF CECIL COUNTY	101,300	57,800	31,900	191,000
UNIVERSITY MARYLAND	781,900		15,500	797,400
WASHINGTON ADVENTIST	207,400	117,300	51,200	375,900
WASHINGTON COUNTY	174,800	77,800	92,900	345,500
YEAR TOTAL	11,213,500	4,687,400	3,793,500	19,694,400

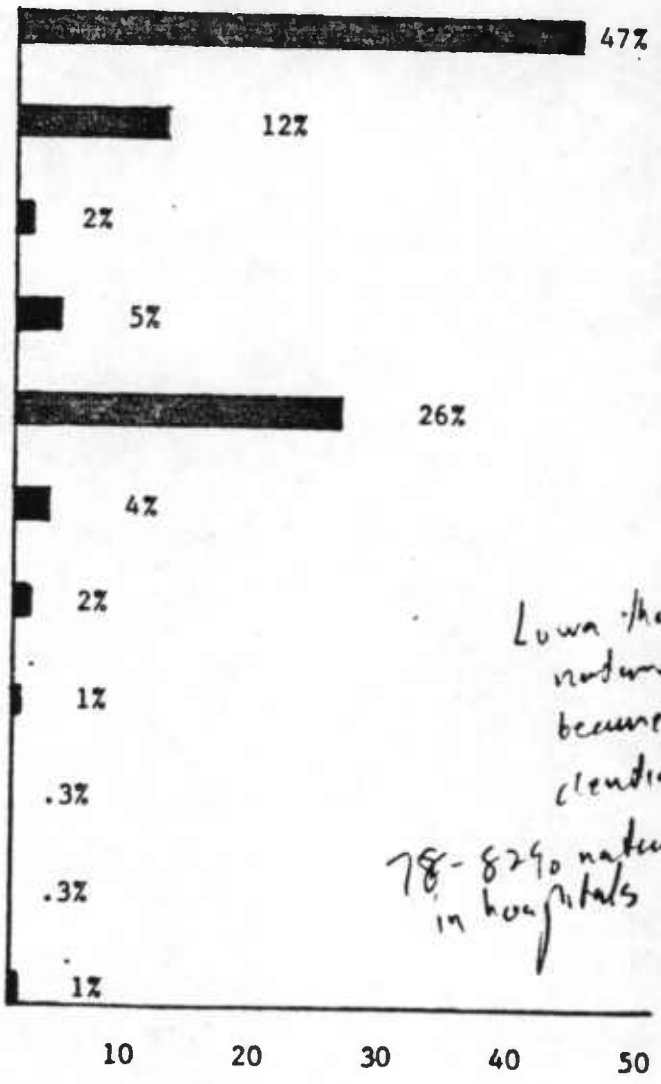
Only 2-3 hosps have salaried emegdh.
Pathologists in hospitals
Pediatricians
Radiologists also
Nurse-Anesthetists.
Full time Anesthesiologists—
Contract Travelers

1.6 billion aggregate budget

TABLE 5

PLACE WHERE INCIDENT OCCURRED

PLACE	NUMBER OF CLAIMS	PERCENTAGE OF CLAIMS
Hospital In-patient Facility	362	47%
Emergency Room	92	12%
Hospital Outpatient Facility	18	2%
Hospital/Physician's Office	35	5%
Physician's Office or Clinic (including dentists)	198	26%
Other Outpatient Facility	34	4%
Patient's Home	17	2%
Nursing Home	8	1%
Telephone Diagnosis	2	.3%
Telephone Prescription	2	.3%
Unknown	5	1%
TOTAL	773*	



Lower than national because of dentist

78-82% nation in hospitals

*One case is missing due to absence of data regarding place of incident.

Source: Johns Hopkins Study of Health Claims Arbitration Process.

MEDICAL MUTUAL
ALL CLOSED CLAIMS BY YEAR OF CLOSING

	1978	1979	1980	1981	1982	1983 (9 Months)
Number of Claims With Indemnity Payment	13	13	38	49	103	151
Number of Claims Closed	48	69	219	293	615	462
Percent with Indemnity	27%	19%	17%	17%	17%	33%
Total Indemnity	1,070,700	564,900	3,940,100	5,237,600	8,117,900	10,675,700
Total Defense Costs	67,000	182,600	406,800	546,500	1,284,900	1,779,500
Number of Claims Closed Without Indemnity Payment	35	56	181	244	512	311
Defense Costs on Claims Closed Without Indemnity Payment	20,000	154,600	182,000	274,900	672,600	506,200

App. E

App. F

HEALTH CLAIMS ARBITRATION OFFICE

STATE OF MARYLAND

CASE STATISTICS

YEAR	NUMBER FILED	CLOSED BY PANEL DECISION	CLOSED BY NON-PANEL TERMINATION	TOTAL CLOSED	CASES STILL OPEN	CASES CLOSED IN EACH YEAR
1977	2	2	0	2	0	0
1978	93	37	52	89	4	8
1979	269	95	149	244	25	47
1980	326	99	181	280	46	104
1981	428	131	201	332	96	276
1982	462	85	143	228	234	358
*1983	558	6	22	28	530	410
	2,138	455	748	1,203	935	1,203

*Through December 11, 1983; H.C.A. Case #83-558.
In November: 40 cases filed, 44 closed
(82% of all open cases are less than 2 years old;
60% of all open cases are less than 1 year old)

App. F

TABLE 28

METHOD OF CASE DISPOSITION

METHOD OF CASE DISPOSITION	NUMBER	PER CENT
Dismissed	272	35%
Closed: Settled prior to the pre-hearing conference	127	16
Closed: Settled prior to hearing	180	23
Closed: Settled during hearing	13	2
Closed: Hearing completed No appeal filed	84	11
Closed: Hearing completed-- claim on appeal	98	13
TOTAL	774	100%

Source: Johns Hopkins Study of Health Claims Arbitration Process

TABLE 29

TYPE OF DISMISSAL

TYPE OF DISMISSAL	CLAIMS	
	NUMBER	PER CENT
Dismissed by:		
Claimant prior to pre-hearing conference	114	43%
Claimant prior to hearing	76	28
Claimant during hearing	4	2
Chairperson prior to pre-hearing conference	25	9
Chairperson prior to hearing	28	10
Chairperson during hearing	10	4
Out of Jurisdiction	11	4
TOTAL	268*	100%

*There were 272 dismissals. Four cases are missing because the type of dismissal was not known.

Source: Johns Hopkins Study of Health Claims Arbitration Process

TABLE 31

OUTCOME OF PANEL DETERMINATION*

Outcome	Number	Percent
Liability Determination		
In favor of claimant	76	43%
In favor of defendant	102	57
Total	178	100%
Number of Cases Appealed	108	61%
Case Appealed By:		
Defendant	27	25%
Claimant	67	62
Both defendant and claimant	14	13
TOTAL	108	100%

*There were 182 cases that completed the arbitration hearing process. Four are missing from this table due to the absence of data.

Source: Johns Hopkins Study of Health Claims Arbitration Process

CLAIM APPEAL STATUS BY LIABILITY DETERMINATION
(percentaged by column)

CLAIM APPEAL STATUS	LIABILITY DETERMINATION		ROW TOTAL
	AGAINST DEFENDANT	IN FAVOR OF DEFENDANT	
Not Appealed	49%	45%	83
Appealed by:			
Defendant	18%	12%	26
Claimant	16%	42%	55
Both Defendant and Claimant	17%	1%	14
COLUMN TOTAL	76	102	178

Exh. I

MEDICAL MUTUAL
CLOSED CLAIMS NOT DISPOSED BY SUIT OR HEALTH CLAIMS ARBITRATION BY YEAR OF CLOSING

	1978	1979	1980	1981	1982	1983 (9 Months)
Number of Claims With Indemnity Payment	9	8	7	20	42	56
Number of Claims Closed	36	30	124	180	329	220
Percent with Indemnity	25%	27%	6%	11%	13%	26%
Total Indemnity	40,700	55,400	27,100	912,500	706,900	1,147,700
Total Defense Costs	1,600	1,600	1,900	29,200	151,700	324,700
Number of Claims Closed Without Indemnity Payment	27	22	117	160	287	164
Defense Costs on Claims Closed Without Indemnity Payment	1,500	1,600	1,900	5,000	56,200	96,000

App. I

MEDICAL MUTUAL PREMIUMS BY YEAR

Territory III
(Baltimore City and
Baltimore, Howard & Anne Arundel Counties)

Occurrence Speciality	1M/3M Class	1975	1979	1980	1981	1982	1983
Ophthalmology	80114	$2181	$2618	$2759	$3721	$4411	$5082
Urological Surgery	80145	4364	5237	5520	7447	6217	7164
OB-GYN	80153	6002	7202	7591	10240	13703	19703
Neurological Surgery	80152	8729	10475	11041	14894	18654	18404
General Surgery	80143	6002	7202	7591	10240	11452	13209
Plastic Surgery NOC	80156	6002	7202	7591	10240	13703	15806

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

RATE LEVEL HISTORY

Period	Rate Change	Rate Level
7/75 - 6/76	Initial Rate	1.00
7/76 - 6/77	None	1.00
7/77 - 6/78	None	1.00
7/78 - 6/79	None	1.00
7/79 - 8/80	+ 20.0%	1.20
9/80 - 3/81	+ 5.4%	1.27
4/81 - 5/82	+ 34.4%	1.70
6/82 - 6/83	+ 21.1%	2.06
7/83 -	+ 9.5%	2.25

I.S.O. MEDICAL PROFESSIONAL LIABILITY RATES BY STATE
$1,000,000/$3,000,000 LIMITS
OCCURRENCE COVERAGE

	Anesthesiology (Code 80151)	Surgery - Neurology (Code 80152)	Surgery - Obstetrics (Code 80168)
Alabama	$ 6,032	$ 18,957	$10,341
Alaska	6,791	21,349	11,644
Arizona	23,676	65,122	35,519
Arkansas	6,831	18,778	10,244
California	36,086	113,412	61,861
Colorado	15,356	48,281	26,332
Connecticut	17,749	55,806	30,435
Delaware	18,863	37,722	26,406
D.C.	21,693	68,201	37,196
Florida	29,936	82,322	44,904
Georgia	13,809	43,392	23,671
Hawaii	10,107	16,165	12,128
Idaho	16,925	53,209	29,018
Illinois	21,431	67,382	36,749
Indiana	9,496	29,840	16,279
Iowa	14,298	44,949	24,514
Kentucky	5,496	14,428	8,248
Louisiana	11,472	18,355	13,766
Maine	14,768	46,427	25,320
Maryland	11,615	36,508	19,914
Michigan	29,267	92,013	50,183
Minnesota	19,041	59,862	32,646
Mississippi	9,421	29,614	16,155
Missouri	18,476	58,087	31,680
Montana	15,645	49,187	26,825

I.S.O. MEDICAL PROFESSIONAL LIABILITY RATES BY STATE (CONTINUED)

	Anesthesiology (Code 80151)	Surgery - Neurology (Code 80152)	Surgery - Obstetrics (Code 80168)
Nebraska	$ 6,793	$ 21,344	$11,643
Nevada	37,997	119,463	65,151
New Hampshire	8,745	13,997	10,500
New Jersey	13,625	32,964	13,625
New Mexico	15,515	48,777	26,603
New York	16,975	25,462	21,219
North Carolina	6,758	21,250	11,588
North Dakota	11,230	35,308	19,255
Ohio	16,280	51,207	27,913
Oklahoma	10,739	29,517	16,098
Oregon	12,762	40,108	21,877
Pennsylvania	20,841	20,841	20,841
Puerto Rico	4,665	14,661	7,997
Rhode Island	9,556	9,556	9,556
South Carolina	7,107	11,372	8,530
South Dakota	16,240	51,057	27,846
Tennessee	4,127	8,251	4,952
Utah	23,169	72,842	39,725
Vermont	6,450	20,263	11,053
Virginia	9,442	25,958	14,161
Washington	21,063	66,219	36,115
West Virginia	10,858	29,859	16,289
Wisconsin	9,885	31,080	16,952
Wyoming	9,927	15,883	11,911

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COVER STORY

EARNINGS SURVEY: FINALLY, A BREAK IN THE INFLATION RACE!

For the first time since 1976, our Continuing Survey shows, physicians' earnings last year rose more than the cost of living.

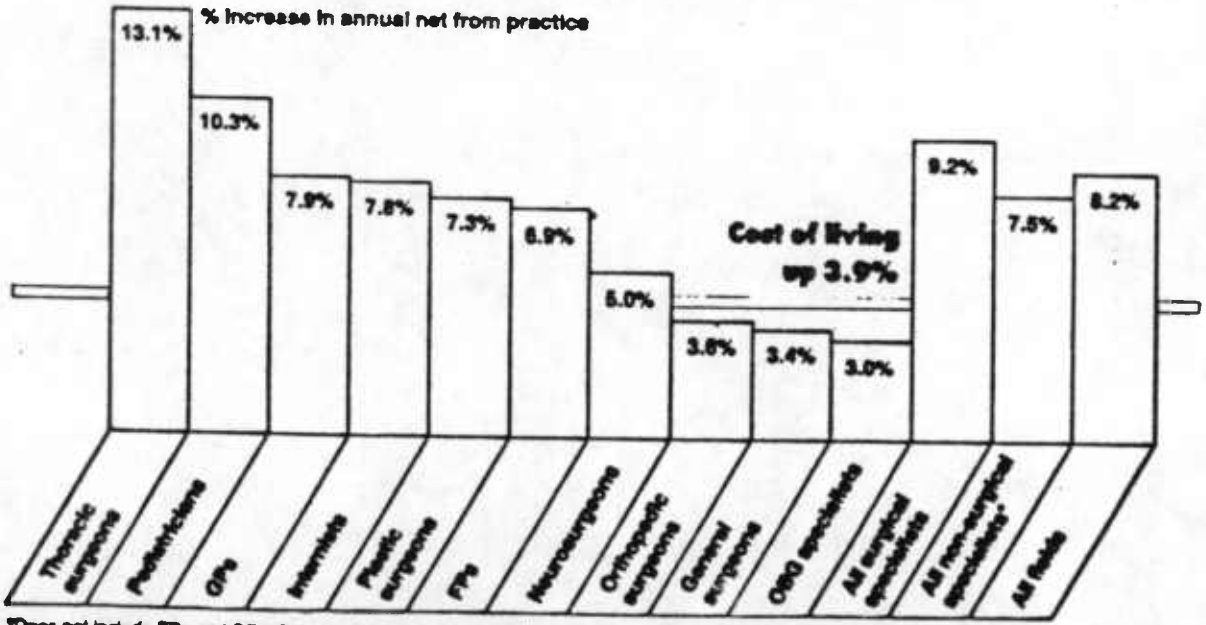
By Arthur Owens SENIOR EDITOR

"Very satisfactory" may be the best way to describe the economic performance of privately practicing physicians last year. The typical office-based M.D. managed to raise his annual practice net to $93,270—8.2 percent more than the previous year's median of $86,210—according to MEDICAL ECONOMICS' latest Continuing Survey. Meanwhile, the cost of living, as measured by the Consumer Price Index, advanced only 3.9 percent during the year. This resulted in the biggest improvement in doctors' purchasing power in 15 years, indeed the *only* such improvement in six years.

The 1982 income gain looks especially good alongside 1981's advance of only 3 percent in the face of 8.9 percent inflation. It even looks good when compared with, for example, the 1979 median earnings rise of 12.8 percent, which was wiped out by an in-

SEVEN OUT OF 10 SPECIALTIES BEAT INFLATION LAST YEAR

Only three times in the past decade have surveyed doctors' annual practice earnings increased by a larger percentage than the overall cost of living. As the chart shows, 1982 was one of those "good" years. It was especially good for pediatricians, general practitioners, and family practitioners, all of whom experienced declines in their median incomes the year before.



*Does not include FPs and GPs. Percent change in the cost of living is based on the Consumer Price Index (all items) for December of each year. Percent changes in physicians' earnings are based on national medians. For unincorporated physicians, net is individual income from practice minus tax-deductible professional expenses, but before income taxes; for incorporated physicians, it's total compensation from practice (salary, bonuses if any, and retirement set-asides) before income taxes. Data in this and the charts and tables that follow apply to office-based M.D.s and, except where otherwise noted, are drawn from MEDICAL ECONOMICS' Continuing Survey. Where no year is specified, data are for 1982.

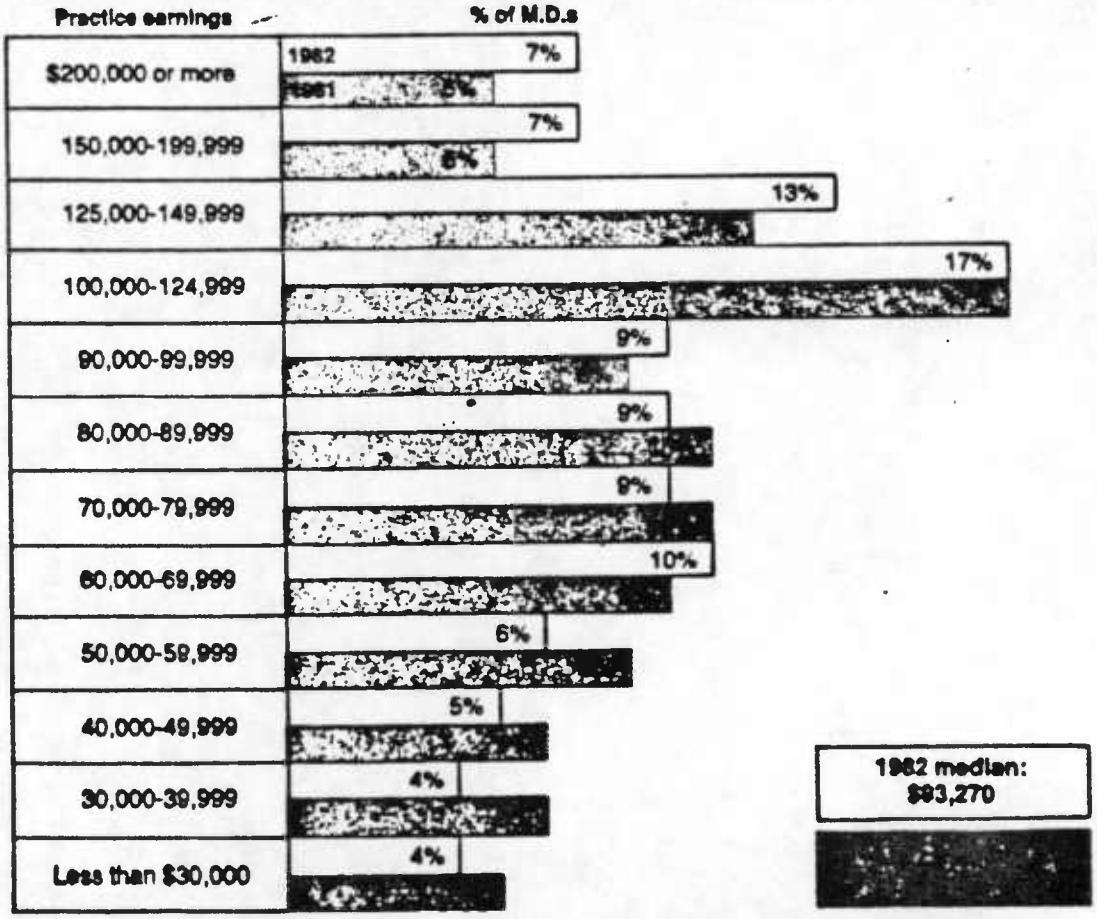
crease of 13.3 percent in the CPI.

Over the past decade, physicians' median net earnings have risen an average of 7.2 percent annually—not quite enough to keep abreast of the 8.7 percent average yearly step-up in the cost of living. For the last five years, the picture has been even less favorable: an earnings increase of 7.4 percent a year vs. a yearly rise of 9.5 percent in the CPI. So whether we look at five, 10, or even years, the 1982 improvement physicians' buying power was i pressive by comparison.

An important contributing f tor was the beginning of a rev

ONE DOCTOR IN SEVEN NOW NETS $150,000 OR MORE

Back in 1978, only one in 20 surveyed physicians netted as much as $150,000 from practice. By last year, the proportion of M.D.s at that level had nearly tripled, and half of them were earning at least $200,000 after expenses. At the other end of the scale, the percentage of doctors earning less than $50,000 dropped from 29 percent in 1978 to 13 percent in 1982.



sal in the eight-year downtrend in professional visits. Between early 1982 and early 1983, the survey indicates, the typical practitioner's patient visits increased by four per week (to 112). That's enough to account for nearly half the gain in median earnings; the rest apparently came from fee increases and possibly from higher total charges per visit.

Interestingly, physicians' fees, as measured by the CPI, rose less in 1982 than in any other year since 1973—only 7.5 percent, as compared with 11.7 percent the year before. This relatively modest overall boost, along with a

SURGEONS GROSS AND NET ABOUT ONE-FOURTH MORE THAN THE ALL-FIELDS NORMS

Because professional expenses vary from one field of practice to another, the specialists with the highest gross earnings don't necessarily enjoy the highest net. Orthopedists, whose median gross tops that of M.D.s in the specialties listed here, rank second in earnings after expenses. Neurosurgeons, who are third in gross, top all others in net. Plastic surgeons are second in gross but only fourth in net. And pediatricians, who gross $1,100 less than GPs, net $3,090 more.

Gross		Net
$227,810	Neurosurgeons	$142,500
$247,810	Orthopedic surgeons	$139,500
$215,130	Thoracic surgeons	$131,940
$236,560	Plastic surgeons	$127,920
$197,000	OBG specialists	$108,330
$164,580	General surgeons	$98,850
$148,460	Internists	$85,910
$144,790	FPs	$74,580
$124,060	Pediatricians	$72,110
$125,160	GPs	$69,020
$195,880	All surgical specialists	$114,950
$134,670	All non-surgical specialists	$85,910
$155,750	All fields	$93,270

Gross represents physicians' individual shares of 1982 receipts from practice before professional expenses and income taxes. All figures are medians.

lower inflation rate, may help explain the improvement in doctors' practice volume and income.

Private physicians may well show even better profits when they close the books for 1983—especially if the recent upturn in patient-visit rates continues. One reason is that inflation is continuing to decelerate. A projection of the CPI (all items) for 1983 based on the first seven months points to a rise of only 3.9 percent. And a similar projection of physicians' fees shows they're going up at an annual rate of 8.9 percent—enough to produce sizable gains in both net earnings and purchasing

HOW MANY IN YOUR FIELD NET AS MUCH AS YOU DO?

More physicians than you might expect clear upward of a quarter of a million dollars from practice in a single year. In that bracket last year were about one in six thoracic and orthopedic surgeons, one in seven neurosurgeons, one in 10 plastic surgeons, and one in 20 OBGs, but only one in 100 general practitioners, family practitioners, and general surgeons. Earnings that high are three times as common among surgical specialists as among non-surgical specialists.

	% of					
Practice earnings	FPs	GPs	General surgeons	Internists	Neuro-surgeons	OBG specialt
$250,000 or more	1%	1%	1%	—*	14%	5%
200,000-249,999	—*	—*	4	1%	14	4
150,000-199,999	2	2	7	6	16	12
125,000-149,999	4	6	16	9	21	19
100,000-124,999	15	13	20	19	11	16
99,000-99,999	10	7	10	12	5	10
80,000-89,999	11	8	8	8	4	8
70,000-79,999	13	11	8	10	5	7
60,000-69,999	15	15	8	11	3	10
50,000-59,999	10	11	6	7	3	3
40,000-49,999	9	8	6	8	2	2
30,000-39,999	5	9	3	5	1	1
Less than $30,000	5	9	3	4	1	3

*Less than 1 percent.

power even if professional expenses shoot up more than usual.

There you have the latest professionwide view of private practitioners' earnings progress. For actual survey-based dollar figures applicable to particular specialties, regions, types of practice, and other variables, see the charts, tables, and commentaries on these and the following pages. A description of how the 1983 Continuing Survey was conducted appears on page 213.

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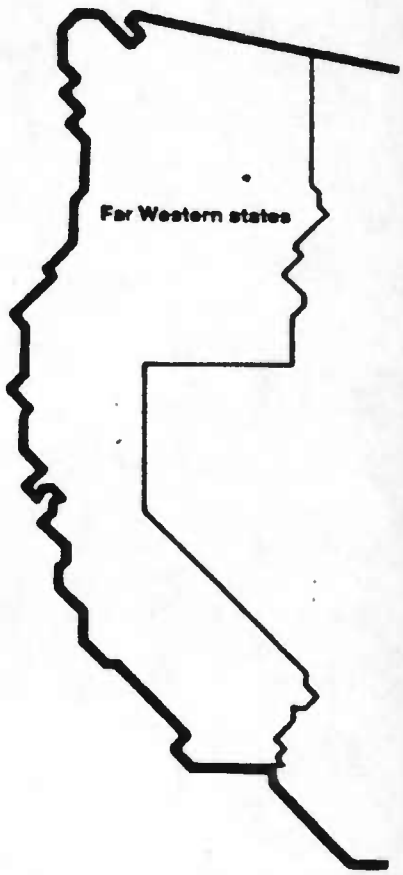
% of					
Orthopedic surgeons	Pediatricians	Plastic surgeons	Thoracic surgeons	All surgical specialists	All non-surgical specialists
16%	—*	10%	17%	6%	2%
13	—*	9	10	5	3
13	—*	11	10	10	6
22	4%	22	19	21	10
17	12	19	16	19	16
5	7	7	4	9	9
3	15	6	5	7	10
4	15	3	6	5	11
4	13	5	6	7	11
—*	12	3	2	3	8
1	9	2	2	3	7
1	7	2	2	2	3
1	6	1	1	3	4

HOW GROSS AND NET EARNINGS VARY BY REGION

Last year, as in other recent years, doctors in the Mid-South (Kentucky, Tennessee, Alabama, and Mississippi) wound up with the highest median practice net—10 percent above the national median. Almost that far *below* the all-U.S. standard were New Englanders, who have traditionally taken last place. Regions with the highest one-year net gains were the Southwest (13 percent), the Plains states, and the Rocky Mountain states (both 11 percent). Median earnings in the Mid-South dropped 3.5 percent from 1981, for a loss of 7.4 percent in purchasing power for M.D.s in that region. The only other region that failed to beat the year's 3.9 percent inflation rate: the Great Lakes states, with a median net gain of 2.6 percent.



	Gross	Net
WEST	$160,260	$88,330
Rocky Mountain states	$165,830	$92,140
Far Western states (including Alaska and Hawaii)	$158,640	$87,220

	Gross	Net
SOUTH	$162,420	$ 98,410
South Atlantic states	$157,620	$ 95,630
Mid-Southern states	$176,000	$102,500
Southwestern states	$161,920	$ 99,420

	Gross	Net
MIDWEST	$157,000	$96,810
Great Lakes states	$158,410	$96,470
Plains states	$153,130	$97,690

	Gross	Net
EAST	$133,820	$85,290
New England states	$127,500	$84,640
Mid-Eastern states	$135,670	$85,710

DIFFERENCES IN PRACTICE INCOME

What's the net-earnings difference between an unincorporated solo practitioner and a doctor in a multiphysician professional corporation? About $49,000 if each is typical for his kind of practice, our survey of 1982 earnings shows. Experience obviously affects a physician's earnings too, but not as strongly. These days, the typical office-based M.D. reaches his earnings peak before he's been in practice 11 years. In uninflated dollars, his annual earnings during the second five years of practice exceed those of years one through five by 35 percent, then taper off 24 percent before the doctor retires.

BY TYPE OF PRACTICE . . .

		Incorporated		
$194,800	Gross	Solo	Net	$98,490
$173,480		Multiphysician practice		$113,550
		Unincorporated		
$112,740		Solo		$64,380
$133,000		Expense-sharing		$77,140
$141,250		Partnership or group		$85,530

AND BY YEARS IN PRACTICE

$123,750	Gross	1-5	Net	$78,500
$175,000		6-10		$106,290
$173,600		11-20		$103,330
$156,670		21-30		$89,310
$139,290		31 or more		$81,070

HOW THIS YEAR'S SURVEY WAS CONDUCTED

Questionnaires for the 1983 MEDICAL ECONOMICS Continuing Survey were mailed early in February to 17,448 office-based M.D.s of all ages—a random sampling from the master list maintained by Clark-O'Neill Inc. A follow-up mailing to non-respondents was made in early March. By the mid-May cutoff date, 5,899 physicians—33.8 percent—had responded. After we set aside returns with apparent discrepancies and those from physicians who hadn't been providing office-based patient care throughout the preceding year, our working sample consisted of 4,188 questionnaires. These were coded by MEDICAL ECONOMICS' research staff, then tabulated by computer under the direction of Harvey Rosenfeld of Digitab Computing Inc. in New York City.

As the accompanying tables show, the survey sample is fairly representative in terms of field of practice, region, and age. It's therefore likely to be representative in other ways as well.

FIELD OF PRACTICE	% of	
	Statistical universe*	Survey sample
Internal medicine	12.0%	11.2%
General practice	8.9	12.0
Family practice	8.1	7.1
General surgery	6.9	7.8
Obstetrics/gynecology	6.7	9.2
Pediatrics	6.3	7.6
Psychiatry	5.4	5.7
Anesthesiology	4.5	4.6
Ophthalmology	4.0	3.8
Orthopedic surgery	4.1	3.9
Radiology	2.4	4.5
Pathology	1.9	1.2
Neurology	1.2	0.8
Plastic surgery	1.0	1.4
Neurosurgery	0.9	0.8
Thoracic surgery	0.6	0.7
All other specialties	25.1	17.7

REGION	% of	
	Statistical universe*	Survey sample
East	23.8%	20.7%
South	30.8	31.7
Midwest	22.6	23.3
West	22.8	24.3

AGE	% of	
	Statistical universe*	Survey sample
Under 35	11.3%	10.2%
35-44	31.6	31.0
45-54	24.7	27.3
55-64	19.9	24.9
65 and over	12.5	6.6

*All office-based M.D.s in patient care as reported by Clark-O'Neill Inc. and the AMA for February 1983. ■

TABLE 14

RELATIONSHIP BETWEEN CLAIMANT AND DEFENDANT
PRIOR TO INCIDENT

Prior Patient of Defendant	Number	Percent
Yes	268	51%
No	263	49%
Total	531*	100%

*243 cases are missing due to the absence of relevant information in claim file.

Source: Johns Hopkins Study of Health Claims Arbitration Process

TABLE 35

LENGTH OF TIME IN MONTHS BETWEEN ARBITRATION PHASES

Arbitration Phases	NUMBER*	MEAN (Months)	MEDIAN (Months)	RANGE (Months)
Incident to Claim Filed	769	24.03	23.03	.60-218.47
Claim Filed to Service of Last Defendant	735	1.71	.68	.00-28.50
Claim Filed to Chair's Acceptance	685	6.49	5.30	.07-36.10
Claim Filed to Health Care Provider's Acceptance	587	9.37	8.19	2.93-41.77
Claim Filed to Public Member's Acceptance	602	9.30	8.13	.67-50.27
Claim Filed to 1st Pre-hearing Conference	467	11.60	9.93	3.07-49.77
Claim Filed to Last Pre-hearing Conference	195	16.50	15.19	4.00-45.23
Claim Filed to Hearing Begun	210	19.27	17.52	1.1-50.33
1st Pre-hearing Conference to Hearing Begun	181	7.47	6.17	.23-34.20
Claim Filed to Hearing Ended	204	19.79	17.72	6.13-51.77
Claim Filed to Disposition	768	16.84	15.50	.33-52.10
Service of Last Defendant to Disposition	741	15.38	13.87	.33-47.77
Disposition to Modification	28	1.47	.88	.20-12.20
Disposition to Appeal	107	1.49	1.05	.03-14.07

Source: Johns Hopkins Study of Health Claims Arbitration Process

*Fluctuating numbers occur because claims were withdrawn, dismissed or settled at different points of time in the arbitration process.

TABLE 36

LENGTH OF TIME (MEAN MONTHS) BETWEEN ARBITRATION PHASES BY METHOD OF CASE DISPOSITION
(Figures in parentheses reflect number of cases that the mean is based upon.)

