MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON JUDICIARY

Call to Order: By Senator Bill Yellowtail, Chair, on March 24, 1993, at 10:00 a.m.

ROLL CALL

Members Present:

Sen. Bill Yellowtail, Chair (D)
Sen. Steve Doherty, Vice Chair (D)
Sen. Sue Bartlett (D)
Sen. Chet Blaylock (D)
Sen. Bob Brown (R)
Sen. Bruce Crippen (R)
Sen. Eve Franklin (D)
Sen. Lorents Grosfield (R)
Sen. Mike Halligan (D)
Sen. John Harp (R)
Sen. David Rye (R)
Sen. Tom Towe (D)

Members Excused: None.

Members Absent: None.

Staff Present: Valencia Lane, Legislative Council
Kathy Collins, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: HB 574, HB 346, HB 236
Executive Action: HB 574, HB 236, HB 191

HEARING ON HB 574

Opening Statement by Sponsor:

Representative Jim Rice, House District 43, stated HB 574 makes permanent the public defender program, which is the program whereby the state provides defense counsel for cases on appeal for indigent defendants which have been convicted at the district court level.

Proponents' Testimony:

William Hooks, Public Defender for Montana, stated in the past the court would have to appoint counsel from the private bar to represent indigents on appeals to the Supreme Court. Mr. Hooks said the court would also have to appoint counsel for certain post-conviction actions after a trial. Mr. Hooks stated there were inherent problems with that system: the cost involved for private counsel, and the problem with the court finding attorneys to appoint to these cases. Mr. Hooks said the Appellate Defender Office was created early in 1992 to remedy those problems. Mr. Hooks stated that with the present program, his office is able to provide the court with a prompt and efficient option for those difficult and time-consuming cases that would otherwise cost the counties a great deal of money. Mr. Hooks said he gets paid far less than what a private attorney would charge for these cases.

District Judge Dorothy McCarter, Chairperson, Public Defenders Commission, stated the program has been extremely successful since its inception. Ms. McCarter said the program has been saving taxpayer dollars, and she urged the Committee's support of HB 574.

Beth Baker, representing the Department of Justice and the Montana County Attorneys Association, stated she supported HB 574 because the provision of competent legal services is always an advantage to the prosecution as well--it's in the best interest of the state to have experienced, capable counsel on both sides of a case. Ms. Baker stated Mr. Hooks is operating the program in an efficient, capable manner, and she urged the Committee's support of HB 574.

Pat Chenovick, Administrator, Supreme Court, stated the Court supported HB 574.

Gordon Morris, Director, Association of Counties, stated he supported HB 574.

Sally Johnson, Deputy Director, Department of Corrections and Human Services, stated these cases can be very costly, the defendants have the right to counsel, and utilizing Mr. Hooks in these cases saves the state money.

Opponents' Testimony:

None.

Informational Testimony:

None.

Questions From Committee Members and Responses:

Senator Blaylock asked Representative Rice what the cost of the

program was. Representative Rice stated the cost of the program is $100,000, which comes exclusively out of the District Court Reimbursement Fund.

Closing by Sponsor:

Representative Rice stated this program is a service the state is legally required to provide, and it is the best way to provide that service.

HEARING ON HB 346

Opening Statement by Sponsor:

Representative Steve Benedict, House District 64, stated HB 346 came to the Legislature from the Health Care for Montanans Project. Representative Benedict HB 346 references specific areas of state statute where tort reform is necessary to begin to rein in rising medical costs. Representative Benedict stated HB 346 will reduce the escalation of preventive medicine--those unnecessary procedures doctors are often forced to conduct to protect themselves from threats of malpractice. Representative Benedict stated the proponents of HB 346 will show that malpractice insurance rates show clear downward trends when this type of legislation is passed in other states. Representative Benedict said HB 346 was quite different when it was introduced in the House. The cap on non-economic damages was raised in the House to $500,000, nurses were added under the definition of "health-care provider", and some of the areas of concern regarding prenatal care were stricken from the bill. Representative Benedict said HB 346 was an excellent example of the careful and thoughtful deliberations of many people to achieve consensus on some of these issues.

Proponents' Testimony:

Jerry Loendorf, representing the Montana Medical Association, stated he supported HB 346. Mr. Loendorf stated Section 1 limits the recovery of non-economic damages in a suit against a hospital, doctor, nurse or dentist to the sum of $500,000. HB 346 imposes no limit on economic damages, nor does it impose any limit on punitive damages. Mr. Loendorf stated non-economic damages are those subjective damages which are defined in HB 346. Mr. Loendorf said economic damages are such things as loss of wages, health-care costs, and those things which can be measured in terms of costs. Mr. Loendorf stated other states have enacted similar provisions limiting damages, and Montana has limits on damages in certain areas such as workers' compensation claims and wrongful discharge claims. Mr. Loendorf stated non-economic damages are difficult to assess, and by having some limit there would be more stability in the liability insurance market place. Mr. Loendorf said the second provision of HB 346 limits the attorney's contingency fees, and it limits fees to a percentage

of the amount recovered. The limits would be 40% of the first $50,000 recovered, 33.3% of the next $50,000 recovered, 25% of the next $500,000 recovered, and 15% of the amount over $600,000. Mr. Loendorf said the important consideration is that these limits not be so strict that attorneys are discouraged from representing these types of claimants. Mr. Loendorf stated Montana has a limit on attorney fees in a number of cases through statute in the areas of probate, workers' compensation, and in the recovery of certain retail and installment sales. Mr. Loendorf said the American Bar Association special committee on malpractice liability recommends decreasing maximum schedule for contingency fees as proposed in HB 346. Mr. Loendorf stated the third provision of HB 346 amends the Montana law concerning the award of future damages in periodic payments. The amendment would require that when awards of future damages are made of $100,000 or more, they be made in periodic payments unless the court determines that periodic payments are not in the best interest of the plaintiff. Mr. Loendorf stated future damages are awarded for damages which would occur in the future, such as lost wages. Mr. Loendorf stated existing law already provides for periodic payments, and the advantages are savings and the structuring of those payments to meet the particular needs of the individual. Mr. Loendorf stated the purpose of HB 346 is to have some effect on liability insurance premiums, which would then have an effect on health care costs.

Gary Spaeth, representing the Liability Coalition, stated the Coalition consists of 250 businesses and associations whose primary concern is the liability and tort situations as they affect their businesses and operations in the state of Montana. Mr. Spaeth stated health care costs is a major concern for the country as a whole, and it's important to address that concern. Mr. Spaeth urged the Committee's support of HB 346.

Mona Jamison, representing the Doctors' Company, stated the Doctors' Company is the primary medical malpractice insurer of Montana, covering 70% of all medical liability insurance and approximately over 80% of the specialties. Ms. Jamison stated she supported HB 346 because tort reform works toward stabilizing premiums for medical malpractice insurance, and stabilization of premiums results in two primary things. One is less movement of physicians out of the high-risk specialty areas, and two, the dramatic change in the practice of defensive medicine, which drives costs up. Ms. Jamison stated it is important to realize that the cap is on non-economic damages only, and the $500,000 cap is reasonable. Ms. Jamison said many things were taken out of HB 346 in the House, and the bill before the Committee is the bare-bones bill that can still accomplish tort reform and at the same time be fair to people who have been harmed by physicians in various situations.

Dr. Paul Gorsuch, neurosurgeon, stated that for every dollar spent on insurance premiums about $2.75 is spent by doctors on defensive practices. Dr. Gorsuch stated he estimates $600 -

$1000 is spent on defensive medicine for every new patient he sees. Dr. Gorsuch said defensive medicine does not necessarily contribute to quality patient care, and he urged the Committee's support of HB 346.

Jim Smith, representing the Montana Psychological Association, stated he supported HB 346 on the basis of lowering health care costs.

The following people stood in support of HB 346:

Jim Arenson, President, Montana Hospital Association
Mike Schwitzer, physician
Barb Brewer, Executive Director, Montana Nurses Association
James Tutweiler, Montana Chamber of Commerce
Russ Cater, Chief Legal Counsil, Department of Social and Rehabilitation Services
Senator Cecil Weeding, Senate District 14
Dale Schaffer, neurosurgeon
Jim Mendenhall, anesthesiologist

Opponents' Testimony:

John Hoyt, attorney, Great Falls, stated a doctor is trusted by the person who comes to him for services. If the doctor commits negligence and that person is seriously injured, the doctor goes to his insurance company, and the insurance company takes over. Mr. Hoyt stated the injured person has to go to a lawyer, but the person cannot afford to pay the lawyer so the lawyer works on a contingency basis. Mr. Hoyt stated to restrict non-economic damages is to take dead aim at women, young people, and the poor who have no great earning capacity or record. Mr. Hoyt said a person's non-economic damage may be their greatest damage, and that person's only recovery would be through recovery of non-economic damages. Mr. Hoyt stated HB 346 should be tabled.

Randy Dix, attorney, spoke from prepared testimony in opposition to HB 346 (Exhibit #1).

Dennis Conner, attorney, stated he opposed HB 346. Mr. Conner recounted a case he had worked on involving a young girl who was severely brain injured at the age of two years as a result of negligence. Mr. Conner said in the case of this girl, economic damages would be difficult to determine, leaving her and her family relying on the recovery of non-economic damages. Mr. Conner stated the caps on attorney fees would discourage attorneys from taking cases where people desperately need the representation. Mr. Conner urged the Committee to table or reject HB 346.

Tom Bolin, attorney, distributed copies of data concerning HB 346 (Exhibit #2). Mr. Bolin said HB 346 was an "insurance company relief act" and is specific to the Doctors' Company, which covers 70% of the doctors in Montana. Mr. Bolin stated 12 states have

repealed cap legislation previously passed, and he suggested the trial lawyers, doctors, and the Insurance Commissioner's Office get together and fund and develop a study so public policy can be made "in the light of day and not in the dark of night."

Doug Buxbaum, attorney, stated HB 346 was not good legislation or good public policy. Mr. Buxbaum submitted copies of written testimony with suggested amendments (Exhibit #3).

Dave Ditzel, representing the local Board of Engineers, submitted written testimony in opposition to HB 346 (Exhibit #4).

