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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

1995-96
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance, Securities and Corporate Policy...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2012)

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Josephine W. Musser
Commissioner

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MEMORANDUM

TO: State Rep. Mark Green

FROM: Peter Farrow
Executive Assistant, ext. 4-6239

DATE: April 6, 1995

RE: Questions regarding AB36

This memo is in response to the question of why the Senate reinstated the provision in AB36 to require the Patients Compensation Fund (PCF) to pay full future medical expenses to the plaintiff *until the account is exhausted or the patient dies*, rather than until the patient dies.

This change is required as part of the changes made in the Senate to preserve the fiscal integrity of the PCF. As passed by the Assembly, language determining payment of fees to the plaintiff's attorney was not clear and could have created a situation in which the PCF would pay these fees in addition to future medical expenses. This interpretation was shared by Legislative Council.

Attorney fees are paid by the plaintiff out of the award settlement. It was agreed by the authors of the bill that the intent of the bill was to preserve this practice. The Senate substitute amendment's goal was to clarify the language and structure it in a way as to:

- preserve the practice of payment of attorneys by the plaintiff,
- allow for full up front payment of attorney's fees,
- and preserve the fiscal integrity of the PCF without raising its costs.

If language had not been changed regarding the exhaustion of the future medical expense account, the PCF's costs would have increased by roughly 30% (the portion of the award covering attorney's fees).

According to the PCF's actuarial consultants, future medical expenses comprise approximately 50% of the costs of costs to the PCF. A 30% increase in future medical expenses would therefore lead to a 15% increase in total PCF costs - roughly the same amount as the savings due to a cap on noneconomic damages. In other words, without the language of paying until *the account is exhausted* or the patient dies, the net effect

of AB36 would be no gain compared to present costs. Without this savings, it can be assumed that premiums charged by the PCF to health care providers would not decrease and could be expected to increase at its current pace.

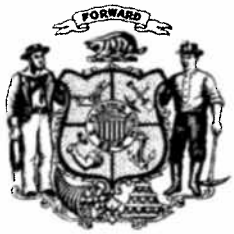
The intent of AB36 is to reduce costs to of medical malpractice awards in an effort to help bring down costs of health care. Without the provision in the the current version of AB36, there would be no net costs savings.

Return to language similar to pre-June 14, 1986

It is important to note that the provisions regarding payment of future medical expenses in the Senate version of AB36 is not new language. This language is similar to statutes governing the PCF prior to June 14, 1986. The major difference between the pre-1986 language and the proposed language in AB36 is that sec. 655.013(1)(b) capped the amount of future medical expenses that attorneys could collect fees on at $25,000.

Sec. 655.015 directected the PCF to establish an account similar to the language AB36 for awards entered into or rendered prior to June 14, 1986. This section includes language that payments shall be be made out of the, according to a process developed by rule, *"until either the amount is exhausted or the patient dies.The provision of payment."*


WISCONSIN STATE LEGISLATURE


FORWARD

ASSEMBLY BILL 36 (LRB 1913/3)

After discussions with the author and staff counsel, we reviewed the language again and consulted with our attorneys. Although the language itself does not pose the problem since the collateral source rule and those who have subrogation rights function independently, we continue to have concerns about future interpretations based on a creative application of the "made whole" doctrine.

Therefore, we would appreciate your consideration of the following two options for modifications.

1. Insert within the committee record a reference, which would be included in the comment section of the annotation to the statute, the following reference:

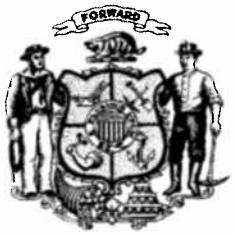
"This section (section 7) relates to the collateral source rule. It does not limit the substantive or procedural rights of persons who have claims based upon subrogation."

2. The alternative would be to amend the bill on Page 4, Section 7, line 20 through the addition of the following language:

"This section does not limit the substantive or procedural rights of persons who have claims based upon subrogation."

It is critical that the reference contained in option one appear within the annotated statutes. If there is a possibility that reference would not appear in comments section, we believe it is necessary to include the statutory language outlined in option two.

WISCONSIN STATE LEGISLATURE



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✧✧✧ LEGISLATIVE UPDATE ✧✧✧

Judith M. Pendergast, RN, JD, Executive Administrator

AB 36 Establishes a cap on non-economic damage awards for medical malpractice at $350,000. Applies to all health care providers. Passed the Assembly. Passed the Senate. Support

AB 83 Increases the penalty for conviction of the crime of battery against an emergency room worker. In the Assembly Criminal Justice and Corrections Committee. Support

AB 141 Requires trigger locks on guns purchased. In the Assembly Criminal Justice and Corrections Committee. Support

SB 1 Allows for the death penalty upon conviction for first-degree homicide of a child younger than 16 years of age. In Senate Judiciary Committee. Watch

SB 36 Requires a pharmacist or practitioner who dispenses to include the expiration date on the label. In Senate Health, Human Services and Aging Committee. Support

There are two bills I would like to highlight in this Update. The first is **AB 83** which creates a new crime of battery against an emergency department worker. The second is **AB 186** which will add the advanced practice nurse and the physician assistant to the list of providers allowed to sign disability certificates.

AB 83, introduced by **Representative Frank Urban**, makes battery against an emergency department worker a Class D felony. Currently this type of battery is only a misdemeanor. Wisconsin law has created the Class D felony battery for law enforcement officers, fire fighters, and parole and probation officers. Emergency department workers should also have this increased protection. The Wisconsin Nurses Association has expressed its strong support of this bill.

The rate of violence in our society is escalating. Unfortunately, violence is viewed by some as a quick solution to every day stresses. Emergency departments are also seeing an increase in violence. Some of the factors for this have been described as: long waiting lines, high stress illnesses, ready availability to drugs and hostages, and twenty-four hour a day open door policy.

The extent of violent behavior in the emergency room is published in a 1988 survey of 127 U.S. teaching hospital emergency department medical directors. The return rate of this survey was 75% indicating the importance placed on this issue. The findings include:

- 32% reported at least one verbal threat each day.
- 18% reported that weapons were displayed as threats to the staff at least once each month.
- 57% reported at least one threat of violence with a weapon against a staff person.
- Two respondents reported the taking of hostages at knifepoint.
- 43% reported the frequency of attacks on a staff member as once or more each month.
- 80% reported an injury to staff in the preceding 5 years, and
- 7% reported that an attack resulted in death in the preceding years.

Source: Lavoie, F., Carter, G., Kanzl, D., Berg, R., "Emergency Department Violence in United States Teaching Hospitals", *Annals of Emergency Medicine*, 17 911 0, 1227-1233.

This study clearly shows that the threat of violence and the actual violent behavior is a reality for the emergency department workers, many of whom are registered nurses.

At a recent Assembly Criminal Justice and Corrections Committee hearing, testimony was given by nurses who work in emergency departments and who have experienced violence first hand.