Arbitration Phase	DURATION (MEAN MONTHS) BY METHOD OF CASE DISPOSITION								Total	Level of Significance*
	DISMISSAL:			CASE SETTLED:						
	Requested By Claimant	Ordered By Panel Chair	Other	Prior To Pre-Hearing Conference	Prior To Hearing	During Hearing	Through Panel Determination	Panel Determination Outcome Appealed		
Incident to Claim Filed	26.0 (190)	26.0 (63)	46.3 (16)	21.2 (127)	22.7 (179)	13.9 (13)	21.7 (84)	24.6 (97)	769	p<.001
Claim Filed to Service of Last Defendant	1.3 (174)	2.3 (63)	1.7 (18)	1.4 (120)	1.7 (176)	2.6 (13)	1.3 (77)	2.7 (94)	735	p<.05
Claim Filed to Chair's Acceptance	6.1 (154)	7.6 (60)	7.3 (12)	6.5 (93)	6.2 (176)	8.3 (12)	5.9 (82)	7.1 (96)	685	N.S.
Claim Filed to Health Care Provider's Acceptance	8.5 (111)	9.9 (47)	9.9 (9)	8.6 (64)	9.5 (166)	10.2 (13)	9.1 (83)	10.6 (94)	587	N.S.
Claim Filed to Public Member's Acceptance	8.5 (121)	10.1 (50)	11.2 (10)	8.7 (65)	9.2 (170)	9.9 (13)	9.5 (80)	10.1 (93)	602	N.S.
Claim Filed to 1st Pre-Hearing Conference	11.4 (79)	12.3 (33)	15.4 (7)	--	11.1 (175)	12.6 (10)	10.9 (69)	12.8 (88)	461	N.S.
Claim Filed to Last Pre-Hearing Conference	15.9 (29)	20.3 (11)	14.0 (4)	--	16.7 (68)	11.2 (2)	15.6 (34)	17.1 (45)	193	N.S.
Claim Filed to Hearing Begun	18.4 (8)	21.2 (8)	--	--	--	17.7 (12)	18.3 (84)	20.2 (98)	210	N.S.
1st Pre-hearing Conference to Hearing Begun	13.3 (4)	6.7 (7)	--	--	--	4.4 (10)	7.8 (71)	7.3 (89)	181	N.S.
Claim Filed to Hearing Ended	22.0 (6)	21.2 (8)	--	--	--	17.3 (11)	18.4 (83)	21.0 (96)	204	N.S.

App. O

TABLE 36

LENGTH OF TIME (MEAN MONTHS) BETWEEN ARBITRATION PHASES BY METHOD OF CASE DISPOSITION
(Continued)

Arbitration Phase	DURATION (MEAN MONTHS) BY METHOD OF CASE DISPOSITION								Total	Level of Significance*
	DISMISSAL:			CASE SETTLED:						
	Requested By Claimant	Ordered By Panel Chair	Other	Prior To Pre-Hearing Conference	Prior To Hearing	During Hearing	Through Panel Determination	Panel Determination Outcome Appealed		
Claim Filed to Disposition	14.3 (187)	19.1 (63)	14.3 (19)	13.0 (125)	18.5 (179)	19.1 (13)	18.7 (84)	20.5 (98)	768	p<.001
Service of Last Defendant to Disposition	13.4 (174)	16.9 (63)	13.0 (18)	11.9 (121)	17.0 (178)	16.5 (13)	17.4 (79)	18.0 (95)	741	p<.001
Disposition to Modification	.9 (2)	1.7 (4)	--	--	1.4 (1)	--	1.9 (10)	12.0 (11)	28	N.S.
Disposition to Appeal	--	1.4 (10)	1.4 (2)	--	--	--	--	1.5 (93)	105	N.S.

*Based on one-way analysis of variance between groups.

TOTAL DOLLARS AWARDED THROUGH PANEL DETERMINATION

SIZE OF AWARD	NUMBER OF CLAIMS	TOTAL DOLLARS AWARDED	PERCENTAGE OF TOTAL DOLLARS AWARDED	CUMULATIVE PERCENTAGE
$1,000,000-3,565,415	4	$9,415,415	54%	54%
$ 750,000-999,999	1	$ 750,000	5%	59%
$ 500,000-749,999	4	$2,252,784	13%	72%
$ 300,000-499,999	4	$1,310,000	7%	79%
$ 200,000-299,999	4	$ 900,000	5%	84%
$ 100,000-199,999	12	$1,543,353	9%	93%
Less than $100,000	47	$1,131,197	7%	100%
TOTAL	76	$17,302,749	100%	100%

App. Q

EXHIBIT 1A

DICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND - CLOSED INCIDENTS

CIDENT YEARS 1975 THROUGH 1980 CLOSED INCIDENTS AT ACTUAL VALUES

INDEMNITY RANGE	NUMBER INCIDENTS	PERCENT TOTAL	INDEMNITY	PERCENT TOTAL	AVERAGE INDEMNITY	EXPENSE	PERCENT TOTAL	PERCENT INDEMNITY	AVERAGE EXPENSE	INCURRED LOSS	PERCENT TOTAL	AVERAGE INCURRED
0	1,178	78.6	0	0.0	0	2,161,412	40.4	0.0	1,835	2,161,412	5.8	1,835
1- 5,000	88	5.9	189,041	0.6	2,148	238,651	4.5	126.2	2,712	427,692	1.1	4,860
5,001- 10,000	35	2.3	269,904	0.8	7,712	161,661	3.0	59.9	4,619	431,565	1.2	12,330
10,001- 15,000	21	1.4	282,648	0.9	13,459	73,126	1.4	25.9	3,482	355,774	1.0	16,942
15,001- 20,000	12	0.8	228,794	0.7	19,066	95,993	1.8	42.0	7,999	324,787	0.9	27,066
20,001- 25,000	14	0.9	340,500	1.1	24,321	129,294	2.4	38.0	9,235	469,794	1.3	33,557
25,001- 30,000	7	0.5	206,000	0.6	29,429	68,178	1.3	33.1	9,740	274,178	0.7	39,168
30,001- 40,000	11	0.7	388,575	1.2	35,325	128,922	2.4	33.2	11,720	517,497	1.4	47,045
40,001- 50,000	21	1.4	1,010,500	3.2	48,119	230,629	4.3	22.8	10,982	1,241,129	3.3	59,101
50,001- 75,000	16	1.1	1,007,176	3.1	62,949	254,226	4.8	25.2	15,889	1,261,402	3.4	78,838
75,001- 100,000	24	1.6	2,238,220	7.0	93,259	344,163	6.4	15.4	14,340	2,582,383	6.9	107,599
00,000- 150,000	16	1.1	2,056,931	6.4	128,558	164,882	3.1	8.0	10,305	2,221,813	6.0	138,863
50,001- 200,000	12	0.8	2,255,729	7.1	187,977	167,465	3.1	7.4	13,955	2,423,194	6.5	201,933
00,001- 300,000	14	0.9	3,584,361	11.2	256,026	300,718	5.6	8.4	21,480	3,885,079	10.4	277,506
00,001- 400,000	10	0.7	3,792,000	11.9	379,200	267,867	5.0	7.1	26,787	4,059,867	10.9	405,987
00,001- 500,000	5	0.3	2,315,000	7.2	463,000	72,491	1.4	3.1	14,498	2,387,491	6.4	477,498
00,001- 600,000	1	0.1	593,227	1.9	593,227	64,864	1.2	10.9	64,864	658,091	1.8	658,091
00,001- 700,000	3	0.2	2,020,890	6.3	673,630	136,507	2.6	6.8	45,502	2,157,397	5.8	719,132
00,001- 800,000	6	0.4	4,569,405	14.3	761,568	144,705	2.7	3.2	24,118	4,714,110	12.6	785,685
00,001- 900,000	0	0.0	0	0.0	0	0	0.0	0.0	0	0	0.0	0
00,001-1,000,000	2	0.1	2,000,000	6.3	1,000,000	50,777	1.0	2.5	25,389	2,050,777	5.5	1,025,389
OVER 1,000,000	2	0.1	2,646,986	8.3	1,323,493	87,512	1.6	3.3	43,756	2,734,498	7.3	1,367,249
TOTAL	1,498		31,995,887		21,359	5,344,043		16.7	3,567	37,339,930		24,927
NON-ZERO ONLY	320		31,995,887		99,987	3,182,631		9.9	9,946	35,178,518		109,933

App. R

EXHIBIT 2A

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND - CLOSED INCIDENTS

ACCIDENT YEARS 1975 THROUGH 1980 CLOSED INCIDENTS TRENDED AT 10.5% ANNUALLY TO 1983 LEVELS

INDEMNITY RANGE	NUMBER INCIDENTS	PERCENT TOTAL	INDEMNITY	PERCENT TOTAL	AVERAGE INDEMNITY	EXPENSE	PERCENT TOTAL	PERCENT INDEMNITY	AVERAGE EXPENSE	INCURRED LOSS	PERCENT TOTAL	AVERAGE INCURRED
0	1,178	78.6	0	0.0	0	3,867,687	41.8	0.0	3,283	3,867,687	6.1	3,283
1- 5,000	58	3.9	95,817	0.2	1,652	135,474	1.5	141.4	2,336	231,291	0.4	3,988
5,001- 10,000	34	2.3	242,224	0.4	7,124	222,126	2.4	91.7	6,533	464,350	0.7	13,657
10,001- 15,000	25	1.7	306,209	0.6	12,248	232,696	2.5	76.0	9,308	538,905	0.8	21,556
15,001- 20,000	11	0.7	192,145	0.4	17,468	90,695	1.0	47.2	8,245	282,840	0.4	25,713
20,001- 25,000	13	0.9	304,154	0.6	23,396	91,497	1.0	30.1	7,038	395,651	0.6	30,435
25,001- 30,000	6	0.4	166,535	0.3	27,756	75,736	0.8	45.5	12,623	242,271	0.4	40,379
30,001- 40,000	13	0.9	449,126	0.8	34,548	145,768	1.6	32.5	11,213	594,894	0.9	45,761
40,001- 50,000	12	0.8	555,574	1.0	46,298	166,818	1.8	30.0	13,902	722,392	1.1	60,199
50,001- 75,000	24	1.6	1,490,644	2.7	62,110	535,873	5.8	35.9	22,328	2,026,517	3.2	84,438
75,001- 100,000	14	0.9	1,186,914	2.2	84,780	270,714	2.9	22.8	19,337	1,457,628	2.3	104,116
100,000- 150,000	23	1.5	2,723,064	5.0	118,394	607,744	6.6	22.3	26,424	3,330,808	5.2	144,818
150,001- 200,000	19	1.3	3,220,043	5.9	169,476	411,666	4.4	12.8	21,667	3,631,709	5.7	191,143
200,001- 300,000	17	1.1	4,036,621	7.4	237,448	326,660	3.5	8.1	19,215	4,363,281	6.8	256,664
300,001- 400,000	13	0.9	4,436,994	8.1	341,307	366,236	4.0	8.3	28,172	4,803,230	7.5	369,479
400,001- 500,000	5	0.3	2,316,702	4.3	463,340	213,109	2.3	9.2	42,622	2,529,811	4.0	505,962
500,001- 600,000	7	0.5	3,788,791	7.0	541,256	295,928	3.2	7.8	42,275	4,084,719	6.4	583,531
600,001- 700,000	5	0.3	3,247,560	6.0	649,512	153,704	1.7	4.7	30,741	3,401,264	5.3	680,253
700,001- 800,000	5	0.3	3,725,054	6.8	745,011	167,708	1.8	4.5	33,542	3,892,762	6.1	778,552
800,001- 900,000	2	0.1	1,667,250	3.1	833,625	56,429	0.6	3.4	28,215	1,723,679	2.7	861,840
900,001-1,000,000	1	0.1	977,045	1.8	977,045	106,831	1.2	10.9	106,831	1,083,876	1.7	1,083,876
OVER 1,000,000	13	0.9	19,356,047	35.5	1,488,927	718,730	7.8	3.7	55,287	20,074,777	31.5	1,544,213
TOTAL	1,498		54,484,513		36,372	9,259,829		17.0	6,181	63,744,342		42,55
NON-ZERO ONLY	320		54,484,513		170,264	5,392,142		9.9	16,850	59,876,655		187,115

App. S

TABLE 2
INFORMATION ON CLAIM DISPOSITION AS OF JUNE, 1971

Year of Occurrence	Total N	Still Pending	Closed Claims						Other Expenses	Grand Total
			No Payment To Claimant	No Info Available	Settled Out of Court N	Settled Out of Court $	Court N	Court Award $		
1960	13	5	3	1	4	12,166.67	-	-0-	-0-	12,166.67
1961	30	5	8	4	13	49,988.90	-	-0-	8,763.18	58,752.08
1962	39	9	19	-	11	87,600.00	-	-0-	10,659.28	98,259.28
1963	35	9	16	-	8	19,115.60	2	350,750.00	1,445.46	371,311.06
1964	59	18	29	1	11	83,824.52	1	25,000.00	80,454.77	189,279.29
1965	59	19	20	1	16	225,353.95	3	345,500.00	53,577.69	624,431.64
1966	42	15	17	1	8	169,750.00	1	31,802.98	17,860.47	219,413.45
1967	59	35	18	-	6	11,735.00	-	-0-	4,436.31	16,171.31
1968	25	16	6	-	3	61,750.00	-	-0-	4,769.25	66,519.25
1969	14	12	2	-	-	-0-	-	-0-	-0-	-0-
1970	6	5	1	-	-	-0-	-	-0-	-0-	-0-
Totals:	381	148	137	8	81	721,284.64	7	753,052.98	181,966.41	1,656,304.03
Percent:		40%	36%	2%	21%		2%			

MEDICAL MUTUAL
CLOSED CLAIMS INITIATED IN HEALTH CLAIMS ARBITRATION BY YEAR OF CLOSING

	1978	1979	1980	1981	1982 (9 Months)
Number of Claims with Payment	-	2	22	25	45
Number of Claims Closed		6	57	88	181
Percent with Indemnity		33%	39%	28%	25%
Total Indemnity		9,500	1,615,000	4,358,000	4,017,000
Total Defense Costs		15,300	188,000	398,000	948,000
Number of Claims Closed Without Payment		4	35	63	136
Defense Costs on Claims Without Liability		9,000	84,900	213,400	496,800

App. I

DAMAGES AWARDED BY CLAIM APPEAL STATUS

DAMAGES AWARDED	NOT APPEALED	APPEALED BY			
		DEFENDANT	CLAIMANT	BOTH DEFENDANT AND CLAIMANT	ROW TOTAL
$1,000-4,999	5	1	2	0	8
$ 5,000-9,999	6	1	2	1	10
$10,000-49,999	13	3	3	2	21
$50,000-99,999	4	1	2	1	8
$100,000-199,999	5	1	0	6	12
$200,000-299,999	0	4	0	0	4
$300,000-499,999	2	0	1	1	4
$500,000-999,999	2	2	1	0	5
$1,000,000-3,565,415	1	1	0	2	4
COLUMN TOTAL	38	14	11	13	76

Judicial Circuit	Number of Cases	Venue Breakdown
First	17	Wicomico - 11; Worcester - 3; Somerset - Dorchester - 1; Caroline - 0
Second	14	Talbot - 6; Cecil - 4; Kent - 2; Queen Anne's - 2
Third	361	Baltimore - 250; Harford - 111
Fourth	30	Washington - 17; Allegheny - 11; Garrett
Fifth	104	Anne Arundel - 66; Howard - 32; Carroll -
Sixth	161	Montgomery - 149; Frederick - 12
Seventh	151	Prince George's - 139; Charles - 6; St. Mary's - 4; Calvert - 2
Eighth	401	Baltimore City - 401

TABLE 34

SEVERITY OF CLAIMANT'S INJURY
BY DAMAGES AWARDED

DAMAGES AWARDED	SEVERITY				
	EMOTIONAL ONLY	TEMPORARY	PERMANENT	PERMANENT: GRAVE	DEATH
$1,000-4,999	-	29%	13%	-	-
$5,000-9,999	-	14	16	-	13%
$10,000-49,999	50%	57	26	-	17
$50,000-99,999	-	-	13	17%	13
$100,000-199,999	-	-	23	-	22
$200,000-299,999	50	-	3	-	9
$300,000-499,999	-	-	3	17	9
$500,000-999,999	-	-	3	17	13
$1,000,000-3,565,415	-	-	-	50	4
Total	2	14	31	6	23

Source: Johns Hopkins Study of Health Claims Arbitration Process

MEDICAL MUTUAL
ALL CLOSED CLAIMS BY YEAR OF CLOSING

	1978	1979	1980	1981	1982 (9 Months)
Number of Claims with Payment	13	13	39	52	83
Number of Claims Closed	48	69	220	308	475
Percent with Indemnity	27%	19%	18%	17%	17%
Total Indemnity	1,071,000	564,900	4,029,000	5,659,000	6,056,000
Total Defense Costs	67,000	182,600	412,400	629,000	1,286,000
Number of Claims Closed Without Payment	35	56	181	256	392
Defense Costs on Claims Without Liability	20,000	154,600	177,800	323,700	660,200

App. X

TABLE 38

YEARS OF EXPERIENCE OF PANEL CHAIRPERSON
BY METHOD OF CASE DISPOSITION

Method of Case Disposition	Mean Years of Experience	N
Dismissal:		
Requested by claimant	12.85	145
Ordered by chairperson	13.70	56
Other	12.78	9
Case Settled:		
Prior to pre-hearing conference	12.26	84
Prior to hearing	12.37	169
During hearing	10.40	10
Through panel determination	12.11	78
Panel Determination-Outcome		
Appealed	10.97	88
TOTAL	12.33	639*
	N.S.	

* A chairperson was appointed in 734 cases. The Chairperson's years of experience is missing in 95 cases due to the absence of data.

Source: Johns Hopkins Study of Health Claims Arbitration Process.

TABLE 39

YEARS OF EXPERIENCE OF PANEL CHAIRPERSON
BY OUTCOME OF PANEL DETERMINATION

Years of Experience	LIABILITY DETERMINATION	
	For Claimant	For Defendant
Less than one year	3%	1%
One year	-	3%
Two years	-	5%
Three years	11%	7%
Four years	9%	2%
Five years	7%	7%
Six to ten years	38%	32%
11-15 years	13%	19%
16-20 years	4%	7%
21-25 years	7%	3%
26-30 years	7%	8%
More than 30 years	1%	7%
Total	71	91

* There were 182 cases that completed the arbitration hearing process. Twenty cases are missing from this table due to the absence of data.

Source: Johns Hopkins Study of Health Claims Arbitration Process.

TABLE 37

YEARS OF EXPERIENCE OF PANEL CHAIRPERSONS*

YEARS OF EXPERIENCE	CHAIRPERSONS NUMBER	PER CENT
Less than one year	4	1%
One year	12	2
Two years	27	4
Three years	42	7
Four years	36	6
Five years	43	7
Six to ten years	197	31
11 - 15 years	99	15
16 - 20 years	56	9
21 - 25 years	42	7
26 - 30 years	47	7
More than 30 years	34	5
TOTAL	639**	101%***

*Length of time between date individual passed State Bar examination and date accepted panel chair position.

**A chairperson was appointed in 734 cases. The chairperson's years of experience is missing in 95 cases due to the absence of data.

***Percentage greater than 100% due to rounding procedures.

Source: Johns Hopkins Study of Health Claims Arbitration Process

Health Claims [illegible] - as of August 31, 1983 App. A

Recorded in Office of the Sec. of State.

	H.C.P.s	Attny.s	P.M.s		
ALLG	40	7	16		
ANAR	123	84	205		
BCIT	472	413	372		
BLCO	341	166	616		
CLVT	7	6	6		
CRLN	2	4	1		
CRRL	22	17	31		
CECL	13	17	2		
CHAS	10	9	8		
DRCH	7	3	5		
FRDR	26	28	6		
GRRT	13	5	1		
HRFD	21	37	42		
HWRD	46	43	49		
KENT	5	3	6		
MTGM	385	236	111		
PGEO	309	249	145		
QANN	1	7	1		
STMA	10	9	12		
SMST	4	1	4		
TLBT	32	15	13		
WSHG	42	23	10		
WCMC	55	31	7		
WRCS	4	11	1		
	1,990	1,424	1,670		

TABLE 40

SPECIALTY OF HEALTH CARE PROVIDER PANEL MEMBER

Specialty	Number	Percent
Dentistry	70	12%
Internal Medicine	61	10
OB/GYN	53	9
Physician-Not otherwise classified	49	8
General Surgery	46	8
Orthopedic Surgery	41	7
Family Practice	34	6
Nursing	24	4
Pediatrics	22	4
Ophthalmalogy	20	3
Radiology	18	3
Psychiatry	12	2
Cardiology	9	2
Gasteroenterology	9	2
General Practice	9	2
Pathology	8	1
Urology	8	1
Dermatology	7	1
All Others	90	15
TOTAL	587*	100%

*There were 615 HCP panel members named. The specialty of 28 panel members is missing due to the absence of data.

Source: Johns Hopkins Study of Health Claims Arbitration Process.

Claims Terminology

CLAIMS-MADE POLICY—a policy covering the hospital for claims made during the policy year resulting from incidents that occurred that year or since the retroactive date of the coverage.

EXPOSURE UNIT—one bed, crib, or bassinet, or 1,000 outpatient visits.

IBNR (INCURRED BUT NOT REPORTED)—a calculation that estimates the potential losses from incidents that have occurred but have not been reported. IBNR also takes into account other factors that predict the eventual level of total incurred losses.

INCURRED LOSSES—paid losses plus reserves, including IBNR.

LOSS RATIO—a measurement of losses calculated by dividing **incurred losses** by the **premium.**

LOSS RESERVES—a calculation of the estimated costs to settle a claim that has been reported, but not yet closed.

OCCURRENCE—an incident that may result in a liability claim, sometimes called a "potentially compensable event."

OCCURRENCE POLICY—a policy covering the hospital up to policy limits for losses resulting from incidents that occur during the policy year, regardless of when the claims are filed.

PAID LOSSES—actual losses paid on claims; USF&G's paid loss figures include legal defense costs.

REPORTED (OR DISCOVERED) OCCURRENCE—an occurrence of which the insurer is aware, through incident reporting, an attorney's letter, or the filing of a formal claim.

Frequency of claims. Figure 1 shows that the frequency of claims increased more than 50% over four years, rising to 4.7 claims per 100 exposure units in 1980 compared to 3.1 for 1977.

The 1981 year is too recent to evaluate, but the number of claims per 100 exposure units has **already** reached 4.2—and if present trends continue—is projected to exceed 5 claims per 100 exposure units at the next evaluation. The ultimate number of claims per exposure unit will be even higher, because the "long tail" delays discovery.

Average incurred loss per claim. The average incurred loss per claim **increased by 445%** from 1974 to 1980. Figure 2 demonstrates that for claims of less than $100,000, the average incurred loss (including paid losses and loss reserves) rose to $67,554 for 1980, up from $15,159 in 1974. (The year refers to the year of the occurrence, not the year of settlement.)

Many factors contribute to the escalating costs per claim, including:

- inflation,
- higher jury awards,

Figure 1. Frequency of Claims

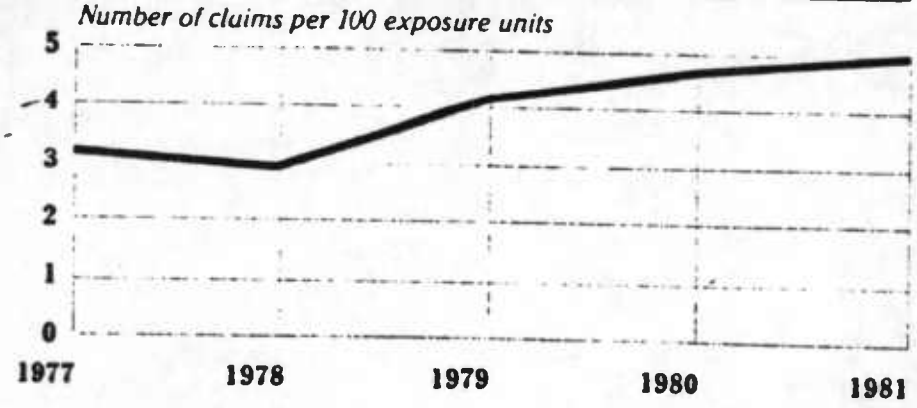


Figure 2. Average Incurred Loss Per Claim, 1974-1980

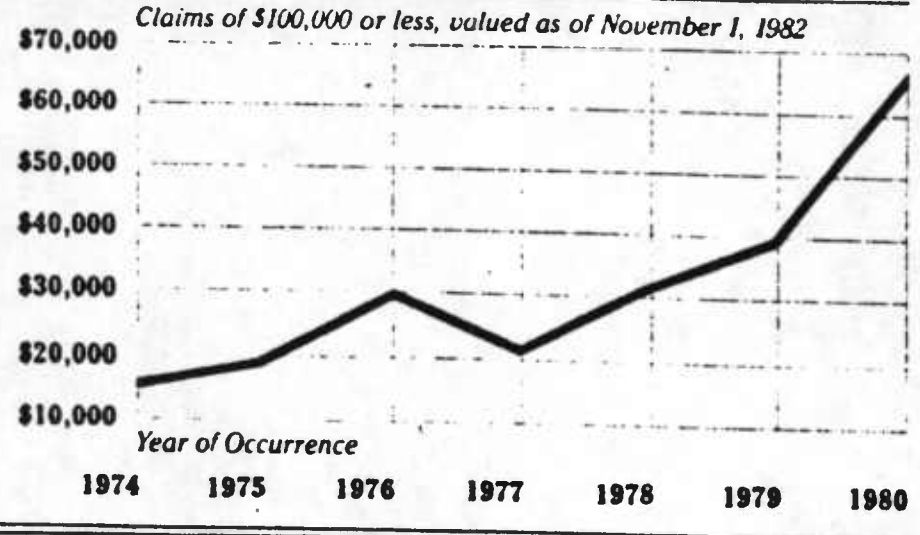


TABLE 23

SOURCE OF PAYMENT FOR MEDICAL CARE OF INJURED PARTY

PAYMENT SOURCE	NUMBER	PERCENT
Blue Cross/Blue Shield	127	29%
Other Private Insurance	95	21
Medicare	20	5
Medicaid	26	6
Medicare and Medicaid	2	*
Medicare/Blue Cross/Blue Shield	9	2
Medicare/Other Private	4	1
Self Pay	119	27
Type Unknown	41	9
TOTAL	443**	100%

*Less than 1 percent

**331 cases are missing due to the absence of data.

Source: Johns Hopkins Study of Health Claims Arbitration Process

Decision ratios, which are related in a general way to the degree of justice provided by the settlement process, were found to be generally from 0.27 to 0.34 in the medical-legal panels' settlements over a period of time, and to be 0.34 for all defendents in jury verdicts.[2]

The court-settled ratio indicated for Maryland above, in contrast to the out-of-court settlement ratio, may show the tendency of the carrier to settle most cases out of court where he does not have advantage. The ratio involving Med-Chi panels does appear to favor defendent, but it may be that the cases are screened before they are brought to panels, like those settled in court. One would therefore like to study the characteristics of court-settled and the panel-involved claims to determine why the ratios are so different from the others.

4. Physicians Involved in More Than One Malpractice Event (Incident or Suit)

The report states, "of the 322 physicians involved in incidents over the ten-year period researched, 46 (14%) had multiple claims. Of those, 36 had two claims each, 7 had three claims each, and 3 had four claims each." The report also indicates that Med-Chi's program insures 3,166 physicians. From these given data, the following table and analysis can be constructed along the line of R. A. Fisher's celebrated example.[3] This table compares the observed distribution of the 3,166 physicians (shown in column 2) by frequency of claim with the expected distribution (shown in column 4). The expected distribution is what might be expected from selecting the 381 numbers (representing claims) from a bowl containing the 3,166 numbers (representing physicians), replacing the number, and mixing after each selection. Repeated drawing of the 381 numbers will show some variation in the number of pairs, triples, etc., arising from the well known laws of chance.

Frequency of Claim	Observed Number of Physicians	Number of Claims	Poisson Expected Percent*	Expected Number of Physicians	Chi-Square Statistic
0	2,844	0	88.69	2,808	0.46
1	276	276	10.64	337	7.72
2	36	72	0.64	20	
3	7	21	0.25	1	29.76
4	3	12	0.00	0	
Total	3,166	381	100.00	3,166	50.74**

* Based on the observed rate = 381/3166 = 0.12 or 12 per 100 physicians

** Very significant for $X^2_{0.001, 2} = 13.82$

The number of physicians involved in only one claim is expected to be 337, much greater than the number observed to have one claim (276). The number expected to have more than one claim is only 21, in sharp contrast to the 46 observed. The chi-square test of significance shows that this difference between expected and observed, especially the difference between 21 and 46, is very significant; that is, this big difference might not be expected by chance more frequently than once in a million times.

The conclusion is thus a strong one that malpractice claim-proneness among physicians does exist. The data do not explain why it exists, however. Further investigation of the 105 claims in which the 46 multiple-claim physicians were involved might shed some light on the nature and possible cause of proneness. The proneness could be related to speciality, age, personality, training, nature of practice, or other factors. If proneness is found to be associated with specialty, further exploration using the techniques above might be made to determine whether individual doctors within a specialty were also malpractice-prone.

This conclusion does not disagree with the general ones reached in the report. It simply uses the available statistical tools to make more precise use of the admittedly limited data.

5. Lawyers and Law Firms Handling More Than One Claim

The report rejects the hypothesis that "specific law firms are involved in a large number of cases". This conclusion can be made more specific by an examination of the basic data on 204 cases involving lawyers (out of the 256 claims) as shown in the following table:

Frequency of Cases per Lawyer	Observed Number of Lawyers	Number of Cases
1	149	149
2	19	38
3	0	0
4	1	4
5	1	5
8	1	8
Total	171	204

The American Bar Association reports that there were 4,624 lawyers in private practice in Maryland in 1970. (Statistical Abstract p. 154) With one malpractice claim to every 20 lawyers, one would expect by chance alone that no more than five lawyers would have more than one case and that 194 would have just one case. The fact that there were 19 lawyers with two cases and three others with multiple numbers does suggest that some few lawyers do seek out such cases or are sought out for handling them. Some 9% of the cases were handled by the multi-case lawyers and nearly 19% by those handling two cases. Thus there is evidence that some lawyers, at least the three multiple ones, do have affinity for malpractice claims. This questions thus whether the report hypothesis is properly rejected. Whether there is a difference in the type of claim handled by the single versus multiple-case lawyer in terms of injury severity or settlement amount might add much to the study.

[2] *Ibid.*

[3] R.A. Fisher, *Statistical Methods for Research Work*, 8th. ed., London, 1941.

NUMBER OF TIMES DEFENDANT NAMED IN DIFFERENT CLAIMS

(Individuals Only)

	NUMBER	PERCENT
Named in 1 claim	909	90%
Named in 2 claims	80	8
Named in 3 claims	13	1
Named in 4 claims	4	*
Total number of different defendants	(1006)	

*Less than 1%

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Friday - October 14, 1983
501 St. Paul Place
15th Floor Conference Room
Baltimore, Maryland

MINUTES

Present

George W. Liebmann, Chairman
George B. Hankins, Public
W. Minor Carter, Public
Ellen L. Zamoiski, Public
J. John Spinella, Insurance Industry
Grover Czech, Insurance Industry
Edward J. Muhl, Insurance Commissioner
Israel H. Weiner, Health Professions
Delegate Gene W. Counihan
Senator Francis X. Kelly
Michael Connolly, Asst. Commissioner
Paula Rosenberger, Recording Secy.
Mike Fallon, Law Clerk

Absent

Harold A. Cohen, Ph.D.
Health Services Cost
Review Commission
Delegate Joel Chasnoff
Senator Jerome F. Connell, Sr
James Paul Durkan, M.D.
Health Professions

* * * *

The first meeting of the Governor's Commission on Health Care Providers Professional Liability Insurance convened at 9:30 a.m. in the 15th Floor Conference Room at 501 St. Paul Place. Chairman George W. Liebmann started the discussion by reviewing the Commission's charge. He explained the first meetings will focus on the gathering of accurate statistical data and discussing problems in terms of insurance rates and the magnitude of costs. Mr. Liebmann then addressed the other members for their comments in preparing for this Commission.

Delegate Counihan passed for an open agenda.

Minor Carter stated the magnitude and difficulty cannot be understated. This is a very difficult problem, and indicated a hope that the commission can accomplish something. He also remarked that we may be involved in some opposition from various interested groups on the subject matter.

Mr. J. John Spinella added that he agreed with the comments Mr. Minor expressed. Deficiencies can be addressed and suggested we look into the processes under Health Claims Arbitration System.

Dr. Israel Howard Weiner explained that our role should be to try and avoid an increase in malpractice insurance in Maryland.

Commissioner Edward J. Muhl would like the commission to explore the possibility of a better system to stop or slow the spiraling costs of health care. There seems to be a tremendous duplication of processes in the present system.

Mr. Hankins questioned how the costs are measured. He stated they are out-of-line and the costs should be kept down.

Senator Francis Kelly added he is very interested in the increasing costs of health care; the average being 18 to 20 percent. He stated that he is objective as far as the issue of monopolies is concerned. The Senator would like a thorough briefing along with the history of the issue. He concluded that the commission needs facts before it can proceed with any deliberations.

Ms. Ellen Zamoiski stated she had nothing to add to what had already been said.

Grover E. Czech informed the commission that he has been involved in this issue at least eight years. Mr. Czech added that he agrees with the points made by Minor Carter. He questions what solutions would have some impact. We can identify specific reforms to the system. He is not optimistic that we will succeed.

Chairman Liebmann defined that the commission needs to direct their attention on the following five points:

1) We need to look at the movement of rates and premiums over the last ten years in Maryland.

2) We need some sense where the costs come from as far as processing costs and awards. How much is due to the awards from relatively small cases and how much is due in more generalized areas.