Dominic Carestia, attorney, stated he opposed HB 346.

Russ Hill, representing the Montana Trial Lawyers Association, submitted written testimony in opposition to HB 346 (Exhibit #5).

Dan Shea, representing himself, submitted written testimony in opposition to HB 346 (Exhibit #6).

Don Judge, Executive Secretary, Montana State AFL-CIO, stood in opposition of HB 346.

Fran Marceau, State Legislative Director for the United Transportation Union, submitted written testimony in opposition to HB 346.

Gary Blakely, representing himself, stood in opposition to HB 346.

Informational Testimony:

None.

Questions From Committee Members and Responses:

Senator Blaylock asked Jerry Loendorf how many suits have been filed against doctors in the U.S. because they did not conduct enough tests. Mr. Loendorf stated he did not have that information.

Senator Blaylock asked Mona Jamison if there have been any promises, on the part of the doctors, that their rates would go down if HB 346 should pass. Ms. Jamison stated there have been no promises made. Ms. Jamison said she believes there will be a decrease in three to six years. Senator Blaylock asked Ms. Jamison if the $500,000 cap would be insufficient for some cases. Ms. Jamison stated regardless of a person's earning income capacity, the $500,000 for pain and suffering, along with damages for medical expenses, is reasonable.

Senator Franklin asked Tom Bolin to elaborate on the role the insurance companies play in this issue. Mr. Bolin drew the Committee's attention to the pie graph in Exhibit #2 which shows

to total health care costs in the country. Mr. Bolin pointed out that the malpractice insurance premiums represent approximately one-half of one percent of the total health care costs. Mr. Bolin stated one of the graphs represent the Doctors' Company earned premiums and paid losses. Mr. Bolin pointed out that while the Doctors' Company premiums are way up, the paid losses remain relatively low.

Senator Crippen asked Ms. Jamison if limiting the fees attorneys can get in medical malpractice cases would limit a client's ability to get competent representation and if she thought the amendments suggested by Mr. Buxbaum would be a more acceptable fee structure. Ms. Jamison stated she wanted to make clear that HB 346 is "not the Doctors's Company bill." With regard to the amendments suggested by Mr. Buxbaum, Ms. Jamison said she was not prepared to comment on those amendments at this time. Senator Crippen asked Ms. Jamison if it was important for both sides in a medical malpractice suit to be represented by capable attorneys. Ms. Jamison stated she supported that idea.

Senator Doherty asked Jerry Loendorf if it fair to place a cap on the plaintiff's attorney and not on the defendant's. Mr. Loendorf stated he knew of no reason defense fees should be controlled, and he knew of no cases where the defense attorney fees have been too high. Senator Doherty asked if Montana has experienced any reduction of health care costs as a result of lower insurance premiums. Mr. Loendorf said "no." Senator Doherty asked Mr. Loendorf if the intent of the periodic payment is for medical malpractice cases or for all cases. Mr. Loendorf stated the latter is the law as it is now. Mr. Loendorf stated one of the reasons for the periodic payment is to protect people who might otherwise unwisely spend a large amount of money. Senator Doherty asked if it would be better public policy to help those people to put that money in an interest-bearing account. Mr. Loendorf stated if someone controlled the account, it would accomplish what the periodic payments are already doing.

Senator Harp asked Ms. Jamison if the current limits on payments in medical malpractice suits are set by the insurance policy a doctor has. Ms. Jamison stated in many instances what is finally paid out is greater than the limits of the insurance policy. Senator Harp asked if the insurance policy distinguishes between economic and non-economic damages. Ms. Jamison stated the policies state a lump-sum amount.

Senator Towe asked Ms. Jamison to respond to the comment made by Tom Bolin that, after looking at the Doctors' Company profits, there is no need for HB 346. Ms. Jamison stated she had not seen the charts distributed by Mr. Bolin before this hearing, so she has not had the opportunity to determine their validity. Ms. Jamison stated in 1992 the Doctors' Company paid out substantially more in claims, settlements, judgements, and defense costs in Montana that were collected in premium dollars. Ms. Jamison said in Montana and other states there are premiums

paid back to the physicians when the reserves are adequate to cover the claims, and the Doctors' Company does pay dividends back to physicians. Senator Towe asked if that has been done every year in recent time. Ms. Jamison stated not every year. Senator Towe asked if Ms. Jamison could provide the Committee with information regarding the Doctors' Company premium collections, pay-outs, and dividends returned for the last several years. Ms. Jamison stated she would provide the Committee with that information.

Senator Towe, referring to the "single incident" aspect of HB 346, asked Mr. Loendorf if a hospital negligently exposed a number of people to polluted water, would this be considered a single incident and therefore, would the $500,000 cap be considered for the people affected as a whole or individually. Mr. Loendorf stated that would be an issue to be argued in court--the single incident would either be the people affected as a whole or each person individually.

Senator Bartlett asked Dr. Gorsuch what he would be doing differently in his practice if HB 346 were in statute now. Dr. Gorsuch stated he would probably be practicing less defensive type things in the long run than he is doing now. Senator Bartlett asked if a point has been reached where there is little distinction between defensive medicine and good medical practices. Dr. Gorsuch stated he believed the distinction to be quite clear, and there are many things being done in the emergency rooms out of the fear of lawsuits.

Senator Grosfield asked Ms. Jamison to comment on physicians and nurses being added to HB 346. Ms. Jamison stated it was reasonable to include these other health care providers.

Senator Halligan asked Jerry Loendorf how the Legislature can govern plaintiff attorney fees when there are rules of professional conduct which already govern those things very strictly. Mr. Loendorf stated he did not believe the contingency fees are governed, and he did not know what rules Senator Halligan was referring to. In order to determine if an attorney has acted in a non-professional manner, the client has to bring action against the attorney. Mr. Loendorf stated 90% of those cases are settled out of court.

Senator Yellowtail asked Ms. Jamison if she could provide empirical evidence based on previous experience for why the $500,000 is a problem in Montana. Ms. Jamison stated she would request that information and bring it to executive action.

Senator Towe asked Mr. Loendorf what the reason was for including impairment and disfigurement in the non-economic damages and if he would consider taking them out. Mr. Loendorf stated there is no real way to measure impairment and disfigurement, and he did not feel they should be subjected to the limit.

Closing by Sponsor:

Representative Benedict waived his closing.

EXECUTIVE ACTION ON HB 574

Motion/Vote:

Senator Blaylock moved HB 574 BE CONCURRED IN. The motion CARRIED UNANIMOUSLY.

HEARING ON HB 236

Opening Statement by Sponsor:

Representative Howard Toole, House District 60, stated HB 236 deals with a problem people have in obtaining copies of medical records. Representative Toole stated the doctors feel the statutes limit the distribution of a person's own medical records. Representative Toole said HB 236 says that any medical care provider who receives a request from the patient for medical records is protected against lawsuits by the patient. Representative Toole stated the purpose of this is to facilitate the acquisition of medical records for a patient when the patient signs a release form which releases the patient's records either through the patient, the patient's attorney, or the patient's insurer who is attempting to evaluate a claim.

Proponents' Testimony:

Jerry Loendorf, representing the Montana Medical Association, stated he supported HB 236.

Opponents' Testimony:

None.

Informational Testimony:

None.

Questions From Committee Members and Responses:

Senator Grosfield asked Representative Toole if the immunity referred to applies only to getting the records from the doctor. Representative Toole stated the intent of HB 236 is to allow the doctor to copy all contents of the patient's file not to grant immunity to some issue relative to medical malpractice.

Closing by Sponsor:

Representative Toole respectfully closed on HB 236.

EXECUTIVE ACTION ON HB 236

Motion:

Senator Blaylock moved HB 236 BE CONCURRED IN.

Motion/Vote:

Senator Towe moved an amendment HB 236 to strike everything after the word "time" on line 7 through the end of that sentence and adding "The revocation is effective form the time it is communicated to the health care provider." The motion CARRIED with Senator Rye voting NO.

Motion/Vote:

Senator Blaylock moved HB 236 BE CONCURRED IN AS AMENDED. The motion CARRIED UNANIMOUSLY.

EXECUTIVE ACTION ON HB 191

Motion/Vote:

Senator Blaylock moved HB 191 BE CONCURRED IN. The motion CARRIED UNANIMOUSLY.

ADJOURNMENT

Adjournment: 12:00 p.m.

Wm Yellowtail

SENATOR BILL YELLOWTAIL, Chair

Linda Casey

KATHY COLLINS, Secretary

BP/kc

ROLL CALL

SENATE COMMITTEE Judiciary DATE 3-24-93

NAME	PRESENT	ABSENT	EXCUSED
Senator Yellowtail	✓		
Senator Doherty	✓		
Senator Brown	✓		
Senator Crippen	✓		
Senator Grosfield	✓		
Senator Halligan	✓		
Senator Harp	✓		
Senator Towe	✓		
Senator Bartlett	✓		
Senator Franklin	✓		
Senator Blaylock	✓		
Senator Rye	✓		

FC8

Attach to each day's minutes

SENATE STANDING COMMITTEE REPORT

March 24, 1993

MR. PRESIDENT:

We, your committee on Judiciary having had under consideration House Bill No. 574 (first reading copy -- blue), respectfully report that House Bill No. 574 be concurred in.

Signed: Wm Yellowtail
Senator William "Bill" Yellowtail, Chair

Amd. Coord.
Sec. of Senate

Doherty
Senator Carrying Bill

661230SC.San

SENATE STANDING COMMITTEE REPORT

March 24, 1993

MR. PRESIDENT:
We, your committee on Judiciary having had under consideration House Bill No. 236 (first reading copy -- blue), respectfully report that House Bill No. 236 be amended as follows and as so amended be concurred in.

Signed: Wm Yellowtail
Senator William "Bill" Yellowtail, Chair

That such amendments read:

1. Page 2, lines 7 through 9.
Following: "TIME" on line 7
Strike: remainder of line 7 through the first "RELEASE" on line 9

2. Page 2, line 9.
Following: "."
Insert: "The revocation is effective from the time it is communicated to the health care provider."