FORWARD
E PLURIBUS UNUM

SENATE SUBSTITUTE AMENDMENT TO ASSEMBLY BILL 36

MEDICAL MALPRACTICE REFORM

There are a number of differences between Senate Substitute Amendment 1 to Assembly Bill 36 (the "Senate Bill") and Engrossed 1995 Assembly Bill 36 (the "Assembly Bill"), both relating to medical malpractice reform.

Interest-Bearing Account

The Senate Bill creates a separate, interest-bearing account for each claimant. The Office of the Commissioner of Insurance would track how much interest earned by the Patients Compensation Fund is attributable to future medical expense payments held by the fund. A proportionate amount of this interest would be credited to each claimant's account. The Assembly Bill does not create such an account.

Future Medical Expenses

Both bills discuss awards for future medical expense payments. Under the Assembly Bill, that portion of future medical expense payments in excess of $100,000 is paid into the Patients Compensation Fund, after deducting collection costs. Under the Senate Bill, that portion of future medical expense payments in excess of $100,000, plus an amount sufficient to pay collection costs including attorney fees, is paid into the Patient Compensation Fund. While the language is somewhat different, according to Gordon Anderson of the Legislative Council Staff, the only difference is that the Senate Bill clarifies that attorney fees are included in the calculation of costs of collection.

Under the Senate Bill, future medical expense payments will be made until the amount in the person's account is exhausted or the person dies. Under the Assembly Bill, future medical expense payments will be made until the person's death, even if the person's account is exhausted.

On Wednesday, March 8, 1995, the Wisconsin State Senate took up AB 36. The Senate passed Senate Substitute Amendment 1 to Assembly Bill 36, as amended, on a vote of 18-14 (Senator Andrea voting with the Republicans).

CONTACT: R. J. Pirlot, ARC

Periodic Payments

Both bills discuss fund payout provisions for awards in excess of $1,000,000. Under the Senate Bill, the fund is to pay to the patient, after deducting collection costs including attorney fees, the full medical expenses each year, plus an amount not to exceed $500,000 per year. This will pay the remaining liability over the person's anticipated lifetime or until the remaining liability is paid in full. Under the Assembly Bill, no provision is made to deduct attorney fees.

Under the Senate Bill, if the remaining liability is not paid before the person dies, the fund is to pay the remaining liability in a lump sum. While the Senate Bill does not specify to whom this lump sum is to be paid, presumably it is to be paid to the person's estate. Under the Assembly Bill, no provision is made to pay the remaining liability in a lump sum if the person dies and periodic payments are to be continued until the amount is paid in full.

The Senate Bill clearly provides that the provision relating to periodic payments of awards in excess of $1,000,000 applies only to settlements or judgments relating to acts or omissions that occur on or after the effective date of the bill. The Assembly Bill contains language that suggests that it attempts to achieve the same effect as the Senate Bill; in actuality, however, it does not have the desired effect.

Contributory Negligence

The Senate Bill provides that damages recoverable for medical malpractice are subject to the provisions of § 895.045, Stats. This statute describes how damages are assessed against multiple defendants, when punitive damages may be assessed, and when a plaintiff may recover in certain situations. In general, Wisconsin currently follows a rule under which a person may collect the total damages from any one of the persons causing an injury. Under the Senate Bill, if Wisconsin were to modify this rule, such changes would clearly apply to medical malpractice action. The Assembly Bill does not contain such language.

Collateral Source Provisions

The Senate adopted an amendment to SSA 1 to AB 36 (Huelsman). This provides that in a lawsuit to recover damages for medical malpractice, proof of compensation for injuries received from any source other than the defendant can be used as evidence. Such language would work to prevent an injured person from recovering more than once for the same injury. The Assembly Bill does not contain such language. This amendment was adopted by voice vote.


FORWARD
E PLURIBUS UNUM

Overdoses of Cancer Drug Revealed by Patient's Death

By LAWRENCE K. ALTMAN

Two patients receiving experimental treatment for advanced breast cancer at one of the country's most prestigious cancer hospitals were given massive overdoses of chemotherapy drugs. One patient died, and the other suffered permanent heart damage.

The incidents occurred at Dana-Farber Cancer Institute in Boston, a Harvard teaching hospital, late last month. Officials at the hospital said they were at a loss to explain how such a serious medical error, which apparently resulted from a doctor's mistaken order last November, escaped attention until a clerk picked it up in a routine review of data last month.

The patient who died was Betsy A. Lehman, an award-winning health columnist for the Boston Globe. The news of the mishap, detailed today in an article published in the Globe, is all the more unsettling because Ms. Lehman, as a health reporter, was presumably knowledgeable about her treatment and would have chosen her hospital with care. Ms. Lehman, who was 39, died on Dec. 3 at the hospital.

Doctors apparently refused to heed her warnings that something was drastically wrong and ignored the results of tests indicating heart damage. Her death came as she was preparing to go home to her two daughters, ages 7 and 3, and her husband, Robert Distel, a scientist who works at Dana-Farber. A pathologist who did an autopsy did not spot the overdose. He also found no visible signs of cancer in her body.

Betsy Lehman

The other patient was a 52-year-old woman who is seriously and chronically debilitated from irreversible heart damage, Dana-Farber officials said. She is now being treated at Beth Israel Hospital in Boston. Her name was not released for reasons of patient confidentiality.

Dr. David M. Livingston, physician-in-chief at Dana-Farber, said his institution "profoundly regretted what has occurred, assumes full responsibility for these tragic events and has taken additional precautions to ensure that they do not happen again."

"It's an extremely sad time here," Dr. Livingston said in an interview.

The overdoses occurred two days apart. Both patients were cared for by the same medical team. Two doctors involved in their care have been suspended from clinical care and are now working full-time in administration pending completion of an independent investigation. The names of the doctors were not released and their patients have been reassigned to other staff members.

Both patients were being treated with an experimental procedure known as autologous stem-cell transplant, a variation on a bone marrow transplant. The therapy involves removing stem cells from the blood instead of the marrow, and holding them in reserve until treatment with high doses of chemotherapy have ideally killed all the cancer cells in the body. Then the stem cells, which form new blood cells, are reinjected to repopulate the blood and replenish the immune system.

Each patient received large amounts of the chemotherapeutic drug cyclophosphamide, or Cytoxan. The amount was supposed to be calculated according to the amount of the patient's body surface. For Ms. Lehman, the correct dosage would have been 1,630 milligrams each day for four consecutive days. Instead she received 6,520 milligrams a day, four times the lethal dose. The other woman received a similarly miscalculated dosage. Each woman also received four times the standard amount of another marketed drug, Mesna, which is used to counter the adverse irritating effects of Cytoxan on the bladder.

According to the Globe, the error was detected only as part of a routine data check performed when a protocol, or blueprint for treatment, is considered experimental.

Associated Press

The Dana-Farber Cancer Institute's physician-in-chief, Dr. David M. Livingston, answering questions yesterday at a news conference about the death of a patient because of a chemotherapy overdose. Dr. Livingston said the institute accepted full responsibility for the error.