3) The subject of Measure of Damages. I question as to whether there should be punitive damages on malpractice cases? There has never been a punitive award.

   We need to address the breakdown of costs, and some sense of the absolute burden of premiums. All varieties relating to the Statute of Limitations.

4) Where to the claims come from? Are there affirmative defenses that can be built in? What are the most serious? What generates the largest claim? The types of malpractice premiums vary by discipline.

5) Finally, we need to examine a whole series of questions on the operation of the Health Care Arbitration Board and whether there is some way determinations can be made to lessen duplication.

Next, the Chairman discussed the materials in the package distributed at the beginning of the meeting. He informed those present he is endeavoring to obtain some material which will reflect in summary some of the amendments of malpractice laws in other states.

Grover Czech called the Chairman's attention to a document in the package. He also mentioned McGuirk's final report.

Minor Carter added that McGuirk's report is a very good publication written in layman's language.

Mr. Liebmann explained that the commission is to scope the meetings and publish same in the Maryland Register. We need to schedule approximately what we are going to do every meeting. Decide what meetings are going to be public hearings and to sketch out who we are going to hear from.

The Chairman proposes the agenda for the upcoming meetings will be:

Thursday - October 27, 1983 at the USF&G Building. (Directions can be obtained from W. Minor Carter.) 5:30 - Adjustment. The meeting will convene at 6:15 p.m. Laura Morelock will report on her study which contains considerable statistical material. Ken Abraham of the Maryland Law School would possibly attend and give an overview of recent approaches in State Law in other jurisdictions. Senator Rosalie Abrams will be in attendance to offer legislative intent of the Joint Resolution. Senator Harry McGuirk will discuss his report on a previous study of malpractice field. Commissioner Muhl together with Mr. Spinella will present a summary of the available statistics as to the movement of the rates by year and the current premium by specialty and the allocation of awards as to the filings.

Thursday - November 3, 1983 at 501 St. Paul Place, 1st Floor Hearing Room. 5:30 - Adjustment. The public meeting will convene at 6:15 p.m. Chairman Liebmann commented that it may be an appropriate time to invite some of the prominent lawyers. Commissioner Muhl questioned if it would be a sufficient amount of time to digest what is accomplished at the October 27, 1983 meeting before meeting with Counsel. Chairman Liebmann felt it would be appropriate timing.

Thursday - November 10, 1983 at the USF&G Building. We will hear from Mr. Tabler and invite witnesses from the Arbitration Panel. This will be a good time to hear from Ed Isaacs, Consultant, who is familiar with Medical Mutual and malpractice matters including history.

Thursday - November 17, 1983 at the USF&G Building. This meeting will be a general work session to assess where we are and where we want to go. Discussion of any other topics.

Thursday - December 1, 1983

A discussion of Medical Mutual related issues will take place at this meeting.

There being no further items for discussion, Chairman Liebmann motioned to adjourn this meeting at 11:00 a.m.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Thursday, October 27, 1983
United States Fidelity & Guaranty Company
Lombard and Charles Streets
15th Floor, Room 7
Baltimore, Maryland

MINUTES

Present	Absent
George W. Liebmann, Chairman	Senator Jerome F. Connell, Sr.
W. Minor Carter, Esquire	Delegate Joel Chasnoff
Edward J. Muhl, Insurance Commissioner	Delegate Gene W. Counihan
Michael Connolly, Assistant Commissioner	George B. Hankins
Paul Durkan, M.D.	
Israel H. Weiner, M.D.	
George Shadoan, Esquire	
Leo A. Hughes, Esquire	
Senator Francis X. Kelly	
Harold A. Cohen, Ph.D.	
Ellen Zamoiski	
J. John Spinella	
Laura Morlock, Ph.D.	
John A. Andryszak, Esquire	
Doris A. Tippett, Recording Secretary	

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Chairman Liebmann began the meeting with introductions, and stating that our speakers, Senators McGuirk and Abrams, could not attend because of prior commitments. Dr. Laura Morlock was present and gave the Commission the benefit of her in depth study.

Mr. Liebmann gave all members of the Commission the January, 1983 Final Report of the Medical Malpractice Task Force. Mr. Liebmann stated the Commission has a difficult task to perform in that the existence of the Commission is not very well publicized. Methods of publication were reviewed and discussed. Mr. Spinella volunteered to have Medical Mutual pay for such publication. Mr. Liebmann asked Dr. Cohen to provide comment on statistical studies that he had available. Dr. Cohen provided information for the years 1981, 1982 and 1983 which showed the malpractice premiums for each of those years for individual hospitals. The analysis which compares hospital malpractice premiums was submitted to the Chairman and recorded. Malpractice claims have not risen at this point, as noted by the study submitted by Dr. Cohen. Hospital malpractice insurance is rising at a less rapid rate than the medical index or CPI. It was noted that the aggregate budget of hospitals in Maryland is $1,600,000,000. Mr. Liebmann asked whether there were any changes in the relationship between

doctors and hospitals in terms of responsibility of obtaining insurance. All hospitals require medical staffs to retain malpractice insurance to maintain their privileges at the hospital. Hospital coverage pays for nurses and full time employees, some of whom may be doctors. It does cover full time practicing physicians at Mercy, including anesthesiologists. Mercy has a separate policy covering physicians for anything that happens to patients.

Mr. Spinella stated that hospitals contractually transfer or shift the exposure.

Mr. Shadoan asked what percentage of hospitals in Maryland have hospital based departments for radiologists, anesthesiologists and pathologists.

Dr. Cohen stated regarding pathologists, we know for example, that up until the new rates in October, how many hospitals paid through the hospital in fees for services, but did not know if they were independent contracts. Up until October 1st, most were in hospitals. Radiology was split 50/50.

Mr. Liebmann wanted figures for a total picture. Hospital budgets have relatively low policies. Malpractice and other (umbrella) policies - what are their limitations?

Dr. Cohen explained his study and the significance of each listed column.

Mr. Spinella stated hospitals have increased their deductibles.

Dr. Morlock presented tables from the report study and stated that the Commission should treat the material as confidential data for a couple of weeks since the report is still in preparation and changes will be made. She presented the following three phases of the study: 1) The background of the study; 2) How the study was carried out; and 3) The highlights of findings and some sense of what kinds of data was utilized.

Dr. Morlock offered to answer any questions following her presentation. The funding for the study came from Medi Chi, Medical Mutual, Maryland Hospital Education Institute and Maryland Hospital Association. It developed from conversations and the consensus of risk management. An agreement was reached to fund a small study to look at the content of closed claims and a decision was made to go through the closed claim files of the Health Claims Arbitration Offic This data was coded through January 31, 1983 and as a result, the 774 closed claim files which were the base of this study, should be regarded as incidents - multiple claimants and defendants of over $5,000.

Table I shows a number of claims closed and open. Current projections for 1983 are for about 600 claims. These figures have increased over 1982.

Dr. Weiner interjected that 10% of Maryland doctors are being sued each year. Then Senator Kelly asked how many doctors have had claims filed against them more than once. Dr. Weiner indicated that only a small number were sued more than once.

Dr. Morlock referred to Table 5 regarding the place where the incident occurred that generated the claim. The Table indicated 47% occurred in hospitals, 12% in emergency rooms and 26% in physicians offices or clinics. The total percentage in hospitals is 65% which is lower than the national data indicates. There are several claims from dentists, which if removed, the percentage is similar.

Table 6 indicates the location in the hospital where the incident occurred; operating rooms, labor and delivery, radiology units, etc., which is consistent with the national pattern

Table 7 indicates the severity of the claimant's injury, utilizing a nine point scale from emotional only to death. Only 1% were allocated to emotional only, while 38% for temporary injurie 42% for permanent (major and minor) and 5% permanent grave, the remainder for death. Severity refers to the amount in dollars. Dr. Morlock will supply us with the well developed coding scheme which was utilized by the Health Claims Arbitration Office.

Table 8 indicates the number of defendants per claim. Approximately one half of the claims involved the hospital as the defendant.

Table 9 indicates the type of defendant.

Table 10 reflects the combination of defendants.

Table 11 indicates the specialty of the defendant. This table is missing some information on 279 specialties. Approximately 15% of all defendants have a specialty in obstetrics and gynecology. The second highest rate was in dentistry.

Senator Kelly asked if there is a correlation of successful claims by practice. Dr. Morlock stated there was and that in claims over $5,000, most were dentistry.

Table 14 reflected a small number of cases and the relationship between the claimant and the defendant prior to the incident. Approximately one half had a prior relationship.

Table 24 indicates the claimant's relationship to the injured party, using examples such as 56% are spouses, 12% are children and 31% parents.

Table 28 reflected the method of case disposition. Approximately 35% of the 774 claims were dismissed.

Table 29 indicated the type of dismissal of the claim. Of about 272 claims which were dismissed, about 43% were dismissed at the request of the claimant prior to the pre-hearing conference. If they are settled prior to the panel discussion, the information is not available.

Table 31 deals with the outcome of the panel determination. Of the 178 which completed the hearing process, 43% were found in favor of the claimant, 57% were found in favor of the defendant. Approximately 61% of the total have been appealed.

Table 33 reflects damages awarded. The total amount of damages awarded last January was $17,302,749. This covers 1978 through January 31, 1983. The largest claim so far has been in the Klein case which was awarded $2.5 million. Final figures which were justifiably awarded by the panel are about 54%.

Mr. Liebmann wanted a breakdown of the tabulation from Dr. Morlock stating cases which are characteristically successful and unsuccessful. It was stated that orthopedic and radiology specialties make out quite well. Dr. Morlock pointed out that this is a pretty small base to make any generalizations on. Mr. Shadoan commented that attorneys fees in most awards are usually one third.

Table 34 lists permanent grave injuries which get higher awards than deaths. Grave permanent losses are defined as paraplegic or the loss of two limbs. If the claim is serious enough to be presented, are there attorneys who file claims indicating they are only temporary? Claims are based on injuries. A fracture of the foot is considered a temporary injury, in other words, there is recovery. If there is no recovery, it would go into the permanent category. We utilized the coding scheme of the NAIC (National Association of Insurance Commissioners) which is useful because it correlates with the length of time it takes to go through the process. It is not perfect but it is good and the data is limited.

Table 35 reflects the length of time in months. The average amount of time is about 16 months. Mr. Liebmann wanted a breakdown of incident and length of claim from Dr. Morlock who agreed to supply such data.

Table 37 lists the years of experience of the panel chairperson. The question was raised whether there was any difference between the amount of time and experience and the year of admittance to the Bar and there was none.

The team which reviewed the files at the Health Claims Arbitration Office were medical records specialists. It was stated that we need to know more about payments as to awards. Mr. Carter stated the major problem is trending and a big argument exists with the IBNR reserving. In a claim a great deal of premiums are set on trends.

Mr. Shadoan stated that we should focus on this, the insurance rate increase proceeding and what impact the arbitration system has and how it has effected the cost of insurance, as it effects the merits of cases. We need to know from the beginning, what the rule of malpractice insurance premiums in the spiraling cost of health care is and what kind of data is available to give us an idea of the role of health care generally. The Insurance Division receives extensive filings and holds hearings from Blue Shield respecting reasonable charges. Regarding the Blue Shield filings, we might be able to get the District of Columbia Department to pick out Maryland portions of their experience. Also we could obtain other data from Medicare and the Federal Trade Commission. Reviewing this data, we can get a meaningful perspective of the percentage of total health care that the malpractice premium constitutes.

Mr. Shadoan is willing to pursue any avenue of information to get to the heart of the problem but he will not agree with any cap on a victim's recovery. Dr. Morlock stated for argument that some costs are defensive medicine. Studies on malpractice insurance contribute to medical fees. She stated that she will provide the Commission with information on this topic.

Table 23 indicates that 27% of claims arise from the self pay category. There is no explanation for this. Some self pay is dental. Dr. Morlock agreed to look into whether or not the private insurance category is higher than usual. Approximately 90% of the states require mandatory reporting provisions for settled malpractice cases to the Commission on Medical Discipline.

Angus Everton stated that settled claims must be reported to the Commission on Medical Discipline. Mr. Liebmann wanted to know whether we should contact this Commission regarding these settled claims. The Commission investigates all closed actions.

Mr. Shadoan stated that the District of Columbia has a group of physicians who are notified by insurance companies when claims come in and they review them. The review is secret and privileged.

Dr. Durkan indicated that doctors have to apply for privileges and they must report everything. If there is more than one incident of malpractice, the person's privileges may be held up at the hospital. Every year doctors' credentials for privileges are renewed and they must report any and all suits against them. There is no waiting for a malpractice claim to be settled; doctors may be dismissed immediately and a hearing held if a serious problem occurs. Dr. Durkan stated that hospitals act quickly.

Mr. Liebmann urged strong attendance at the remaining meetings of the Commission. Commissioner Muhl was impressed with the in depth study presented by Dr. Morlock. The Commissioner's staff has reviewed filings in the Division to get some history on statistical data on premium levels over the past several years. This was accomplished with difficulty because of the many variations. Several class codes were pulled from St. Paul Fire and Marine Insurance Company and St. Paul Mercury Insurance Company for 1982 and 1983. There are too many variables involved.

Mr. Spinella indicated that the adequacy of the premiums should be taken into consideration. Medical Mutual's rate leve history in 1975 was given and charged in 1976 through 1979 and there was no change. In 1979 and 1980 there was an indication that the premiums were inadequate and an increase was due. In July, 1979 through August, 1980, a 20% increase in premiums was granted for the six codes. Subsequent increases were granted as follows: September, 1980 through 1981 - 5.4%; April, 1981 through May, 1982 - 34.4%; June, 1982 through June, 1983 - 21.1% and July, 1983 - 9.5%. At this point Commissioner Muhl read territories' and premiums.

It was stated that coverage of $100,000 and $300,000 are not realistic figures because most doctors obtain $1 million worth of malpractice coverage.

Mr. Spinella stated that the combined ratio for every dollar coming in was $1.40 being paid out. Medical Mutual needs to make a profit. St. Paul created a claims made policy because it benefited St. Paul. St. Paul tried to have the product approved by the Commissioner who disapproved it. However, St. Paul's position held up in Court because the doctors needed a vehicle for medical malpractice insurance.

$2.3 million was obtained to fund Medical Mutual. They charge physicians 20% more than they need. Med Mutual did not have any losses in 1976 but in 1977 the claims started coming in. In 1979 too many claims were received at which time Med Mutual requested a rate increase, which was disapproved by the Insurance Division. When more claims came in, a significant rate increase was requested of 20% which was approved. One year later Med Mutual was granted a 5% increase and then 34%. See Medical Mutual's Sheet entitled "Rate Level History". In 1983 only 9% increase was required. If an increase of 10% each year had been implemented beginning in 1979, we would have the same rate level as today. Approximately 3,700 doctors today are insured by medical malpractice insurance. Medical Mutual is a one line insurance company with no marketing factor in these rates. There are not a lot of commissions paid out therefore, we have a pure rate level.

Mr. Liebmann asked whether Med Mutual was endeavoring to recoup because they had not increased their rates enough from the beginning. It was stated that recoupment is illegal.

Mr. Carter stated that just because a company writes a product for half price, does not necessarily indicate that they know what they are doing. It is uneconomical to charge at a competitive rate. A major factor is hospital costs not physicians fees. A large part of the cost of services are hospital costs.

Medical Mutual had an annual premium revenue for 1982 of $18,775,000 on direct business. After reinsurance, it was $14 million. Claims in dollars incurred resulted in $1.45 to $1.50 pay out. About $27 to $28 million was paid out with approximately $15 million to hospitals.

Medical Mutual does not insure every doctor who comes to them for insurance. The policyholders own the Company so it is different from MAIF.

Regarding the Rate Stabilization Reserve Fund, the Board of Directors determines the amount of surcharge which helps to keep a mass growth surplus before it is consumed by IRS. This is a cleverly designed fund.

Mr. Carter stated that the reason for the legislation was the fear that doctors were not going to charge themselves enough and there was no taxable way to get premiums to pay claims.

Mr. Liebmann asked whether or not Med Mutual should be allowed to sell non-assessable policies. Commissioner Muhl indicated that conversations with Med Mutual and the Division with reference to this topic were taking place. Commissioner Muhl has advised Secretary Corbley of this concern and that it is an issue before the Division which has not been decided.

Mr. Liebmann asked about a shortfall. Mr. Carter stated that insurance reserve accounting is very conservative. Mr. Spinella indicated that it is all a matter of timing and used planning a college education for an example. A short discussion about reserves ensued.

Companies cannot be forced to write medical malpractice insurance, therefore, Medical Mutual was created. The industry is united against so called "bedpan mutuals". First an assessment of all carriers is made, then the Rate Stabilization Reserve Fund comes into play then the Guaranty Fund. Medical Mutual has a $106 million liability. This figure was IBNR computed by outside actuarial consultants. Med Mutual has a $3 to $4 million surplus.

Mr. Spinella stated that discounting premiums means that you can charge less initially and build into premium income enough to cover your expenses. Commissioner Muhl stated that all companies are assessed through the Guaranty Fund. (MIGA - the Maryland Insurance Guaranty Association). A statement was made by Mr. Liebmann that companies could go to the Legislature and protest having to fund MIGA, but Mr. Spinella quickly pointed out that the contrary was true and that the companies are willing to contribute to this fund.

Senator Kelly frankly asked what is the charge of this Commission. Then Mr. Liebmann quoted from the Governor's letter that the charge as set forth in the letter provided for a report which "examines the problems in their entirety", which are increases in health care costs particularly physicians and hospital medical liability insurance since 1975.

Senator Kelly stated that medical malpractice insurance is not contributing to the spiraling costs of health care in a significant way.

Mr. Spinella stated that he disagreed with this statement. Senator Kelly indicated that the Commission was created on the basis of Senator Abrams Senate Joint Resolution No. 14. It was stated that there was no sense to the Resolution.

A concern is that a large portion of annual claims accounts for a relatively small number of cases. Mr. Carter provided that about five cases accounted for about 58% of the claims paid. Another concern was that if there is an increase in a very large number of awards, we could have a situation where there is a sharp escalation of claims.

A discussion ensued regarding the States of New York and Florida regarding their problems and whether we should examine their studies and compare with Maryland. However, it was pointed out that their problems are different than those experienced in Maryland. The question was raised whether or not we have sufficient information to make the charge that the cost of Medical Mutual's malpractice insurance is a problem.

Dr. Weiner stated we will have to look at trends and recognize that the dollar cost as reflected in premiums is not a total cause of malpractice. It is only the tip of the iceberg. Some doctors have the attitude "let the patient die - better a dead patient than a law suit". My philosophy when I look at a patient is 1) what can I do for him, the patient and 2) how can I protect myself from potential suits.

Dr. Cohen stated that the trend is toward defensive medicine in hospitals today. For the past 20 years from about 1962 to 1982, the national data indicates that every year doctors increase the amount of tests done per hospital has risen 3% to 4% per year, however, there has been no increase since malpractice has become an issue. The hospital stay is the same. Doctors

do more tests but not because of medical malpractice insurance. Facts indicate that they do no more per year now than they did in the 1960's.

Senator Kelly asked what impact are we talking about in cost containment issues? Dr. Cohen stated that in Medicare we would have virtually no effect, because Medicare patients do not generate malpractice claims. Most claims are hospital based. People are concerned about the rate of increase but it is no greater than it used to be.

Dr. Cohen stated some concerns that physicians might have would be expectation in economic community because of the growing number of doctors and the awareness of people like the Commissioner that they cannot pass on the cost to the patients. Another concern of the doctors is that increased premiums will be a reduction in their net income. They cannot pass this increase on to their patients through their fees.

Mr. Liebmann asked to what extent medical malpractice costs are broken down in Blue Shield's rate filings. Commissioner Muhl stated that this would be a massive task.

Mr. Shadoan stated that he would be able to supply material on Florida and New York. He stated that Florida has a catastrophe fund. Mr. Liebmann asked what are the facts which cause problems and why are rates multiplying each year?

Mr. Carter stated that the Florida and New York studies are completely different than Maryland and they would serve no useful purpose to the Commission.

Mr. Shadoan also stated that the situation is different in every state and asked if we have a problem that justifies a change in this state now. People seem to think that the answer is more reform which restricts the rights of our citizens.

Commissioner Muhl stated that he wanted Senator Abrams present at this meeting to explain the intent of the Legislature in submitting this Resolution.

Mr. Liebmann stated the Commission should be impartial and that our function is not making a rule for putting caps on awards but in endeavoring to put a rationale on the awarding of claims. Mr. Liebmann asked should we subtract from the award other sources or do we have people over insured so that they collect from two or three different sources and society is taxed accordingly? He also asked if there was any information available to the Commission on how punitive damages effect the system. A statement was made that punitive damages are rarely awarded in these cases. When you place doctors financial statements before the jury, the goal is not to punish the doctor directly but to punish the ratepayers generally.

Mr. Everton stated that punitive damages should not be awarded unless there is a showing of actual malice.

Mr. Shadoan indicated he wanted to see some data on punitive damages, that there were very few claims in this field.

Mr. Everton stated that two out of less than ten cases have a punitive damages prospect.

Mr. Liebmann indicated that we should focus heavily on the rationale of the system of the arbitration process with less on awards. Mr. Shadoan stated that awards by panels are four times as great as those granted by a court of law. (43% by the panel and 10% by the court). The arbitration system needs improvemen

Mr. Carter stated that some are overcompensated and some are undercompensated by the courts and that is what the arbitration system was established to handle.

Mr. Everton stated he believed the arbitration process does not last as long as a jury trial. Six weeks of arbitration is unheard of. Dr. Cohen stated the average duration from start to finish was about six tenths of a month. Mr. Liebmann asked how much time was devoted to direct testimony. Mr. Shadoan stated that attorneys run these proceedings like court trials and they take a lot of time. Mr. Liebmann stated the Commission should recommend steps to expedite things so that there is uniformity of approach.

Mr. Hughes stated that the length of time is not a problem. Mr. Shadoan stated that we should either leave the system as is, abolish it or improve it.

Mr. Liebmann indicated that the next meeting is a public meeting and wanted to know what issues we will be presenting, stating that the public has to be granted the opportunity to give its view before the final published report.

Mr. Liebmann stated that we should arrange for several guest speakers to be present at the next scheduled meeting. The three gentlemen who were mentioned were:

George Bernstein, Esquire
Fred Karl, Esquire - The Florida Association
of Insurance Agents
Professor William J. Curran
Harvard School of Public Health
Boston, Massachusetts

Mr. Liebmann stated that at the November 10th meeting we would focus on the arbitration process when Mr. Walter Tabler is present.

The meeting adjourned at 10:05 p.m.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Thursday, November 3, 1983
501 St. Paul Place
Baltimore, Maryland

MINUTES

Present

George W. Liebmann, Chairman
Edward J. Muhl, Insurance Commissioner
Michael Connolly, Assistant Commissioner
J. John Spinella
George W. Shadoan, Esquire
Israel H. Weiner, M.D.
Grover E. Czech
James P. Durkan, M.D.
Harold A. Cohen, Ph.D.
Leo A. Hughes, Esquire
Senator Harry J. McGuirk
Charles Henderson, M.D.
Robin Brodinsky, Esquire
Jay Seidenman, Esquire
Walter Tabler
Janna Vavroch
Angus Everton, Esquire
Henry Dugin, Esquire
William Mossberg, M.D.
John Sellinger, Esquire
William Gibson
Jonathan Schochor, Esquire
William Whiteford, Esquire
Donald DeVries, Esquire
David Levin, Esquire
Aaron Levin, Esquire
Albert D. Brault, Esquire
Frederick Biever, Esquire
Laura Morlock, Ph.D.
Richard S. Paulson, Esquire
Sharon Martin, Maryland Hospital Association
Doris A. Tippett, Recording Secretary

Absent

George B. Hankins
W. Minor Carter, Esquire
Ellen L. Zamoiski
Honorable Gene W. Counihan
Honorable Joel Chasnoff
Honorable Jerome F. Connell, Sr.
Honorable Francis X. Kelly

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Chairman Liebmann began the meeting by introducing the two guest speakers; Senator McGuirk, who was on a Committee in the last session of the General Assembly on medical malpractice insurance and Walter Tabler from the Health Claims Arbitration Office. Numerous doctors and attorneys were in attendance. Mr. Liebmann then called upon Mr. Tabler to give the Commission the benefit of his presentation.

Mr. Tabler began by stating that his office could utilize more personnel and more equipment, citing file cabinets as an example. Mr. Tabler gave to the Commission statistics from his office on case totals through September 30, 1983, then he gave an explanation of the statistics. Mr. Tabler stated that there were 502 cases filed last year which is approximately 40 more cases than filed in 1982. The Health Claims Arbitration Office was well underway in 1979. Mr. Tabler gave an explanation of the cases filed with his office.

Mr. Shadoan asked how many appeals went to trial in the Circuit Court. Mr. Tabler stated that he could provide him with an idea of how many were disposed of and further stated that about 100 cases were left open on appeal. Mr. Tabler stated that very seldom is a case disposed of and that approximately 75% of the cases are affirmed.

Mr. Czech wanted to know whether there are a lot more medical malpractice cases occurring or if a lot of people are bringing cases against doctors. Mr. Tabler stated that in 1979 there were a large amount of changes.

Commissioner Muhl asked whether there would be any procedural changes occurring in the Health Claims Arbitration Office in the near future. Mr. Tabler replied yes but most cases wind up in one of the Circuit Courts.

Commissioner Muhl asked Mr. Tabler if there was a need for legislative change, to which Mr. Tabler stated yes, most definitely. Approximately 1% of panel determinations have been changed by a jury verdict.

Commissioner Muhl asked whether there was a lot of duplication in the health claims arbitration system and the nisi prius court system. Mr. Tabler stated yes, of course, and that there is a great need for the promulgation of rules and regulations. However, the criticisms against his office are not very substantial when you take into consideration Dr. Morlock's report.

Mr. Liebmann asked about the possible use of retired judges for panel chairmen on the arbitration panels. Mr. Tabler stated that this was an unpopular choice.

Dr. Cohen asked if the physicians receiving a higher salary than the laymen presented a problem. Mr. Tabler stated that the law requires his office not to discriminate as to the type of panel members he chooses. He stated that he had not actively solicited certain areas for panel members as he had doctors and dentists. He utilizes osteopaths, podiatrists, optometrists and licensed and practical nurses most frequently.

Dr. Cohen asked if the nonprovider panelist is paid less to which Mr. Tabler states yes, and gave the figures of $75 as compared to $125 for physicians. Mr. Tabler stated that he has not gotten full cooperation from hospitals regarding the service of nurses as panel members because serving on the panel requires too much time away from their duties at the hospital. Also, it was stated that physicians have some concern when they serve so much time on a panel and the case is settled at the last minute.

Mr. Liebmann asked how often does this type situation occur. Mr. Tabler replied that about once a week his office will get a last minute cancellation. He stated that with both sides in cooperation, the office has a reserve of retired physicians that can be called upon at the last minute. Most retired doctors are very cooperative in this regard. The problem is the calendars of most trial attorneys who have very heavy case loads. Postponements could mean a case carrying over four to six months.

Commissioner Muhl asked whether Mr. Tabler had the authority under the law to promulgate rules and regulations. Mr. Tabler stated he made fair decisions and that he did not feel comfortable with making rules that were contrary to existing laws.

Mr. Hughes asked about a rule Mr. Tabler drafted on informational rules of evidence. He wanted to know if it was being utilized. Mr. Tabler stated that it is being followed a lot by lawyers with a wider circulation in the Washington metropolitan area than here.

Mr. Liebmann announced the next guest speaker, Senator McGuirk.

Senator McGuirk began by talking about Medical Mutual, stating that it was created so there would be a form of insurance for physicians in the malpractice area and that he is happy to say that it was a point of continued health care to the citizens of his district. The question came up as to how do you look at the whole issue. He stated there have been ample hearings on this issue.

The Legislature came up with other things and we as members of the Legislature were representing our constituents in that good health care would be provided. Hopefully, a few changes in the tort reform system would solve the problem. If anything happens, you go to court and sue. This became a problem. We look at the Health Claims Arbitration Office and we recommend that there should be some minimum criteria for the panel members. The average person who chairs the panel is a young lawyer with four or five years experience. Perhaps better criteria for panel members is the solution. Senator McGuirk thinks that one chairman on a full time basis with a good salary would be helpful.

Also we need good rules and guidelines for the panelists. Good ground rules would serve for uniformity of application. The original feelings of the sponsors, was to find an easy way to make a claim. It would save a lot of time in bringing in testimony and things of that nature. Unfortunately, it did not work that way. It opened up a vehicle for the legal professionals. Mr. Tabler stated that one thing that can be established is that both parties bypass the procedure and go to court. There is a lot of duplication in bringing in expert witnesses twice. In the case of the high cost of insurance, this is going to require a complete look at the tort reform system. The only way to lower the cost of insurance is to put a cap on the awards that are made and potential of some of the areas of activities that go with the expert witnesses and merit in cases. These are excellent things to review but not in the area of tort reform. Over 20 years of recommendations were reviewed in the last session. At the final meeting on October 14, 1983, and as a result thereof, we wanted to narrow the area down to make recommendations immediately and reserve for future committees, the reforms in tort reform.

Mr. Hughes stated we have a status quo for now. Would the Legislature make substantial changes if given the reason to do so?

Senator McGuirk stated that he did not foresee any big change by the Legislature. Senator McGuirk stated the only way we will see a change is when the constituents make an outcry because of the increase in cost of doctor bills. Then the Legislature will act.

Mr. Liebmann presented the problem that if there was a full time chairman, he would be powerful more so than the trial judges in the courts and asked if this gave Senator McGuirk any concern.

Senator McGuirk said it did not give him too much concern. He stated that power is an awesome thing, but it depends on how you use it. He also stated that he has no fear unless the chairman is not fair and equitable.

Mr. Czech stated that the Workmen's Compensation Commission has full time chairmen that hear cases and they are fair and equitable.

Mr. Liebmann asked if anyone had any further questions to ask Senator McGuirk. Mr. Czech asked what kind of tort reform the Senator would suggest. Senator McGuirk stated that one thing he fears is that the individual who makes the determination may have a tendency to say one party is giving a good story and so is the other side. However, the bottom line is the individual chairman

will put himself in the role of the victim. He asks himself how much would he want if this was happening to him and you wind up with a large award.

At this point, Mr. Liebmann introduced Dr. Henderson who is a neurosurgeon in Baltimore City. Dr. Henderson stated that he agreed with Senator McGuirk in the respect that for six or seven years we have been testifying before various Commissions with the hope that something will be accomplished. Dr. Henderson cited different figures for medical malpractice coverage in states like New Hampshire with their anticipated increase in the upcoming year using figures for neurosurgeons only. He stated there are all kinds of insurance available but cost is a major factor. He obtained a claims made policy because it is a lot less expensive.

He questions the standards by which physicians are being judged. A national standard of health care implies what a reasonably prudent man would provide. He stated we like to think of ourselves as better than the average physician. Dr. Henderson stated that physicians are competent but not supermen. That is an unattainable goal. He feels that there is, in a large segment of the Bar, attorneys concerned with a fundamental set of changes which are not just cosmetic.

Mr. Shadoan stated that we are most interested in answers to questions from the attorneys and physicians now present in regard to whether the Health Claims Arbitration Office should be abolished, modified or left as it stands. He also posed the question, in what fashion should we modify the system.

Dr. Henderson stated he did not feel the system was worth retaining even with changes. He feels it cannot be changed to make it effective.

Mr. Shadoan stated with reference to the premiums charged for medical malpractice insurance, that we have received information as to the extent to which the cost of malpractice insurance plays in the role of the cost of health care in the State. However, it has been suggested that physician's premiums are passed along to the health care consumer. Mr. Shadoan stated he doubted this could be easily done and, in fact, may be a segment of the medical community which bars them from passing this along to their patients. He stated that this was just a hunch and if this Commission is to address that question, it is necessary for us to have information from the medical community as to their income. He further stated that $20,000 in medical malpractice insurance premiums may be high but not too serious as compared to his income. We need the cooperation of the medical community as to their income.

Dr. Henderson stated that increasing costs are a fact of doing business. Their fees go up just like utility bills go up. He disagreed that passing on the cost of the premium to patients through fees was a general practice among the medical community.

Mr. Czech asked what percentage of patient care was the medical malpractice cost. Dr. Cohen stated he brought in information as to the malpractice costs of hospitals. He stated he agreed with Mr. Shadoan that we need that kind of comparison on the hospital side as well as from the doctors.

Dr. Weiner stated that if we can come up with a ball park figure it will be helpful.

Mr. Liebmann stated he was concerned about the level of premiums in other jurisdictions. He asked if there was any backup material which could be provided to substantiate the statements made.

Mr. Czech stated when a doctor's income is compared to the medical malpractice premium of $25,000, 25% of your income is quite significant. It is quite a lot of money.

Dr. Henderson stated the problem is becoming overwhelming in Florida, New York, etc.

Mr. Liebmann again stated that we need to see some documentation of the problem so we can form our own judgments in this regard. He stated he has not yet seen any hard data on this subject.