-END-

Amd. Coord.
Sec. of Senate

Halligan
Senator Carrying Bill

661648SC.San

SENATE STANDING COMMITTEE REPORT

March 24, 1993

MR. PRESIDENT:

We, your committee on Judiciary having had under consideration House Bill No. 191 (first reading copy -- blue), respectfully report that House Bill No. 191 be concurred in.

Signed: Wm Yellowtail
Senator William "Bill" Yellowtail, Chair

Amd. Coord.
Sec. of Senate

Yellowtail
Senator Carrying Bill

661231SC.San

EXHIBIT NUMBER 1
DATE 3-24-93
BILL NO HB 346

HOUSE BILL 346 TESTIMONY

My name is Randy Dix and I practice law here in Helena. Substantially all of my practice is devoted to the prosecution of medical negligence claims. I appear here today in conjunction with the MTLA but primarily on behalf of clients I have and will serve around this state who are in danger of being denied access to the only system we have that permits them to obtain just compensation for their injuries.

HB 346 is not tort reform. It is a concerted effort on the part of the insurance industry to further limit the access that injury victims need. As I read this proposed legislation, 346 only deals with one side of this medical negligence equation - and that is, how to discourage these kinds of lawsuit, regardless of their merit. It totally fails to even address a host of serious problems that fair legislation would do. It assumes that these claims are without merit and, accordingly, provides fee and caps disincentives for bringing them. The legislation does not provide any mechanism for swift, less expensive disposition of claims that have merit. It offers no requirement to arbitrate, mediate or otherwise settle those claims before the litigation process begins. It offers no compulsion, or even incentive, for insurance companies to avoid spiralling costs associated with defense counsel. Nor does it offer doctors and hospitals who have made mistakes any assurance that they will not endure the endless agony and emotional trauma that litigation invariably brings.

Permit me to offer an example that arises from my experience working in this field. A lady from the Highline called me two years ago asking if I would look into her father's sudden death in a Montana Hospital. I came to find rather quickly that her father died of an anaphylactic (hyerallergic) reaction to a penicillin-based medication even though his admitting history to that hospital made it clear that he was penicillin-allergic. As in all medical negligence cases, this went to the M-L Panel. A 6-0 votes was rendered in favor of my client and the physician responsible for this unnecessary death approached me immediately afterwards, in the presence of his own lawyer, asked that I apologize to the family for this tragedy, told me he would have voted against himself if he had served on this Panel and assured me he wanted the case settled promptly. Needless to say, that did not happen. We were required to pursue expensive discovery, the physician had to endure his own deposition, expert witnesses had to become involved in the process and thousands of dollars were needlessly spent before the insurance company, likely from presssure from the doctor and his private lawyer, finally agreed to settle the case. This is an all too common scenario, driven by the economics of insurance company's holding on to money that should be paid to claimants because they apparently know that it's cheaper to hire defense lawyers, wear down the opposition and retain the interest on this claims money.

This legislation does not even recognize that part of the equation and does not attempt to rectify other similar problems with our medical negligence system. I have a multitude of thoughts about how to impart some rationality to the medical negligence arena but time does not permit it here. But after you listen to the other opponents of this legislation, I earnestly urge this Committee not take the quick fix, easy-way out. I urge you vote against this bill and allow those of us who work in this area every day, doctors, lawyers, hospital administrators and insurance executives, to propose solutions to you in 2 years that rationally serve everyone's best interests.

Update

Comparison of Medical Liability Insurance Rates

When proposed rates for medical liability insurance are approved, the average annual premiums will range from $7,068 in North Carolina to $51,439 in Chicago for a Class 4 physician purchasing liability limits of $1 million/$3 million on a mature claims-made policy. The Class 4 rate reflects the average premium paid by physicians and surgeons insured with The St. Paul.

The map shows proposed average rates for $1 million/$3 million limits of liability except in states where lower limits are mandatory or available due to participation in a patients' compensation fund. Selected major metropolitan areas established as separate rating territories from the remainder of their respective states are indicated in the adjacent listing.

Individual premiums are determined by a physician's specialty or rating class, the state or territory where a physician practices, the limits of liability selected and the number of years insured under claims-made coverage.

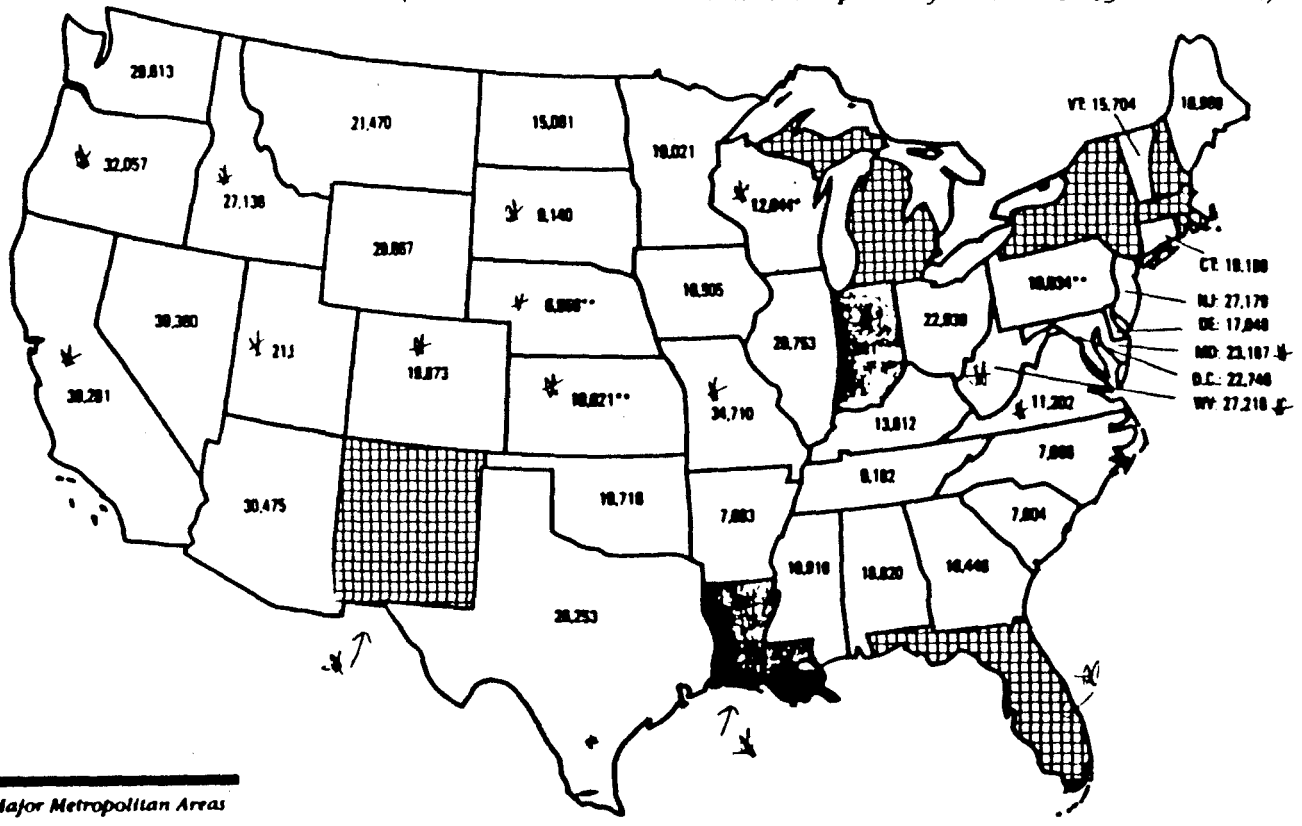
This comparison of Class 4 rates provides an overview of the country. The rates reflect the minimum premium discount available. To determine your exact premium, you must consult your independent agent. With this presentation you may determine an approximate annual rate for your specific specialty by multiplying the conversion factor next to the rating class on the chart below by your state's Class 4 physician rate. (Please refer to the detailed description on page 3 to determine your rating class.)

New Rating Class	Specialty	Conversion Factor
1A	Physicians—no surgery including Allergists, Dermatologists, Pathologists and Psychiatrists	.52
1	Physicians—no surgery, no invasive procedures, no obstetrical procedures	.40
2	Physicians—minor surgery, invasive procedures	.60
3	Family or General Practice—normal deliveries, includes Opthalmologists and Urologists	.80
4	Family Practice—major surgery Emergency Medicine—no major surgery	1.00
5A	Anesthesiologists	1.40
5	Surgery—including General, Emergency, Plastic and Otolaryngologists and Gynecologists	1.60
6	Surgery—including cardiac and orthopedic	2.20
7	Obstetrics	2.76
8	Surgery—Neurological	3.48

Major Metropolitan Areas

Chicago	$51,439
Houston	$39,323
Los Angeles	$47,959
New Orleans	$15,380***
Philadelphia	$20,370**
St. Louis	$41,666
San Francisco	$43,578
Washington, D.C.	$22,746

St. Paul Fire and Marine Insurance Company
Proposed Physician & Surgeon Average Rates
On An Annual Basis After July 1, 1988
(Class 4 doctor/mature claims-made rates primarily at $1 million/$3 million limits)