The original medication order was filled out by a physician who is believed to have been working as a research fellow, the Globe reported, and "who apparently misinterpreted the study protocol." At least five other doctors and nurses countersigned the order including the leader of the team, Dr. Lois J. Ayash. "It was a blunder compounded or overlooked by at least a dozen physicians, nurses and pharmacists, including some of the institution's senior staff," the Globe said. Dana-Farber said the article in the Globe was fair.

The overdoses were repeatedly documented in Ms. Lehman's hospital record.

The experimental protocol involved only Dana-Farber and not other hospitals. The experimental plan was not under the supervision of the Food and Drug Administration, Dr. Livingston said.

Dana-Farber has 57 licensed beds, is one of 20 Federally designated regional cancer centers and is a recipient of $35 million in Federal funding and $25 million in charitable contributions annually. It was founded in 1947. Dr. Livingston said that "in the recorded history of the institution, we can't find any evidence of an overdose induced death."

Despite Dana-Farber's high reputation, it has a troubled past. The hospital often has been criticized by doctors elsewhere for aggressively marketing its scientific expertise.

When Paul E. Tsongas, the former Senator from Massachusetts, ran for President in 1992, two of his doctors at Dana-Farber repeatedly said Mr. Tsongas had been cancer-free since undergoing a bone marrow transplant in 1986 for a lymphoma, a cancer of the lymph system. But in 1987 Dana-Farber doctors found evidence of the disease in a lymph node in Mr. Tsongas's armpit. Mr. Tsongas, who is a trustee of Dana-Farber, suffered a relapse in late 1992.

After Mr. Tsongas said he had erred in not providing full disclosure, Dr. Livingston said that he and Dana-Farber "made a bevy of mistakes" in connection with the way the candidate's health was described by his doctors. A review of the episode led to a new policy of disclosure from the hospital about the illness of patients who are public figures.

Dana-Farber has investigated five allegations of scientific misconduct by its scientists over the last five years. Two cases were dismissed in the inquiry phase, a spokeswoman for the hospital, Gina Vild, said. One researcher, whose name was not released because Federal officials have not completed its investigation, fabricated laboratory work and was fired. Another scientist, Dr. Mark Kowalski, plagiarized. A fifth scientist is currently under investigation for falsification of data, Ms. Vild said.

Both the Board of Registration in Medicine, which issues medical licenses in Massachusetts, and the Division of Registry, which issues licenses to nurses and pharmacists, are launching investigations into allegations of malpractice at the hospital, said Terry Ann Knopf, spokeswoman for the Office of Consumer Affairs.

"The Board of Registration in Medicine will initiate an investigation concerning the double tragedy," Ms. Knopf said. "The investigation will focus both on the hospital's systemic safeguards — what safeguards are supposed to be in place it and if those safeguards were indeed in place — and also take a look at the question of physician competence."

Ms. Knopf said the agencies first learned of the two deaths at Dana-Farber from yesterday's report in The Boston Globe.

Dr. Livingston said that Dana-Farber has begun an internal investigation of the circumstances surrounding the overdoses and has appointed Dr. Vincent T. DeVita, a former director of the National Cancer Institute, a Federal agency in Bethesda, Md., who is now in charge of the cancer center at Yale, to head a panel of outside experts to review the overdose problem at Dana-Farber.

Dana-Farber has also installed a new computer program similar to those in use elsewhere to signal pharmacists when a doctor orders an unusually large amount of a drug.

Dr. Livingston said that the existing system has built-in checks and balances.

"Why it didn't work is what I want our investigators to tell me," Dr. Livingston said. "I am deeply troubled by that."

Another internal group is auditing the records of all patients in the experimental therapeutic program. A report of the audit is to be sent to the National Cancer Institute, which paid for the research with taxpayer money.

Within 24 hours of learning of the overdose, Dr. Livingston, doctors involved in the care of the two patients, and other staff members directly informed both families.

"Those two meetings, which took place within hours of each other, were the two saddest individual occurrences I remember. I looked into their eyes and all I could see was abject grief and misery. It was the kind of misery that was penetrating."

The Capital Times

MADISON, WISCONSIN HOME FINAL FRIDAY, MARCH 24, 1995

Noted hospital reeling after fatal mistake

By Jon Marcus

Associated Press

BOSTON — When an award-winning health columnist for one of the biggest newspapers in the country got breast cancer, she went to one of the best hospitals in the world.

The Boston Globe's Betsy Lehman, of all people, wound up dead because of a huge mistake at the Dana-Farber Cancer Institute, of all places.

"If this can happen at a place like Dana-Farber . . . what is happening in other places?" asked Dr. O. Michael Colvin, incoming director of the Duke University Comprehensive Cancer Center.

The fatal mistake, disclosed Thursday by the Globe, was the latest in a series of blatant medical errors that have hurt the reputation of some of America's best hospitals and alarmed patients.

Lehman's heart failed after she was given four times the maximum safe dosage of a highly toxic drug during chemotherapy. She was nearing the end of three months of treatment.

At least a dozen doctors, nurses and pharmacists overlooked the error for four days while Lehman continued to receive an overdose of cyclophosphamide, and a four-fold overdose of another drug meant to shield her from side effects.

"She was dealing with horrendous symptoms," Lehman's husband, Robert Distel, a scientist at Dana-Farber, told the Globe. "I guess it was called mucositis. The whole lining of her gut from one end to the other was shedding. She was vomiting sheets of tissue. They said this was the worst they'd ever seen. But the doctors said this was all normal."

Lehman, a 39-year-old mother of two, died Dec. 3. An autopsy found no visible signs of cancer in her body, indicating that the treatment had worked, the Globe reported.

The mistake wasn't discovered until Feb. 13, after clerks went through records.

Just two days before Lehman's death, a 52-year-old woman was a victim of the same mistake. She was rushed into intensive care with serious heart damage and remains hospitalized.

The cancer research and treatment center said human error was the only explanation.

"We accept absolutely full responsibility for these tragedies," Dana-Farber physician-in-chief Dr. David M. Livingston said Thursday. "Every doctor here is humbled by this. Every doctor feels the sense and the gravity of these tragedies."

The 48-year-old hospital, which treats 9,000 people a year, is negotiating a settlement with Lehman's family.

Lehman joined the Globe in 1982 and began her "Health Sense" column in 1986. She wrote about new treatments and other scientific developments, doctors' attitudes toward patients and patients' fears of hospitals.

She wrote about breast cancer but not her own illness.

In a letter she wrote to a colleague in May, Lehman complained that a doctor at Dana-Farber was "cold and rotten" to her, the Globe said.

Two doctors involved in Lehman's case have been assigned to desk jobs until two investigations are completed.

Three pharmacists were suspended briefly and have been banned from dispensing the kind of drugs used in the Lehman case. A computer has been installed to prevent the administration of high doses without review by an expert doctor, nurse and pharmacist.