Mr. Spinella stated he has an exhibit of occurrence rates filed and approved by ISO.

Mr. Brodinsky stated that whatever the details in the Health Claims Arbitration Office are inherent in the legal system because of the problem of correlating the scheduling of cases between defense counsel and the panel chairmen. Reasonable requests for postponements take up to another eight months before proceeding with the hearing. He is not certain if an elective process would be the best one. He feels it would be better to try to conclude the matter through the arbitration system rather than the court system. He feels that there would be some advantage to a full time panel chairman. Mr. Brodinsky stated he could see where counsel would like consistency of rulings and at the same time an independent chairman who is not bound by political ties.

Mr. Seidenman stated that he was the President of the Maryland Trial Lawyers Association. He suggests that the whole Health Claims Arbitration Office be abolished. He feels it is a total duplication of the process. He stated the Legislature, instead of saying to the doctors, if you have a complaint with the insurance company, your complaint should be with them not the courts, and if the charging of rates is too high, go after the insurance company, but do not take away health care to the patient. Instead a law was passed in the heat of a crisis, which

delayed the litigant's entry into the court system by requiring the arbitration process which has built into it delays and expenses. Before a jury trial you have to go through the arbitration process which takes four to eight months. If the case is lost, a party may take an appeal and you wait to get on the docket. Then you wait again and witnesses' memories fade, the expert witnesses move away to another part of the country and do not want to return and participate in the case, the clients are older, etc. These are just a few problems. Also you will never remove the sympathy factor from the case. We have rules of evidence and a system in place that has worked in the past and can work now. My suggestion is that we do away with the duplication of process, expense and move these cases back into the court system where they belong so that trained judges can assess the case. If the case does not belong in court, the case can be weeded out.

Mr. Czech indicated that the small number of appeals from panel determinations seems to indicate that panel determinations are being accepted by plaintiffs and defendants. The arbitration system is working better than it has in the past.

Mr. Seidenman stated he does not know if that means the system is working effectively. He thinks that people are being discouraged because of delays and expense. Mr. Seidenman stated when you have a total duplication of the process, how can that mean the system is working? Mr. Seidenman stated these four steps which are used in the system: 1) the arbitration process, 2) jury trial, 3) the Court of Special Appeals and 4) certiorari to the Court of Appeals.

Mr. Czech stated as he recalled the original purpose of setting the arbitration mechanism was to keep cases away from the court system.

Mr. Seidenman stated many of the appeals were being taken by the plaintiff and even if they won, were trying to get a higher verdict. If the verdict is low, they file a motion for a new trial and have a hearing very quickly, usually within two weeks.

Mr. Czech asked if Mr. Seidenman was seeing a higher award coming out of juries to which Mr. Seidenman replied that it is difficult to say. Mr. Czech asked whether awards were higher through the panel or the courts and it was stated that they are very close. Juries are sophisticated people that have high intelligences. We should not underestimate them.

Mr. Liebmann asked that since the Court of Appeals adopted the rule to allow videotaping at depositions, to what extent has this method been utilized. Mr. Seidenman stated it was minimal.

Mr. Shadoan stated the jury tends to go to sleep in these situations. Dr. Cohen stated that one suggestion is that both parties agree not to go to the arbitration system and he wonders how often both sides agree to skip the process, if this is one of the options. Mr. Seidenman stated it was difficult to say.

Mr. Seidenman stated he much preferred the jury system to the arbitration system because of the higher quality of justice.

Commissioner Muhl asked if the arbitration system was abolished, would he be in favor of binding arbitration to which Mr. Seidenman replied no. Commissioner Muhl then asked why and Mr. Seidenman replied because he did not think anyone should be deprived of a jury trial.

Mr. Everton suggested that the best way to aide the arbitration system was to have a permanent panel chairman in place. He stated it would develop a body of law to follow and panel members would be expected to know the Maryland Rules of Procedure. He suggested that there is a way to avoid a straight cap on awards. Mr. Everton suggests a cap on all awards that do not reflect a pecuniary loss. In this way you overcome the objection to such caps which penalize the people who are severely injured. Medical expenses would be recoverable in their entirety. We need to have the panel breakdown the award in dollar amounts as to each type of damage. This would effectively limit run away verdicts based on prejudice. If a cap is instituted, he suggested that the cap should be a relatively generous one on the type of damages requiring pain and suffering.

Mr. Liebmann suggested language such as in making an award for pain and suffering, the trier of fact shall not award an amount greater than that reasonably necessary for future care of the patient in conditions of ease and comfort.

Mr. Everton stated we should cap things that you cannot rationally quantify such as how many dollars worth of pain and suffering has this person suffered.

Mr. Shadoan stated it is the amount of money that is paid that determines whether there is a need. Until we know what that amount is, we cannot determine whether there is a need or not.

Mr. Liebmann stated that we need to get a handle on the very large awards and asked Mr. Tabler to give us some detail on the history of awards for $1 million or more and trace these through the system.

Mr. Shadoan stated he would like to know whether or not there is a consensus of the amount of the payment that was for pain and suffering as opposed to pecuniary losses. He stated that we need to have a breakdown.

Mr. Dugin was introduced and he asked that the Commission members identify themselves. At this point, all members were introduced. He stated that if the Commission assumes that there are in fact victims of malpractice, it assumes that there are some people who have been injured by care that was not in keeping with the standard of care. It is only fair to look not only at the financial impact on doctors, but on the victims whose cases are going to be heard by an arbitration panel or by a jury. Tangible expenses are medical bills. We are going to make sure the doctor is paid who takes care of the victim. In terms of outrageous verdicts, I have not seen a case in Maryland where I would change places with the victim's award. Every one of the large verdicts that you have heard about has been appealed. Since about 1974, Mr. Dugin stated that he has consistently said that what is being done in the arbitration panels is wrong philosophically. If someone is injured, it makes no difference in terms of the way the case should be handled. It makes no sense to treat people differently. He stated that looking at nothing but the cost of malpractice insurance premiums, misses the boat entirely. Look at the costs to the victims. A study in Boston alone estimates that the cost of malpractice in terms of medical cost runs into the billions. Mr. Tabler has done everything he can to make the panel run smoothly but this is not the problem. It is wrong to treat this group of people differently than other groups in our society. There are basically three concrete problems with the panel: 1) the chairman, 2) the health care provider and 3) the layman.

The problem with the chairman who is full time is that once you know him, you probably know the outcome of the case. The chairman is the major problem. If you take him beyond the discovery phase, you reduce the fairness in the system. The problem with the health care provider lies with the availability of the doctor for the hearing. The panel receives last minute cancellations from physicians. Also a big problem is that doctors are insured by mutual insurance companies so every time an award is given it increases the premiums that they are going to pay. Also the quality of the people who volunteer in the health care field are not the people at the top of their profession. Therefore, the panel is not as fair in that someone who has excellent credentials can look at the case more objectively.

Mr. Shadoan asked how many hearings Mr. Dugin has had to which he replied about 21. Mr. Shadoan asked how many of them had a physician as a health care provider and Mr. Dugin stated that many of the panelists were dentists.

Mr. Shadoan stated there are an astounding percentage of claims against dentists. He asked if they were being as fair as they could be. Mr. Dugin stated it is 50-50. The problem with the lay member of the panel is there are so few. Many are retired. We find the same names on the lists again and again.

Mr. Shadoan stated that as lawyers, we get upset because the panel chairmen make rulings that are wrong. How often is the case effected by the incompetence of a panel chairman.

Mr. Dugin stated he has obtained some bizarre rulings from the panel. The cost to the victim of the arbitration system is enormous if the victim loses. For example, a week worth of hearing is probably about a $4,000 to $5,000 loss to the victim as opposed to a jury trial where the victim would only be out about $75.00. The burden is on the claimant. Hospitals charge a dollar per page just to copy hospital medical records.

Dr. Mossberg was introduced stating that he is a neurosurgeon in Baltimore. He stated that the crisis in 1975 was one of availability of insurance. It was indeed a crisis. We are not going to be able to practice medicine without insurance, therefore, the remedy was the creation of a physicians insurance market through Medical Mutual. The crisis at the present time is not one of availability but of cost of insurance and type of insurance. We presume to know the principles of claims made insurance. Above and beyond this being a crisis in cost, all physicians are concerned with the lack of insurance.

The present dilemma is one that effects a limited number of physicians and surgeons who are in the high premium category. The premium that Dr. Mossberg paid last year was $24,653. Medical men such as internists were only paying $2,000 per year. The OB/GYN men have, unfortunately for them, risen to the prime category with higher premiums. The question was raised as to whether the premiums are passed along to the patient. That is the only place the money is coming from to pay the premiums. The question was presented how much do neurosurgeons make. In point of fact, Dr. Mossberg stated he grossed as total income only $100,000. He has been associated with six other physicians in his career and no one has ever approached $200,000 per year.

The percentages are out of line and there have been no judgments or suits filed against me, stated Dr. Mossberg. The net result of this, is that older neurosurgeons who taper off their business are unable to continue in practice. Many neurosurgeons have retired and Dr. Mossberg states that he is the senior neurosurgeon in the State of Maryland. Dr. Mossberg stated that this appalled him to think he has reached this status. Many have retired because they cannot afford to pay the high premiums for malpractice insurance and stay in business. Senior

physicians by virtue of their experience, have provided assistance and counsel to many new physicians and now this is lost to Maryland. Premiums in Florida are now in excess of $50,000 per year. The statement was made that there is no place in the country where there is a cap on awards. This is not true. There are caps in Nebraska and Indiana.

Mr. Czech stated that there are caps in Virginia also. Dr. Mossberg stated the premium for neurosurgeons in Nebraska is less than $4,000 per year and in Indiana less than $6,000 per year. He stated that he agreed with Mr. Everton that a cap on the matter of pain and suffering should be placed. He stated that he would not want to trade places with many of these people but at the same time he has had some things happen to him in terms of illness and suffering that he would not be willing to take a certain amount of money for voluntarily. A structured award is something that Dr. Mossberg advocates. He stated that the sympathy factor is torpedoing us to death.

Dr. Mossberg's suggestions are to have some cap on awards and some way of balancing out premiums for malpractice insurance so that a small group of physicians are not paying a large tab for their business.

Mr. Shadoan asked Dr. Mossberg if the $100,000 income was gross or after paying out expenses including his medical malpractice insurance. Dr. Mossberg stated it was his gross income before all insurance and expenses. Dr. Mossberg stated an associate, Dr. Arnold, stopped operating before he retired and he got a reduction in his malpractice premiums, however, he went on to state, if you limit your practice by not operating, that is the only way your premium will be reduced.

Mr. Spinella stated that Medical Mutual offers a 50% discount to physicians who practice less than 20 hours per week and they are allowed to operate.

Mr. Shadoan asked Dr. Mossberg if he had any suggestion as to whether the arbitration system should be abolished, changed or left as is. Dr. Mossberg stated he felt a full time permanent chairman would suffice if the system was left in place.

Mr. Sellinger stated he would like to make some observations and stated he thought that the physician who just spoke referred to something he felt we should all focus on which is tort reform. He asked what can we do about the way premiums for physicians are set and do not inflict the punishment on the injured patient who is entitled to be compensated. He stated as to the arbitration system, that if we look around this room, we have an assortment of physicians and attorneys that have all suggested that the system should be abolished. This is the feeling generally, abolish the system, since it has not worked. The arbitration system is a device to screen out frivilous claims,

and the result has been just the opposite.

Mr. Spinella stated that he keeps hearing about delays that the arbitration system imposes. Mr. Sellinger stated that the system has failed in that it has generated claims that would not have been brought in Circuit Court. They are frivilous cases.

Mr. Spinella stated he fails to see a slow down in claims disposition. In Maryland, it is faster than the national average.

Mr. Shadoan stated that based upon what Dr. Morlock's study revealed, he felt that there is a real problem with neurosurgeons because they are getting hurt by these premiums. It alters the way they practice. We would like neurosurgeons and other high risk specialties not to have to pay so much money in malpractice premiums. He made this suggestion that before we make a fundamental alteration, we should make a change in the way the risk is spread.

Mr. Spinella stated we should look at the way the premiums are set.

Mr. Shadoan stated that maybe we have to alter the Insurance Code.

Mr. Spinella stated that the expense ratio of Medical Mutual is 15% of the overall premium. The public's idea of a $5,000,000 judgment paid by an insurance company, is that the insureds of that company had to come up with this money.

Mr. Gibson introduced himself as an engineer who stated he was the survivor of a wonderful person and victim, his wife, Fran Gibson. She died one year ago today. As far as health care is concerned, he stated he has mixed emotions about filing suits. He feels he lost his wife to these physicians. He feels that there is a fragmented responsibility on the part of doctors. He stated his wife was 59 years old and healthy and strong. A week after being admitted to the hospital she was operated on for a small obstruction but in the process the physicians removed her esophagus, stomach, spleen and intestines. He stated the doctors do not communicate with the patient and that they take unwarranted authority in the operating room. He stated medical doctors have to take responsibility for the whole patient.

Mr. Jonathan Schochor was introduced, stating that he was a partner of Marvin Ellin. Stating that he would be brief and answer the questions posed by Mr. Shadoan, he stated he would be in favor of abolishing the arbitration system, if there could be a provision made for those 1,035 cases that are presently pending and growing everyday. He stated that some priority should be given to those cases when sent back to the circuit courts. The question arises how would the cases be handled in that point in time with the limited number of judges available. We would propose

that if the system is to be abolished, that the cases sent back to the circuit court level be given priority to be tried.

Mr. Shadoan stated if the system is determined to be kept, then he thinks a mandatory provision should be made to bypass the system by an agreement of attorneys.

Mr. Schochor stated that he is a member of the Bar Association Committee to rewrite the arbitration system if it is kept. The system is not working as presently constituted. A problem we now face is that the persons available to serve as members on the panels are too few in number and some names are constantly repeated. We need compulsory participation by law members, health care providers and physicians on the panel. If there were a significant number of persons in the State to serve on the arbitration panel, it would not be limited to those who volunteer. A system like the Attorneys Client Security Trust Fund would suffice in that if you are called, you must serve. We are playing roulette with the arbitration system. The problem with the arbitration system is the lack of effective voir dire. Also the panel needs some level of expertise. Updated information should be kept current as to whether or not the panel that was selected, will be able to render justice in the case. If we keep the system, it should be revamped to dispense justice.

Commissioner Muhl asked if there would be regulations forthcoming in the near future from the Committee on which Mr. Schochor serves. Mr. Schochor stated yes, and that it was an enormous undertaking. He stated the target date for the regulations is the end of November. Commissioner Muhl asked if he could supply this Commission with the regulations to which Mr. Schochor replied he would if the Chairman of the Committee agreed.

Mr. Liebmann at this point asked Mrs. Tippett to send copies of our minutes to Mr. Prendergast of Smith, Somerville and Case.

Mr. Schochor stated that it would be unfair to ask Mr. Tabler to revamp the arbitration system in lieu of his other responsibilities.

Mr. Liebmann then called upon Mr. Brault to speak to the Commission.

Mr. Brault stated he is an attorney from Rockville. He stated that he thought it was unfortunate that in some respects the litigants are identified with one side of the table or the other. He stated that in his experience in the course of his career as a litigant with rules and procedures, he has been working on a complete review of all civil procedures for the Courts of Maryland.

He went on to state that the best solution to the problem is to eliminate the arbitration system and place the cases back in the judiciary where they belong. He stated that the arbitration system needs improvement but he is not sure that if new rules are created or deleted that the end result would be unnecessary procedures. The problem with the procedure is that it takes time and costs money. The arbitration system is time added on to the judicial system, which is too long already.

The question is what have we received as a result of this system and what can we achieve in the future. He stated that the answer would be nothing that he can look toward which shows that the passage of this Act has caused a benefit. He suggests abolishing the system. He stated that one or two changes, however minor in nature, could become a liability to that physician in damages which would reduce the amount of damages twofold. He urged the Commission to propose legislation that would authorize the courts of appeal to review the amounts and the size of awards for adequacy. The Commission should study the merits of awarding for pain and suffering to those who have already died. He also stated that he would not oppose a cap.

Mr. Liebmann asked about the power of the appellate courts to change the amount of the award.

Mr. Brault stated that there has never been a reversal on the size of the award by the Court of Appeals. He stated that he was appalled by the number of frivilous cases brought to the arbitration system.

Mr. David Levin suggested that if we look at the statute as a whole, that it does not perform as expected and if that is the case, it should be abolished. He stated we are wasting time with our recommendations to abolish the system to the Legislature because he does not feel that this would be accomplished. One of the major complaints is when trying a major case, we realize that this is the worst system in which to litigate.

We use this system to our advantage. He suggests that we use $50,000 as a limit. Mr. Levin stated we should limit the amount of money that can be dealt with in an arbitration case. If you do this, then those cases go into the court system. This will limit the number of cases in arbitration because there are a limited number of attorneys who deal with this on a particular basis. If every case in the system could obtain an award because of a panel result for $250,000 to $500,000, then the insurance companies will want the best representation they can afford. If they know the damages in these cases are limited, you will not see the same attorneys every time. The smaller

claims can be handled on an expedited basis. Even the system in place now would be satisfactory if a limit were set because there would be fewer problems.

Mr. William Whiteford stated he would be brief and that he agreed with what had been said so far. The system does not work properly. There is no uniformity in this system. The system is supposed to give people quicker methods of solution, but it takes too long. Any case that goes to arbitration is going to be appealed by one side or the other. Therefore, there is really a lot of duplication and a waste of time and money. He does not know whether or not the arbitration system can be salvaged. He stated that the insurance industry might not agree with him, but he feels there should not be a cap. An area that could be looked into is a contingent fee. He does not think the system is working.

Mr. Aaron Levin stated we do not have a cap on awards in Maryland because we do not put a cap on the value of human life. We look at human life without ceilings. Mr. Levin stated that inexperienced panel chairmen can get eaten alive by experienced attorneys. He agreed that we should abolish the system.

Mr. DeVries stated that it has all been said. His position is that the system should be abolished. It has not worked in any way. It has increased expenses, duplication and in reality, is in every case we have tried, there has been an appeal. He agrees with the premise that you can look at the case and tell whether or not you will try it twice. The Legislature will not follow the suggestion of the Commission if it recommends abolition of the arbitration system. He indicated that quarterly reports would be helpful if given out to panel chairmen. He recommended a uniform set of guidelines also be sent to all panel members. A system of compulsory participation on the panels needs to be dealt with. We need a viable alternative as to how to make the system work if it is not to be abolished.

At 10:00 p.m. the meeting was adjourned. All future meetings are public meetings. Mr. Liebmann urged attendance and the presentation of written materials.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Thursday, November 10, 1983
United States Fidelity & Guaranty Company
15th Floor, Room 7
Lombard and Charles Streets
Baltimore, Maryland

MINUTES

Present

George W. Liebmann, Chairman
Edward J. Muhl, Insurance Commissioner
Michael Connolly, Assistant Commissioner
Paul Durkan, M.D.
John A. Andryszak, Esquire
Israel H. Weiner, M.D.
Leo A. Hughes, Esquire
Harold A. Cohen, Ph.D.
David L. Bowers, Esquire
Timothy L. Mullin, Jr., Esquire
Philip Sturman, Esquire
Janna Vavroch
William Gibson
Elizabeth Gibson
Doris A. Tippett, Recording Secretary

Absent

Senator Francis X. Kelly
Senator Jerome F. Connell, Sr.
Delegate Joel Chasnoff
Delegate Gene W. Counihan
George W. Shadoan, Esquire
W. Minor Carter, Esquire
J. John Spinella
Grover Czech
Ellen L. Zamoiski

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Chairman Liebmann began the meeting by stating that we would hear from various persons who wish to give their input. He further stated we would next review the information received by the Commission so far to determine what is needed and what the members feel needs to be obtained in order that the Commission can give consideration to proposals for changing the system.

Mr. Liebmann stated he would like a person from the Commission on Medical Discipline to address the Commission at our next meeting regarding the adequacy of the reporting requirements of the Maryland Statute in regard to the reduction of malpractice insurance claims. The question was posed as to what statistics should be obtained. Janna Vavroch handed Mr. Liebmann copies of panel chairmen and court opinions rendered during the last two years from the Health Claims Arbitration Office, which Mr. Andryszak volunteered to photocopy and forward to Mrs. Tippett for distribution to all Commission members.

Mr. Liebmann then asked the Commission members what other material they feel is necessary to obtain and distribute. Then he proceeded to state that at the next meeting, we will embark upon a discussion of the various proposals for change in the tort reform and arbitration procedures with a view toward

ventilating the process. He stated we will then be in a better position to vote and draft proposed legislation and pass this on to the Legislature.

Mr. Liebmann then introduced Mr. David L. Bowers, an attorney with Miles and Stockbridge.

Mr. Bowers stated he has spent the last 10 to 15 years dealing with medical malpractice cases. He is interested in changing the regulations promulgated for the Health Claims Arbitration Office. He stated he would like to see some improvement in the structure of the system. He also stated that if the system is rewritten, that there are a number of points that should be changed in the regulations or statutes. Mr. Bowers stated that many panel members posed the question - do we have the authority to grant motions. The regulations should be changed to include rules which pertain to motions to dismiss and to provide for summary judgment in health malpractice claims to lessen the burden. He stated the panel chairmen should be allowed to grant a judgment in a panel hearing the same as a judge could in a court proceeding. If the case does not meet the standards, then the members of the panel should not be given the option of finding a verdict in that case. He stated the weakness in the panel chairman leads to duplication of process.

Mr. Bowers stated the panel may in fact apportion damages to libel health care providers on any basis other than the pro rata shares. He stated that under the Health Claims Arbitration Office Title, COMAR 01.03.01.12.2 b and d, it is provided that the panel shall apportion damages among the health care providers found to be libel. Most panel chairmen are reluctant to go beyond what they learned in common law. He stated that the panel chairman system is a weak system but he agrees that an affirmative step would be a permanent panel chairman.

It was stated that a problem is that there is no filing fee whatsoever for the filing of a claim with the Health Claims Arbitration Office.

Mr. Liebmann asked if there was a fee, how much would go to health claims and to panel members. He also asked what purpose a filing fee would serve.

Mr. Bowers stated that certainly a fee would not stop a claimant from filing a claim. There are many frivilous claims in the Circuit Court. He stated he was concerned about the means by which the health claims arbitration proceeding goes along ignoring the rules of evidence. There are many inconsistencies about how this is to be accomplished which has an unfortunate effect on enforcing evidence rules. These rules should be enforced.

Mr. Liebmann asked whether the rules should be enforced to the same degree as a jury trial to which Mr. Bowers replied like a court trial because there is no need to hide anything from the trier of fact. Mr. Bowers stated that the problem is the panel members do not know what they are supposed to do. He feels a booklet for the panel members should be prepared so that they know how far they can go to make determinations or rulings in these cases. Panel members need clear and definite instructions about what rules they should apply. The panelists should be educated as to the rules in this procedure.

Mr. Liebmann asked Mr. Bowers who he thought should prepare the booklet. Mr. Bowers stated he felt that the State Bar Committee should prepare the booklet.

Mr. Mullin stated that he is a member on this Committee and that he will bring us up-to-date on this subject.

In regard to apportioning awards to those found libel in the multiple defendant case, Mr. Bowers stated the award is split on a pro rata basis. For example, if two doctors are fined $1 million, each doctor pays half.

Mr. Liebmann stated the panels have the power to apportion but they do not use it. Mr. Bowers stated, yes, that is true. He stated the trier of fact should apportion the award. He also added that the average duration of a case is far less than that of a jury trial.

Mr. Hughes asked Mr. Bowers if he would support the Health Claims Arbitration Office being run like a court trial. Mr. Bowers stated yes, that he does not see why not, because it works in court. It was stated that this proceeding is a strict court trial which will precede another strict court trial which is a total duplication of the process.

Mr. Hughes asked Mr. Bowers if he wished to state an opinion as to whether the system works and if he would be in favor of abolishing the Health Claims Arbitration Office.

Mr. Bowers stated yes, it should be abolished. Mr. Hughes asked if he thought it delays the result of the case to which Mr. Bowers stated that some cases are settled prior to hearing and sometimes after the panel renders its opinion. Therefore, the system has some benefit in airing out problems in the case. He stated it has value but not enough to warrant keeping the system.

Mr. Hughes stated he had at the last meeting, asked Mr. Tabler of the Health Claims Arbitration Office, how broad the use of his letter opinion was, that medical reports could be introduced without bringing in the doctor to testify before the panel hearing.

Mr. Mullin stated that it is frequently raised but inconsistently applied. Mr. Hughes stated that the most common happening is that the chairman will not allow the opinion in lieu of testimony.

Mr. Mullin stated when the doctor does not appear that the letter or medical report is the only expert witness.

Mr. Liebmann asked if the inadmissibility of medical reports can be dealt with by rule or are there other problems of equal magnitude.

Mr. Bowers stated the claims themselves tend to be hearsay which are excluded in court rulings. He also stated there are no hearsay rulings in these proceedings and that the rules are relaxed.

Mr. Liebmann then asked Mr. Mullin what took place at the meetings of the Bar Association Committee.

Mr. Mullin stated that there should be more interfacing between the Bar Association Committee and this Commission. He stated we should address not a change in the system, but to propose solutions in the procedural system as it now exists. He stated it was the opinion of just about everyone on the Committee to abolish the system, but we will propose minor changes to the Legislature. Addressing the subject of the booklet for the panel members, he stated that the Committee has been formed to do just this task. He stated it is important to help the system as it now stands, which is one of the major reasons for forming the Committee. He stated that none of the panel members know what they are doing. The booklet will give them some guidance. He stated his Committee has worked through the process from the filing of a claim to the appeal process to identify the problems and to seek solutions to these problems. Mr. Mullin stated that it originally looked like a simple task, but it has become a monumental one, stating the last three meetings lasted at least four hours.

Mr. Mullin said the Committee has not even begun the task of drafting a statute or a legislative form for changes. He stated that at this point, the Committee has reached the directive verdict step. The Committee has addressed problems ranging from evidentiary problems such as summary judgment motions to voir dire of panel members. The Committee will recommend some form of universal service on the arbitration panels.

There are approximately 1,000 lawyers in the State participating on the panels and about 600 to 700 physicians. Since the bulk of the cases are in the Washington and Baltimore areas, there is not enough participation if this is going to work.

Mr. Tabler draws panelists from judicial circuits. He stated at this point, the Committee is trying to formulate the changes but stated further that topics regarding summary judgment motions come up and that leads to something else which steers the Committee off on another track. He stated that health care providers almost always get the presumption on the summary judgment motion. He stated that most lawyers in the system try to make the arbitration process like a trial.. He also said that the charge is to attempt to make this system not like the lawyers operate. The Legislature should have given us some guidelines as to whether the system should be like a trial or an arbitration process. In Maryland law, there is initially no review of this decision. Many frivilous claims are filed. Mr. Mullin stated the Committee has determined a need for prehearing determinations.

Mr. Sturman asked what is to prevent the plaintiff from going to the arbitration process.

Mr. Hughes stated Circuit Court judges have indicated that we have no jurisdiction to bring these cases to court. On a motion for summary judgment, you do not get the chance to submit evidence. Mr. Hughes stated when he has a law suit that has merit, that in ten months we are still at round one. Why should these people have to pay this twice.

Mr. Mullin stated the Committee will recommend that there be mutual waiver of arbitration.

Commissioner Muhl asked if the Committee feels there is a chance to salvage the health claims arbitration system to which Mr. Mullin replied yes, and further added the procedural changes will make the system look totally different. He stated this is because the Committee is trying to think through aspects which have never been reviewed before.

Commissioner Muhl asked if the Committee can accomplish this task in the near future before the next legislative session, and Mr. Mullin replied no.

Mr. Liebmann asked what are the recommendations of the Committee. Mr. Mullin stated there have been few problems with discovery. The minor problems are how to deal with discovery procedures in the absence of panel chairmen. He stated the system we will be working with will be a panel chairman drawn from the ranks of the attorneys. We will adopt a statutorily appointed and paid permanent panel chairman.

Mr. Hughes asked if the Committee will make the panel hearings similar to a trial. Mr. Mullin replied yes.

Commissioner Muhl then asked what purpose are we serving. Why not go with the court system, because it appears we are creating another formal system.

Mr. Hughes stated the problem lies with the attempts of attorneys to make the process a structured trial. He stated the system works best when used as it was designed to be used.

Mr. Mullin stated the Committee is trying to find out what kind of system this is supposed to be in the first place. The Committee leans toward making the system a more structured format. He stated that a certain percentage of plaintiffs go through the arbitration process just to get their day in court.

Commissioner Muhl asked what Mr. Mullin's opinion was as to binding arbitration to which Mr. Mullin stated that it terrified him.

Mr. Bowers stated that he did not think that anyone would want to go to binding arbitration. Mr. Mullin stated that his personal experience has been rather poor with arbitration.

Dr. Cohen asked if the panel should be restricted to certain dollar limits on awards. Mr. Mullin replied the Committee suggested raising the jurisdictional amount of $10,000. Mr. Hughes stated if the case is above $50,000, you can go to Circuit Court.

Mr. Liebmann asked if anyone thinks that increasing the amount from $5,000 to $50,000 would be a problem. Mr. Hughes stated no because it costs that much to get the expert witness to the arbitration panel. He stated that he sits as a panel chairman. He also stated that attorneys are terrified to do anything after they file the claim, but when you dismiss it, they scream.

Dr. Weiner stated attorneys want the easy arbitration process with its uniformity.

Mr. Mullin stated the Committee will recommend some compulsory participation in the panels. Mr. Liebmann stated that the system has 10% of the Bar to which Mr. Mullins stated there have been complaints about retired lawyers, etc. as panel chairmen. He stated we need greater voir dire by the Director in order to find out what kind of competence the potential chairmen have. The Committee prefers to have the option of taking a one year attorney.

Dr. Weiner asked if anyone has proposed drafting a qualifying examination for potential panel chairmen. Mr. Liebmann asked about using retired judges and Mr. Bowers replied that he feels comfortable with that position.

Mr. Liebmann asked the Committee's thoughts on this topic. Mr. Mullin stated he cannot speak for the Committee because they have not addressed this subject.

Mr. Hughes stated that we have to make a decision as to whether or not we are looking for a totally different system. If so, retired judges would make the system very formal resulting in the arbitration system being trial number one and then the case on appeal would result in trial number two. He stated that as long as the system is not compulsory, the panels will draw a large number of inexperienced persons as panel chairmen.

Mr. Liebmann stated that he has the impression that the Bar is outraged because of inexperienced panel chairmen. Mr. Hughes stated that some standardization is needed so we know where we stand. He stated that he is a trial lawyer and thinks his success comes from his knowledge of the rules of evidence.

Mr. Liebmann then announced Mr. Philip Sturman, who is an Associate in the Law Office of M. Wayne Munday, P.A.

Mr. Sturman stated he had just begun practice in the area of medical malpractice. He stated that attorneys know a decision can be appealed and the presumption is that the decision is prima facie. He stated that from the statistics he has seen, about 140 cases were appealed from panel determinations. He stated that he would like an explanation of how that many cases could be resolved by the system and on the other hand, how can this Commission wish to do away with the system. He stated he was on the Workmen's Compensation Commission's Arbitration Panel when he was employed by Smith, Somerville & Case, for the past five years.

Mr. Hughes stated that workmen's compensation is an administrative game and that they deal with Commissioners in a judges role in an evidentiary hearing. He stated that there should be a middle ground or someone who can make binding determinations on the panel.

Mr. Liebmann asked whether when an appeal is taken and the expert witness has testified below, should there be a limitation on the persons ability to depose him on the Circuit Court level. Mr. Mullin stated if you lose below, you have your eggs lined up when you go before the Circuit Court.

Dr. Durkan stated he has only had experience from panel to court and stated the trials and the presentations are so different. He asked whether this was a general experience or a unique experience. Mr. Bowers stated yes, that this happens.

Dr. Durkan asked if there is any possibility that the first process is unfair because the attorneys are testing to see how it hangs. It may be potentially unjust.

Mr. Liebmann stated that you have to identify the expert witness before the arbitration panel and then wanted to know if this has an abstract effect.

Mr. Hughes stated that if the doctor gets ripped apart at the panel hearing, he will not come back and testify in court. He stated that his approach in arbitration is to try to get it over with in the informal proceeding and if the case is lost, appeal and pull all the stops in court. When trying to win a case, you must realize that the panel is informal and the court is formal.

Mr. Liebmann stated that our next discussion should relate to what further data the Commission needs to obtain. He feels that we need information from the Commission on Medical Discipline regarding the reporting of claims and also the collateral benefits rule.

Commissioner Muhl stated that one of the charges of the Commission is to review Medical Mutual. A discussion was raised as to Medical Mutual issuing nonassessable policies. The Commissioner indicated that the matter was currently before the Division as to whether or not we will grant them the authority to write this type of policy. The Commissioner asked if the Commission intended to explore this aspect. Mr. Liebmann stated that it was not in the Commission's charge and we are not qualified to explore this aspect.