Limits Table

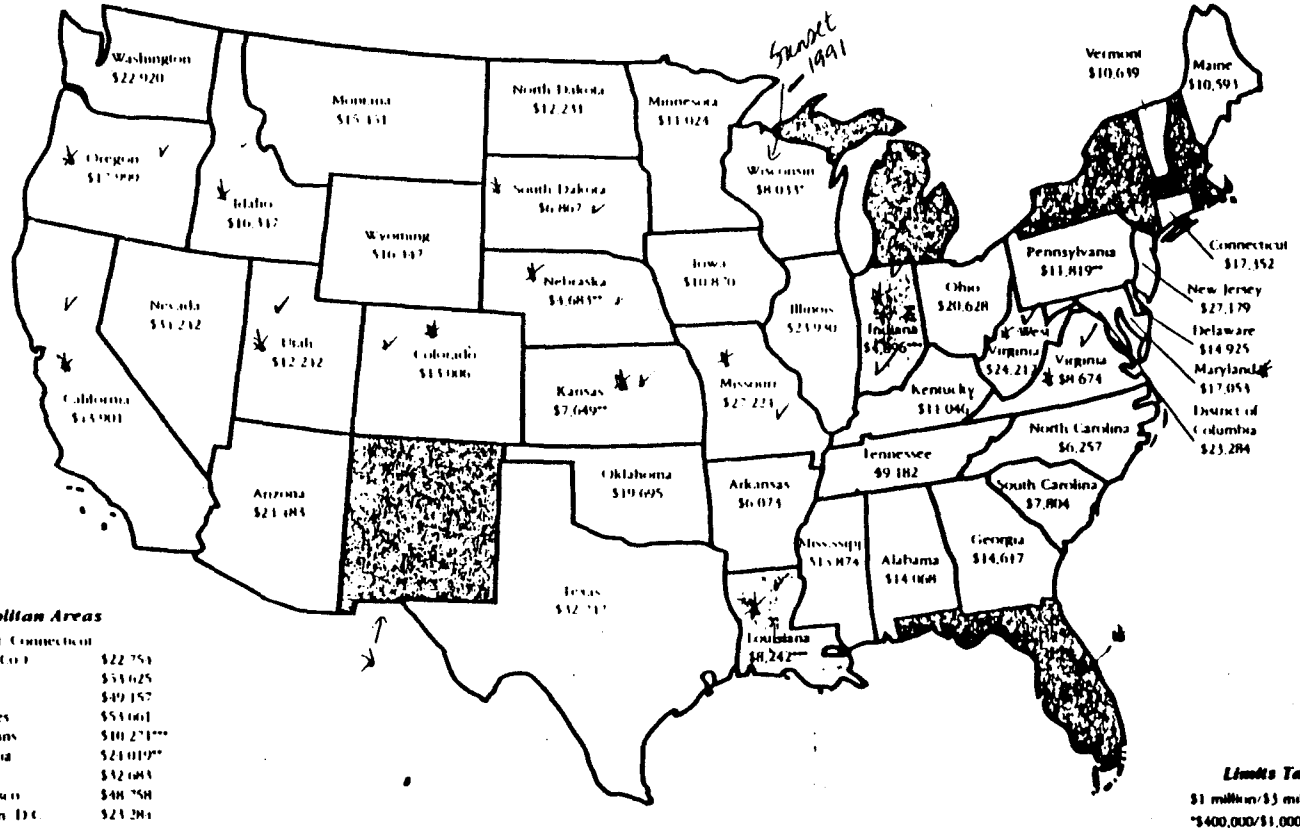
$1 million/$3 million
*$400,000/$1,000,000
**$200,000/$600,000
***$100,000/$300,000

The St. Paul does not offer physician and surgeon medical liability insurance in these states.

* - Cap on non-ec dams

St. Paul Fire And Marine Insurance Company
Current Physician and Surgeon Average Rates on An Annual Basis As of July 1, 1991

(Based on Class 4 doctor/mature claims made rates primarily at $1 million/$3 million limits)



Metropolitan Areas

Bridgeport, Connecticut (Fairfield Co.)	$22,751
Chicago	$33,625
Houston	$49,152
Los Angeles	$53,661
New Orleans	$10,271**
Philadelphia	$24,019**
St. Louis	$32,683
San Francisco	$48,758
Washington, D.C.	$23,284

The St. Paul does not offer medical liability insurance for physicians and surgeons in these states

Limits Table

$1 million/$3 million
*$400,000/$1,000,000
**$200,000/$600,000
***$100,000/$300,000

Comparison of Medical Liability Insurance Rates

Currently average annual premiums range from $6,073 in Arkansas to $53,661 in Los Angeles for a Class 4 physician purchasing liability limits of $1 million/$3 million at mature claims made policy rates. The Class 4 rate reflects the average premium paid by physicians and surgeons insured with The St. Paul.

The map shows average rates for $1 million/$3 million limits of liability except in states where lower limits are mandatory. Selected metropolitan areas established as separate rating territories from the remainder of their respective states are listed separately.

Individual premiums are determined by a physician's specialty or rating class, the state or territory where a physician practices, the limits of liability selected and the number of years insured under claims made coverage.

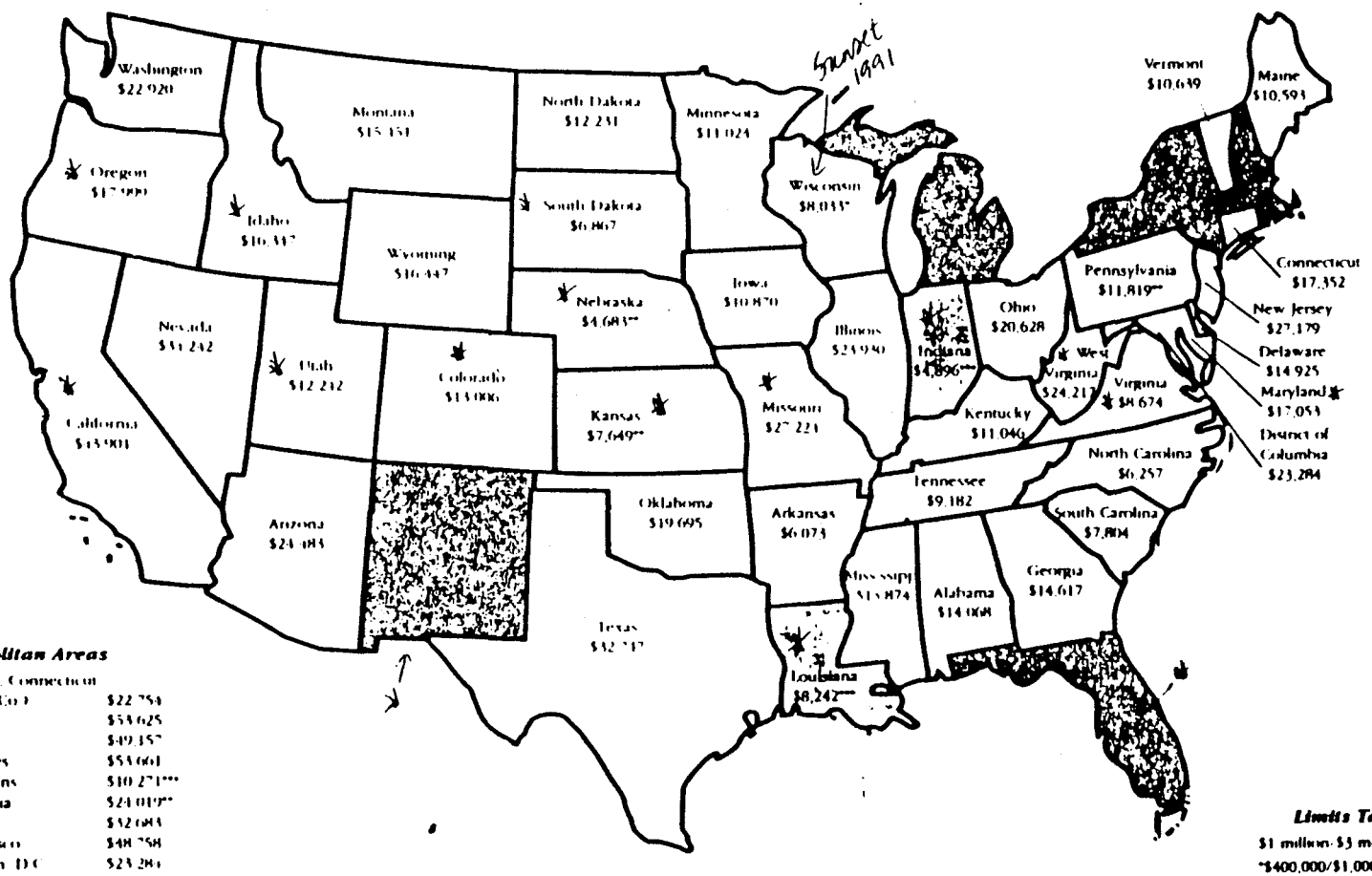
This comparison of rates for Class 4 physicians purchasing $1 million/$3 million limits on a mature claims made policy provides an overview of rates countrywide. **To determine your exact premiums, please consult with your independent insurance agent.**

FILE NO. CS-120-090-020

* = cap on non-economic damages

St. Paul Fire And Marine Insurance Company
Current Physician and Surgeon Average Rates on An Annual Basis As of July 1, 1991

(Based on Class 4 doctor mature claims made rates primarily at $1 million/$3 million limits)



Metropolitan Areas

Bridgeport, Connecticut (Fairfield Co.)	$22,754
Chicago	$53,625
Houston	$49,357
Los Angeles	$53,661
New Orleans	$10,271***
Philadelphia	$24,019**
St. Louis	$32,083
San Francisco	$48,758
Washington, D.C.	$23,284

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Limits Table

$1 million/$3 million
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This comparison of rates for Class 4 physicians purchasing $1 million/$3 million limits on a mature claims made policy provides an overview of rates countrywide. **To determine your exact premium, please consult with your independent insurance agent.**