"Maybe everybody (on the medical team) was assuming that someone else had everything under control," said Sharon Batt, author of "Patient No More" and a former cancer patient who was treated with cyclophosphamide.

About 40,000 people each year come to Massachusetts to be treated in its hospitals, according to the Massachusetts Hospital Association.

Lehman was a three-time winner of the top journalism award from the Massachusetts chapter of the American Cancer Society, which will present her posthumously with its first-ever lifetime achievement award on April 5.

In other recent medical mistakes, a surgeon at a Tampa, Fla., hospital on Feb. 20 amputated the healthy leg of a 51-year-old diabetic instead of the diseased one. At the same hospital on March 3, a 77-year-old man died after a technician mistakenly disconnected him from a breathing machine.

At a hospital in Grand Rapids, Mich., a surgeon performing a mastectomy on a cancer patient last month removed the wrong breast, WZZM-TV has reported.

The Capital Times The Weekend of March 11-12

Which Body Part is the RIGHT one?

By Mike Wilson
St. Petersburg Times

A 51-year-old diabetic checks into the hospital to have his right leg amputated and wakes to find that the right leg is all he has left.

Nearly two weeks after the worst day of Willie King's life, people everywhere are asking:

How could such a thing happen? How could a doctor cut off the wrong body part?

Answer: easily.

How could a doctor cut off the wrong body part? Answer: Easily.

Though hospitals, doctors and nurses generally take great care to avoid mistakes, health care professionals — and the lawyers who sue them — say there are still plenty of ways for surgery to go wrong.

"I'm sure that every hospital in America has had a case where they prepped the wrong something, and surgery commenced," said George Lanza, a Dade County malpractice lawyer.

So what could go wrong? Well, the doctor's office could give wrong information to the hospital's scheduling person. The scheduling person could hear "left kidney" and write "right kidney" instead. A doped-up patient, asked which finger needs the operation, could point to the wrong one.

Financial pressures caused by changes in the insurance industry also could cause problems. A surgeon hustling from patient to patient because he needs volume to make money could get careless.

Continued on Page 8A

Body Part

■ Continued from Page 1A

University Community Hospital says Dr. Rolando Sanchez amputated King's better leg just below the knee because of "the breakdown of a system." But of course the system is made of people — doctors and nurses who, like the patients splayed out before them, are human.

"There are so many things you have to think about as a surgeon," said Dr. Roberto Moya of Hialeah, Fla., an orthopedic surgeon who was fined by the state of Florida last year for operating on a wrong knee.

"You have all the responsibility. A pilot has a co-pilot. A surgeon doesn't have a co-surgeon."

There is no telling how often doctors perform surgery on the wrong body part. Though virtually every case becomes a lawsuit, few go to trial because most doctors and hospitals would rather pay a big settlement than face the wrath of a jury.

Still, it is clear that King is not alone in his anguish. You know what they say about misery:

■ A Rhode Island woman needed exploratory surgery on her left foot. She was wheeled to the operating room on her back. The doctor prepared to operate on the correct foot — the one to his right. Then he asked the staff to flip the anesthetized patient onto her stomach — and forgot that the correct foot was now to his left.

"He foolishly operated on the spot on the table where her foot had been, instead of operating on the foot," said Mark Mandell, the woman's lawyer.

A jury awarded her $2.8 million, which the judge reduced to $800,000.

■ A man in Atlanta went in for a cornea transplant, but the doctor operated on the wrong eye. Realizing his mistake, the doctor fixed the other eye — then billed the patient for both operations. The patient went blind from glaucoma that he said he developed as a result of the surgeries. He settled for $4.2 million.

■ A high school soccer player in Arizona sued his doctor for operating on his right knee when it was the left knee that was injured. The doctor admitted operating on the wrong knee, but said the procedure improved its condition — a common defense in wrong-site surgery cases. The jury awarded the patient $400,000.

■ A 53-year-old woman went to Putnam Community Hospital in Palatka, Fla., to have two screws removed from her left ankle. According to a complaint filed by the state Board of Medicine, "Patient's right (incorrect) ankle was prepared for surgery." The doctor made an incision but could not find the screws. He checked the patient's records, realized the error, then performed surgery on the other ankle.

The doctor, who did not admit fault, paid a $1,250 fine.

■ In Dade County (Miami), Fla., a high school track athlete tore a ligament in her left knee during the long jump. A surgical resident mistakenly placed a tourniquet on the right knee and the doctor began to operate. Halfway through, the surgeon realized his error, closed the right knee and repaired the left. The hobbled athlete got $212,500 from a jury.

"Somebody went, 'Eeny, meeny, miny, moe,' and picked the wrong moe," said the long jumper's lawyer, Ronald B. Gilbert.

To understand how the wrong leg, kidney or ovary gets removed, you must first know how patients get to the operating room. Insurance companies have strict guidelines for just about everything, so most doctors and hospitals do things essentially the same way.

When patients agree to surgery, doctors generally have them sign a form consenting to the operation. A doctor or staff member might write the wrong body part on the form. The patient may not catch it because many do not read the documents they sign.

Then the doctor's staff calls the hospital and schedules the surgery. If the information is already wrong, the patient could be in for trouble. If not, the scheduling person still could get it wrong.

Let's say the patient arrives at the hospital on the day of the operation — a common practice now because of insurance limitations. The nurses already know what kind of operation is planned because they will have read the Operating Room schedule — which, again, may be wrong.

Of course, the nurses have ways to double-check. They can read the patient's chart. They can read the consent form that the patient signs upon entering the hospital. And they can talk to the patient. Most hospitals train their nurses to avoid surgical mistakes by asking patients, "Which foot" — or whatever — "are we operating on today?"

"That's basic. You just do that all along," said Charlene Long, an assistant professor of nursing at the University of South Florida.

The moment of truth arrives when the patient is prepped for surgery. Often, he or she has been sedated or anesthetized and therefore can't point out the sick body part. Sometimes nurses can easily tell which part needs surgery — if the patient is in for bunion surgery on one foot, you prep the foot with the bunion on it.

But sometimes they can't tell. In those cases, nurses can refer to the Operating Room schedule and the consent forms. Virtually all of them do so. But some don't.

Then the doctor comes in. Many doctors say they would like to be present while their patients are prepped for surgery. But they say they don't have time. Besides, many hospitals are so busy that they insist on readying patients before the doctor arrives. Many doctors end up just picking up the scalpel and starting to cut.

"The doctor is just going to assume that the right part has been prepped," said Dr. Brad Castellano, a podiatrist in Fort Myers.

Castellano said he makes it a point to visit patients before surgery. (He recommends that patients demand to see their doctors before the operation.) He always directs the nurses to use a felt-tip pen to write "NO" on the foot or leg that is healthy. University Community Hospital has adopted that practice since the King incident.

Moya, the Hialeah orthopedic surgeon, also does that. He learned the hard way.