Commissioner Muhl stated that his reason in asking that question was based on the fact that this subject is very sensitive and controversial. Mr. Liebmann stated that his view of the matter was not to pursue this aspect unless someone else wants to review it. The pleasure of the Commission at the meeting, was not to pursue this review.

Mr. Hughes asked whether this has any serious effect on jury trials.

Mr. Liebmann stated that claimants collect several times with the result of increasing insurance rates. He stated that health care costs are rising too quickly.

Commissioner Muhl stated that there is no subrogated interest in this aspect. Mr. Hughes stated Blue Cross is subrogated in all but a few contracts, and that Blue Cross is definitely a subrogated item.

Mr. Liebmann stated that we should address the question as to whether there should be some system for notifying the health insurer. Mr. Bowers stated that when someone is hospitalized they receive a questionnaire as to whether the injury was work related.

Dr. Weiner stated that we have to recognize that this system is in trouble and the averages do not look bad. The item the Commission has to review is how to take the pressure off the availability and price of medical malpractice insurance.

Mr. Bowers stated that if the argument is the plaintiff bought and paid for his medical insurance, then he should not be denied the benefit of his investment into those items. As Social Security payments are the creature of his work, so the same argument applies here.

Dr. Weiner stated that the money which is paid in is not enough to cover what is paid out. He feels that we are dealing with a different kind of bird when talking about a privately purchased disability policy.

Mr. Liebmann stated that if the system is to work, the trier of fact is to render his verdict without collateral sources.

Mr. Hughes stated the person who caused the act benefits from the person who is prudent enough to buy the policy. Mr. Liebmann stated subrogation systems are expensive and the other problem is there are collateral sources that do not involve the payment of premiums, Social Security being one of them.

Mr. Hughes stated the insurance industry has no qualms in selling two or three different insurance policies to a person, and asked how do you curtail without denying people their right to recover for damages.

Dr. Weiner stated it troubles him to see negligent doctors compared to drunk drivers. He stated he would like to see people recognize that most malpractice cases involve physicians who were doing their best but under a microscope someone decides they could have done something differently.

Mr. Hughes stated he feels that medical malpractice insurance has not become too expensive as a whole. He further stated that the Commission needs to hear about the $1 million cases. The Commission wants to avoid the case of the instant millionaire which was brought up at our last meeting. These type cases are few and far between.

Commissioner Muhl stated that under an experience rated system, neurosurgeons are paying a greater amount because of higher incidents. Dr. Weiner stated that neurosurgeons are playing for higher stakes.

Mr. Andryszak stated this makes a difference to doctors. Doctors would be up in arms about this. Flattening was discussed at this point.

Mr. Liebmann suggested flattening the litigation expenses in the indemnity payments. Dr. Cohen stated that we are not taking anything away in having a system for making the plaintiff whole.

Mr. Hughes stated if you are insuring yourself, why should the tort feasors benefit from this. Mr. Liebmann stated that in theory, the claimant is not allowed to over-insure himself.

Commissioner Muhl stated one can insure himself for a higher amount, but he would have difficulty in limiting that which a victim would normally receive. He stated he would be more inclined to decrease Mr. Hughes' fees.

Dr. Cohen stated he tends to think the Commission would want the system, as a whole, not to overcompensate.

Commissioner Muhl stated in regard to flattening that we would have a great deal of difficulty justifying this.

Dr. Durkan stated that OB/GYN and neurosurgeons are where the biggest loss lies.

Commissioner Muhl stated the handling of the loss itself is expensive. Mr. Bowers said that a firm would assign their senior counsel to these type cases.

Dr. Weiner stated he believes that Medical Mutual flattens to some degree now.

Mr. Liebmann stated we should have a discussion as to the transferring of responsibility to the hospital. Dr. Cohen stated that it was not at all clear that it is the hospital which is the cause. It should be a cost of the particular service and not a cost of the hospital. He stated if it is a social cost, recommend to the Legislature that it tax all the people in Maryland.

Mr. Liebmann stated that operations in hospitals are elective. Dr. Weiner stated that 70 to 80% of malpractice claims occur in hospitals, but that we should not try to hang the responsibility on the hospitals.

Commissioner Muhl stated that there is a certain amount of unfairness in this. Mr. Andryszak stated if we cap fees, is the person being made whole if attorneys are taking one third off the top of the award whether the award be $30,000 or $2 million.

Mr. Hughes stated he would far prefer to handle cases on an hourly basis, however, people do not have that kind of money. Costs to attorneys are immense in terms of preparation and research, therefore, one third of the award is justly earned.

Mr. Liebmann stated that these were interesting issues but in the limited amount of time remaining, he would like to know what the Commission members would like the next meeting to address. He feels we should obtain someone from the Commission on Medical Discipline to speak at our next meeting and some discussion should focus on the improvement in the reporting mechanism. Also we should focus on legislation on informed consent. Then Mr. Hughes asked if that was part of the Commission's charge.

Dr. Cohen asked if we would be talking about flattening. If so, he stated we will need to know more about physician's net and specialties.

Commissioner Muhl stated that Mr. Spinella would be able to offer statistical information on this issue. Commissioner Muhl stated that Mr. Spinella is an actuary and the Executive Director of one of the largest writers of medical malpractice insurance. He stated that Mr. Spinella would be able to give various statistics regarding specialties.

Dr. Weiner stated the problem is in the money because if you use dollars as an index to the problem of the standard insurance from Medical Mutual, that is why he elected to go with the claims made policy, because it is cheaper insurance. He stated that this represents the beginning of a decompensation of the system. He does not have the protection he used to have, and also that if these trends continue, things will fall apart.

Dr. Cohen stated we should worry about the problems here in Maryland, not in New York and Florida. Mr. Bowers stated that in New York everything is more expensive.

Commissioner Muhl asked how that can effect the State of Maryland. He further asked how do you prevent something like this from permeating the minds of panels and juries in Maryland. Mr. Bowers stated that we cannot prevent this. Mr. Hughes stated that much harm has been caused by the movie The Verdict. Mr. Bowers said that it makes an impact.

Mr. Liebmann stated that Mr. Brault mentioned at the last meeting that there be a statutory provision for a remitter at the Court of Special Appeals level, to upset excessive awards. The other suggestion Mr. Brault made was the wrongful death case. Mr. Liebmann asked about the pain and suffering of the deceased.

Mr. Hughes stated that he does not know. Mr. Liebmann stated that pain and suffering is an issue. Mr. Hughes said that there are very few cases of wrongful death that have a lot of pain and suffering.

Dr. Cohen asked when was death relative to the case, before or after. Mr. Hughes stated he thought it was before the case.

Mr. Liebmann asked if there were other things that could be eliminated. Dr. Weiner stated we should focus on the bad doctor and try to determine gross negligence and simple negligence. He asked if there is a difference in how you compensate victims of these kinds of negligence. He asked if we can put a definition on gross negligence.

Mr. Hughes stated the defense representatives would squalk the most about this. Mr. Bowers stated his feeling as to gross versus simple negligence is that there would be a shooting gallery for gross negligence.

Dr. Cohen suggested that negligence should not be a matter of being a good or bad doctor. Physicians should not be required to be perfect.

Mr. Hughes stated that in routine cases, we cross an incredible hurdle to convince someone that a doctor has been grossly negligent. He stated that lining up an expert witness is very difficult and expensive. He also said that he would not as a rule, personally file an action against a doctor without having in his file some medical opinion that the doctor was, in fact, negligent in the case.

Mr. Liebmann stated that it may be helpful if we had all the collateral benefit statutes arranged by state and if we could obtain some figures regarding income from physicians.

Dr. Weiner stated we would be able to obtain this information from Medical Economics in New Jersey.

Mr. Hughes stated that the questions posed by George Shadoan in his October 28, 1983 letter, should be addressed because the aforementioned questions will definitely be presented before the upcoming session of the Legislature.

Dr. Cohen stated that attorneys and physicians think the system should be abolished because of duplication and they feel a more structured form is needed. He then asked what the feeling of plaintiffs are as to whether the panel should be continued.

Mr. Bowers stated that Medical Mutual's position would be to improve the system. Mr. Hughes stated that the system is inadequate because with this system, you try the case twice. He stated that he informs his clients about this from the onset.

Elizabeth Gibson stated she felt the social issue is a fundamental reason to decide on continuing the system and wanted to know if it is beneficial to the physician and the plaintiff or if it is just another legal battle. She feels the problem boils down to doctors do not have good communication, and asked that the Commission address informed consent. She feels that informed consent is the foundation on which insurance liability builds and that there should be more consumers present at these meetings.

As to pain and suffering, she stated justice should be rendered and the person compensated. In her personal situation, she stated the family dismissed pursuing compensation because of the cost involved. She stated people go for the money because they have to pay their legal costs. Also she pointed out that if a plaintiff does not ask for damages, it seems they should not even have gone to arbitration to begin with.

Mr. Hughes asked if she, as the victim, was able to contribute anything to the Commission.

Ms. Gibson stated that as an educated person she would be intimidated by the whole arbitration hearing because it is very structured. She asked what the goal is in arbitration whether it be a settlement out of court or a preliminary trial.

Dr. Weiner stated he would like to know also. He stated that if a substantial number of malpractice cases are designed to hold physicians accountable, perhaps the frivilous case is allowed as a forum to air their complaint. He stated that doctors can be pretty hard on other doctors.

Ms. Gibson stated the only people who will benefit is the insurance companies and stated the social issue has to be addressed because the Legislature acted in a moment of crisis. Now we have the opportunity to plan, not react.

Dr. Cohen asked what if any likelihood there is the problem will rise in other states and what can we do to head this off. He stated that we do not want insurance premiums to reach the point where the physician cannot afford to be in practice.

Mr. Sturman stated that very few doctors found guilty of malpractice are disbarred by their peer review groups.

Mr. Hughes asked if anyone had any feelings as to whether the arbitration system or the court system would be preferable.

Mr. Gibson stated that medical testing has improved enabling physicians to better evaluate the patient. He stated he tends to believe that physicians should be more accountable for their actions, stating the authority aspect is very important along with responsibility and formality aspects. He feels the Commission should look into this.

Ms. Gibson stated she feels a problem is obtaining qualified people to sit on the arbitration panels to better service the general public. She wants to know, if the panel is retained, what checks and balances are there for removing a panelist who is not performing adequately. She asked if they could be asked to step down if not doing their job properly.

Mr. Hughes stated the State is divided into eight judicial districts from which panelists are chosen.

Dr. Cohen asked if there are any reports as to attorneys interpretation of the competence of the panel members. Mr. Hughes stated no that there was no official report file.

Mr. Hughes stated that if a panelist is not doing his job, Mr. Tabler will hear about it, and that there is a procedure for which a panelist or chairman may be removed.

Mr. Liebmann asked if Mr. Tabler should try to obtain panelists who are readily willing and able to serve on multiple cases per year. Mr. Hughes stated that he would have to think about this.

Dr. Weiner stated he has a problem with the lay panel member. He wants to know what his reasons are for wanting to serve on this panel.

Mr. Liebmann asked if judges should preside. Mr. Hughes stated if retired judges serve as panelists, the system will be very structured. He also stated that if arbitration is to be beneficial, it should be quick and easy to see if a solution can be worked out. If you are not using the system to eliminate frivilous claims, then why have it. We need standardization if the system is going to be retained.

At 9:50 p.m., Chairman Liebmann adjourned the meeting.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Thursday, November 17, 1983
United States Fidelity & Guaranty Company
15th Floor, Room 7
Lombard and Charles Streets
Baltimore, Maryland

MINUTES

Present

George W. Liebmann, Chairman
Edward J. Muhl, Insurance Commissioner
Michael Connolly, Assistant Commissioner
Senator Jerome F. Connell, Sr.
James P. Durkan, M.D.
Israel H. Weiner, M.D.
George W. Shadoan, Esquire
Leo A. Hughes, Esquire
J. John Spinella
Grover Czech
Harold A. Cohen, Ph.D.
John A. Andryszak, Esquire
Walter Tabler
William Gibson
Angus Everton, Esquire
Doris A. Tippett, Recording Secretary

Absent

Delegate Gene W. Counihan
Delegate Joel Chasnoff
Senator Francix X. Kelly
W. Minor Carter, Esquire
Ellen Zamoiski

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Chairman Liebmann began the meeting with a discussion of the scheduling of upcoming meetings. It was proposed that on December 6th and December 13th, the meetings be held in Annapolis. Senator Connell stated the Commission can arrange for a room in the James Senate Office Building for these meetings and left Mrs. Tippett to make the arrangements. Mr. Liebmann stated that Dr. Karl Mech from the Commission on Medical Discipline would be attending the Commission's December 1st meeting. At this point Mr. Liebmann stated that Mr. Spinella and Mr. Tabler would speak and then the Commission will direct its attention to the list he prepared entitled "Issues for Consideration", which is a consensus of all topics presented by those who have testified before the Commission.

Mr. Tabler was introduced. He announced that he was advised that a $81,000 recovery in subrogation in a case handled by his office was rendered.

Mr. Spinella distributed countrywide rates for specialties from ISO, stating ISO is the data collection agency which compiles information and generated a rate filing. The list displays the rates approved by the regulators of each state responding to requests by the ISO office. These rates reflect the last approved rate by the respective insurance department.

Dr. Weiner asked if Medical Mutual uses ISO rates. Mr. Spinella stated that Medical Mutual makes independent rates and does not use ISO rates.

Dr. Weiner then asked if these rates were based on accepted actuarial standards.

Commissioner Muhl stated that it is difficult to obtain actual premium costs by state. In Maryland, you have Medical Mutual occurrence insurance policies at a low amount but not to physicians. There are wide variances. ISO has based its statistics and breakdown by territories, a rate representative of cost and experience and they file this rate with the respective insurance department which approves it. Any company that subscribes to the ISO service can use this rate. This is just a base rate on a large area. Companies can deviate from this rate.

Mr. Spinella stated the Insurance Commissioner of New York has not approved a rate increase for New York in the past three years.

Commissioner Muhl asked Mr. Shadoan if these statistics were meaningful and he stated they were not.

Mr. Spinella stated at best they are relative figure levels. Further discussion continued regarding the ISO rate information which Mr. Spinella distributed regarding occurrence coverage on $1 million and $3 million limits.

Mr. Czech stated the NAIC study goes into paid and incurred losses but does not look at rates at all. He stated we should look at the severity of the claims.

Mr. Shadoan stated he was concerned about the relevance of pursuing some of these questions and asked if we should address the need for tort reform regarding the payout to victims and what we can do with the arbitration system. With respect to tort reform, we want to investigate medical malpractice insurance premiums as they are an important part in the spiraling cost of health care. An unfair burden is imposed upon segments of the medical community, namely neurosurgeons and OB/GYN specialties. This concern with respects to premiums seems to have limited relevance. The cost of hospitalization in this State is such that the premiums for malpractice insurance charged the hospitals is 7/10ths of 1% of the health care cost associated with hospitals.

Mr. Liebmann asked if there is a cap on what awards are recoverable against hospitals. Mr. Shadoan stated the statute provides that the hospitals carry adequate insurance and there is no limit on the exposure of the hospital. They are limited by statute and not required to carry more than $100,000.

Dr. Weiner stated that hospitals do not trust the statute.

Senator Connell stated the statute requires that you are limited to the amount of your insurance.

Mr. Shadoan stated in protecting the public against the unreasonable cost of health care, that is in terms of total premiums charged Maryland physicians, we can quantitatively state that $35 to $45 million annually is a significant part of health care costs in this State. We are talking about equity among high risk specialties and he believes the things we are talking about are not relevant unless we can reduce these premiums.

Mr. Czech stated he would suggest that there is a problem of increasing costs and it goes back 7 or 8 years. Look at premiums collected and look at incurred losses.

Commissioner Muhl stated he questions whether or not there is a real problem in Maryland regarding neurosurgeons.

Dr. Weiner stated he had switched from occurrence to claims made insurance. He stated he feels this is the beginning of decompensation of the system. Physicians do not have the same protection they used to have. When a physician retires he is not going to buy the tail. Doctors no longer have this protection and potential claimants do not have a source of recovery. Dr. Weiner said he has claims made insurance because he decided the dollars were not worth the difference in the value.

Mr. Liebmann asked if there was any tendency to underinsure because of the high rates and a tendency not to buy the limits physicians really need. He also asked if doctors insulate themselves against potential liability.

Mr. Shadoan stated his attitude toward this has been that he views the physician as a human being. He does not wish to see a doctor's personal assets being invaded. He stated that as an attorney in regard to the award of large verdicts, there has never been a physician threatened by him in this respect.

Mr. Czech stated the mere fact that insurance exists leads to litigation and a request for inordinate damages.

Mr. Shadoan stated he feels that it is a mistake to start making any serious changes in the law or taking away anyone's rights.

Dr. Weiner stated he feels that $1 million is barely adequate protection. He stated he has taken steps to reduce his personal exposure.

Dr. Durkan said everyone knows that you cannot protect your personal assets completely. The whole game would change.

Dr. Weiner stated once you have a judgment, some attorneys do go for personal assets. Mr. Liebmann stated that we need more data on what the rates really are in the high rate jurisdictions for medical specialties. Mr. Shadoan asked why. Mr. Liebmann stated because if it can really happen, we want to make sure it does not happen here in Maryland.

Commissioner Muhl stated this would be difficult because we are talking decisions by the courts, attitudes of people, etc.

Mr. Shadoan stated it is misleading to look at a premium in another state and know all the intricacies. He stated he came into this meeting believing the premium increase in medical malpractice insurance for physicians had been 100% in the last year which was having a very bad effect on the large part of health care costs.

Dr. Cohen stated that in the GMENAC (Graduate Medical Education National Advisory Committee) projections of physicians by specialty, the shortage is in the low areas not in the high areas. Therefore, physicians are not in short supply in those areas where malpractice is high. There is no projected shortage.

Mr. Liebmann stated we are not in a situation where heroic measures are called for, as in the crisis of 1975, thus we should be concerned with guarding against abuse and a change in psychology which would produce a high escallation of rates. It should be possible to do some things that do not deprive anyone of fair compensation and at the same time improve the operation of the system. It is common sense that if you have publicity to a few very high awards you have claims conscientiousness, and you run the risk of effecting the whole system. Part of the complaint about the arbitration system is that it produces strange results.

Mr. Shadoan stated with a large verdict, there are cases in which negligence has occurred and if any kind of justice is to occur, compensation will be required of a present value in excess of $1 million.

Mr. Liebmann stated that this year there were two $5 million awards granted in Maryland. He stated when the trier of fact is not required to provide a rationale for an award of this size, there are grounds for concern. It is hard to justify $5 million for anything in these economic times.

Mr. Shadoan stated he is not opposed to special verdicts but he is not prepared to start laying restraints on the substantive law and rights of citizens in this State.

Mr. Liebmann said his suggestion is that we walk through the items on the list he distributed, mentioning the first item which is arbitrary caps.

Mr. Czech stated he had three studies conducted by ISO, E. James Stergiou (Risk Consultants, Inc.) and Tilling Hast Nelson & Warren, Inc. (Consultants and Actuaries), which were based upon two senate bills still pending in the New York Legislature. In the New York study, a cap on pain and suffering at $100,000 would eliminate about 30% of total awards. It has an impact on premiums across the board. This is not a cap on the overall award but on everything.

Senator Connell stated the legislative report also tracks what we are talking about here. Mr. Liebmann asked if anyone felt a general cap would be appropriate.

Commissioner Muhl asked Senator Connell what his thoughts were in reference to the feeling of the Legislature for acceptance of changes in the arbitration system on awards.

Senator Connell stated that they will not react until it is clearly proven that there will be no detrimental effect on the public and no adverse effect on the medical community. He stated that a general cap on awards would be difficult to get through the Legislature.

Mr. Shadoan stated, as he referred to the list distributed by Chairman Liebmann, that the items listed all have one thing in common, they restrict the rights of the people who are bringing claims in this State. There is no need for any of this. Mr. Shadoan stated he motions "no" to all of these items because there is no need to restrict the rights of Maryland citizens.

Mr. Liebmann stated that not all of the items on the list restrict citizens rights.

Commissioner Muhl stated that caps, in his personal opinion, or limiting damages on awards will be impossible to get by the Legislature.

Mr. Liebmann stated that a cap on pain and suffering awards would be a relative cap rather than an absolute cap.

Mr. Czech presented another approach to pain and suffering, namely a no fault pain and suffering policy. Sell a $50,000 pain and suffering policy and price it on a no fault basis. Physicians would buy it and the individual would have to choose if they want that kind of coverage or go to court and sue for recovery.

Commissioner Muhl asked Mr. Czech if he would draft such a piece of legislation stating it would be unrealistic in terms of the problems that would arise.

Mr. Czech stated it would be third party coverage. He stated that he could not give us details at this time.

Dr. Cohen stated he was not against a cap on pain and suffering but questions to what extent we are trying to make some people whole if it is coming from the general public. He thinks we should not dismiss the idea of a cap.

Commissioner Muhl suggested that the Commission agree that capping in one form or another would be a viable idea and we should recommend this to the Legislature.

Senator Connell stated the next session of the General Assembly will be a difficult one. Whatever comes to the Legislature from this Commission should be meaningful and brief.

Dr. Cohen stated awards should be itemized and we can review them in one year and consider whether capping should be required. He feels we should not dismiss the idea of a cap.

Mr. Shadoan stated that we should make recommendations to the Legislature which will be well received and there is no need to pursue tort reform. It will not be well received.

Mr. Czech stated we have to do something with the tort system which is the only way we can reduce malpractice premiums. A cap on pain and suffering would change the cost of the system in a reasonable fashion.

The Commissioner asked the Commission for their reaction to flattening of premiums.

Mr. Czech stated you have the same market problems with flattening as in any insurance mechanism. It causes a market availability problem for them.

Commissioner Muhl stated he is not advocating this, he was just inquiring. Mr. Liebmann stated that flattening is something we need to look at. Mr. Czech stated another way to do this is the chaneling of liability.

Mr. Liebmann stated the regulation of attorney fees has little impact on the level of premiums. At this point a discussion ensued regarding attorneys fees.

Mr. Shadoan stated attorneys do not want regulation of their fees in this State. Most attorneys limit their fee to one third of the award. The arbitration panel used to have the authority to award attorneys fees, however, this has changed.

Mr. Czech stated a California study shows the dollar in pieces indicating the plaintiff's attorneys fees were 25% and the defendant's 12.5%. The plaintiff's fee was significantly larger than the defense fee.

Mr. Liebmann stated the statute of limitations for medical malpractice insurance is illogical. Most of the limitation statutes which were passed after the 1975 movement speak in terms of x years from occurrence or x years from discovery whichever is greater with a maximum of x years. Their purpose is to take the ordinary occurrence statute and extend it where discovery is delayed and cap it. Discovery is delayed and therefore, there should be a longer period. The situation is if the injury is discovered two years and one month from its occurrence, the plaintiff can wait three years before filing suit. Why do we give people three years from discovery to file suit?

Mr. Everton stated all statutes of limitation work on the discovery principle regardless what kind of claim. Is it appropriate to allow a discovery period at all?

Mr. Liebmann stated the General Assembly states we should have a five year general limitation. Mr. Shadoan stated he thinks that at the time the thinking was the normal statute of limitation for a person injured was three years.

Insurance companies tell us if we eliminate this long tail all the problems will go away.

Senator Connell stated that insurance companies agreed to this and the Legislature removed the tail. Then the insurance companies advised it had very little effect and make little difference to them. The Legislature asked the companies if the tail was curbed, would they write malpractice insurance at a fair rate in this State to which they replied yes, they would.

Mr. Liebmann asked to what extent is there a tendency to delay until the statute runs out. Mr. Shadoan stated it does not happen. It is very rare statistically speaking.

Commissioner Muhl suggested since the list contained numerous items, that we respond to Mr. Liebmann in some fashion as to whether or not we agree or disagree on each and why. Then we will see if there is a consensus by this Commission and discuss these matters at a later meeting. He stated when we make recommendations to the Legislature, they should be meaningful and of benefit for their consideration. If there is a wide variance, it would be an exercise in futility. This subject matter has been the topic of many discussions and we should be in a position to offer meaningful changes that have credibility to the Legislature.

Mr. Liebmann stated that everyone should try to comment on each of these items in written form before the next meeting. Then it was stated the tail as respects minors is 16 years of age in this State. Mr. Liebmann mentioned he is offended by this young age. OB/GYN specialties have a problem with the length of the tail. Should we cut it off at 16 or go down lower?

Mr. Shadoan stated you have one year from reaching the age of majority to take action.

Senator Connell stated that the Legislature wants to protect the minor.

Dr. Cohen asked if an OB/GYN doctor is sued for a baby problem which occurred 15 years ago, who is the insurer in the case. Mr. Spinella stated the occurrence insurer.

Mr. Liebmann conducted a further discussion of the items on the list at this point. Regarding item 5.a. about the power of a remittur in the Court of Special Appeals, Mr. Shadoan stated this is just another bargaining chip which is totally unnecessary.

Mr. Liebmann stated he found this an appealing solution, because it is kept under control by letting the appellate courts supply some influence.

Dr. Weiner stated that doctors deal with pain and suffering everyday, further stating that it is their business. In regard to legal evaluations of pain and suffering with a dollar award, doctors never try to charge on the basis of pain and suffering.

Mr. Shadoan stated there is no yard stick, but this does not justify the fact that we can limit an award. These suggestions are major alterations that change law. We are not here to change the tort laws in this State.

Dr. Cohen asked if punitive damages are found against a Medical Mutual claimant, does Medical Mutual pay punitive damages. Mr. Shadoan stated if a physician is grossly out of line, Medical Mutual would look closely as to whether they would want to cover the physician. In an institutional setting the insurer would look carefully to see if corrective action should be taken and if their rates will increase.

Mr. Liebmann adjourned the meeting at 9:30 p.m. He asked if anyone had thoughts as to subject matter for the next meeting, stating that Dr. Karl Meck from the Commission on Medical Discipline will speak. He mentioned we should focus on questions to be directed to Dr. Meck at the meeting.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Thursday, December 1, 1983
United States Fidelity and Guaranty Company
15th Floor, Room 7
Lombard and Charles Streets
Baltimore, Maryland

MINUTES

Present

George W. Liebmann, Chairman
Edward J. Muhl, Insurance Commissioner
Michael Connolly, Assistant Commissioner
George W. Shadoan, Esquire
James P. Durkan, M.D.
Israel H. Weiner, M.D.
Leo Hughes, Esquire
Ellen Zamoiski
J. John Spinella
Barry Cohen
Senator Rosalie Abrams
Elza Davis, Med Chi
John Brassel, Esquire
Roy Cowdrey, Esquire
Walter Tabler, Director, Health Claims Arbitration Office
Dr. Karl Mech, Commission on Medical Discipline
Angus Everton, Esquire
Laura Morlock, Ph.D.
Conrad Varner, Esquire
David J. Fasano, Group Administration Services
William Gibson
Doris A. Tippett, Recording Secretary

Absent

Honorable Gene W. Counihan
Honorable Joel Chasnoff
Honorable Jerome F. Connell, Sr.
Honorable Francis X. Kelly
W. Minor Carter, Esquire
Grover E. Czech
Harold A. Cohen, Ph.D.

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Chairman Liebmann began the meeting by announcing the three guest speakers, former Senator Rosalie Abrams, Dr. Karl Mech from the Commission on Medical Discipline (CMD) and Elza Davis from the Medical and Chirurgical Faculty of Maryland (Med Chi). He stated that in addition the Commission will hear testimony from the others present and then devote the remainder of the meeting to the list of issues from the last meeting. Mr. Liebmann then introduced Senator Rosalie Abrams to address the Commission regarding Senate Joint Resolution #14.

Ms. Abrams stated the Commission should look at all the issues seriously in light of the presentations of Senator McGuirk and all who have testified before the Commission. The feelings of the Legislature were that the whole issue should be looked into by a group of people who could study the problem to determine if the establishment of the Health Claims Arbitration Office has lessened the time period for claims being solved, etc. She stated the Legislature was concerned as to awards of judgments and the impact this is having on how people who practice medicine, particularly high risk fields, in terms of what this has done to the cost of medical care. Does this discourage the practice of medicine. Are doctors looking over their shoulders to see if a possible suit will be filed against them. Ms. Abrams indicated that her purpose in proposing the resolution was for the Commission to render advice to the Legislature and offer recommendations.

Commissioner Muhl stated that this has been studied several times before.

Mr. Hughes asked if the Legislature would respond if the Commission made suggestions to abolish the Health Claims Arbitration Office.

Ms. Abrams stated it would depend on what the Commission finds. She stated that in 1976 the issue was much more dramatic because it was the first time it had been brought to the attention of the Legislature and they responded so as to speed up the process of claims handling.

Mr. Liebmann then introduced Dr. Karl Mech from the Commission on Medical Discipline to address the Commission on informed consent and reporting requirements.

Dr. Mech stated that he would give the Commission some general remarks to begin and then answer any questions posed. He stated that he is a practicing surgeon in Baltimore City and that this whole situation hits home with him. He stated he is on the Board of Licensed Medical Examiners. We are really concerned with the quality of medicine and dealing with the problem of those not delivering quality medicine. The total number of cases that fall into that category is very small. In 1969, they were not well known and there were only a few cases (about 15 or 20) in the first year. This rose to a high of 450 cases approximately two years ago and now it has fallen back and will continue to stay there or fall, so that our total number of claims are 375. He stated, however, of these, he does not believe 10% are cases to really worry about. The source of the case is what we are interested in. He stated for example of the cases presented to them, a drunk physician, sometimes reported by the wife, would be a serious case.

The CMD is strongly concerned about the quality of care. He stated that medical incompetence can take a number of forms and went on to state mental incompetence, physical incompetence, substance abuses such as drug problems and medical incompetence.

Dr. Mech stated that at this point, he will address the question of where cases come from indicating that the Commission gets them from many sources. For example, a person complains to their local medical society that a doctor treated him improperly and he obtains a second opinion from another physician who reinforces this. The patient feels this first doctor should be put out of business. He stated his Commission administers a law stating 25 reasons why a doctor can be brought before his Commission. Sanctions from the CMD have gone all the way to revocation of a license to practice medicine. He stated the Commission is bound by the law to give them a true hearing, the right of counsel and also written into the law is the right to appeal. It is a full legal process.

He stated one area of concern is reference to the Commission by the insurer. Under the Insurance Code, Article 48A, §490B, insurers are required to report medical malpractice claims and actions. The provisions of §490B provide as follows:

> (a) Every insurer providing professional liability insurance to a practitioner of medicine licensed in Maryland in accordance with Article 43, title "Health", subtitle "Practitioners of Medicine", or to a hospital, nurse, dentist, osteopath, podiatrist, optometrist, chiropractor, or blood bank licensed under Article 43, and every self-insured hospital shall report periodically, but in no event less than once each year, any claim or action for damages for personal injuries claimed to have been caused by an error, omission, or negligence in the performance of the insured's professional services, or based on a claimed performance of professional services without consent, if the claim resulted in:
>
> (1) A final judgment in any amount;
>
> (2) A settlement in any amount;
>
> (3) A final disposition not resulting in payment on behalf of the insured. Reports shall be filed no later than March 15th of the year following the occurrence of (1), (2) or (3) above.

(b) The reports required by subsection (a) shall contain:

(1) The name and address of the insured;

(2) The insured's policy number;

(3) Date of occurrence which created the claim;

(4) Date of suit if filed;

(5) Date and amount of judgment or settlement, if any;

(6) Date and reason for final disposition if no judgment or settlement;

(7) A summary of the occurrence which created the claim;

(8) And such other information as may be required.

(c) Reports relating to practitioners of medicine shall be filed with the Commission on Medical Discipline, and reports relating to hospitals, nurses, dentists, osteopaths, podistrists, optometrists, chiropractors, or blood banks shall be filed with the Commissioner of Insurance.

(d) The reports filed in accordance with this section shall be treated as confidential records. The reports shall be released only for bona fide research or educational purposes. Reports relating to physicians may be released to the Board of Medical Examiners; reports relating to hospitals and blood banks may be released to the Department of Health and Mental Hygiene; and reports relating to nurses, dentists, osteopaths, podistrists, optometrists, and chiropractors may be released to the appropriate licensing board for such health providers. The recipient of the report in its sole discretion shall determine the validity of the request for any reports.

(e) There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer reporting hereunder or its agents or employees, or the Commission or its representatives, or the Commissioner of Insurance or his representatives for any action taken by them under this section.

Dr. Mech stated that in addition to the insurer, there are other people who are required by statute to report to the Commission. Reliable sources are hospitals and related institutions that reduce privileges of doctors on their staff, however, there must be a good reason behind such reduction. The statute calls that these cases be reported to the Commission. When a case is reported, the Commission has in the statute a methodology for handling these case. Dr. Mech stated he is proud of the Commission's business indicating he has been a member since its inception.

Dr. Mech stated a reported incident must be referred to an investigative body. We have stipulated that the medical society examine the case, hear witnesses and investigate, then report to CMD. This report should contain a recommendation. These complaints are passed out for investigation and if the Commission feels more is needed, it is done and the case can be closed out if it has no merit. An informal meeting is sometimes held or increased studies can be made with a followup report from these places. The court is included in the law to report to the Commission. We have reporting by hospitals, courts and insurers. He stated not many cases are going down the drain. The Commission is on its toes.