* = cap on non-economic damages

U.S. TOTAL MEDICAL MALPRACTICE PREMIUMS 1991
RANKED BY P/L RATIO

STATE	DIRECT PREMIUMS EARNED MEDICAL MALPRACTICE	DIRECT LOSSES PAID MEDICAL MALPRACTICE	PAID LOSS RATIO
WV	32,533,682	33,018,002	101.49
IL	290,381,344	288,745,327	99.44
DC	37,547,156	34,389,921	91.35
NM	8,208,815	5,612,686	68.37
TX	203,305,986	131,133,168	64.50
MI	169,369,646	99,669,260	58.85
DE	19,464,989	11,450,834	58.83
MO	112,301,276	60,255,285	53.66
NY	812,095,866	409,388,834	50.41
CA	529,122,651	262,155,481	49.55
PA	223,082,123	109,695,138	49.17
FL	168,172,834	82,183,268	48.87
NV	25,250,303	12,214,902	48.38
KS	27,058,827	12,968,387	47.93
WY	8,123,588	3,871,664	47.66
NJ	242,379,127	115,028,576	47.46
VA	74,066,492	35,146,400	47.45
RI	7,923,499	3,757,421	47.42
OH	246,042,440	115,789,330	47.06
CO	29,937,974	14,066,783	46.99
IA	44,062,441	19,714,217	44.74
CT	103,232,735	44,818,261	43.41
AR	23,127,480	9,871,414	42.68
KY	58,107,032	24,601,342	42.34
NC	91,832,822	37,052,223	40.35
ND	12,754,581	5,102,758	40.01
OR	48,146,152	19,044,517	39.56
OK	14,293,922	5,452,778	38.15
AZ	107,876,795	40,812,997	37.83
SC	8,422,460	3,107,567	36.90
MD	107,730,718	39,214,901	36.40
IN	34,160,476	11,983,242	35.08
LA	50,765,114	17,490,604	34.45
VT	12,596,269	4,300,758	34.14
GA	133,955,841	45,194,101	33.74
MT	16,648,597	5,529,675	33.21
HI	16,133,665	5,338,597	33.09
UT	24,329,652	8,049,139	33.08
NE	18,001,259	5,626,820	31.26
NH	10,250,952	2,987,196	29.14
WA	104,335,235	30,393,915	29.13
MN	62,911,843	18,164,160	28.87
ME	27,620,803	7,820,804	28.31
TN	87,513,090	24,176,930	27.63
MA	31,155,915	8,508,327	27.31
WI	59,226,118	15,774,276	26.63
AK	13,733,529	3,628,558	26.42
MS	22,105,241	4,700,514	21.26
AL	84,735,002	17,315,010	20.43
SD	9,985,029	1,987,714	19.91
ID	14,841,751	2,688,482	18.11
TOTAL U.S.	4,721,061,137	2,330,992,464	49.37

U.S. TOTAL MEDICAL MALPRACTICE PREMIUMS 1991
RANKED BY P/L RATIO

STATE	DIRECT PREMIUMS EARNED MEDICAL MALPRACTICE	DIRECT LOSSES PAID MEDICAL MALPRACTICE	PAID LOSS RATIO
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*ID	14,841,751	2,688,482	18.11
TOTAL U.S.	4,721,061,137	2,330,992,464	49.37

* = CAP ON NON-ECONOMIC DAMAGES

HEALTH CARE COSTS IN THE U.S. (1990)

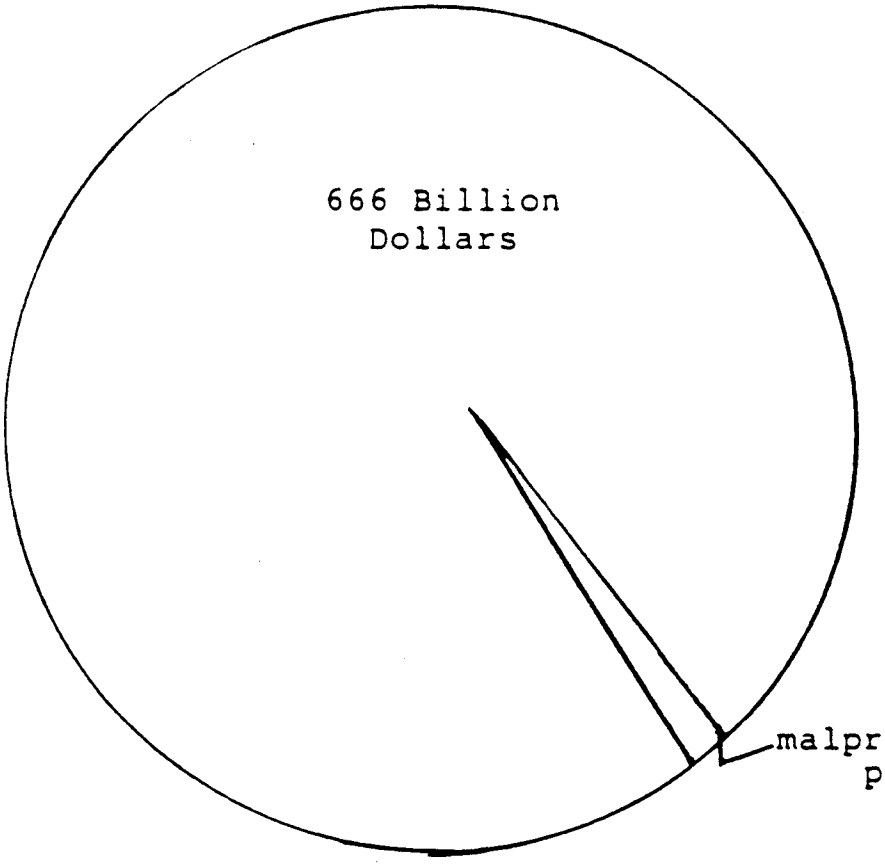
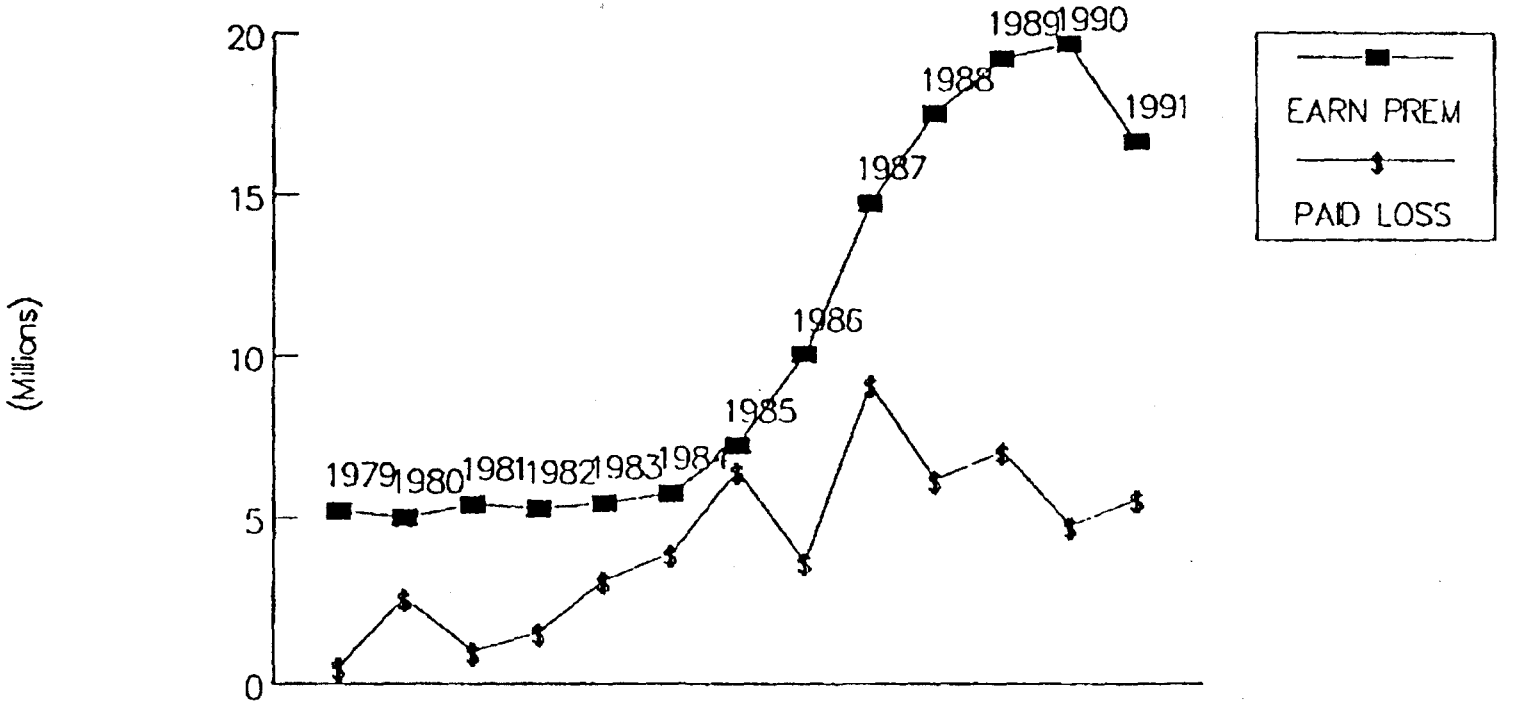