On Sept. 16, 1991, a woman came in for an arthroscopic examination of her left knee. After she was sedated, the staff mistakenly prepared the right knee. Moya made three small incisions so he could insert the arthoscope. Then he realized the error and called off the operation.

The patient sued. Moya paid her $10,000 to settle. He said he also paid $15,000 in fines and legal fees.

Moya said the incident happened partly because the surgery center did not have clear guidelines for its operating room staff.

He also blamed himself for not checking the patient's consent form before he started cutting.

Moya said doctors everywhere are under pressure because insurance companies generally are paying smaller fees than they used to.

"That means we have to see more patients and do more surgeries in order to maintain our standard of income," he said. As a result, some doctors hurry from patient to patient, he said. When they hurry, they make mistakes.

There are other kinds of money pressures. Many doctors are joining insurance capitation plans, which pay them a fixed fee every month to care for a certain number of people. The fewer patients the doctors see, and the less money they spend treating them, the more money they keep.

As a result, some doctors may be tempted to spend less time with "capitated" patients than they do with other people.

Perhaps the most serious problem, doctors say, is that people trust them too much. Castellano, the Fort Myers surgeon, tells of a doctor who mistakenly told the lab to take X-rays of a patient's healthy foot instead of the injured one.

The patient, sheep-like, allowed the technician to X-ray the good foot.

Said Castellano: "She just figured the doctor must be right."

Wrong Lung Taken; $9 Million Accord

NYT 4-3 45 C11

DALLAS, April 2 (Reuters) — The family of a Texas man, who died of cancer after a surgeon removed his healthy right lung and left a tumor in his left one, settled a suit with the hospital for about $9 million.

The Fort Worth Star-Telegram said on Saturday that the hospital, Osteopathic Medical Center of Texas, admitted no wrongdoing in the case but said it settled the family's wrongful-death lawsuit on Friday to avoid the uncertainties of a trial.

In October, a group of seven doctors paid the Jones family $5.5 million in the case, and the surgeon, Robert McFaul, admitted in a signed statement that he had negligently removed the wrong lung, the newspaper said.

The man, Benjamin Jones, a 62-year-old machinist, died in February 1994, nearly three years after his surgery in July 1991, the newspaper said.

The New York Times

THURSDAY, MARCH 16, 1995

A Mistake, a Rare Prosecution, And a Doctor Is Headed for Jail

By ADAM NOSSITER

The elderly nursing home patient was suffering from total kidney failure. She was blind and she could not speak. On the afternoon of May 18, 1990, Dr. Gerald Einaugler mistook a dialysis catheter in her abdomen for a feeding tube, and ordered feeding solution pumped through it.

Six days later, Alida Lamour, 78, was dead, and Dr. Einaugler, a Brooklyn internist, was in trouble. But this was not ordinary doctor trouble; he faced criminal prosecution, not civil suit.

In July 1993, the doctor was convicted of two misdemeanors — reckless endangerment and willful violation of the health laws — and sentenced to 52 weekends at Rikers Island. And so the American Medical Association, the Medical Society of the State of New York and two other doctors' groups have taken up an impassioned defense of Dr. Einaugler, with the claims that he is being subjected to unprecedented and unwarranted persecution.

Physicians' groups contend that the criminal prosecution of Dr. Einaugler represents a threatening departure from the established way in which society deals with doctors who make mistakes. They assert that criminal charges have wrongly replaced civil sanctions in Dr. Einaugler's case.

The doctor's appeals were turned down, and yesterday, on his 51st birthday, he was ordered to report to Rikers starting the weekend of March 25. Before Dr. Einaugler was handcuffed and led away for fingerprinting, he said that the conviction had devastated him.

"It has financially destroyed me," he said. "It has emotionally and physically destroyed my wife and

Continued on Page B8, Column 2

Chester Higgins Jr./The New York Times

Dr. Gerald Einaugler

A Mistake, a Rare Prosecution, and a Doctor Will Spend 52 Weekends in Jail

Continued From Page A1

children."

The medical groups claim that Dr. Einaugler's case will "irreparably chill" the practice of medicine. A doctor's medical judgment has never before been subject to criminal prosecution in New York, they say. And prosecutions like this are "extraordinarily uncommon" anywhere in the nation, according to the A.M.A.'s general counsel, Kirk Johnson.

"He made a clinical judgment," said the A.M.A.'s executive vice-president, Dr. James S. Todd. "He used his best judgment as to what to do. Our concern is that mistakes of judgment should not be liable to criminal prosecution. Traditionally, errors in judgment are handled through peer review and malpractice. Society has been poorly served by this decision."

Mr. Todd said the A.M.A. had been "inundated" with letters from doctors "frightened out of their wits" by the case, which he called "seminal" because of its potential for making physicians fear criminal prosecution for medical decisions.

Deputy Attorney General Edward J. Kuriansky, however, has said the prosecution of Dr. Einaugler has nothing to with punishing him for bad judgment. Rather, the case is about the doctor's "willful failure" to give his ailing patient good care by transferring her to a hospital as soon as the mistake with the catheter was discovered, the prosecutor said in court papers. The case was referred to Mr. Kuriansky, a special prosecutor for Medicaid fraud control with jurisdiction over nursing homes, by investigators for the state Health Department. Ms. Lamour had no living relatives.

While the case does not appear to be widely known outside medical circles, several experts on law and medicine said that criminal charges against doctors, which are rare, usually depend on strong evidence of deliberate intent to harm a patient. The state cited only two previous cases, a 1976 abortion case and an 1881 child neglect case, to answer defense contentions that the prosecution is unprecedented.

"The question is, what kind of punishment do you give to physicans who screw up royally?" asked Dr. Lee Goldsmith, a local doctor and lawyer familiar with the case. "The question is really, we are talking about a policy decision for a society to make. It was not intentional. Each and every one of us screws up. How many times are we going to be allowed to be screw up? Did he intentially do this so she would die? Let's differentiate between intentional acts and negligent acts."

Nobody disputes that Dr. Einaugler made a dreadful error that May afternoon in the Jewish Hospital and Medical Center of Brooklyn nursing home when he failed to recognize the dialysis tube implanted in Ms. Lamour, who was undergoing dialysisfor her condition. However, the doctor was not prosecuted for this mistake, but for what happened after the error was discovered.

Nurses following Dr. Einaugler's instruction that weekend had difficulty feeding Ms. Lamour through the dialysis tube and fiddled with the tube to make it work, according to the doctor's court documents. They continued to use the wrong tube to pump about two quarts of solution into her abdomen, according to testimony at the trial. The nurses were given immunity from prosecution even though some of them subsequently destroyed notes from Ms. Lamour's chart, apparently in an effort to conceal their role, according to the defense.

Physicians' groups see a chill on the practice of medicine.

Early Sunday morning, a nursing supervisor called Dr. Einaugler to tell him of the mistake. Before going to the home, he called Dr. Irving Dunn, head of the dialysis unit of Interfaith Medical Center, who had been treating Ms. Lamour. What happened between them is critical to the state's case against Dr. Einaugler.