Mr. Liebmann asked the question whether the law is sufficient in requiring malpractice claims be reported by insurers when the file is closed rather than when open. Dr. Mech stated that he is the Executive Secretary and claims come to him first. He admitted that a case concerning something that occurred in 1977 which arrives on his desk in 1983, is disturbing. He indicated that with this in mind, he believes it would be worthwhile to receive them at an earlier date, but reporting of a case at inception is sometimes of little consequence.

Commissioner Muhl asked Dr. Mech in referring to §490B of the Code, does he receive any volume from the insurance carriers. Dr. Mech stated yes, the Commission does. He stated that Medical Mutual gives the Commission quite a few many of which have been discontinued by the complainant. Dr. Mech stated the Commission investigates death cases.

Commissioner Muhl stated his reason for raising this point is that a group was formed by the Governor this year titled the Ad Hoc Committee to Study Legislation. This Committee reviewed the Insurance Code and the Insurance Division. One of the recommendations they made was a partial amendment or total elimination of §490B. Over the past three years, we have had only two inquiries for such information. No one makes use of this information, yet you suggest that there is a need for such information. Then Commissioner Muhl asked Dr. Mech if he would like to take a look at the rest of the information having to do with hospitals, nurses and dentists.

Mr. Liebmann stated reports should go to health boards rather than the Insurance Commissioner. Commissioner Muhl stated the law provides that they come to the Insurance Division.

Mr. Liebmann stated that insurers are required to report periodically these closed cases. He then asked if it is the practice to not make the report and dump them on the Commission once a year. Dr. Mech stated yes.

Commissioner Muhl stated it would be good to eliminate this law because of the lack of usage. The only people who seem to utilize this information are researchers or college students preparing project papers or reports.

Mr. Liebmann asked Dr. Mech if he had an opinion as to informed consent and whether there is any regulation that would be helpful from the CMD's point of view.

Dr. Mech stated this is an important matter, so important that the hospitals have picked up and will not allow physicians to have patients in the hosptial unless they have such consent. Practitioners have no objection to this. The problem is there are people not fit to write their own consents. He stated that proper legislation should be written and it would be worthwhile to get compliance in this area.

Dr. Durkan asked Mr. Liebmann if he was trying to determine what the Maryland law was on the topic of informed consent and stated that at a hospital level, it is very explicitly stated. He further said that most hospitals now through their counsel try to educate their staff as to Maryland law and statutes, therefore the principles are as clear as mortals can handle.

Roy Cowdrey stated he does not know of any case won strictly on informed consent. He stated he does not think this is a problem that warrants an attempt to legislate a solution.

Mr. Liebmann stated it is to let people know what is expected of them. Dr. Mech indicated that the Commission has very few cases regarding informed consent.

The question was posed to Dr. Mech regarding the average number of doctors removed by the Commission on an annual basis. Dr. Mech stated the numbers would be small, approximately ten or less in the course of a year. If the Commission instructs a physician to repeat his residency, this means taking him out of his practice. Other times a doctor is sent off to take courses and many elderly physicians retire because they do not want to go back to school.

Mr. Shadoan stated regarding early reporting requirements, there are two things to consider. One being some tertiary care institutions do not want to point the finger at a doctor who is referring patients to them and two, and more importantly, I am concerned that physicians involved are laboring over the disability that they may well indeed injure other people. This may be viewed as an action to assist the malpractice claim.

Dr. Mech stated this is not viewed so by the Commission.

Mr. Shadoan asked if there should be a change in the reporting requirements as to when settled rather than when closed. Dr. Mech indicated that if there is a suspicion of lack of quality of care, this should be reported to the Commission. Loss of a limb is not indicative of incompetence. The Commission would analyze the process which led to the loss of a limb.

Commissioner Muhl asked if the Commission would review this case if it were subject to litigation. Dr. Mech stated yes. Some cases in litigation would benefit if a decision from the Commission were made.

Commissioner Muhl asked if the information the Commission obtains through its investigation has any degree of confidentiality. Dr. Mech replied total confidentiality. When the case is completed, then it becomes public record, that is, none of the material on file would become public, only the result.

Mr. Shadoan stated perhaps if there is a reporting requirement concerning claims it would be desirable to be early rather than later.

Commissioner Muhl asked how would this effect Med Mutual's underwriting guidelines regarding coverage. Mr. Spinella stated we would only know the same information that is public record. Regarding trending towards incompetence, in each hospital there is a mechanism for picking this up every year. Each hospital is required to ask physicians if there have been any claims made against them. They are separately evaluated by the head of the department. Now the collective staff of hospitals have an obligation to review all quality matters every year.

Dr. Weiner asked of the approximately 375 cases per year how many are the product of a malpractice action. Dr. Mech stated that very few were citing approximately ten or twelve. He further stated that there is no real background on this, just a suspicion on his part.

Dr. Weiner asked how many investigations does the Commission perform and how many result in some substantative action against a physician.

Dr. Mech stated that in about twelve or fifteen cases, he requires the hospital to provide their charts to determine whether or not there is a case. He stated the Commission does have subpoena power.

Mr. Liebmann asked Dr. Mech if his Commission was sufficiently known or should measures be taken to deal with this problem. Dr. Mech stated that the Department of Health and Mental Hygiene was concerned about this. As a result, brochures have been printed regarding CMD.

Mr. Liebmann then introduced Elza Davis who is the Communications Director of Med Chi.

Ms. Davis stated that one way or another a report gets to the CMD because most people go to their local medical society to report a claim. If there is a question of competence, the person should report the physician. She stated that she is familiar with the Texas informed consent law and that maybe some legislation in this area would be helpful. She then stated in response to Commissioner Muhl's question about the cases now piled up in his office, that in the code revision process, almost every health licensing board has enhanced their laws which deal with discipline.

She stated that Med Chi's position on the abolition of the Health Claims Arbitration Office is neutral. Med Chi was a strong supporter of the legislation in 1976 because it was a way to assist the process along. They were interested in keeping Med Mutual as the only medical malpractice insurance company in the State of Maryland. Med Chi felt it would speed up the process and give greater access to the public. In 1979, when the process really got going, the system did not work. At this point Mr. Tabler helped the whole process become more efficient. Senator Curran looked at the process and the Committee did make a few adjustments to the system at that time. She stated what the physicians are in the main concerned about is the large awards coming down. The large number of cases being appealed increases the cost of medical malpractice insurance premiums to the physician. Instead of making the whole process less expensive, it has made it more expensive.

When the resolution was introduced, Med Chi supported it because it felt we needed guidance from the outside. She stated the system is working as well as it can as it is presently constituted but it is not doing a whole lot of good. However, we do not have any formal vote saying we oppose it. She stated that in November, Med Chi declined to take a negative position and asked the Legislature to look at this more.

Dr. Weiner stated that Med Chi's neutral position could better be stated as undecided.

Ms. Davis stated that physicians responded very well in the beginning but now there is a falling off.

Mr. Liebmann asked with respect to this problem, if there is any ethical obligation of a physician to serve on the panel. Ms. Davis stated that physicians felt the obligation in the beginning to become part of the process. She stated that twice in the past, they have actively recruited physicians to serve on the panels. They conducted an informal house survey about how physicians felt about the Health Claims Arbitration Office and about 50% stated they liked it, however, they were those with a favorable decision. Those on the other side felt it was not a good system.

Mr. Liebmann asked Ms. Davis what issues Med Chi would propose regarding tort reform.

Ms. Davis stated some definition of the qualifications of expert witnesses would be helpful. Another idea is the certificate of merit, stating you must have one physician say that this case has some kind of medical basis. However, Med Chi has not brought this kind of legislation to the General Assembly because it would not be terribly useful. She stated that the cap on awards is an idea that Med Chi is currently considering. She indicated that premiums have not been lowered in states who have a cap. Also, placing a cap on pain and suffering portion of the award and compensating for the full amount of the medical injuries is another idea Med Chi is currently considering.

Med Chi is also interested in mandated structured settlements on certain cases where the person is rendered totally disabled, as in cases where a minor is concerned so that a guaranteed amount of money will be paid out over a length of time. Currently structured settlements are provided for where it is agreed to by the parties involved.

At this point Roy Cowdrey, Esquire was introduced. He stated he is from Easton and that he defends physicians and also has served on the Bar Committee on the same issue. The Committee's view is to abolish the whole system and let the court system handle these claims because there is a duplication of the process. He stated it costs him 80% to try and then re-try the same case. The retrials are stale, flat and they revolve around a presumption of correctness. He suggests dumping the whole process.

Mr. Cowdrey stated the charge of the Bar Committee was to patch up the Health Claims Arbitration Office but the bottom line is to abolish it.

Mr. Spinella stated that if you address the problem with the arbitration process so that you actually have a minimum number of appeals, then everybody benefits. If you are successful in reducing the range of outcomes so that boththe plaintiff's side and the defendant's side has a common feeling for expectation of HCAO, the hearing, then you would not have appeals.

Mr. Cowdrey stated that he disagrees. He stated it costs too much money to try a case twice. Also he indicated that people will not stop appealing and they think they will get more from a jury than a judge. This is not necessarily so.

Mr. Shadoan stated he thinks Mr. Cowdrey is right about this. He stated the doctor on the panel is providing an expertise that is not present on the jury in doing something that was unexpected. The doctor is calling the shots the way they fall. When you look at some of these cases, especially some of the bigger ones, you are finding some doctors who have some expertise not a podiatrist in a brain surgery case. They are looking at this and saying this is wrong folks. And that is why you are not seeing me pounding the table to get rid of the system. The arbitration system should be abolished because it is expensive and it does some things that are socially wrong. But as far as saying that you are going to have better results in court before a jury, this is a myth.

Mr. Tabler stated for the record that he was not one among the twelve people who sat in the Committee meeting that voted to abolish the system. He stated a quick look at the figures reveal that the Health Claims Arbitration Office has totally disposed of about 1,200 cases in about five years, 425 cases by panel determinations and there have been 160 appeals taken or about 40% of the panel determinations, not mentioning the other 750 some that have been disposed in other ways.

Mr. Tabler stated that he will bet that 25 of those have not come to trial and will not come to trial. It is a rarity but I know each of the fellows sitting here, Leo, Roy and I know George has tried cases on appeal but I suggest you ask them how many of them have actually gone to trial after the appeal has been filed. He stated that in the State of Maryland with 2,120 malpractice cases having been filed since July 1, 1976, that there aren't 25 open malpractice cases awaiting a trial by a court and jury right now. Now with that in mind, he asked can it be said that the system is not doing its job. He suggests to the Commission that it is doing its job. He further suggests the filing of an appeal is in no way tantamount to the trial of an appeal and it is 2,120 cases that have not been filed in our already overcrowded circuit courts. These are things to take into consideration.

Mr. Liebmann asked Mr. Tabler if he is aware of the number of malpractice cases filed in the circuit courts prior to the creation of the arbitration system. Mr. Tabler stated the estimate that the Committee had was approximately 75 per year. He feels this is low but then again, he was not on this Committee. This was the estimate that resulted in the staffing of the Health Claims Arbitration Office at the rate of one Director, an Assistant and a Secretary.

Mr. Liebmann asked how many people are on staff at present, and Mr. Tabler replied twelve. There have not been 25 cases tried and he doubts that there are 25 cases open now. He stated he only knows of about ten cases that have been tried.

Mr. Cowdrey stated that with all due respect that if Mr. Tabler had not come to that office the arbitration system would have been in utter chaos. He stated 720 or so of these cases that Mr. Tabler stated were resolved, were settled. Cases just have a way of settling on door steps, they can be arbitration door steps or courthouse door steps. It is moment of truth time, do you want to roll the dice and the case is settled. He does not think that the arbitration system can claim any credit because at the day of disposition a number of people backed out and said they would rather deal with certainty than uncertainty.

Even if there have been only 25 cases tried, the point is that it drags it out longer than it needs to. I am worried about the doctors and the patients. My wife goes in and she is a patient, when I go in I am a patient.

Mr. Cowdrey stated that there is no disincentive to file an arbitration claim, there is not even a filing fee. You can allegedly try these things with written reports but he thinks that they have encouraged suits which otherwise would not have had been filed if we simply had the court system.

Mr. Everton stated.he feels there is a disincentive to file an arbitration claim that is not present in court and that is the claimant will have to pay several thousand dollars in costs if he loses. That is a significant disincentive.

Mr. Hughes stated the number of cases that are dismissed prior to a hearing are a significant indication of the number of cases that should not have been brought under the old system.

Conrad Varner, Esquire was then introduced. Mr. Varner stated that he represents physicians primarily in the western counties of the State of Maryland. He stated that western Maryland does not have the volume of claims that Montgomery and Baltimore Counties and Baltimore City have but his experience is very similar to that of Mr. Cowdrey.

His objections can be dealt with by reform. He feels the procedural deficiencies of the system should be reformed. He thinks we could probably structure a system which has a competent panel and structured evidence taking in a way that there would not be the tremendous incompetency that we see in most of these panel hearings. This could be dealt with by very strong kinds of regulation or legislation.

One aspect of the statute which he believes cannot be reformed is that unless you do away with the trying of these cases twice, we are not going to accomplish any purpose. He believes if cases were filed directly in the court, far fewer cases would be filed. The frivilous case would not get anywhere. If you try these cases twice you can appreciate the tremendous excruiating experience that you go through and it is not just the attorneys. It is also the physicians and the claimants.

When you go through a panel procedure, if you do not represent your client in the same manner that you do in a court proceeding, you are practicing malpractice yourself as an attorney. Consequently, what you end up doing is spending thousands of dollars in preparation of the case, thousands of dollars in paying experts to be present and thousands of hours trying to find sufficient experts, trying those cases as though you were before a jury and then winding up doing the same thing over again in court. This has been my experience and I do not see any logic in retaining the system, particularly in its present form.

A very difficult problem with the panel is that it is not only not versed in the law but too often the panel chairman is responsible. He is often an inexperienced attorney who has not tried a case and the person ultimately making the decision is not the attorney but usually the doctor and he can be wrong about the law. The system should be abolished and we should go back to the old system and hopefully back to normalcy.

Mr. Liebmann then stated that the Commission will have to make a judgment as to the continuance or abolition of the arbitration system. Even if the recommendation is that it be abolished, there will have to be a recommendation as to the mode of abolition. He submits even if the recommendation is for abolition, there should also be a set of recommendations relating to desirable changes in the arbitration system in the event abolition does not prevail in the General Assembly. The major problem that any recommendation for abolition would face, would be the fear that it will open up an explosion in the courts with respect to both levels of awards and caseload.

There are a lot of practitioners who feel that the effect of abolition would be to cause the caseload to fall back to a level of 75 cases a year from the present 400 or 500. There are many practitioners who believe that you would not have $3 million awards in the rural counties, if the matter went back to the courts. If abolition is recommended as a matter of policy in terms of the acceptability of the Commission's recommendation, there should be also recommendations which address at least some of the so-called tort reform issues. This is just an observation merely as a justification for continuing despite the urging of some of the Commission's members to march through the list of issues from the last meeting before we get to the issues surrounding the arbitration system. Mr. Liebmann suggested that the meeting take the direction of discussing his list of issues beginning with the collateral benefits rule and then structured settlements. At the next meeting the arbitration process will be discussed.

Commissioner Muhl suggested to Chairman Liebmann that future meetings be closed to commission members only so we can prepare our recommendations to the Legislature, if we are indeed finished receiving testimony. Mr. Liebmann stated he would receive testimony from anyone who would want to be heard. He then mentioned that there are two scheduled meetings in Annapolis on December 6th and December 13th and encouraged attendance.

Mr. Shadoan asked the Chairman if he intends to include John J. Sellinger's ten items stated in his November 28, 1983 letter as topics of discussion when we complete the thirty item list. Mr. Liebmann replied yes. Mr. Shadoan questioned considering the collateral benefits rule as the right approach to the Commission's charge. Mr. Liebmann stated that he is not prepared to say we are not going to discuss the collateral benefits rule. Mr. Shadoan stated he has not heard anyone else supporting the position of the Chairman. He stated he does not agree with what Mr. Liebmann is doing.

Mr. Liebmann stated that the trial bar is not the only body that has insights that may be of value in this field. He stated his list is composed of testimony from earlier meetings and he is not going to forego the suggestions in Mr. Sellinger's letter. Having stated this he again turned the discussion to the collateral benefits rule, stating there are a variety of ways it has been modified in various jurisdictions.

Dr. Weiner stated the average premium paid is not a burden but we have heard enough evidence that the point of the problem is regarding the high risk specialties, that they are in trouble and predictably in progressive trouble in the next couple of years. He feels that we have to look at tort reform proposals

and from this standpoint the Commission can consider some modification of the collateral benefits rule which would be the least offensive from the plaintiff's standpoint.

Mr. Hughes stated his concern is if you assume that Dr. Weiner's point should be discussed, what is it curing. Commissioner Muhl asked the realities of all this and will we be able to make recommendations to the Legislature so that something meaningful will come out of it.

Mr. Liebmann stated that if we present a report which recommended tort reforms and a return of cases to the court system, it is likely to be accepted by the Legislature. If the arbitration system is retained the interest on awards is important.

Dr. Weiner stated he feels that serious consideration should be given to abolishing the system.

Mr. Shadoan stated the notion of equity is that the person who has the benefits has paid for them. The person who created the injury did not pay for them. The cost of such premiums is indeed quite high. It is the whole business of health care which we cannot resolve that has reached considerable proportions. If medical malpractice cases were the cause of this, I would be interested in seeing what we can do. When a physician is sued and he comes to respond to this claim, in return for his premiums he gets a free attorney and free litigation costs. He is embarrassed and he loses time and income, but he does not have to pay an attorney. The victim who is innocent and seriously injured will get an award which does not give him litigation expenses and attorneys fees which are quite large. By enjoying benefits of the collateral benefits rule, there is some approach to parity between these opposing parties in a medical malpractice case. That parity should not be disturbed.

We are suggesting that medical malpractice premiums paid by the doctor affords certain benefits. They are the cost of litigation and a defense. The plaintiff is paying premiums too. If you want to tell the jury everything, tell them the amount of the premiums. He is not paying $20,000 for expenses as his client is paying.

Mr. Liebmann stated we are dealing with a social problem. How do you hold the problem within bonds fairly without being arbitrary. If you try to do something to contain the level of awards a logical place to begin is where they are duplicative.

Mr. Shadoan stated we should not be prepared to take rights away from people on the basis of potential problems. Mr. Liebmann stated that if there is a reasonable burden upon certain physicians, that is important to deal with.

Dr. Weiner stated that $100,000 a year income for a physician is a generous one.

Mr. Spinella asked Mr. Shadoan if a 100% increase for OB/GYN specialty in a two year period was alarming to him to which he replied it was.

Mr. Cohen of Med Mutual stated if a jury believes that someone has incurred huge medical bills, it effects their ability to render a verdict particularly if they believe a person is going to be destitude.

Mr. Shadoan stated his problem is that this issue has been before the General Assembly for seven years and he is concerned about what will happen with the report which the Commission renders. He stated that one of the problems is that there is an assumption in which you have indulged yourself that juries are rendering vast awards for pain and suffering. If this is true, for some reason it has eluded me. It is certainly true that the jury does take into account the numbers respecting pecuniary loss. There is no question that if you modify the collateral source rule, it will reduce the awards that people have. Is this just? No, because in fact, most people who have suffered serious injury are never adequately compensated. If you are suggesting a modification of the Insurance Code which requires the companies to write subrogated policies and then Commissioner Muhl and his Division will determine what premiums are satisfactory, he is not so sure that he would be so hostile to that kind of recommendation. But that is an entirely different kind of recommendation from taking it away from the guy who has paid for it and giving it to the guy who is hurting.

Mr. Shadoan stated that the jury and insurance people want to know what expenses are and this has an important impact on what an appropriate total award should be. The laws of evidence contain about 13 volumes that reveal what you can and cannot tell a jury.

Mr. Liebmann went on to the next item which is structured settlements. He stated the main issue of structured settlements is should it be activated only where a party requests it. He further indicated that his opinion would be yes, it should. He asked if it should be mandatory or allow the court discretion in appropriate cases.

Mr. Cohen stated he does not believe mandated structured settlements are an acceptable way of telling people they must accept their moeny.

Mr. Shadoan stated if you reduce the cost (amount of money awarded) you have to adopt a resolution that payments will stop upon the death of the injured person. You cannot make a case that we are doing this to help the victim. Mandatory settlements will in some cases save money. Mr. Shadoan stated that he is against structured settlements.

The meeting was adjourned at 10:05 p.m.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Tuesday, December 6, 1983
James Senate Office Building
Room 300, 110 College Avenue
Annapolis, Maryland

MINUTES

Present	Absent
George W. Liebmann, Chairman	Edward J. Muhl, Insurance Commissioner
Harold A. Cohen, Ph.D.	George W. Shadoan, Esquire
Israel H. Weiner, M.D.	Honorable Gene W. Counihan
James P. Durkan, M.D.	Honorable Joel Chasnoff
J. John Spinella	Honorable Francis X. Kelly
Leo A. Hughes, Esquire	Honorable Jerome F. Connell, Sr.
Walter Tabler, Director, Health Claims Arbitration Office	W. Minor Carter, Esquire
Janna Vavroch	Grover Czech
Angus Everton, Esquire	Ellen Zamoiski
Jane Nishida, Legislative Reference	
Barry Cohen, Esquire	
Gerald J. Carroll, M.D.	
Laura Morlock, Ph.D.	
Doris A. Tippett, Recording Secretary	

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Chairman Liebmann began the meeting by stating that the Rand Corporation's study, which was distributed to members, appeared to be a summary and stated the data could be clearer. He indicated with some interest that the statement regarding states mandating the offset of compensation from collateral sources in January, 1975 had 50% lower awards by January, 1977 whereas estimates (not reported here) showed no significant effect of laws admitting evidence of collateral compensation without mandating offset. On the subject of structured settlements, there is an existing provision of the Health Claims Statute which as introduced, provided that as an incentive to insurers to make advanced payments that where an insurer made an advanced payment when it returns a verdict, the panel or court could order that the amount by which the award or verdict exceeds the amount of advanced payment to be paid over a period of time consistent with the needs of the claimant rather than in a lump sum and authorize part of it so that the creation of a trust or other mechanism to insure periodic payments. The court was permitted to do this if the court finds that the advanced payments were reasonable. The idea of this being it would give the insurers an incentive to make advanced payments. This was introduced on the recommendation of the study commission in 1976 on medical malpractice. As it went through the Legislature, it was amended to add a sentence which read: "the panel or court shall provide to the claimant the option to choose either a lump sum or payments

paid over a period of time". We had talked about giving the court discretion after the final award was entered to order payment of the actuarial equivalent to totally disabled persons or infants. Mr. Liebmann stated that we will hear from Barry Cohen of Medical Mutual and then return to the list of issues.

Mr. Tabler stated in the 2,120 cases before the panels, that no advanced payments have been granted.

Mr. Liebmann asked if a provision had been enacted into law regarding the court recommending elimination by statute any contractual right of physicians to concur in settlements by the insurers. Mr. Everton stated yes, it is part of Article 48A.

Mr. Liebmann stated in the 1976 Report, statistics obtained from the Commission on Medical Discipline relating to the numbers of cases, which stated that in 1974, 61 cases were tried to judgment and 60 resulted in judgments for the physician. In 1973, 50 cases were tried to judgment of which 48 resulted in favor of the physician. The statistics also related that there were 169 other claims in 1974, 46 resulting in settlement and 123 in no payment and in 1973, there were 160 other claims, 37 settlements and 123 no payments. Mr. Liebmann questioned these figures.

Mr. Everton stated the figures introduced into evidence were in the case of the Attorney General v. Johnson and they were considered to be accurate at that time. They were apparently obtained from a search of the clerks offices in all of the courthouses across the State.

Mr. Liebmann referred to another item in the report with reference to a committee created by the Secretary of Health to study informed consent. Mr. Liebmann asked if anyone knew of such a committee. Mr. Tabler stated that he served on this committee representing Union Memorial at the time. He stated the committee came up with a 30 page report.

Mr. Liebmann stated that there is a three volume report issued by the President's Commission for the Study of Ethical Problems of the Medical Profession, titled "Making Health Care Decisions" that deals entirely with informed consent problems which was published last year. There is not much contained in the report relating to statutory change although there is reference to the Texas procedures. There is a board in Texas that promulgates the definitions of what constitutes adequate disclosure for each type of medical procedure.

Dr. Weiner asked what happens in the case of a payment before award if the defense wins. Mr. Liebmann stated that the statute addresses this and says it is tough luck for the defense. If the advanced payment exceeds the liability of the person making it, the arbitration panel or court on appeal may order justice as justice may require under the award or verdict including where appropriate contribution by other parties found to be libel. Dr. Weiner stated this would be a disincentive for advanced payments.

Mr. Cohen was introduced and stated he is the Litigation Superintendent of Medical Mutual. Over the last thirteen years, he has had an opportunity to observe the malpractice problem from the hospital, physician and plaintiff point of view. In his present capacity at Med Mutual which insures almost 80% of the physicians in the State, almost 80% of the law suits cross his desk and are reviewed by him. He also has the opportunity to either review the facts concerning most of the cases that go to trial and in a number of cases, actually view the trial. He stated regarding the arbitration system, the real question is should it be repealed and if not what changes should be made and adopted into our laws to make the arbitration system work better. In 1975 no malpractice case reached trial before 2 1/2 years. This was before the tremendous increase in the number of claims filed against physicians. This raises serious doubts in his mind as to the ability of our court system to dispose of malpractice cases as expeditiously as most people think they will be able to.

He feels an objective observation from an administrative point of view since Mr. Tabler's arrival, would lead one to believe that administratively the arbitration office is functioning extremely well. Cases have been litigated in arbitration within one year to 15 months of filing. Our court system would not enjoy that expeditious a result. Most of the problems which he observes in the arbitration system are the legal or procedural matters and not truly within the ability of the arbitration office to rectify.

He stated that our judicial system is over 200 years old and most people still find great fault with it. If this is true, is it fair to assume that arbitration would be perfect after only six years of operation. Most attorneys in 1976, 1977 and 1978 withheld law suits until finding out if the Act would be declared constitutional. Most of the cases did not come in until subsequent to 1978. Again, he stated that in six years, is it really our function to say that it is not a system that will work. He feels this bears some consideration.

Mr. Cohen stated we need a full time referee in arbitration whose purpose and function would be to rule on matters of law and to be responsible for decisions of a discovery nature. This referee should be nonvoting and the position should be full time, unencumbered by another practice of law. He should be appointed by the Governor to insure his or her experience, expertise and competence in the field of medical malpractice and in the law.

Our judicial system has gone to great lengths to select judges who are highly experienced and competent and we recognize that their experience and knowledge is essential in maintaining discipline during the trial of the case and in guiding and assisting the jury in arriving at an equitable verdict. But, we

have not taken the same steps in arbitration considering the fact that it is one of the most complicated fields of law. We presently have promulgated no rules or standards of experience for the panel chairman in the law of medical malpractice, the rules of evidence or rules of civil procedure. We cannot assume that just because a person has passed the Bar that he is capable of handling the complicated issues that arise in medical malpractice.

It would appear that common sense should tell the Commission that we should strive to the highest level of professional competence in this select area. He believes the panel should continue to be composed of an attorney, a laymember and a physician along with the full time nonvoting referee. The panel would remain the same and their voting would remain the same, but the decisions of law and motions would be heard by this nonvoting referee. The presence of a full time voting chairman with no standards of performance have subverted the effectiveness of the system.

Additionally, there are inherent conflicts when the decider of the law is also placed in the position of voting on the liability issues involved. Motions to exclude inflammatory evidence would never be heard by the jury and yet under our arbitration system the only avenue for excluding this evidence, is to make a motion before the panel chairman. The chairman cannot vote objectively once he has heard this evidence. If the purpose of arbitration is to help us dispose of cases expeditiously, it should be noted that settlement conferences are very feared by insurance carriers. The settlement conference can only be held before the panel chairman. The mere fact that he knows that the carrier may be considering payment, leads one to believe that he is influenced as to his view in the case.

Full time experienced referees would serve to add consistency to the rulings made in arbitration. The formal rules of evidence should apply in arbitration. Medical Mutual is concerned that arbitration is not to be relegated to the status of the Workmen's Compensation Commission where everyone seems to get some money.

Hearsay evidence is referred to as the most unreliable testimony. Prejudicial statements and information have been placed before panels by both plaintiffs and defendants with no ability of the other side to cross-examine the proper testimony. I do not believe that any attorney would object to the hearing of a case in arbitration subject to those formal rules of evidence.

If this Commission is to examine medical malpractice, he would submit that they cannot do so without examining legal malpractice. In examining approximately 30 law suits per month, Mr. Cohen stated he can assure us that 50% of the suits filed have no basis for being filed. They are instituted by attorneys

who have done inadequate investigation in one of the most complicated areas of law and their work has not proven a reasonable basis to institute suit.

He stated that physicians who are sued do not take suits for granted. This Commission must take steps to address attorneys who institute suits with little or no investigation. Attorneys when confronted with the statute of limitations running out file suit. When a suit is contemplated by an attorney, it is well known by any competent attorney, that medical expert testimony must be offered that the physician deviated from the accepted standard of care and that the deviation directly caused injury to the patient. It is reasonable to require that a certificate of merit which states that an expert has been retained and is willing to testify against the physician who has been sued, should be filed with the suit. Since most cases that come from attorneys who have done little or no work before filing the law suit, certificates of merit would not obstruct legitimate issues and legitimate law suits which have a place in our system. But suits without merit cost millions of dollars in defense, they tie up our court and arbitration systems and are ultimately dismissed. These should not be missed in being addressed by this Commission.

We have heard reference to the number of appeals and there is one loophole which should be the subject in the recommendations by this Commission. The statute does not address that an award rendered in favor of the plaintiff may not be rejected in part. That is, a plaintiff may not reject an award on the basis of damages and accept the award on the basis of liability. When a plaintiff's award is rejected, it results in a de novo trial in court. Mr. Liebmann stated this would not be a popular recommendation.

Mr. Everton stated he has seen defense attorneys reject awards in favor of the plaintiff and they can also reject an award in part. Attorneys have rejected the liability portion of an award but not the award of damages. It can be done by both sides.

Mr. Cohen stated that attorneys who have valid law suits will be able to obtain expert witnesses but those cases without merit, should be addressed by this Commission because it slows down the arbitration process which results in the backlog which may even filter to our court system. He stated that Med Mutual will make recommendations on other areas of legislation which would make the arbitration system work more effectively.

Mr. Liebmann asked in regard to the certificate of merit, that if these matters were returned to the courts and if the arbitration system were abolished, what is the real chance or opportunity to get rid of cases on summary judgment. In other words, if a defendant submits an expert's affidavit saying

there is nothing here and the plaintiff fails to respond, under the caselaw, would the defendant get out. It is very difficult to obtain summary judgment from a judge except in the simplest of cases. Some judges just do not grant them. He asked if a way should be provided for getting rid of the frivilous case early.

Mr. Hughes stated he thinks a way is provided in the court system, but not so in the arbitration system. You either produce or the case is dismissed. Knowing this, he submits that we did not have the degree of problems under the old system that we have under the new system.

Mr. Cohen stated the truly meritious cases are not not avoided. Plaintiffs lawyers who handle these cases do not seem to have a problem with the certificate of merit. If an attorney knows he has to have an expert and he has adequate time to work up the case, why doesn't he do it before suing the physician. What is the problem with this?

Mr. Hughes stated deposition power. As long as someone knows that if we can find a way to keep them from getting a certificate of merit, it cannot get into court and becomes another road block. He stated he has no objection to a certificate of merit at a given period of time, say 90 days after filing. You either produce your expert or you are out of arbitration. Putting it as a step that must be crossed prior to the filing of suit creates problems. It eliminates the right to take necessary depositions.

Mr. Everton stated that the answer to his question came down from the Court of Special Appeals and that it is provided, except in exceptional circumstances, there will be no summary judgment for failure to disclose an expert witness prior to trial. It is to be held until directive verdict time and then if the expert is not disclosed, directive verdict is appropriate. In the case that came down in the last three months, it was stated that in most unusual circumstances, a court should never grant summary judgments merely because of failure to disclose an expert witness. This was not a malpractice case but one in which expertise was involved. Mr. Everton stated he will try to obtain the case for the Commission.

Dr. Morlock presented the Commission with the data requested at a prior meeting regarding recent malpractice claims experience of health care providers in Maryland, which she reviewed with the members.

One of the first questions posed was whether we knew how many defendants had multiple claims against them and the first table addresses this. The table indicates that 90% of the individuals named in claims remained in only one claim, etc. These figures are from the beginning of the arbitration system through January, 1983.

Another question which arose was what percentage of physicians in this State have had a claim against them and the answer depends on what denominator you use. If you use the denominator of the 8,223 non-federal practicing physicians in 1980 including residents but excluding teaching faculty and research faculty of medical institutions and subtract claims against dentists and podiatrists and nurses, you get 880 as the closed claims against physicians which gives you about 11%. Another question was how many times panel members have served on more than one panel and the second table addresses this issue. These figures indicate 77% of the chairpersons have served once, 82% of health care providers have served once and 75% of public members have served once, etc.