FIGURE 2

APPROXIMATELY ½ of 1% of
TOTAL HEALTH CARE COSTS

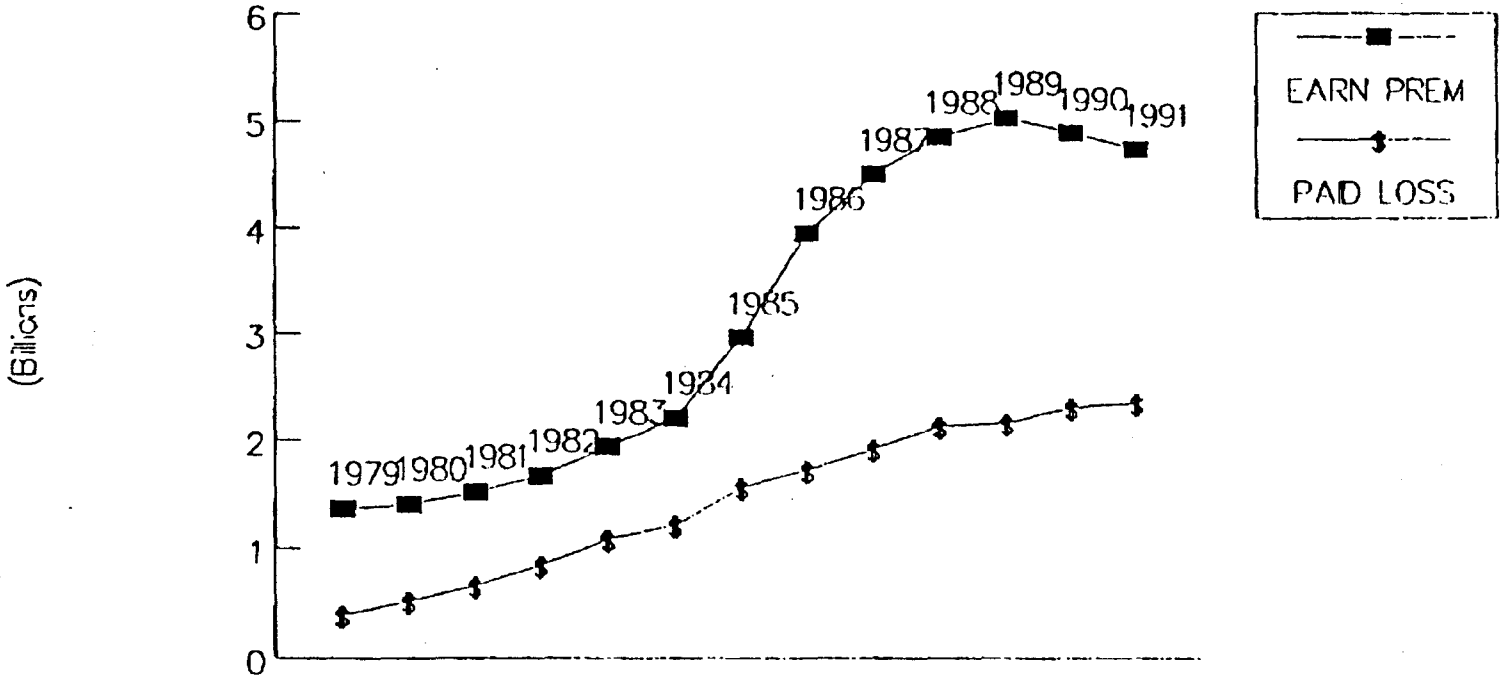
MEDICAL MALPRACTICE PREMIUMS

MONTANA 1979–1991



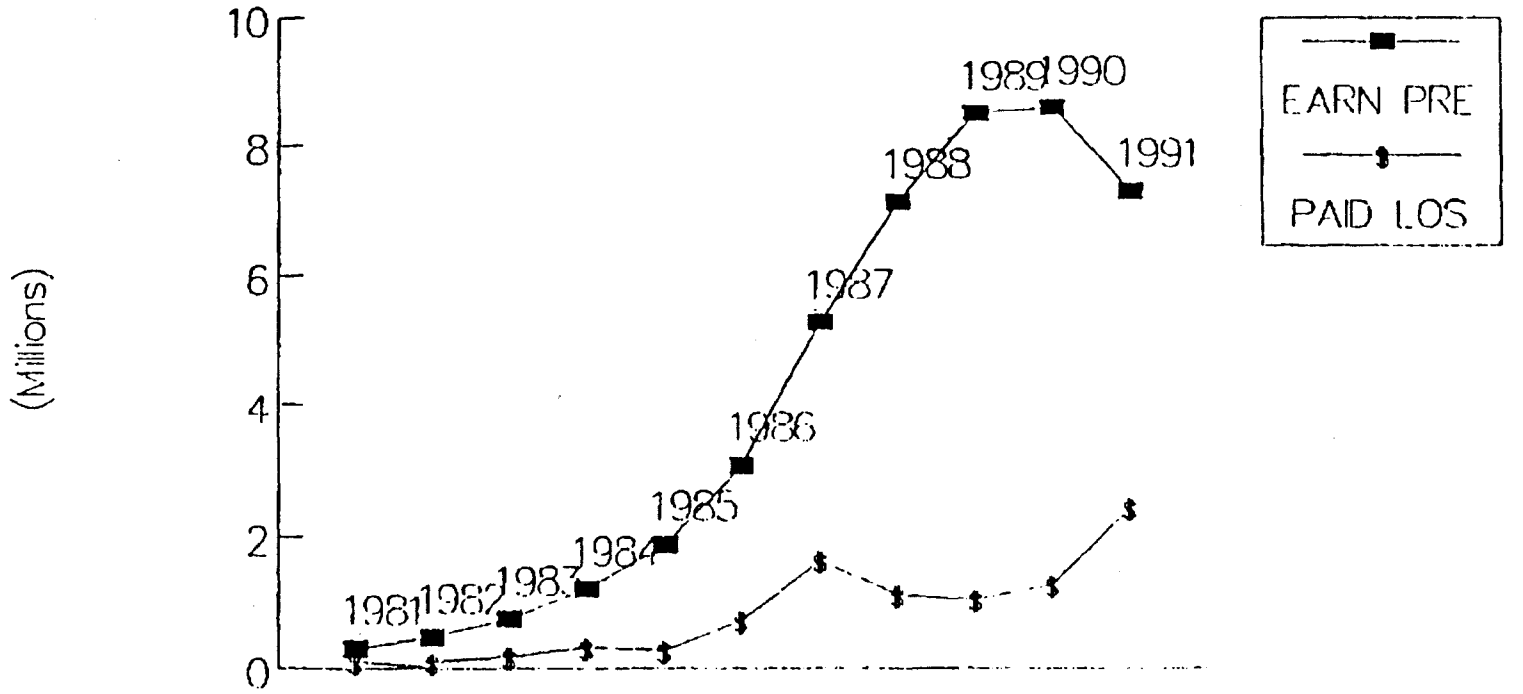
MEDICAL MALPRACTICE PREMIUMS

U.S. TOTAL 1979–1991



MEDICAL MALPRACTICE PREMIUMS

MONTANA 1979–1991



DOCTORS' CO INS GRP

St. Paul Fire And Marine Insurance Company
Proposed Physician and Surgeon Average Rates
On An Annual Basis After July 1, 1992

(Based on Class 3 doctor/mature claims-made rates primarily at $1 million/$3 million limits)

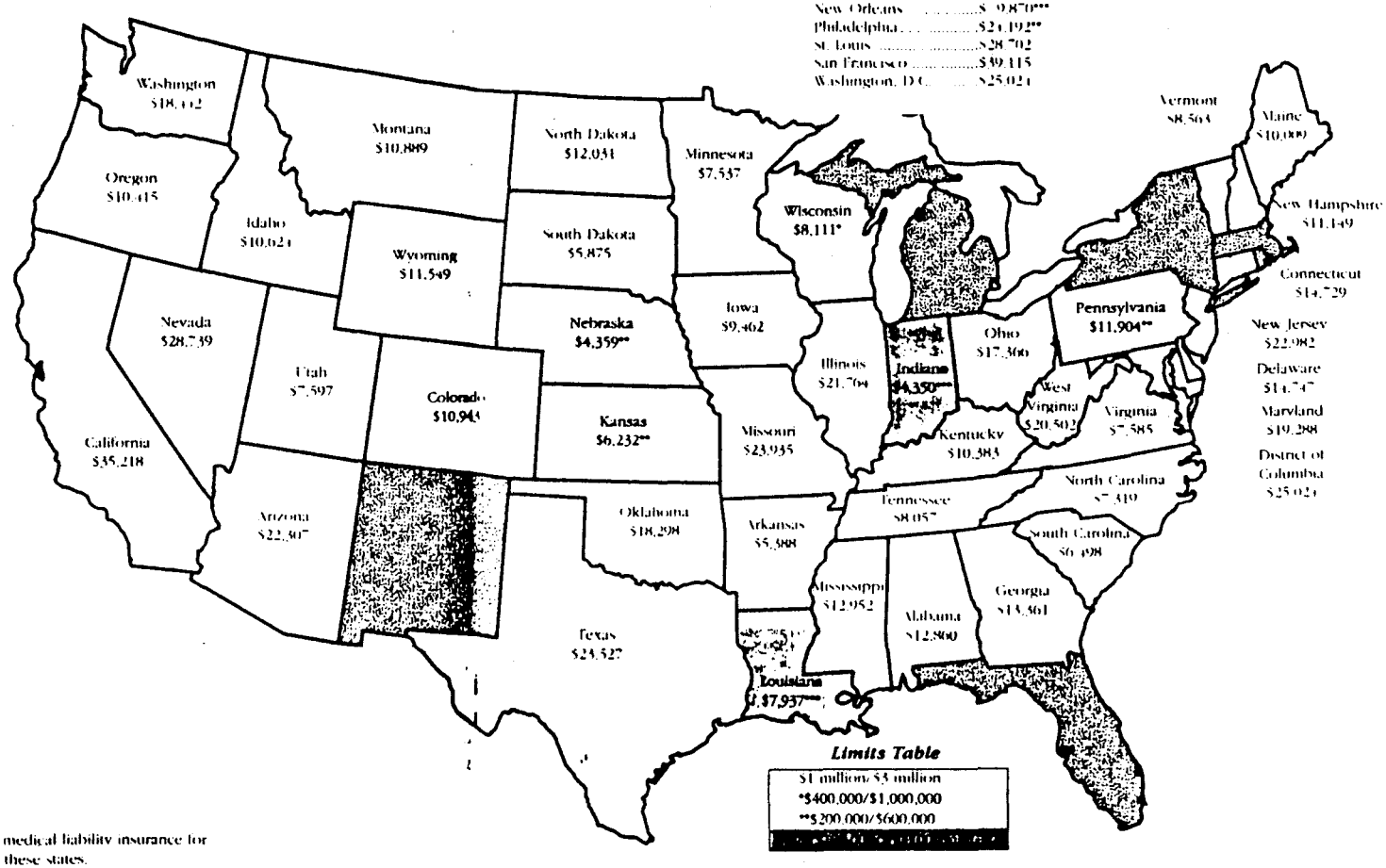
Comparison of Medical Liability Insurance Rates

Currently, average annual premiums range from $5,388 in Arkansas to $48,718 in Chicago for a Class 3 physician purchasing liability limits of $1 million/$3 million at mature claims-made policy rates. The Class 3 rate reflects the average premium paid by physicians and surgeons insured with The St. Paul.

The map shows average rates for $1 million/$3 million limits of liability except in states where lower limits are mandatory. Selected metropolitan areas established as separate rating territories from the remainder of their respective states are listed separately.

Individual premiums are determined by a physician's specialty or rating class, the state or territory where a physician practices, the limits of liability selected and the number of years insured under claims-made coverage.

This comparison of rates for Class 3 physicians purchasing $1 million/$3 million limits on a mature claims-made policy provides an overview of rates countrywide. **To determine your exact premium, please consult with your independent insurance agent.**



The St. Paul does not offer medical liability insurance for physicians and surgeons in these states.

Updaw

Comparison of Medical Liability Insurance Rates

When proposed rates for medical liability insurance are approved, the average annual premiums will range from $7,068 in North Carolina to $51,439 in Chicago for a Class 4 physician purchasing liability limits of $1 million/$3 million on a mature claims-made policy. The Class 4 rate reflects the average premium paid by physicians and surgeons insured with The St. Paul.