Prosecutors said Dr. Einaugler was told by the specialist to get Ms. Lamour to a hospital "promptly" and "with dispatch," so she could be treated for peritonitis, or infection of the peritoneum, the membrane lining the abdomen, according to court documents. But he left the nursing home without doing so — because, the state asserts, he wanted to cover up his original mistake. The state contends that Dr. Einaugler wanted to downplay the severity of his initial mistake and so did not immediately seek to transfer Ms. Lamour to a hospital.

Dr. Einaugler says he returned twice to the nursing home to check up on Ms. Lamour. Prosecutors said the doctor has no record of his second visit. The defense said she appeared to be in stable condition, with no signs of distress. But late in the afternoon, around 4 P.M., a nurse called to tell the doctor she was weakening. At the trial, a prosecution expert testified that the delay had exposed Ms. Lamour to "numerous and substantial risks." She was taken to the hospital at about 5 P.M., where she was diagnosed with peritonitis and given dialysisthe next day. She died four days later.

No autopsy was done. At Dr. Einaugler's trial in 1993, the prosecution put on the witness stand a city medical examiner who testified that Ms. Lamour died of peritonitis, even though no autopsy had been performed. That testimony was "devastating" to the doctor, his lawyers charged, inflaming the jury against him though he had not been charged with causing her death.

Dr. Michael Baden, former Chief Medical Examiner of the City of New York, testified for the defense that he did not think Ms. Lamour died of peritonitis, and that it was wrong to offer a definitive opinion without an autopsy.

A hearing committee of the State Board for Professional Medical Conduct concluded that waiting to put Ms. Lamour in the hospital until late that afternoon was "untimely," and that she should have been transferred "as soon as the mistake was discovered." A majority thought this "was not a close judgment call," especially given "the enormity of the anatomical insult to her;" it was a "clear and obvious one."

Still, the medical committee declined to penalize Dr. Einaugler, or take his license away, ultimately finding that the doctor's "wrong decision" was not a "flagrant or dramatic departure from standards" because he had consulted with Dr. Dunn, and visited Ms. Lamour.

Mr. Kuriansky, the prosecutor, declined to comment.

Dr. Einaugler's defenders were not nearly so circumspect. "This is an absolute outrage," said Dr. Morton Kurtz, immediate past president of the state medical society. "It's just horrendous to me."

Why protect doctors?

Sometimes it takes large punitive awards to make doctors more responsible for their actions

COUNTERPOINTS
By Susan Estrich

LOS ANGELES — "Living in terror at the thought of a $100 million lawsuit is something that leaves its mark on everyone," says the spokesman for freshman Rep. Jon Christensen, R-Neb., explaining his strong support for limiting medical malpractice suits.

Growing up without your mother also leaves its mark. Betsy Lehman left two young daughters when she was killed by the incompetence of her caregivers at the acclaimed Dana-Farber Cancer Institute. She was receiving treatment for breast cancer. She was as informed as any patient could be — an award-winning writer for *The Boston Globe* who specialized in medical and health issues. Her husband is a scientist employed by Dana-Farber. If anyone could protect themselves, they could. But they couldn't.

Lehman was given four times the correct dosage of a powerful anti-cancer drug. Each day, five people signed off separately on the treatment.

When she became violently ill, vomiting sheets of tissue, her husband questioned her doctors. They dismissed his concern. When her blood and electrocardiogram tests turned abnormal, the results were written off as side effects of treatment. When another woman, undergoing the same treatment and similarly overdosed, was rushed into intensive care with permanent heart damage, no one made any connection or checked the records.

In 1993, the Massachusetts medical board officially warned hospitals of the danger of overdoses of chemotherapy and recommended a three-part checking system to guard against errors. Somehow, it didn't work in Lehman's case.

Had it not been for a clerk entering numbers in a computer for a report three months later, the mistakes that killed Lehman and permanently crippled another woman never would have come to light.

Last month, with freshmen Republicans leading the way, the House enacted historic legislation that would make it more difficult for those injured by medical malpractice to bring suit, and would limit recoveries for pain and suffering and for punitive damages. Its supporters say the legislation is aimed at frivolous lawsuits. It also is aimed at families like Lehman's.

By Cliff Vancura, USA TODAY

The hypocrisy of the House approach is transparent. These are the freshmen who want to block any new federal regulation on the environment and leave school lunches to the states. But their commitment to deregulation and states' rights goes only so far. Under the House bill, suits for tort injuries and medical malpractice, long the province of the states, would be governed by new federal rules. Punitive damages would be limited by economic loss, an invitation to defense claims that the loss was minimal since the plaintiff might have died anyway. This isn't about federalism; it's a question of who has friends in high places.

"I would hate to see an isolated incident be translated into an indictment of clinical research," says Dr. David Livingston, the physician in chief at Dana-Farber.

No one is indicting clinical research. It's gross negligence that's at issue. I don't think the doctors and nurses and pharmacists at Dana-Farber are worse than those at other institutions. They may well be better. That's what worries me.

In just the last month, we've heard of surgeons amputating the wrong leg of a man, and a technician mistakenly disconnecting a patient's breathing machine in the same Florida hospital. Then there's the woman in Michigan who had the wrong breast amputated. And these are just the cases that are newsmakers.

Medical malpractice claims aren't responsible for driving up the cost of health care. Malpractice premiums add up to less than 1% of what we spend for health care. They aren't responsible for clogging the courts. In 1992, 7% of all tort claims involved professional negligence of any sort.

It's true that large awards can be a windfall to an injured party and a boon to plaintiffs' lawyers. But sometimes it takes a large award, or the prospect of one, to force change. That's what deterrence is all about. It's why, for all the caricatures, good lawyers help save lives. If punitive damages are responsible for making institutions more careful, for forcing them to program their computers to set off alarms when someone orders an overdose of dangerous medicine, then I'm all for them.

I hope Betsy Lehman's family has a very good lawyer. For all our sakes.

EDITORIAL SECTION

The Capital Times ■ Thursday, March 16, 1995

JOHN NICHOLS

Malpractice cap adds insult to injury


Nichols

Karin Smith died just in time to avoid seeing her elected representatives shame themselves.

A victim of medical mismanagement, as she preferred to call herself, Smith was one of Wisconsin's most passionate foes of so-called "tort reform." While special interest groups argued for severe curtailment of the ability of citizens to hold incompetent doctors and profit-first health maintenance organizations responsible for the harm they do, she held out for the view that ordinary people have a right to demand quality medical care.

Smith was not just "an interested observer." She lived the reality of the medical malpractice debate.

In 1988, Smith was a 22-year-old member of a Milwaukee HMO, from which she sought care after experiencing minor vaginal bleeding. Between June of 1988 and May of 1991, during which time the bleeding became so profuse that she began to pass out, the accountant from Nashotah made roughly 20 calls to doctors associated with her HMO. At her request, she had three Pap smears and three biopsies performed.