In regard to a cap being placed on awards, she stated that the third table explains this in more detail. Table 3 addresses this issue stating the last column gives a cumulative percentage. Through January, the largest award from a panel was $3.5 million and there have been higher awards since then. These figures are conservative. Another issue that arose was whether there are any differences in size of awards by experience of the panel chairman. Previously she had provided information that excluded size of awards and that there seemed to be no differences in length of time that a claim takes to go through the process, no differences in liability determination. Since then, she has looked at the differences in the size of the awards and there are no differences in length of time between passing the Bar and serving as a panel chairman.

Mr. Tabler stated the biggest gripe he has is that there is a relatively small number of brand new attorneys. This is one of the most common complaints people have about the system.

Dr. Morlock stated the last two tables give additional information on whether we could say anything more about the characteristics of claims that are or are not appealed. This information indicates that there are really no differences in terms of the liability determination for cases that were appealed and not appealed. The last table looks at whether the claim was appealed by damages awarded. Since the numbers are small she has not percentaged these, because it can be misleading. For example, of the 8 claims, 5 were not appealed and of the 3 that were appealed, the table breaks down who they were appealed by. In summary there are no statistically significant differences by size of award as to whether the case was or was not appealed. The important point is the percentage appealed does not bear it very much by size of the award. Again the number of cases with panel awards is relatively small.

Mr. Tabler stated the language of the statute provided for use of the word "award" throughout, however, the word "decision" would have been more appropriate. He stated the Health Claims Arbitration has a budget of $496,000. Mr. Tabler said the amounts we collect go into general funds through the administrative office of the executive branch and are not set off against our budget. He commented that once liability is established, it is the physician that is the health care provider member of the panel, who is the generous one. It is he who is thinking the big dollars and it is he that is basically responsible for the big awards.

Mr. Liebmann then directed the Commission to the list of issues. Then a discussion began on informed consent. Mr. Liebmann stated he is trying to obtain the Texas regulations on informed consent. The Texas approach is an effort to define the medical procedures of what should be disclosed. He stated there is a problem with informed consent as a cause of action because we have a liberalized statute that one can get to the jury without expert medical testimony.

Mr. Hughes indicated that it is probably true in some circumstances but asked if it is a problem.

Mr. Cohen stated if a physician can justify the need for the procedure, it is rarely a case that we lose. If we show that the physician reasonably had a basis for recommending and going forward, juries or panels do not tend to believe that someone would not submit to the necessary surgery. As a practical matter, it has not been a major obstacle. Physicians view informed consent as a large problem.

Mr. Everton stated that physicians are very confused about what they are supposed to do and say. From a defense perspective, the issue is frequently there is no malpractice involved. The case is not meritorious. You have to defend against this. His suggestions are informed consent should be treated in the same way that deceit and fraud are. It should be required to be proven by clear and convincing evidence because it usually becomes a swearing match between two people.

He stated that 90% of the cases would dry up and go away if it was possible to make a hindsight testimony of the claimant as to what he personally would have done if he had known he was going to get cancer or whatever, be inadmissible. This has nothing to do with the standard of care. When you are exploring the question of what is reasonable information to allow a person to act, testimony such as "if I had known that this arteriogram was going to give me a stroke, I would never have gone through with it" should not be admissible because it doesn't address the issue. The issue is the state of the man's medical condition at the time the arteriogram was prescribed and would

a reasonable person have gone through this procedure bearing in mind the risks involved. If the claim were rationalized I think there would be no problem at all with it. The reason claimants do not win is because they do not realize how hard these cases are to win. The statute should make this more explicit.

Dr. Weiner stated it is a problem for doctors. Many doctors have, in trying to avoid being charged with inadequate informed consent, go to excessive lengths to inform patients to the point where they generate a tremendous amount of anxiety and refusal by patients of obviously needed procedures. This is a medical problem and I would like to see it nailed down in some concrete way. He stated he would like to see something that says, if a standard consent form is signed, then informed consent is presumed.

Mr. Hughes stated a standard approved form will eliminate the doctors explaining to the patient what will happen. The magic form scares me. Most consent forms are useless.

Mr. Everton stated that three quarters of informed consent cases he has seen have been ones filed by people who have never read the Sard case. Of the two that he has tried, the plaintiffs have the mistaken notion that they do not need an expert to testify as to what the alternatives and the risks were. The rules are there, but the people prosecuting the cases do not realize that certain things are required. It is indeed very difficult to establish an informed consent case.

Mr. Cohen stated the good samaritan law excludes emergency rooms and stated that it applies to everyone who renders care, not only physicians.

Dr. Durkan asked if there is a model code for informed consent. He stated the problem in the Sard case was the physician did not tell the patient that he was going to use the Madlener technique which has a high failure rate done at the time of cesarean section. The issue was that if he had told the patient that he is going to do a tubal ligation and he is going to use this particular technique which has a 1 in 50 failure rate and she still consented, it would have been okay. Her problem was that she was not told that, in fact, he was going to use this procedure because that is the one the doctor knew. The real issue was that the patient could not sign her name because she could not write nor could her husband and the caselaw states, you will give as much information as a reasonable person would need in order to make a judgment. What makes this complicated is what is reasonable for that patient. What would you tell her if she cannot read and understand anatomy. The physician did not go into great enough detail as to the technique and that is what makes the case.

Mr. Liebmann stated that the patient needs to be properly informed. He stated we need to educate doctors as to what to tell patients and the attorneys as to how difficult these cases are. Doctors need to know what is expected of them.

Dr. Weiner stated if Maryland adopted some form of regulation as in the Texas approach, more problems would be created in terms of a bureaucracy. It would have to be constantly updated.

Mr. Liebmann stated we will turn our discussion to the arbitration process and asked if it should be abolished and how it should be done. At this point, Mr. Liebmann asked all Commission members present, their informal opinion as to abolition.

Mr. Spinella stated he is against the system as it is presently constituted and if it cannot be improved to correct its deficiencies, then abolish it.

Dr. Durkan stated he is convinced it should be abolished.

Dr. Weiner stated in considering the opinions of the attorneys and everyone testifying before the Commission, he feels it should be abolished.

Mr. Hughes stated that the attorneys Bar was opposed to its creation. He further added abolish it, because it does not work.

Dr. Cohen stated he has been impressed by the large number of people who have suggested abolition because of the duplication of the process and is in favor of abolition also. He stated if after abolition, cases are dumped back into the court system, we could reinstate the system. He indicated that abolition may turn out to be a mistake.

Mr. Liebmann stated that abolition is a leap into the unknown and again mentioned the need for tort reform.

Mr. Tabler stated the State Bar Association Committee considered the arbitration system and submitted a copy of their minutes to his office which recommended 12 to 0 for abolition of the system. The minutes went on to state that consideration be given to not abolishing the system but the number one step would be that both sides could agree that it should then not apply. The other recommendation was it need not be mandatory if either side did not want to go through with it. These were the two alternatives to total abolition. They were considered with some degree of favor although they did not reflect in the final vote. These are two options which I present to the Commission for consideration.

Mr. Liebmann stated if we are going to keep the panel in operation for a period of years to wind down the existing cases, it seems that there might be something said in favor of a procedure allowing post July 1, 1984 cases to go to panel where the parties so agree to waive their appeal rights.

Mr. Cohen stated he believes those supporting abolition of the system including insurance carriers and attorneys on both the plaintiff and defendant sides are not of the belief that the Legislature will be willing to make the necessary tort reforms. The arbitration system as it is constituted is unacceptable to both sides.

Mr. Liebmann asked if the Legislature would enact experience requirements for panel chairman, would this help the system.

Mr. Cohen stated full time referees would give consistency to rulings.

Mr. Everton stated that in the statistics Mr. Tabler handed out, he sees a trend that of cases filed each year determined by the panel, fewer are appealed which indicates a growing degree of acceptance of panel awards.

Mr. Tabler stated his office finds a lesser number of appeals being taken each year. He stated that 81% of the open cases are less than two years old. The system may have many faults but with a delay of less than two years, it seems incongruous that this could be a consideration for abolishing the office. Again he stated that there are not 25 cases out of 2,000 that have been tried in the court system that have come through his office. Of the 160 appeals that have been taken, he proposes not 10% of them have been tried. In referring to some statistics presented to the Commission, he stated that in 60% of the cases, the award of the panel is upheld when the case is tried. When you look at the 1,169 cases that have been disposed of, he does not see how this Commission can say the system is not working. These are cases that our circuit courts do not have to deal with.

Mr. Everton stated a firm rationale for abolition is that the system allows too many people to litigate their claims. This is the major argument of attorneys. This is part of the idea for enacting the system to give a forum to certain litigants who would not otherwise have one. The system is successful in that respect. He personally believes that arbitration generally is going to be the way of the future in litigation simply because our society grows more litigious every year. The court system will never be expanded to the extent to handle the litigation. He stated the reason the system

was enacted was a profound feeling on the part of the General Assembly and most people who address it, that these cases could no longer go through the court system appropriately. There was a malpractice crisis.

The problem had to be solved so we could get the litigation over with quicker and more expeditiously. If you abolish the system, he questions whether we are not going to go back to the very problems that arose in 1976. The cases will be filed in great numbers and the courts will not be able to handle them without hiring 30 to 40 judges.

Mr. Liebmann stated if there is going to be abolition of the system, there has to be a rigorous screening process designed to get rid of bad cases early on. There probably also has to be some measures which are designed to have a depressing effect on awards simply because it is a leap in the dark. He stated he does not want to be the architect of a social problem two or three years from now.

Mr. Hughes stated the only thing that tort reform will do is to take something away from the victims.

Dr. Cohen stated that he is not sympathetic to having the victim collect twice.

Mr. Liebmann stated we need more meetings before we make a judgment even though we are under great time constraints. Mr. Hughes stated we need to talk more and when it comes down to seriously talking about how we are going to vote, the meetings should be closed sessions.

Mr. Liebmann stated that there are two different approaches we could take that will not be an exercise in futility. The first approach is the conservative one of recommending generally agreed upon changes in the arbitration process. We can suggest a variety of things which are noncontroversial which everyone agrees would improve the process.

The other approach is the drastic one of abolition and the return of cases to the court system and some of the tort reform measures as a package. If we recommend only that these cases go back to the courts, we will not get the Legislation enacted. There would be an outcry from the medical profession and the insurance companies. The curtailing of plaintiff's rights, if recommended, would not be successful. It seems to me that there are really only two possible ways of handling this. One is returning everything to the court system and at the same time making sure that things do not

get out of hand there. The second thing is keeping the arbitration system and improving it in a way which is not controversial.

Mr. Liebmann indicated we need to hear from the administrative offices of the courts regarding the returning of cases to the court system and we need the attendance of the four legislators on our Commission in order that we can make a decision. He asked that an attempt be made to get these members to attend our next meeting in Annapolis along with Delegate Owens and Senator Miller. Mr. Liebmann asked the members who they would like to have attend the next meeting.

Mr. Tabler stated that Judge Adkins' experience over the past years would be helpful.

Mr. Liebmann stated we will work our way through the list of issues at the next meeting with the understanding that afterward, we will make the basic judgment as to whether we will write a conservative or drastic report. Mr. Liebmann asked Doris Tippett to contact Mr. Prendergast at Smith, Somerville & Case to obtain the minutes from the State Bar Association Committee on the arbitration process for our next meeting.

Dr. Morlock indicated that she feels an issue the Commission must deal with is that 43% of panel determinations were in favor of the claimant. Since the creation of the system was to increase the accessibility to claimants and since we have a system that looks like it is coming out with verdicts more in favor of claimants then certain other systems, the Commission should address these issues because they will be raised in the Legislature. The plaintiff's Bar is not taking this stand and it is puzzling to me why this is not discussed because it is a potentially important issue.

Dr. Cohen stated he felt the four legislative members of our Commission should be present to help make a decision from the political point of view and give advice.

The meeting was adjourned at 9:20 p.m.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Tuesday, December 13, 1983
James Senate Office Building
Room 200,, 110 College Avenue
Annapolis, Maryland

MINUTES

Present	Absent
George W. Liebmann, Chairman	Honorable Joel Chasnoff
Edward J. Muhl, Insurance Commissioner	George W. Shadoan, Esquire
Honorable Jerome F. Connell, Sr.	James P. Durkan, M.D.
Honorable Francis X. Kelly	Ellen Zamoiski
Honorable Gene W. Counihan	
Israel H. Weiner, M.D.	
Harold A. Cohen, Ph.D.	
J. John Spinella	
Leo A. Hughes, Equire	
Grover Czech	
W. Minor Carter, Esquire	
Angus Everton, Esquire	
Barry Cohen	
Howard Friedman	
Gerald J. Carroll, M.D.	
James Norris, State Court Administrator	
Honorable Joseph E. Owens	
Walter Tabler, Director, Health Claims Arbitration Office	
Janna Vavroch	
Judy Wood, Med Chi	
Albert D. Brault, Esquire	
Lucile Bodtke	
Doris A. Tippett, Recording Secretary	

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Chairman Liebmann began the meeting by discussing the handout material which was distributed to the Commission. This material includes the Annual Report prepared by United States Fidelity and Guaranty Company relating to the hospital policies written by it. There is an indication that their incurred losses have consistently outrun reserves and that there is a fairly consistent pattern of increases in both the frequency of claims and the average loss per claim.

He stated the second item is the Minutes of the Bar Association Committee that has been reviewing the operation of the arbitration system. The principal recommendations are that the public members be drawn at random from the jury roles, the attorney members be drawn at random from the Client's Security

Trust Fund list, that the panel chairman be equipped with power to rule on all matters of law, that the Director be permitted to rule on preliminary matters in the absence of a panel chairman, that questions of law ruled upon by the panel chairman be appealable to the courts under a reversible error standard, that costs be assessed against a plaintiff who dismisses unless the parties otherwise agree that the jurisdictional amount be raised from $5,000 to $10,000 to reflect the change in the jurisdictional amount of district court, that the panel chairman be expressly provided with authority to direct a verdict on matters before the arbitration panel, that the parties be allowed to waive arbitration and go directly to the courts if they so stipulate, that the trial court be allowed to grant interest on awards but that this be discretionary and not a rule in every case where an award is upheld on appeal, that the rules of evidence be made applicable by statute to arbitration proceedings, and that the State bear all costs of arbitration.

The third item is in response to questions about income of particular classes of medical specialists which was raised at a prior meeting. This data is prepared by Medical Economics on the basis of a survey of all doctors in the country.

Next is the Texas Regulation on the medical disclosure panel which is that which administers the rather unique informed consent statute along with the standard release form.

Finally, there is a letter to Mr. Norris from Mr. Tabler which breaks down the number of pending arbitration cases by judicial circuit and by county. The main point of interest in this letter is that to a very heavy degree, the arbitration cases are concentrated in four of the metropolitan jurisdictions stating Montgomery, Prince Georges, Baltimore Counties and Baltimore City. Courts in these jurisdictions will be primarily impacted by the return of arbitration cases to the courts.

Mr. Liebmann then introduced Mr. James Norris who is the State Court Administrator. Mr. Norris stated the letter from Mr. Tabler indicates that 935 open cases are distributed mostly in the populated area of Montgomery County. If these cases are returned to the circuit court system, there will be a substantial impact on the courts. These particular cases take at least a week to try and they will tie up the courts.

Commissioner Muhl asked Mr. Norris if he would oppose or support proposed legislation returning these cases to the court system. Mr. Norris replied that he cannot say because his office deals with legislation as it becomes necessary.

Dr. Weiner asked how long is the delay for civil cases and Mr. Norris stated from about a year on up for a civil case from the time it is filed.

Mr. Liebmann introduced Delegate Owens of the House Judiciary Committee. Delegate Owens stated the fact that the trial bar is united in getting rid of the arbitration system, does not mean the Legislature will abolish the system. He indicated that more statistics would have to be furnished to prove the system is not working.

Mr. Liebmann questions whether there should be changes in the rules regulating damages. There is some thought that the return of these cases to the courts might be more acceptable if these changes were made because it would set aside the fears of people that premiums would go out of control. He stated the Commission is considering items such as the collateral benefits rule and structured settlements.

Delegate Owens stated regarding structured settlements that he does not have any opinion on this subject because he doesn't think there has ever been any legislation proposed.

Mr. Liebmann said there is some material in the law which relates to it but it has been completely ineffective. There is a provision in the arbitration law which basically states that if an insurer makes voluntary advanced payments, the arbitration panel may award a structured settlement. He stated on the way to the General Assembly, it was amended to state the plaintiff shall have the right to either elect or reject to take a lump sum. The Commission has been giving thought to minors and disabled persons and in these cases, the panel or court should have discretion to direct that the settlement be paid as a structured settlement.

Delegate Owens stated the Legislature would need figures regarding Maryland, not Texas or another State.

Commissioner Muhl stated a concern is the duplication of process, in fact, it has been stated that every case is tried twice, once before the arbitration panel and in most cases no matter what the outcome, again on appeal in court.

Delegate Owens stated there is some duplication but the percentage appealed is not that great, indicating about one tenth. Two aspects for creating the system were the cost of insurance and the panic among the medical profession. Now that we have the system, it has taken some of the load off the courts.

Commissioner Muhl asked when the system was initially created if it was the intent of the Legislature to cause an easy access for individuals into this sort of system.

Delegate Owens replied that he does not know that it was an easy access but he thinks that one big thing was the hope that many cases could be eliminated at the arbitration level.

Commissioner Muhl asked Delegate Owens, if as part of the Legislature, he would be receptive to reform of the arbitration system. Delegate Owens replied the word reform means nothing. He would favor improvement, but the Commission will have to show why and this is not easy. He stated it was a struggle putting the system in place.

Mr. Spinella asked in what ways has arbitration depressed the rate of acceleration of malpractice premiums. Delegate Owens indicated he does not know. Arbitration has not depressed it. He stated he does not know how much insurance has gone up but he stated the fees the medical profession charges has certainly gone up.

Mr. Spinella asked if he felt rates would have gone up more or faster without arbitration than with it. He stated he would hope so but he has no figures on this. Mr. Spinella stated the percentage of increase is about 120% since 1975 which is more than double.

Mr. Liebmann stated the concern that exists arises from the fact that with some medical specialties you have a situation where the premiums in this State are at the level of $20,000 or $30,000 per year, while the premiums in some other states are two or three times this. When you hear of large verdicts, there is a fear that you may have another explosion resulting from the greater tendency of people to bring suits and the greater acceptability of large awards.

He indicated the fear is not that the burden now is pressing, but if it were to double quickly, this would be a problem. For some medical specialties, it distorts the doctors judgment when he is paying premiums that amount to 10% to 15% of his net income. It makes people more careful. It has costs that go beyond the insurance and the judicial system and it effects medical practice in ways that it should not.

Delegate Owens stated that this is exactly the same argument that was used to put in the arbitration system. Mr. Liebmann stated there are various proposals for limiting awards mentioning the cap on awards. More serious ones involve eliminating the double recovery of medical expenses where the plaintiff recovers once from his insurer and then again from the malpractice claim. This is not acceptable to the plaintiff's trial bar and would be resisted vigorously unless there is some-

thing to balance it on the other side. Either we leave the system as it is, maybe improve it in some ways or we return the cases to the courts and at the same time try to limit damages.

Delegate Owens stated the Legislature is interested in the public. If you can improve the system, then go ahead and improve it. The Commission has to show real positive reasons for abolition before the Legislature will act.

Mr. Brault was announced and stated that he is familiar with Delegate Owens' views and feels the true solution would be to abolish the whole system. Creation of the arbitration system was designed to reduce the cost of defending medical malpractice litigation. Delegate Owens suggests that one of the major goals of the system was to eliminate the frivilous claim. The system as currently established is not accomplishing this goal the way it was designed to. He asked who is speaking for the potentially injured. He feels the elimination of the collateral source laws is an important matter that would accomplish all of the goals that the system was set out to gain. It represents a procedure in which people can make a claim for damages which they never sustained. He feels that this Commission should strongly urge the elimination of the collateral benefits rule. It has outlived its usefulness. Everyone has some form of collateral source.

He urges the use of certificates of merit to eliminate the special damage rule to enable those who feel they have been mistreated by the filing of frivilous actions of professional malpractice to have the ability to retaliate in court on somewhat an even stance with the patient/plaintiff who has frivilously brought the action against the professional. He urges the Commission not to consider prejudgment interest because it has constitutional implications. He stated he has had experience in this area citing that New Jersey has promulgated a prejudgment interest rule and it was attached in the New Jersey court system.

Mr. Liebmann stated he has questions regarding prejudgment interest. He stated if you want to have prejudgment interest on unliquidated claims, it is much more compelling where the suggestion is that the interest should run on the arbitration award from the date of its entry where the award is upheld by the circuit court. The award is in a sense liquidated by the decision of the arbitration panel and if the case is further litigated, it is being litigated at the instance of the defendant and if the defendant does not prevail, a case can be made for interest being paid.

Mr. Brault stated there is no balance in that rule. Suppose the defendant prevails in arbitration and the plaintiff takes the defendant up, the defendant is then economically and financially penalized by that ongoing litigation that the plaintiff has already been told is without merit. What penalty

is ascribed to that litigant for carrying on the litigation? There is none. On the other hand, if the defendant believes that the decision is wrong, there is a penalty associated with continuing to pursue the right of ongoing litigation.

He goes on to suggest that the Commission consider the use of some procedural offer of judgment. We have gotten into the question of whose fault is the delay. If you are talking about some penalty associated with continuing the litigation beyond arbitration, the opponent could trigger some consideration of early settlement by filing an offer of judgment to come from either side.

Mr. Liebmann stated that from the overall cost to the insurer it is not clear to him that would necessarily increase costs. Mr. Spinella stated it cannot serve to reduce costs.

Mr. Brault stated the arbitration presumption is far more effective for a plaintiff than it is for a defendant. There can be an effective argument of bias on the panel because of its inclusion of the health care provider. The defendant who has lost to the panel, can't say I lost to one of my buddies. It just doesn't work. So the presumption of correctness is far more effective on the defendant. The plaintiff feels that once he has the award in arbitration, that is the floor of what he will get and then he can argue from that to a higher award. The defendant has a lot of risk and has to make a very careful decision about appeal.

Mr. Hughes asked Mr. Brault how many of these losses are appealed. Mr. Brault stated that every substantial case he has been involved in has been appealed.

He indicated an argument against prejudgment interest is that in the areas of pain and suffering, mental anguish and all aspects of the noneconomic side which can be the major recovery in these cases, compensation continues so that while you can say that for pain and suffering the award stopped at the day of the arbitration hearing, and they ought to get interest on that, when they go to the jury, the jury will be told that they are entitled to recover compensation for the pain and suffering to the date of the trial. They can ask very logically to increase the award of the arbitration panel because the plaintiff has been screaming in pain in the two years since the one trial to the other. If you add interest on top of this, then you are in a seriously escalating recovery. The problem is that there is no counterprevailing penalty assessed against the other side of the litigation. All of the costs of the litigation goes into the cost of the doctors insurance.

Mr. Liebmann stated we are trying to assure people of their recovery and limit the costs on the medical profession by eliminating forms of awards that are extravagant or duplicative.

Mr. Howard Friedman was introduced as an actuary from Medical Mutual. Mr. Friedman distributed various tables regarding Med Mutual's experience regarding the cost of non-meritorious cases, impact of very large claims and the change of settlement patterns in recent years. These tables are the result of his work on classifying claims by size and reviewing loss adjustment expenses paid on claims.

Exhibits 1A and 2A are a collection of closed claims that Med Mutual has incurred by various accident years. These exhibits show the claims broken down by size of indemnity paid into intervals, the number of claims in each interval, the indemnity paid on those claims, the expenses paid on those claims and the incurred loss of the total of the indemnity and expense.

Exhibits 1A and 1B shows the actual value of the claim. Exhibits 2A and 2B show all the claims on somewhat a consistent basis. They were developed from the basic data in Exhibit 1 numbers but were brought up to 1983 values by inflating the claims at 2 1/2% per year. Exhibit 2A shows all the claims that were closed on a consistent level, as if they all occurred in 1983 categorized by size.

He indicated he is trying to show us the significant amount of indemnity on very large claims because this is something the Commission should be looking at. We should be concerned with the amount of money that is expended on extremely large awards and the increase in those very large awards that we will see in the future. There is a very large potential for very large claims.

Exhibit 3 breaks down the amount of money spent defending nonmeritorious claims. Two things stand out. One being 15% of the claims closed without payment were for defendant's verdict, however, these use up 43% of our total expense payments on nonmeritorious claims. We have had an average of $7,000 per claim. The other categories use up less of our total expense payments on an average basis to dismiss claims, and cost 54% of our total expense payments to defend. This is some sort of breakdown by type of nonmeritorious claim of what was spent and possibly suggesting some methods or reducing these claims.

Exhibit 4 shows settlement rates of claims by reported year. This exhibit indicates that from 1978 or 1979 claims were settled faster. We think this has to do with the arbitration proceedings although we do not have any definite evidence of this.

Mr. Liebmann asked if this has to do with the fact that while the constitutional litigation was going through the courts, people delayed filing their claims and that this is the reason why the rate was so slow in the earlier years.

Mr. Friedman stated that actually in 1976 and 1977 the settlement rate was faster than in any of the other years. The reason being the peculiarity of Med Mutual's experience and that claims reported to us were minor claims and easier to settle. This data indicates to us that there does seem to be an increase in settlement rates and it may be a result of arbitration.

At this point Mr. Liebmann directed the discussion to his list of issues beginning with whether or not the Commission should recommend the adoption of regulations and recommend rulings on common problems of evidence.

Mr. Hughes stated there should be some form of standardization of the rules.

Mr. Everton suggested that the rules of evidence should be used in arbitration. He stated that medical reports are usually virtually always stipulated in. It has been his experience that most attorneys try to make sure that the rules of evidence apply which makes for the best type of trial.

Mr. Hughes stated he does not want to have to go through the motions twice. He stated he tries frequently to go with the medical report upon due notice and their right to take deposition. He has tried a case where he simply put in the medical report of an expert witness. They were first notified of it and had the right to go to New Jersey and take the deposition first and they put this into evidence as their cross-examination.

Dr. Weiner asked Mr. Hughes if this was equivalent to cross-examination. Mr. Hughes stated he thinks it is but they think it is not.

Mr. Everton stated he does not think it is the same thing at all. He stated when you take a deposition you are trying to find out what he is going to say beyond what is in a one or two page report. Then when you know this, you may want to cross-examine him at more length at trial.

Dr. Cohen asked if he is not there to give more than the report, why do you need to go beyond this. Mr. Everton stated we want to get into his opinion in more detail. He indicated with regard to an expert's opinion, that a mere sheet of paper that is passed as a report, should be admissible in evidence. He said he has a lot less trouble with treating physician's records because as a general rule, they are not occupying what amounts to a partisan physician.

Mr. Liebmann stated the outcome of these cases are subject to an appeal de novo. To demand perfection is to demand too much. Mr. Everton stated the presumption of correctness inheres to the benefit of the plaintiff.

Mr. Hughes stated the expert opinion is a major consequence. In a $10,000 case, you go out-of-state and bring in an expert witness, you are going to pay $5,000 which eliminates the $10,000 case. This man has a right to do something. If he gets a report, let him use the report subject to their right to go take his deposition. I see nothing hurt by the de novo trial. It saves the consumer money.

Mr. Liebmann asked what the objection is to allowing it in unless the defendant exericses the right to take a deposition in which case the deposition would be admitted in lieu of a report.

Mr. Everton stated it would make sense if the defendant were allowed to take two depositions of the out-of-state witness, the first being a discovery deposition and the second being a cross-examining deposition for trial purposes. This is the answer to Mr. Hughes' question about the out-of-state expert because in many instances his deposition is now admitted. It can be done under the Maryland Discovery Rules.

Mr. Liebmann asked what the objection is to a rule which would say that the reports would be admissible unless the defendant exercised his right to depose the expert in which case the deposition would be admissible including the deposition as supplemented by any direct examination of the plaintiff. Mr. Everton stated it puts the onus on the defendant to depose the expert rather than on the plaintiff to bring him in and prove his case.

Mr. Spinella stated that this would just introduce another delay. Mr. Liebmann asked aside from the onus of cost, what is the unfairness if the plaintiff would have to bear the cost of going to the deposition also. What is the unfairness if what is then admitted is the transcript of cross-examination without the report. Mr. Everton stated it is not cross-examination, it is discovery.

Mr. Liebmann stated that it is not clear to him that admitting the transcript of testimony subject to cross-examination is to inherently unfair that it ought to be excluded in an arbitration process subject to an appeal de novo.

Mr. Cohen stated plaintiffs are going to use reports and then appeal and state that their expert was not present at the arbitration hearing, but hear him now. When you get less formal, you generate more and more appeals. Inevitably when you have a chairman who sticks with the formal rules, these cases do not seem to be appealed as much. When both parties feel the case was tried fairly, the losing party is not inclined to appeal that case.

Mr. Everton stated the discovery rules are explicitly applicable to arbitration. If a deposition is taken out-of-state and the opponent is outside the jurisdiction of the court, it is admissible.

Mr. Liebmann stated the rule he is suggesting is the claimant's report and the defendant's report would be admissible except that where the opposing party elects to depose that physician, the election to depose renders the report inadmissible and the deposition is admitted in lieu of the report.

Mr. Everton stated that would be a bad system because from practical experience, he can see a lot of problems with this.

Mr. Hughes also stated he would not like this because the deposition that goes in would be the deposition limited to the defendant's cross-examination of the expert rather than first having laid out his testimony. The whole issue is the cost.

Commissioner Muhl stated if a consensus of these aspects is reached and submitted as recommendations for change to the Legislature, some of these items which change the process will be difficult if not impossible to accomplish.

Senator Connell stated there will have to be compelling testimony showing the changes are beneficial before the Legislature will be persuaded to change the law.

Mr. Cohen stated we can live with not worrying about the de novo appeal, if the expert were not to show up at trial and the risk at arbitration is that you don't depose someone because you don't expect him at trial. Then he walks in and you haven't had the chance to depose him. Mr. Cohen feels that for the smaller case it is an expense that is difficult for the plaintiff. If you have the report and the right to depose him and he is not going to show up at arbitration, this is probably the fairest.

Mr. Everton raised the point of the degree of applicability of the Rule 604 which is the rule which permits you to recover costs if you are the prevailing party and the other party has brought an action in bad faith. He stated there is a real question whether or not the rule is applicable to health claims arbitration. It is significant because it does provide some restriction on the meritless suit.

Senator Connell stated this type of question arises every year before the Legislature. The Legislature is reluctant to depart from the current law which basically states that unless a suit is brought for the purpose of harrassment or to intimidate another party, this is the only time courts will generally award the costs against the other party bringing the action.

Mr. Liebmann asked about third party claims and inconsistency. Mr. Everton stated that there is a real problem with this issue because under the present law a person is unable to bring a third party claim after he files his response to the statement of claim. This is a real hardship. There is no discretion left to the panel chairman and it means that if you discover, after the case has gone forward that there is a third party you ought to bring in, you cannot do it.

Mr. Liebmann asked if this is a large problem and Mr. Everton stated yes, it is. Mr. Hughes stated it is not that large a problem to him personally, but stated he does have cases where he wishes to bring an action against a health care provider and he is effectively prevented from doing this.

Mr. Liebmann stated that the Bar Association Committee Minutes addresses this issue stating that where there is a products liability claim and a malpractice case that are interwoven, it should be possible to sue in the courts and that the prior liability claim then falls out to be relegated to the arbitration process for the claim against the physician.

Mr. Cohen stated it is a big problem because when you get a suit you do not know whether the hospital may be involved, whether another physician may be involved, before you have a chance to assess your claim. Mr. Liebmann asked how we should address this.

Mr. Everton stated that you remove one sentence from the law, then the rules of procedure apply.

Mr. Tabler stated it would pose no problem because the plaintiff would be foolish to object to a third party defendant being added. Generally what happens when the original defendant wants to do it, the plaintiff will file an amended declaration and include what would have been the third party defendant.

Mr. Everton stated the third party can object if the plaintiff doesn't do this. The third party is the person who has the right to raise the objection. This does not effect plaintiffs. It is between the third party claimant and the third party defendant.

Mr. Czech stated that perhaps this is a way of spreading the loss to other people. Mr. Everton stated this would mean bringing in another defendant and another insurer. And Mr. Czech added perhaps the negligent party.

Mr. Liebmann then moved on to the next item on the list regarding amending the statute to empower the Director of the arbitration office to impanel alternatives at his discretion. Mr. Tabler stated it would be a good modification.

Regarding permanent motion judges or discovery chairmen, the Bar Association Committee Minutes recommend that in the absence of a chairman, the Director may rule on pretrial motions. He asked if anyone had any difficulty with this. Mr. Tabler indicated the Bar Association Committee was pretty much in agreement with this.