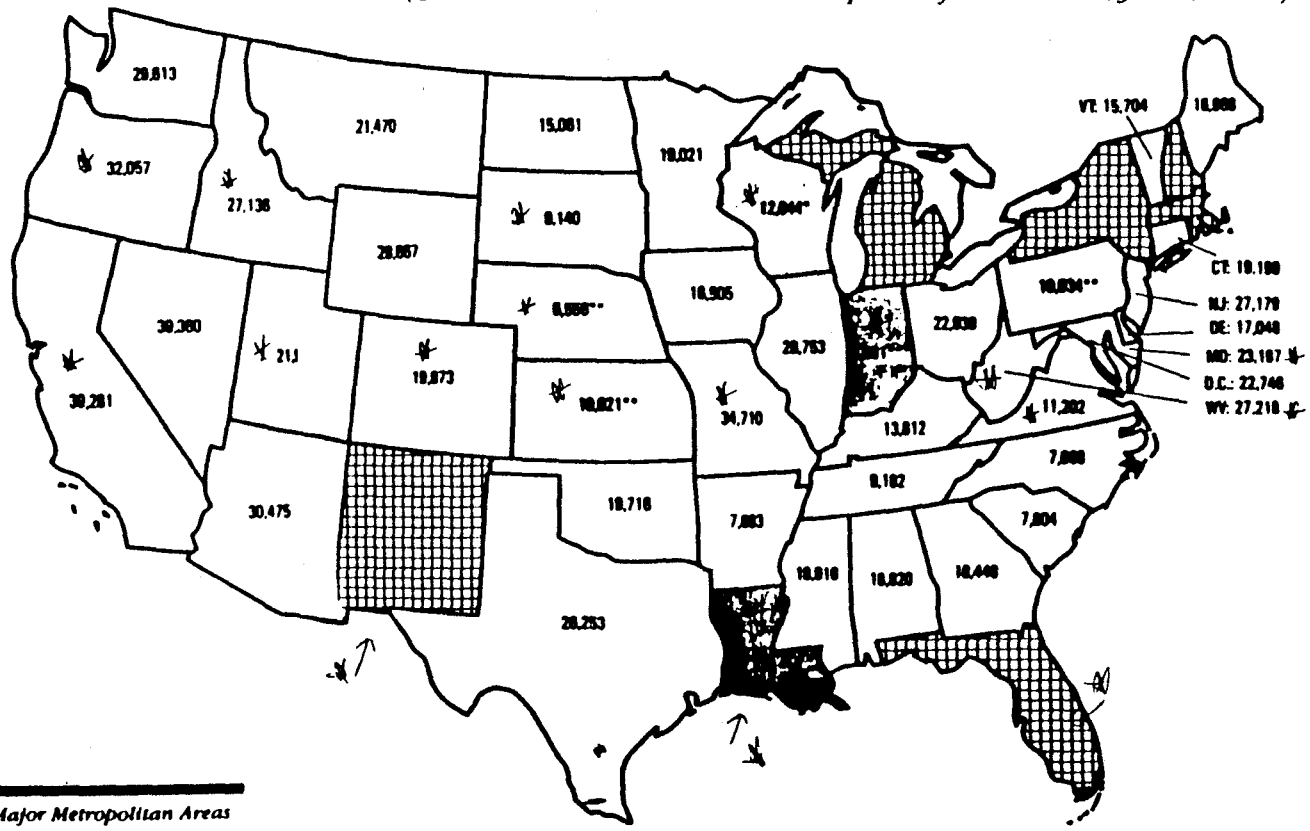
The map shows proposed average rates for $1 million/$3 million limits of liability except in states where lower limits are mandatory or available due to participation in a patients' compensation fund. Selected major metropolitan areas established as separate rating territories from the remainder of their respective states are indicated in the adjacent listing.

Individual premiums are determined by a physician's specialty or rating class, the state or territory where a physician practices, the limits of liability selected and the number of years insured under claims-made coverage.

This comparison of Class 4 rates provides an overview of the country. The rates reflect the minimum premium discount available. To determine your exact premium, you must consult your independent agent. With this presentation you may determine an approximate annual rate for your specific specialty by multiplying the conversion factor next to the rating class on the chart below by your state's Class 4 physician rate. (Please refer to the detailed description on page 3 to determine your rating class.)

New Rating Class	*Specialty*	*Conversion Factor*
1A	Physicians—no surgery including Allergists, Dermatologists, Pathologists and Psychiatrists	.32
1	Physicians—no surgery, no invasive procedures, no obstetrical procedures	.40
2	Physicians—minor surgery, invasive procedures	.60
3	Family or General Practice—normal deliveries, includes Ophthalmologists and Urologists	.80
4	Family Practice—major surgery Emergency Medicine—no major surgery	1.00
5A	Anesthesiologists	1.40
5	Surgery—including General, Emergency, Plastic and Otolaryngologists and Gynecologists	1.60
6	Surgery—including cardiac and orthopedic	2.20
7	Obstetrics	2.76
8	Surgery—Neurological	3.48

St. Paul Fire and Marine Insurance Company
Proposed Physician & Surgeon Average Rates On An Annual Basis After July 1, 1988
(Class 4 doctor/mature claims-made rates primarily at $1 million/$3 million limits)



Major Metropolitan Areas

Chicago	$51,439
Houston	$39,323
Los Angeles	$47,959
New Orleans	$15,380***
Philadelphia	$20,370**
St. Louis	$41,666
San Francisco	$45,578
Washington, D.C.	$22,746

Limits Table

$1 million/$3 million
*$400,000/$1,000,000
**$200,000/$600,000
***[illegible]

The St. Paul does not offer physician and surgeon medical liability insurance in these states

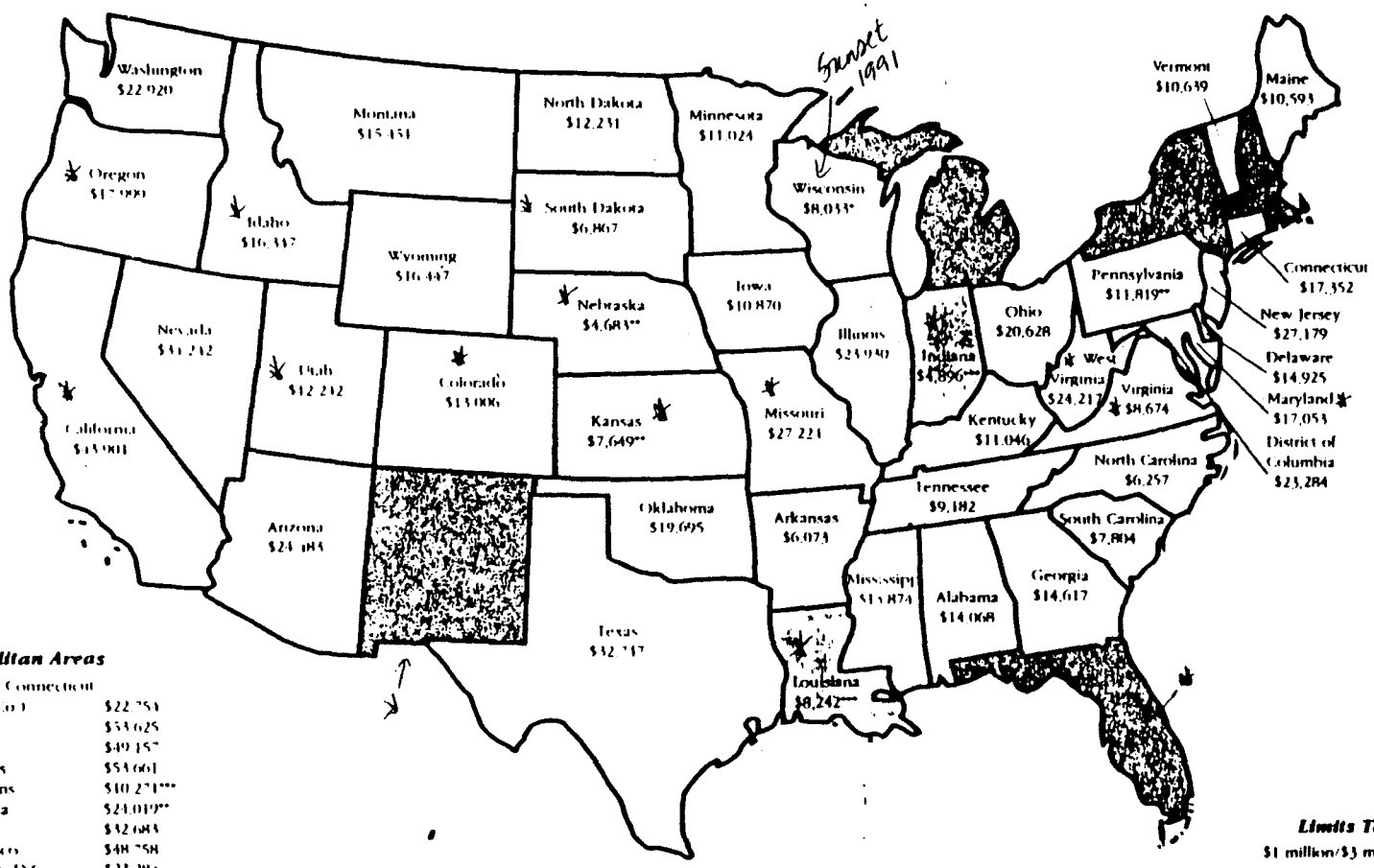
= Cap on non-econ damages

CS 190-090-020

St. Paul Fire And Marine Insurance Company

Current Physician and Surgeon Average Rates on An Annual Basis As of July 1, 1991

(Based on Class 4 doctor/mature claims made rates primarily at $1 million/$3 million limits)



Metropolitan Areas

Bridgeport, Connecticut	
(Fairfield Co.)	$22,751
Chicago	$53,625
Houston	$49,157
Los Angeles	$53,661
New Orleans	$10,271***
Philadelphia	$23,019**
St. Louis	$32,683
San Francisco	$48,758
Washington, D.C.	$23,284

The St. Paul does not offer medical liability insurance for physicians and surgeons in these states.