In a moving recollection of her experiences in what some call "the finest health care system in the world," Smith wrote, "Unfortunately, my cries for help were not heard, and all of my laboratory tests, with the exception of one Pap smear, were misread. When I left (the HMO) in May of 1991 and sought the opinion of a gynecologist outside the plan, my diagnosis was made within two weeks."

What all of the other so-called medical specialists had missed was the fact that Smith was suffering from cervical cancer — generally one of the most treatable of all cancers.

Had Smith been diagnosed when she first went to her HMO doctor in 1988, her chances of living a normal lifespan would have been 95 to 97 percent. Because of the three years of bumbling, those chances fell to around 10 percent. She underwent radical surgeries, at least three courses of radiation and a six-month course of chemotherapy.

As she was struggling for her life, Smith's HMO continued to nickel-and-dime her, refusing at one point to pay for a wig after radiation treatments caused her hair to fall out.

Faced with a prospect of a lifetime of pain and suffering, Smith was aghast when she learned that some legislators — who had accepted contributions from medical special interest groups — were seeking to limit the ability of victims to sue HMOs and doctors for the sort of egregious mistreatment she received.

She became an activist, arguing that attempts to place minuscule caps on pain and suffering awards in medical malpractice suits would do little or nothing to lower medical costs, and would make the lives of victims like herself more miserable.

In an opinion piece she wrote two years ago, Smith explained, "It is a common perception that tort reform is strictly a battle between doctors and attorneys. What is painfully ignored is that victims are in the middle of this war. This is ironic because these are the very people whom the tort system was designed to protect."

When the state Senate began to debate "tort reform" proposals, Smith did everything in her power to convince legislators that a proposal to place a $350,000 cap on pain-and-suffering awards was a bad idea. She had plenty of evidence — malpractice insurance premiums account for 1 percent of health care expenditures in this country, and the Congressional Budget Office says changing the medical liability system would have virtually no effect on total health spending.

No serious observer saw the $350,000 cap as a good idea. Even Gov. Tommy Thompson — no friend of malpractice victims — had, in two successive budgets, recommended a $1 million cap.

But on Wednesday, March 8, the Wisconsin Senate approved the $350,000 cap. The fight was between the Karin Smiths of the world and the special interests, and by an 18-14 margin the legislators chose the special interests.

It was not the only fight Karin Smith would lose that day. Early Wednesday, as the senators were preparing for a final debate on the issue, death claimed this courageous battler against both her own cancer and the cancer of indifference and self-service that permeates our political system.

When state Sen. Lynn Adelman, one of the few senators who truly sympathized with Smith's plight, sought to adjourn that Wednesday session in her honor, several Republican legislators hissed their contempt.

They need not have bothered. The Senate majority had already shown its contempt for Karin Smith — and all the citizens of Wisconsin — in its wrong-minded and evil vote.

John Nichols is assistant editorial page editor for The Capital Times.

The New York Times

OP-ED FRIDAY, OCTOBER 7, 1994

Crushed by My Own Reform

By Frank Cornelius

CARMEL, Ind.

In 1975, I helped persuade the Indiana Legislature to pass what was acclaimed as a pioneering reform of the medical malpractice laws: a $500,000 cap on damage awards, and elimination of all damages for pain and suffering. I argued successfully that such limits would reduce health care costs and and encourage physicians to stay in Indiana — the same sort of arguments that now underpin the medical industry's call for national malpractice reform.

Today, from my wheelchair, I rue that accomplishment. Here is my story.

On Feb. 22, 1989, I underwent routine arthroscopic surgery after injuring my left knee in a fall. The day I left the hospital, I experienced a great deal of pain and called the surgeon several times. He called back the next day and told my wife to get me a bedpan. He then left on a skiing trip. I sought out another surgeon, who immediately diagnosed my condition as reflex sympathetic dystrophy — a degenerative nervous disorder brought on by trauma or infection, often during surgery.

A few months later, when a physical therapist improperly read the instructions on a medical device, I received a tremendous current of electricity through my left leg. This seriously complicated my condition.

In August 1990, another physician proposed a medical procedure, but used the wrong instrument; that left me with several holes in the vena cava, the main vein from the legs to the heart. I would have bled to death in my room if my wife had not come to see me that evening and called for help. As another physician tried to save my life, he punctured my left lung.

The cost of this cascading series of medical debacles is painful to tally:

- I am confined to a wheelchair and need a respirator to keep breathing. I have not been able to work.
- I have continuous physical pain in my legs and feet, prompting my doctor to hook me up to an apparatus that drips morphine. My pain used to rate a 10 on a scale of 1 to 10. Now it's about a 4.
- Twice, I have received last rites from my church.
- My marriage is ending, and the emotional fallout on our five children has been difficult to witness, to say the least.
- At the age of 49, I am told that I have less than two years to live.

My medical expenses and lost wages, projected to retirement age if I should live that long, come to more than $5 million. Claims against the hospital and physical therapist have been settled for a total of $500,000 — the limit on damages for a single incident of malpractice. The Legislature has since raised that cap to $750,000, and I may be able to collect some extra damages if I can sue those responsible for the August 1990 incident that nearly killed me. But apparently because of bureaucratic inertia, the state medical review panel that certifies such claims has yet to act on mine.

> I lobbied for limits on malpractice suits. Now I'm sorry.

The kicker, of course, is that I fought to enact the very law that limits my compensation. All my suffering might have been worthwhile, on some cosmic scale, if the law had accomplished its stated purpose. But it hasn't.

Indiana's health care costs increased 139.4 percent from 1980 to 1990 — just about the national average. The state ranked 32d in per capita health care spending in 1990 — the same as in 1980.

It's understandable that the damage cap has done nothing to curb health care spending; the two have almost nothing to do with each other. In 1992, the Congressional Budget Office reported that medical malpractice litigation accounted for less than 1 percent of total health care spending. I doubt that the percentage in Indiana is much different.

Proponents of Indiana's damage cap argue that doctors here pay less for malpractice insurance than their colleagues in other states. What they don't say is that malpractice premiums are artificially low because insurers need to offer only $100,000 of coverage. Negligently injured patients who are entitled to more than $100,000 must look to Indiana's state-run excess compensation fund.

Because that fund is supported by a surcharge on doctors, the true cost of malpractice insurance in Indiana can be calculated only by adding premiums and surcharges together. And the surcharge for the compensation fund has ballooned.

Doctors and insurers have spent millions propagating the myth that America is awash in unjustified malpractice suits and crazy jury verdicts. And apparently they have captured the attention of the President and Congress: malpractice damage caps were part of many health care measures in Congress this year, and they are sure to be back when the issue resurfaces in the next session.

The prospect that these "reforms" will be enacted is frightening. Make no mistake, damage caps are arbitrary, wholly disregarding the nature of the injury and the pain experienced by the plaintiff. They make it harder to seek and recover compensation for medical injuries; extend unwarranted special protection to the medical industry; and remove the only effective deterrent to negligent medical care, since the medical profession has never done an effective job of disciplining negligent doctors.