Mr. Cohen stated this does not address the problem with inflamatory evidence that both plaintiff and defendant may want to exclude. You cannot exclude this evidence unless you exclude the panel chairman and this is just what you do not want to do because he votes. In the court system when you make a motion to the judge, he does not vote and the jury does not hear the inflamatory evidence. You cannot make a motion to a voter on the facts of inflamatory evidence because it influences his vote.

Mr. Liebmann moved on to the experience requirements of panel chairmen and asked if this was really controversial.

Mr. Hughes states that youth has not been a problem but inexperience has been the real problem. Mr. Tabler stated that anything less than two years experience would be extremely harmful, indicating that these should be two years of active trial experience.

Dr. Cohen stated he does not see anything wrong with making panel service one of the responsibilities of licensure. Dr. Weiner stated it is a responsibility that all doctors will have to accept. He indicated it could be like the Baltimore City jury system.

Mr. Liebmann stated the explicit adoption of a summary judgment procedure and the issue whether a judgment is that of the panel chairman or the judgment of the panel directed by the chairman and whether it activates the presumption, was addressed by the Bar Association Committee.

Their judgment was the chairman along should be able to rule on motions for summary judgment as a question of law. When his judgment is appealed, if it is upheld by the court, then the statutory presumption attaches to it. If it is not upheld by the court, then the jury tries the case de novo without a presumption.

Mr. Everton stated that this is very similar to what is in the law now regarding motions raising preliminary objection. When you raise preliminary objection to what happened at the panel below, if you win on that point, the award is simply nullified and the case goes on to trial.

Mr. Liebmann stated that everyone seems to agree on the desirability of getting rid of the frivilous case early. Dr. Cohen stated we have never heard from anyone who has actually brought a frivilous case.

Regarding the item of interest on panel awards, Mr. Liebmann stated that if the collateral benefit rule were curtailed, there would be a case for interest on the monetary portion of the claim. Mr. Hughes stated he did not agree to this. Mr. Liebmann stated that if the collateral benefits rule were abolished, it might be fair to allow interest on the monetary portion of the remaining claim.

Senator Connell stated the general consensus of the Legislature is they consider it to be coercive to some extent to bring people to settlement or get settlements moving before they may be ready. They think that judgment should be made by legislators on the interest on awards. At that time we considered interest on awards and turned it down.

Regarding the certificate of merit, it was stated that there will be such a procedure but it will not be triggered until a given number of days after filing. Mr. Liebmann stated the idea is to screen out frivilous cases early.

In speaking of a statutory requirement that panel members submit questionnaires under oath prior to service, Mr. Tabler stated that panel sheets are renewed every two years. He indicated that panels are totally dependent upon volunteers. He suggests some compulsory service on the panels. If he tells people they will be subject to the penalties of perjury if they make a mistake on their panel sheets, he would lose many panelists.

Mr. Liebmann stated that he finds this very hard to believe. Mr. Tabler stated hard to believe or not, it is true.

Commissioner Muhl questioned Mr. Liebmann as to the scheduling of future meetings and at what point we will get to a vote on the abolition or retention of the arbitration system.

Mr. Liebmann suggested the next meeting be scheduled for Monday, December 19th as an informal dinner meeting to discuss whether or not to maintain the arbitration system and to discuss the collateral benefits rule and informed consent. Following this meeting, we will need two more for drafting a report and reviewing it and drafting legislation.

The meeting adjourned at 9:45 p.m.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Monday, December 19, 1983
Chiapparelli's Restaurant
237 South High Street
Baltimore, Maryland

MINUTES

Present

George W. Liebmann, Chairman
W. Minor Carter, Esquire
James P. Durkan, M.D.
Honorable Jerome F. Connell, Sr.
Grover Czech
Harold A. Cohen, Ph.D.
J. John Spinella
Israel H. Weiner, M.D.
Leo A. Hughes, Esquire
Barry Cohen
Laura Morlock, Ph.D.

Absent

Edward J. Muhl, Insurance Commissioner
Honorable Gene W. Counihan
Honorable Francis X. Kelly
Honorable Joel Chasnoff
George W. Shadoan, Esquire
Ellen Zamoiski

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Chairman Liebmann began the dinner meeting by handing out a list of tentative recommendations to be reviewed by the Commission. This list is a consensus of the so-called topics of agreement to resolve the frivolous claim quickly, improve the arbitration process if retained, eliminate excessive damages and improve medical practice.

The following is a brief review of the items to encourage early resolution and improve the arbitration process if retained.

Item 1 - "not going to the ultimate issue of negligence" to be eliminated.

Item 2 - it was suggested it be amended to add ten days notice unless good cause is shown.

Item 3 - "jurisdictional limit of the District Court" to be substituted for $10,000. "Ten days notice unless good cause shown" to be inserted.

Item 4 - a discussion ensued regarding hearsay evidence and the APA (Administrative Procedures Act). Mr. Hughes asked that his objection be noted for the record to this item and that he would be in favor of the APA.

Item 6 - it should be added "before the panel chairman is selected".

Item 7 - should be amended to state that the chairman be required to rule <u>in camera</u> on any motions <u>in limine</u>.

Item 8 - should be amended to add cross claims and to use Maryland Rules language.

Item 9 - Dr. Morlock suggested that we should explain experience in more detail - since admission to bar.

Item 10 - it should be added that the director should question in writing or verbally as to matters bearing on conflicts of interests. Service on the panels should be enforceable by the appropriate licensing board. Mr. Hughes stated he opposes this item and objects to the same panel chairman serving. He suggested there be increased voir dire of panelists. The suggestion was posed that a panelist serve no more than once every two years.

Item 11 - Mr. Hughes noted for the record his objection to this item.

Item 12 - the basic idea here is to avoid unnecessary duplication. It was voted to retain this item.

Item 13 - it was voted to retain this as is.

The following is a brief review on items to eliminate excessive damages.

Item 1 - where there is a punitive damage claim and a judgment is rendered, the financial statement goes in and the second trial for punitive damages is a bifurcated trial. Mr. Hughes and Mr. Czech oppose this unless reworded to make more clear that bifurcation is contemplated.

Item 2 - it was stated that the collateral benefits rule should be restricted to allow evidence of remarriage only where support or consortium is an issue. Wrongful death cases where the wife remarries was used as an example. Mr. Hughes stated he opposes this even with the above amendment.

Item 3 - a dicussion regarding Medicaid ensued. Mr. Hughes stated for the record that he opposes this item.

Item 4 - it was indicated that the collateral benefits rule is better than an arbitrary cap on awards. Mr. Hughes stated he opposes this item. Dr. Cohen would prefer the subrogation approach.

Item 5 - Mr. Czech stated this will help identify pain and suffering and makes the jury more conservative. Dr. Weiner opposes this item. Mr. Hughes opposes this item because we are creating tort reform and the medical malpractice field should not be singled out for tort reform.

The following was reviewed regarding measures designed to inprove medical practice.

Item 1 - it was stated that claims should be reported to the Commission on Medical Discipline when closed and when opened. Mr. Spinella stated he has trouble with this aspect because it could prejudice the defense in a case. Insurance carriers must report to the Insurance Commissioner who in turn reports to the Commission on Medical Discipline. CMD can investigate incidents of malpractice insurance where the doctor has had two or three claims filed against him. Now every case must be reported at disposition. This item suggests that the claim should be reported at the beginning. When voted upon, Mr. Czech objected stating the report should come from the arbitration system. Upon opening of a claim file or upon filing of suit, whichever comes first, it should be reported to CMD. Mr. Spinella objects unless reporting at the beginning of a claim is accompanied by the filing of suit. Mr. Liebmann stated the CMD should determine what gets filed.

Item 2 - voted to retain as is.

Items 3 and 4 - the basic fact is that the doctor is told what he can do. Dr. Durkan stated this is not a problem because hospitals have addressed this in great detail. Each hospital has their own regulations. It was stated that informed consent is not a real problem. These items were opposed.

After this discussion, Mr. Czech stated that the Legislature will not support any modification of the collateral benefits rule. Mr. Liebmann stated there are three major problems which must be addressed:

1. getting rid of the frivolous claim

2. the general level of rates

3. problems surrounding informed consent

An informal vote was taken regarding the arbitration process. Chairman Liebmann read Commissioner Muhl's letter reflecting his position. Mr. Carter stated his position would be retention of the system. Dr. Cohen, Chairman Liebmann and Dr. Weiner voted to abolish the system and change the collateral benefits rule. Mr. Hughes voted for abolition outright. Mr. Czech, Mr. Spinella and Dr. Durkan voted for retention of the system with modification.

The scheduling of meetings was discussed. The next two meetings are scheduled for Tuesday, January 3, 1984 and Monday, January 9, 1984 at United Stated Fidelity and Guaranty Company at 5:30 p.m. Dr. Morlock is requested to be present, together with someone from Legislative Reference.

The meeting adjourned at 11:00 p.m.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Tuesday, January 3, 1984
United States Fidelity & Guaranty Company
15th Floor, Room 7
Lombard and Charles Streets
Baltimore, Maryland

MINUTES

Present	Absent
George W. Liebmann, Chairman	Honorable Francis X. Kelly
Edward J. Muhl, Insurance Commissioner	Honorable Joel Chasnoff
Israel H. Weiner, M.D.	Honorable Jerome F. Connell, Sr.
James P. Durkan, M.D.	W. Minor Carter, Esquire
Leo A. Hughes, Esquire	Grover Czech
Harold A. Cohen, Ph.D.	Ellen Zamoiski
J. John Spinella	
Honorable Gene W. Counihan	
George W. Shadoan, Esquire	
Barry Cohen	
William Gibson	
Lucille Bodtke	
Walter Tabler, Director, Health Claims Arbitration Office	

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Chairman Liebmann began the meeting with the distribution of his draft report for the Commission to consider. At this point, he introduced Lucille Bodtke who asked to be heard on the issue of informed consent.

Ms. Bodtke stated she had been working with Delegate Pitkin regarding informed consent legislation and that Delegate Pitkin had drafted three bills entitled: Breast Implantations - Full Disclosure to Patients, Breast Implantations - Operations Prohibited and Physicians Information on Breast Cancer. She stated that Drs. Sawada and Smith of the Department of Health and Mental Hygiene have been discussing the legislation as well. She is making a recommendation that any legislation include full disclosure of items A and B of the Texas Statute, in addition to requiring full disclosure for simply mastectomy. The Texas Statute excludes simple mastectomy. She proposes legislation should have a mandatory documentation of physicians 100 hours of continuing medical education as a requirement for licensure.

Mr. Liebmann thanked Ms. Bodtke for her presentation and stated it is doubtful that on the basis of our discussions our report will contain much in the way of substantive recommendations on informed consent because it is an area in which we have

relatively limited information. The only area in which there may be some recommendation, is the suggestion that there be a Certificate of Merit requirement for all cases including informed consent cases. This would require a Certificate stating that the standard of care or disclosure has not been complied with to be filed within ninety days of the case. Aside from this and on the basis of the information the Commission has received, we would not be justified to make any drastic recommendations in the informed consent area.

Commissioner Muhl asked if the bills which Delegate Pitkin has drafted will be submitted before the 1984 Legislature and if she desired this Commission to include the informed consent issue in its report. Ms. Bodtke stated the bills were drafted to go before the upcoming General Assembly and that she feels informed consent is a problem which is the reason she is in attendance. She indicated interest in the outcome of the Commission's findings to determine the need for future studies on informed consent and the need for legislation in this area.

Mr. Liebmann then directed the members to the draft report which he distributed and went into a brief summary of the topics discussed therein. He stated that page 1 is the usual language regarding the work of the Commission. Page 2 is a partial effort to discuss the premise of Senator Abrams resolution that malpractice premiums were having a significant effect on health care costs. The conclusion reached is that malpractice premiums account for approximately 2% of the total cost of health care and perhaps 5% or 6% of the costs of physicians care. Page 5 is an effort to discuss the impact of the so-called high risk specialties on the basis of the available data in Maryland.

Mr. Liebmann indicated he intended to add information relating to the rates in other states but it is difficult from filed rates to gain any accurate idea of what rates are actually charged. He indicated the purpose of the introductory portion of the report is basically to discuss the overall impact of both the relation to health costs generally and the incomes of the classes of physicians. He stated the Abrams resolution contains recitals of the alleged problems presented by premiums for younger physicians and on page 6 there is a paragraph which describes the discount plan of Medical Mutual.

The Resolution contains a recital relating to the problems of retiring physicians and page 6 of the report states the possible issuance of policies providing for discounts for reduced practice limited to and certified by a particular hospital.

Page 7 reflects a discussion of the pros and cons of the arbitration process indicating the diminished enthusiasm that exists with respect to the process.

Page 12 sets out the majority recommendations of the Commission. There are a number of members who favor abolition outright, a number who are prepared to support abolition accompanies by curtailment of the collateral benefits rule and a group who are opposed to abolition provided the system is improved in various ways. The page 12 recommendation is for prospective abolition of the system and there is set out the argument in favor of abolition of the system accompanied by curtailment of the collateral benefits rule. Page 13 sets out the vote of the Commission on this issue and finally the recommendations for prospectivity.

Next there are about 11 pages of recommendations. Some are designed to promote the early resolution of insubstantial claims. On page 14 are the statistics relating to the number of claims temporary or purely emotional injuries which are tried and result in award, the defense costs attached to claims that are dismissed at an early or later stage, illustrations of the type of case regarding insubstantial claims and the amount of time it takes to resolve them.

On page 15 there is a list of the recommendations that deal with the sixty days advanced notice of suit, the certificate of an expert within ninety days of filing, the increase in the jurisdictional limit to the District Court limit, and the application of the summary judgment rule.

Page 16 indicates a series of recommendations relating to improvement of the arbitration process if it is retained including mutual waiver, a discussion of the rules of evidence, namely that the rules adopted should be those commonly applied by judges sitting without juries, the recommendation that the chairman of the panel be allowed to rule on motions in limine, that the Director of the arbitration office be allowed to rule where a panel chairman is not serving, that the rule relating to third party claims be changed, that the Director be allowed to empanel alternates in particular cases, that there be a minimum three years experience requirement for panel chairmen, and licensing bodies be empowered to discipline for refusing to serve.

There are measures designed to eliminate duplication between arbitration and court hearings. There are recommendations designed to improve medical discipline and practice.

Regarding the informed consent issue, there are two proposed recommendations on page 24. Plaintiffs in informed consent cases will be required to establish by expert testimony the appropriateness of the disclosures alleged to have been wrongfully omitted, and supply a certificate thereof within ninety days of the claim which basically is the Certificate of Merit. And finally, that consideration be given to the wisdom of legislation such as the Texas Statute.

Mr. Liebmann stated that since the report was just distributed to members, that it would be unfair to ask for a vote at this meeting until everyone has had an opportunity to review it. Therefore at the next meeting we will review the report page by page making appropriate amendments to unsatisfactory portions.

A discussion ensued as to how to present our report to the Legislature. There are uncontroversial recommendations such as the screening of bad cases, improving the arbitration process, eliminating duplication, improving reporting and there are the controversial issues of abolition of the arbitration system coupled with restriction of the collateral benefits rule and whatever is done with respect to the collateral benefits rule in the health insurance area.

Mr. Liebmann stated if we suggest a bill which endorses abolition, there should be a second bill which relates to improvement to the present process because as a matter of realism, the Legislature will not adopt abolition now. He stated he would be reluctant to see the possibility of improvements to the system overlooked because we present a report or bills which only speak of abolition.

Mr. Liebmann stated that the majority of members feel that the answer is abolition accompanied by some curtailment in the damage doctrine. We realize that this recommendation may take some time for the legislators to grasp and may not be adopted now. Some improvements to arbitration relate to matters which would be relevant even if there were abolition such as the itemized verdict, improvements to the reporting to the Commission on Medical Discipline, etc. If we were unanimous for abolition, then a case could be made for going in with a full report which spoke essentially to that issue and stop there. It is obvious at this point, that there does not exist anything close to unanimity. We should be trying to set forth our consensus on that subject and go forward with those things generally agreed upon.

Commissioner Muhl stated it has been indicated that the Legislature will not consider abolition unless there is demonstrated a strong need and it is backed with statistical proof. It would be an exercise in futility to propose abolition if we as a Commission are not in consensus.

Mr. Liebmann stated we should make known we are not enthusiastic about the arbitration process and we are willing to see it abolished either conditionally or unconditionally.

Commissioner Muhl again stated he has difficulty with presenting two pieces of legislation, one for abolition and the other for improvement. He stated his personal preference would be to make a decision for abolition and go with it or in

the alternative for improvement, but do not give the Legislature two bills to choose from. Dr. Weiner indicated we should be strong in the report but he does not wish to see the opportunity for improving the system lost if abolition is not accepted by the Legislature.

Mr. Cohen stated that perhaps there is a consensus, that arbitration is not functioning and is not acceptable to anyone as it exists now. The question that is being addressed by this Commission is the hope that remedial legislation may turn everyone around and this could be proposed to the Legislature. He stated we could propose that no one is happy with arbitration as it exists now and make recommendations which we hope will correct the deficiencies which in turn may enable arbitration to function.

Dr. Cohen agrees that arbitration is not doing the job and some changes need to be made. He stated that the majority of members think the change should be abolition of the system with or without some change to the collateral benefits rule. Mr. Hughes stated this would be easy to spell out in a report but harder to put in the form of legislation.

Mr. Liebmann stated if there were a majority recommendation for conditional abolition with some curtailment of the collateral benefits rule the first bill would address the arbitration office abolishing it and would give recommendations for changes to the collateral benefits rule. Then there would be a bill which would include all other recommendations of this report with the sole exception of the recommendation as to health insurance and the collateral benefits rule which the majority of the Commission members favor even if nothing is done about the arbitration process.

Mr. Liebmann indicated we can use bills from previous sessions as guides which identify the necessary sections to be amended and provide the kind of language, in terms of identifying where it should be amended and the enacting clauses, etc.

A discussion ensued regarding whether we should submit a report to the Governor or draft bills to submit to the Legislature. Dr. Durkan stated he is against the press or anything which would prejudice or embarrass the Governor in making his decision regarding our report. Commissioner Muhl indicated we are obligated as appointees of the Governor, to submit our report to him without going to the press and let him make the final decision.

Commissioner Muhl feels that we should go directly to the Governor with the report as he may not agree with the two pieces of legislation we present. Dr. Weiner stated that the Commission was established by vote of the Legislature and there is an obligation to report back to the Legislature as well as the Governor.

Delegate Counihan stated he is new to the Legislature having only served one year. He feels the report should go to the Governor first as a matter of protocol and then he can determine what should go to the Legislature. He prefers that proposed draft legislation go with the report. If there is going to be legislative action this year, the Commission should not try to propose bills which would jeopardize anything happening this year in terms of the dilemma about whether to go for abolition or improvement to the system. If you go for modification you do not have to endorse the whole arbitration process. Reservations and concerns can be articulated in the report. He indicated if we file a report for abolition, there will be other proponents that will pick up the recommendations and draft them into legislation.

Mr. Liebmann stated that there is a great area of agreement. There are a lot of things that can be done to get rid of bad cases early and make the whole process more rational and eliminate duplication and delay that will make a big difference. It is important that the Legislature know our Commission is studying this issue and that there is not much enthusiasm for the system as it now exists.

Mr. Shadoan indicated we have to decide whether we view our role as trying to cause a bill to be passed in this session of the Legislature or to try to honestly approach the problems as we see them and then let the Legislature do what they will. Chairman Owens stated previously that there will not be an abolition of the system this year. It is his feeling that we are not going to have a bill emerge from our work that will be significant and pass. In view of this, he would rather have direct statements as to things generally agreed upon that might have some influence in future years. It would be a good idea to see if there is a consensus as to two approaches. One approach would be to see if what we propose will pass in the Legislature and the other approach would be to make clear statements we feel are necessary in the report.

Commissioner Muhl again expressed his position regarding posing two pieces of legislation stating it should be put in a report. The report should state the system does not function well, here are our recommendations and proceed with the report to the Governor. He stated his preference is to prepare a strong report to submit to the Governor and let him decide what should be presented to the Legislature.

Mr. Cohen stated that the Commission should consider procedural agreements that would make arbitration less expensive and function better. There are a lot of things agreed upon which would make litigation in the arbitration process better.

Mr. Shadoan stated that no party in a case is well served in the arbitration system. He asked if the Commission has considered the recommendation of Mr. Levin regarding when a case is over $50,000 to bypass arbitration. The ability to bypass the system is better than not having that ability. A lot of these things are improvements over the present system but he believes that none of the participants in a major case are well served by the current system. He indicated that we have discussed collateral benefits at great length but we have not addressed it from the point of reducing medical malpractice premiums paid by physicians.

At this point Mr. Gibson asked to address the Commission. He stated as a professional engineer, if he were charged with wrong doing, he would prefer arbitration. He further stated that as a public observer, he feels the Governor and the Chairman are interested in protecting the consumer and that the Commission should get to the problems and not be concerned so much about the effects. He suggested we look at the informed consent form and that there should be a document which attempts to make a contract between the physician and the patient

Mr. Gibson stated he would vote for abolition of the arbitration process from a consumer point of view. He also indicated that from a doctor's point of view, he would want to retain the system.

Mr. Shadoan stated that our meetings should be closed to Commission members so we can take a vote on recommendations one by one. Mr. Liebmann informed him that at the last meeting a vote was taken by the members who were present and a majority consensus was reached. He feels when a vote is taken it is fundamental that only members be present. Mr. Liebmann stated that he endeavored to informally enforce this rule indicating he understands Mr. Shadoan's view and shares it.

Mr. Hughes stated that the report distributed is a draft report and it should not be given out indiscriminately and Commissioner Muhl and Dr. Weiner indicated that in view of the fact the report is indeed a draft subject to change, that all copies distributed to nonmembers be collected.

The next topic of discussion was the scheduling of meetings. The consensus of the Commission was to change the scheduled January 9, 1984 meeting to January 10, 1984. Another meeting was scheduled for January 17, 1984 in Annapolis.

Mr. Liebmann suggested he will try to obtain an audience with the Governor sometime during the week of January 23rd in order that we may submit our report. Commissioner Muhl suggested all members be notified by telephone to be present at the next meeting in order that we may take a formal vote on abolition and alternatives for modification of the system.

Mr. Shadoan again stated the charge of the Commission. The question of need and the impact on health care costs should be separated out from the functioning of the arbitration system.

The meeting adjourned at 9:15 p.m.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Tuesday, January 10, 1984
United States Fidelity & Guaranty Company
15th Floor, Room 7
Lombard and Charles Street
Baltimore, Maryland

MINUTES

Present	Absent
George W. Liebmann, Chairman	Honorable Jerome F. Connell, Sr.
Edward J. Muhl, Insurance Commissioner	Honorable Francis X. Kelly
Israel H. Weiner, M.D.	Honorable Joel Chasnoff
Harold A. Cohen, Ph.D.	Honorable Gene W. Counihan
Leo A. Hughes, Esquire	W. Minor Carter, Esquire
George W. Shadoan, Esquire	Grover Czech
Barry Cohen	J. John Spinella
Walter Tabler, Director, Health Claims Arbitration Office	James P. Durkan, M.D.
Doris A. Tippett, Recording Secretary	Ellen Zamoiski

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With only six of the fourteen voting members present, it was established that there was not a quorum and therefore, the meeting was adjourned at 7:00 p.m.

Chairman Liebmann has urged 100% attendance at the next meeting in order to vote and revise the draft report.

GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS
PROFESSIONAL LIABILITY INSURANCE

Tuesday, January 17, 1984
State House, Calvert Room
Annapolis, Maryland

MINUTES

Present

George W. Liebmann, Chairman
Edward J. Muhl, Insurance Commissioner
Grover E. Czech, Esquire
Israel H. Weiner, M.D.
Harold A. Cohen, Ph.D.
James P. Durkan, M.D.
Honorable Gene W. Counihan
Leo A. Hughes, Esquire
George A. Shadoan, Esquire
J. John Spinella
W. Minor Carter, Esquire
Honorable Joel Chasnoff
Doris A. Tippett, Recording Secretary

Absent

Honorable Jerome F. Connell, Sr.
Honorable Francis X. Kelly
Ellen Zamoiski

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Chairman Liebmann indicated that the purpose of tonight's meeting would be to review, vote and make necessary amendments to the draft report.

Page 1 - delete the language "a number of academic and other authorities on the subject of the Commission's work" from the third paragraph.

Mr. Shadoan stated that he would like his January 10, 1984 handout list incorporated into the final report regarding the need for tort reform in medical malpractice litigation. The Chairman pointed out that basically all of these items are incorporated in the draft report with the exception of the data regarding the burden on high risk specialties relative to income.

Page 2 - Regarding paragraph 2 in the second sentence, Mr. Shadoan objected to the term "quite modest" since it has been demonstrated that the premium increase is actually less than 1%.

In the last paragraph of page 2, strike the following language, "the results of the two studies on this point seem comparable".

Page 3 - in the first paragraph, strike the word "few" Maryland hospitals and add the word "no" in its place.

Page 4 - in the second line change Marylanders "would" to Marylanders "might".

After the sentence "Dr. Morlock's study of the 774 claims closed by the Health Claims Arbitration Office prior to January 1, 1983 indicates that 272 were dismissed without hearing and without settlement and that 102 of the 178 panel determinations were in favor of the defendant", add the language, "Some of these cases are subject to judicial appeal".

In the last sentence of the first paragraph, change the word "rogue" verdicts to "excessive" verdicts.

In the second paragraph, delete the words "so-called bedpan mutuals" leaving "including mutuals".

Pages 5 and 6 are unchanged.

At this point, it was decided to vote on the policy judgment on page 12. Item 1 - strike the language "such restriction to take the form of mandatory deduction by the court after verdict of collateral compensation other than life insurance received by the plaintiff after crediting the plaintiff with premiums paid for insurance resulting in such compensation" and substitute the language "such restriction to take the form of an evidentiary rule making evidence of collateral benefits admissible before the jury". The majority of the members opposed this amendment.

Chairman Liebmann indicated that the recommendations with respect to substantial restriction be modified to pick up the suggestion later on page 21 that the restriction be on the collateral source rule as applied to health benefits rather than a general restriction. In other words, the condition on abolition would be that the collateral source rule be eliminated as to health benefits not necessarily to disability benefits and so forth. A vote was taken to add this language from page 21 onto page 12 inserting "as to health benefits" to which the majority were in favor.

Mr. Shadoan suggested that a statement be incorporated to the effect "the Commission also finds that a viable method of modifying the collateral benefits rule would be to provide mandatory subrogation of the health benefits paid to the insurer providing those benefits".

Dr. Weiner indicated we are talking about small amounts of money in relation to health care insurance costs and a relatively small amount of money as far as medical malpractice is concerned. He stated our purpose is not to hurt the victim but to ease the strain on this system at least to some degree. He indicated if you give money to Blue Cross, you are penalizing the victim and not helping the system at all.

Mr. Shadoan stated that this assumption underlies every proposal for tort reform in connection with malpractice and that is, that if we make this reform, yes, it will reduce the benefits of the system to some plaintiffs but the result will be more tolerable insurance costs and the system will survive. A discussion regarding subrogation ensued.

A motion was raised that proposed the language in item 1 be amended to read "That abolition of the arbitration system as to cases filed after the effective date of an amendatory act be implemented if, and only if, there is substantial restriction of the collateral benefits rule as to health benefits either by an offset or by mandatory subrogation". The vote on this motion for amendment failed.

The motion was raised and passed regarding the recommendation of abolition conditioned upon impairment of the collateral benefits rule as to health benefits only. It is stated for the record that Commissioner Muhl, Messrs. Carter, Czech and Spinella opposed this amendment.

Page 7 - Mr. Spinella made a motion that the statement regarding "Even sweeping changes" be amended to state "Extensive changes of a statutory nature in the composition functioning of the arbitration system would be required to remedy its inherent defects". This motion resulted in majority opposition.

Commissioner Muhl raised his concern regarding legislation stating his preference would be to submit a report to the Governor without legislation and leave that aspect to his discretion. If he reviews the report and agrees with our recommendations, we can aid him by having legislation available to supply upon request.

Mr. Liebmann stated he has arranged a meeting with the Governor on January 26, 1984 to present our report and indicated that the Commission should not be discouraged from submitting legislation. He feels our efforts would be futile to submit a report without legislation.

Also on page 7, third paragraph, is amended to read "Nonetheless, a majority of the Commission is constrained".

Page 8 is unchanged.

Page 9 - in the second paragraph, change "rogue" verdicts to "excessive" verdicts.

Page 10, 11 and 12 are unchanged.

Page 13 - Mr. Liebmann stated that the statement regarding physicians will have to be rewritten.

Page 14 - unchanged.

Page 15 - recommendation 1 - Mr. Shadoan indicated some ideas that would improve the recommendations. Reference was made to a Virginia Statute requiring a claimant to give the physician a written notice explaining what his claim is about. The physician has 60 days after that to demand arbitration if he wants it. If there is no panel decision within six months, the claimant is permitted to exercise his common law remedies. Mr. Shadoan feels this would not be inconsistent with the recommendations made here and stated the provisions seems to be functioning well in Virginia.

Mr. Shadoan stated if we could identify the complex cases, the Commission might agree that it is not in the interest of anyone that these cases go through the arbitration process. Then if the counsel for claimant filed an affidavit stating he will produce evidence of special damages in excess of $100,000, the panel in arbitration will automatically divest itself and the case would go to court. He feels these items are important and the Commission should consider them.

Regarding recommendation 1, Mr. Spinella suggested we delete "the expiration of the statute of limitations to be tolled during the notice period". It was indicated this would shorten the statute by 60 days.

Regarding recommendation 2, Certificate of Merit, it was suggested the words "for good cause shown" be deleted and the motion failed.

Recommendations 3 and 4 remain unchanged.

At this point, Commissioner Muhl proposed the motion that we not include any legislation in bill form to the Governor with the report. Upon vote, the majority of the members favored sending the report without legislation.

Page 16 - recommendation 1 - unchanged.

Page 17 - recommendation 2 - Mr. Hughes indicated that he prefers the APA indicating that chairmen on panels do not know what the rules of evidence are and that the APA would clear up this situation. The vote on this motion failed.

Page 17 - recommendation 5 - Mr. Shadoan indicated he would like to see "and agrees not to call the maker of the report at the arbitration hearing" deleted. Why would we want to prohibit live testimony? Mr. Hughes stated the language "not going to the ultimate issue" should be deleted from recommendation 5. Language to be added to recommendation 5 is "upon good cause shown as applied to the rules of discovery".

Page 18 - recommendation 7 - Mr. Spinella stated we should expand this to provide that the director should not have ex parte communications with either parties.

Recommendation 8 - Mr. Liebmann stated he would like to add language regarding rigid deadlines.

Recommendations 9 and 10 are unchanged.

Recommendation 11 - it was suggested that there be some random selection based on jury roles utilized to select the laymember of the panel. Upon vote, the motion carried.

Page 19 - recommendation 12 - unchanged, except in the last paragraph, change the word "rogue" verdicts to "excessive" verdicts.

Page 20 - recommendation 1 - unchanged.

Recommendation 2 - put a period after the word "liability" and strike the remaining language "for punitive damage".

Page 21 - recommendations 3, 4 and 5 unchanged.

Page 23 - recommendation 1 - expand to state that the findings of the Commission on Medical Discipline be admissible as evidence in a civil proceeding including actions under the health claims arbitration act. Upon vote, the motion failed.

Recommendations 2 and 3 are unchanged.

Recommendation 4 - it was agreed to strike this recommendation.

Mr. Shadoan presented motions for consideration.

1. If counsel for claimant files an affidavit which avers special damages have exceeded $100,000, the panel of the health claims arbitration office shall automatically divest itself and the case will go to court. Upon vote the motion failed.

2. After notice of the statement of claim is filed within 60 days, the health care provider and claimant may file a request for arbitration; in the absence of that request, that case will go to court. Upon vote, the motion carried.

3. Adoption of the Virginia Statute establishing a time period within which the panel must render a decision. Upon vote, the motion failed.

4. That there be a limitation with respect to the experts before the panel that no parties be permitted to submit testimony from more than two experts in any designated specialty before the health claims arbitration panel. Upon vote, the motion carried as to limiting the number of experts to two.

A motion was raised regarding a cap on pain and suffering to $200,000 which motion failed.

At this point a vote was taken regarding the adoption of the report as amended at this meeting and the motion carried.

The draft bill Mr. Liebmann preparedwas circulated for consideration and the meeting adjourned at 11:00 p.m.

January 26, 1984

TO: All Commission Members

FROM: Doris A. Tippett, Recording Secretary

SUBJECT: January 17, 1984 Minutes of the Meeting

Please note the following correction to the above captioned Minutes as brought to my attention by Mr. J. John Spinella of Medical Mutual.

Page 5, Recommendation #1 - should read as follows:

> "Page 23 - Recommendation 1 - expand to state that the findings of the Commission on Medical Discipline be <u>inadmissible</u> as evidence in a civil proceeding including actions under the Health Claims Arbitration Act. Upon vote, the motion failed."

I regret the error and hope it has not caused any inconvenience.

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