Medical negligence cannot be reduced simply by restricting consumers' legal rights. That will happen only when the medical industry begins to effectively police its own. I don't expect to live to see that day.□

Frank Cornelius is a former lobbyist whose clients included the Insurance Institute of Indiana.

HEALTH CARE SECOND OPINIONS
An occasional series.

THE MILWAUKEE JOURNAL

READER VIEWS

Tort reform isn't solution to easing health care woes

THE PRESIDENT'S health care proposal is going to be released within the next few weeks. It is well known that tort reform will be included in his package. There is speculation that the proposed plan will limit pain-and-suffering awards for medical malpractice victims to $250,000. This would not only be unconstitutional, but grossly unfair.

Let me explain.

Five years ago, I was a healthy, 22-year-old woman. Today, I am a victim of both cervical cancer and medical mismanagement. In 1988, I belonged to Family Health Plan (FHP), a Milwaukee-based health maintenance organization. When I began to experience vaginal bleeding, I sought care from FHP.

IN MY OPINION
Karin Smith

Between June of 1988 and May of 1991, my symptoms gradually progressed from minor bleeding to profuse bleeding, to fatigue and passing out. During this time, I made nearly 20 calls to doctors within my HMO to complain of the problems. Also during this time, three Pap smears and three biopsies were performed.

Unfortunately, my cries for help were not heard, and all of my laboratory tests, with the exception of one Pap smear, were misread. When I left FHP in May of 1991 and sought the opinion of a gynecologist outside of that plan, my diagnosis was made within two weeks.

Since my diagnosis two years ago, I have undergone five surgeries, three separate two-month courses of radiation and six months of chemotherapy. I was recently informed that unless I have radical surgery this fall to remove a part of my spine and replace it with a piece of my rib, I will probably be paralyzed by spring.

Because of the three-year delay in diagnosis, my chance for cure has dropped from 95% to around 10%. Even if I am fortunate enough to survive this tragedy, I will be plagued with chronic health problems and a lifetime of uncertainty.

Few would disagree that this is an egregious case that has led to needless emotional and physical pain. Certain legislators and health care specialists believe that my non-economic damages should be limited to $250,000. The state Senate has passed a bill to that effect.

According to the Health Care Financing Administration, national health care expenditures total $675 billion. The American Medical Association says doctors pay $5.6 billion in medical insurance premiums. As an accountant, I can easily calculate the cost of malpractice premiums to be less than 1% of all health care expenditures. Even the Congressional Budget Office has said that changing the medical liability system will have little effect on total health spending.

Furthermore, several states have already placed caps on pain-and-suffering awards. History has shown this has not reduced malpractice premium expenses. The reality is that very few plaintiffs are awarded high amounts. In Wisconsin, almost 70% of claimants have received no payment at all, and only 85 claims have ever exceeded $200,000.

It is important to mention that our country could save an enormous amount of health care dollars by adopting a strict national policy for disciplining doctors.

In Wisconsin, between 1976 and 1988, the top 10 physician defendants accounted for 2.4% of the 2,904 claims filed and 23% of the total payments made. During this time, four physicians were involved in more than one claim over $400,000. The four physicians accounted for 17.8% of all losses paid in that year. Clearly, a small percentage of doctors is responsible for a large portion of claim dollars.

It is a common perception that tort reform is strictly a battle between doctors and attorneys. What is painfully ignored is that victims are in the middle of this war. This is ironic, because these are the very people whom the tort system was designed to protect.

The issue of capping pain-and-suffering awards comes down to one question: Do we allow all citizens the right to a jury trial at which their peers decide a fair level of compensation for pain and suffering, based on the extent of the individual's damages and the facts?

If the answer is no, we are violating the constitutional rights of the most seriously injured victims, while protecting the careers of the most grossly negligent doctors.

Karin Smith lives in Nashotah.

September 15, 1993


FORWARD
E PLURIBUS UNUM

– Its Arguments are
fine as they Relate
to the NON future med.
expenses periodic payment

BUT we are talking about
Future MEDICAL EXPENSES

If the patient dies, no
further medical expenses
will be INCURRED so that
amount of that part of the
award shouldn't accrue to the
estate bc NO medical expenses
are incurred

JO6 Memory

We took it

out at the

recommendation of

OCI

only After we

adopted the ~~OCI~~ amendment

to protect th Attys did

this become a problem

The whole rest of the award

- All the rest of the $)

does go to the estate

just not the future

MEDICAL EXPENSES b/c

dead people dont incur

medical expenses

Didn't work with me — Ignored the 24 hr rule — Orderly — 500,000

Stunts

And it is the average working people whose premiums are sky high & who can't afford health care b/c of high costs driven by defensive medicine practices

~~The only people who don't benefit from this legislation is the trial lawyers.~~

The ~~[scribbled]~~ Dems say this legislation will victimize the victims —

The only ~~truth to that~~ is ~~the~~ victimization of victims ~~at the~~ hands of ~~their~~ Lawyers ~~[scribbled]~~ not the docs.

Yoon

One observation of the AB 36 experience

Yes Trial Lwys opposed caps

Yes ~~they~~ opposed wrongful death

BUT the only item they Really exerted their influence to the 9th degree was their fees

or not

Yoon — Sullivan from the Chairman came to me the day the exec — said get it to my office — well reviewed it —

I never the ... from the Yoon to bring this to the floor —

Justice as the doctor or health care provider cannot guarantee a positive outcome

cannot guarantee competence

I cannot guarantee that this legislation will provide a savings. no one guarantees

- While I dont think its any secret that I was not pleased that the trade attorney amendment passed this body, this is still an important piece of legislation for the people of WI

- Who benefits from this legislation?

Who benefits:

~~the gentleman from the 8th~~ would have you believe it is the evil greedy butcher doctors & none else.

BUT THEY ARE WRONG -

It is the JUST WRONG

- Emergency Room Doctors who SAVE LIVES as A way of life.

Who will be benefitted b/c the CONSTANT THREAT of lawsuit

- It is the OB&GYN doctors who have a 68% chance of being sued, who can attribute to the continued success of the family in WI

) Guarantee human we err - we pay

) Who benefits - butchers
EM - OBgyn

3) Average working glass -
who might otherwise join
the ranks of uninsured -

4) ~~Committee Semantic~~ - attys last min.
~~All~~ frustrating
pull tricks out of a hat -
~~a~~ secret surprise - just as
the attorneys did in the OJ
Simpson case -

Trial attys opposed the caps
the wrongful death
But what did they go all out for
Themselves + mechs sue

Not taking away
all the fear

deprived -
Not entitled
to profit from
tragedy -
Supposed to be competent
does not equate to
certainty -

8th
Took away
local control
when we created the
PCF.
No stories to cap-
Those opposed to the cap-
More concerned about
access to legal representation
than they are concerned
about cuts or
affordable
care