Limits Table

$1 million/$3 million
*$400,000/$1,000,000
**$200,000/$600,000
***$100,000/$300,000

* = Cap on non-economic damages

Comparison of Medical Liability Insurance Rates

Currently, average annual premiums range from $6,073 in Arkansas to $53,661 in Los Angeles for a Class 4 physician purchasing liability limits of $1 million/$3 million at mature claims-made policy rates. The Class 4 rate reflects the average premium paid by physicians and surgeons insured with The St. Paul.

The map shows average rates for $1 million/$3 million limits of liability except in states where lower limits are mandatory. Selected metropolitan areas established as separate rating territories from the remainder of their respective states are listed separately.

Individual premiums are determined by a physician's specialty or rating class, the state or territory where a physician practices, the limits of liability selected and the number of years insured under claims-made coverage.

This comparison of rates for Class 4 physicians purchasing $1 million/$3 million limits on a mature claims-made policy provides an overview of rates countrywide. **To determine your exact premium, please consult with your independent insurance agent.**

Buxbaum & Carestia LAW OFFICES

1941 Harrison Avenue, Suite B
Butte, Montana 59701-5465
Telephone (406) 723-5600
Facsimile (406) 723-5353

Dominic P. Carestia, Esq.
Douglas A. Buxbaum, Esq.
Laurie J. Bersanti, Admin.

SENATE JUDICIARY
EXHIBIT NO. 3
DATE 3-24-93
BILL NO. HB 346

March 24, 1993

Senate Judiciary Committee
Capitol Station
Helena, MT 59620

Re: HB 346

Dear Members:

My partner, Doug Buxbaum, and I come before you for discussion and submission of the attached amendments to HB 346. In so doing, we emphasize that we are the only law firm to testify before the committee which has served both defendants and plaintiffs in the litigation of medical malpractice claims. More particularly, for over a decade now, we have assisted primarily in the defense of medical malpractice claims on behalf of The Doctors' Company, Aetna, St. Paul, Utah Medical, Physicians Insurance Company, Insurance Corporation of America, and others. Doug Buxbaum has in fact represented doctors and other medical providers at the medical-legal panel literally hundreds of times over that time frame. Correspondingly, I have assisted in the resolution by way of settlement in a similar number of claims.

We appreciate the opportunity to present this information to the committee. We are hopeful that our expertise in this area will be of assistance to the committee, and we thank the committee for this opportunity to assist in shaping this most important legislation.

Sincerely yours,

BUXBAUM & CARESTIA

D. P. Carestia

Dominic P. Carestia, J.D., M.A., CLU, CPCU

D A Buxbaum

Douglas A. Buxbaum, Esq.

DPC:lat
Attachments

NEW SECTION. **Section 1. Medical malpractice noneconomic damages limitation.**

(1) In a malpractice claim against one or more health care providers based on a single incident of malpractice, an award for past and future damages for noneconomic loss may not exceed $500,000 per claimant. Prior to applying the $500,000 limitation per claimant specified in this subsection, other required reductions shall be made in the following order:

(a) first, reductions under 27-1-702;

(b) second, reductions under 27-1-703; and

(c) third, setoffs and credits to which a defendant is entitled.

(2) The $500,000 limit in subsection (1) may not be disclosed to a jury.

(3) The $500,000 limit in subsection (1) shall be adjusted each year on January 1 in accordance with the prior year's consumer price index (CPI-U), as published by the United States Government.

(4) As used in this section the following definitions apply:

(a) "Claimant" includes but is not limited to a person suffering bodily injury; a person claiming as a result of bodily injury to or the death of another; a person claiming on behalf of someone who suffered bodily injury or death; the representative of the estate of a person who suffered bodily injury or death, or a person bringing a wrongful death action.

(b) "Health care provider" means a physician, dentist, or health care facility, as defined in 27-6-103, or a nurse licensed under Title 37, Chapter 8.

(c) "Malpractice claim" has the meaning as defined in 27-6-103.

(d) "Noneconomic loss" means subjective, nonmonetary loss, including but not limited to physical and mental pain or suffering, emotional distress; inconvenience; loss of society, companionship, and consortium (other than household services); injury

to reputation and humiliation. This section, however, shall not limit in any manner claimant's recovery for physical impairment or disfigurement.

NEW SECTION. **Section 2. Medical malpractice contingency attorney fees -- limits.**

(1) An attorney may not contract for, charge, collect, or receive a contingency fee for representing a claimant in a medical malpractice claim, as defined in 27-6-103, against a physician, dentist or health care facility, as defined in 27-6-103, or against a nurse licensed under Title 37, Chapter 8, in excess of:

(a) 33 1/3% of the first $1,000,000 recovered;

(b) 25% of the next $500,000 recovered; and

(c) 20% of any amount above $1,500,000 recovered.

(2) The limits of subsection (1) apply whether the recovery is by settlement, arbitration, judgment, appeal from a judgment, or otherwise. An attorney compensated under 72-3-363 in a malpractice claim against a physician, dentist or health care facility is subject to the limits of subsection (1) of this section, but the court may modify the fees permitted by subsection (1) of this section upon a showing of good cause.

(3) The percentage and dollar amount limits in subsection (1) apply to the combined recoveries in an action in which one or more attorneys represent one or more claimants for one or more injuries or deaths allegedly arising from a single incident of malpractice.

(4) The recovery amounts specified in subsection (1) of this section shall be adjusted each year on January 1 in accordance with the prior year's consumer price index (CPI-U), as published by the United States Government.

(4) As used in this section, the following definitions apply:

(a) "Action" means a proceeding, including arbitration, prosecuted to seek redress for personal injury or wrongful death allegedly caused by malpractice or to assert a right to indemnity or subrogation arising out of a malpractice claim.

(b) "Claimant" includes but is not limited to a person suffering bodily injury; a person claiming as a result of bodily injury to or the death of another; a person claiming on behalf of someone who suffered bodily injury or death; the representative of the estate of a person who suffered bodily injury or death; or a person bringing a wrongful death action.

(c) "Recovery" means the sum received by way of settlement or judgment. Costs of medical care, amounts deducted as collateral sources under 27-1-308, and an attorney's office overhead costs are not deductible disbursements or costs.

SECTION 3. **Periodic Payments -- DELETE.**

SECTION 4. **Compensation of Attorneys -- RECOMMEND NO MODIFICATION TO CURRENT LAW.**

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SENATE JUDICIARY
EXHIBIT NO. 4
DATE 3-24-93
BILL NO. HB 346

Helena, Montana
March 23, 1993

Montana Senate Judiciary Committee
Helena, Montana

Dear Committee Members:

My comments are to be delivered at the hearing for House Bill 346 which is to come before your committee on March 24th.

Previously, I was employed in the Livingston railroad locomotive repair facility then owned and operated by Burlington Northern.

While employed there, I suffered an on-the-job injury, made a subsequent settlement and left the employment of the railroad. At the time of the settlement, I was offered an annuity with periodic payments. My wife and I decided to take a lump-sum payment, as we wanted to get on with our lives.

Subsequently, we moved to Helena and leveraged these funds to get us into a small business which has grown over these past several years. Presently, we own and operate the two Insty-Prints shops here in Helena, and we directly employ 20 people.

We have also participated in the opening of other Insty Print shops in Montana, and we intend to open another shop soon in Hamilton, Montana. We have assisted some of our employees in starting their own shops, in all, over 100 people now have employment because we could start our lives over after the accident by leveraging the funds from the lump-sum settlement.

I can also say that I believe if I had taken an annuity with periodic payments, that today I would be probably be working at a minimum wage job, and not providing a brighter future for myself and family as well as employment for many persons as we now do.

I believe the periodic payment feature in House Bill 346 is wrong, and I urge that it be removed from the bill entirely.

Sincerely,

Clark Broadbent

Montana Trial Lawyers Association

Executive Office
#1 Last Chance Gulch
Helena, Montana 59601
Tel: 443-3124

March 24, 1993

SENATE JUDICIARY
EXHIBIT NO. 5
DATE 3-24-93
BILL NO. HB 346

Sen. Bill Yellowtail, Chair
Senate Judiciary Committee
Room 325, State Capitol
Helena, MT 59620

RE: HB 346

Mr. Chair, Members of the Committee:

Thank you for this opportunity to express MTLA's opposition to HB 346, which limits non-economic damages and contingency fees in medical malpractice cases and restricts the payment of future damages in all cases.

MONTANA DOES NOT NEED HOUSE BILL 346

1. Medical malpractice accounts for less than one percent of Montana's annual health care bill. If absolutely all liability for medical malpractice were abolished and all health care providers were somehow completely protected from frivolous lawsuits, the price of a $40 office visit would decline approximately 25 cents.

2. The absence of doctors in rural areas of Montana is not attributable to medical liability premiums. HB 346, by benefitting far more urban doctors and specialists than rural doctors, will not improve rural access.

3. The number of Montana doctors, including family physicians and OB-GYNs, is increasing. Unlike most other Montana industries, the health-care industry in Montana is growing vigorously.

4. The majority of Montana doctors earned more than $100,000 last year, even after they paid all liability premiums and other expenses. Montana doctors pay a smaller proportion of their net income for liability insurance than Montana truckers do.

5. Two factors more than any other influence the liability premiums paid by Montana doctors: first, the potentially catastrophic nature of injuries caused by medical

malpractice; second, the small pool of doctors among which to spread the insurance costs of those injuries.

6. Only one in 16 victims of medical malpractice receive compensation for their injuries. In fact, even in cases where the liability insurer labels the doctor's conduct indefensible, victims who go to trial lose as often as they win.

7. The costs of medical malpractice insurance are determined by the costs of medical malpractice. More Montanans die every year because of medical malpractice than because of traffic accidents.

8. Montana doctors and their insurance companies choose to settle the vast majority of malpractice claims, often in order to keep those settlements confidential. Since 1984, fewer than 5 percent of Montana doctors have paid multiple malpractice claims, yet that minority has accounted for 40 percent of all malpractice settlements and 60 percent of all payments to malpractice victims. One doctor, for example--identified by the Montana Board of Medical Examiners only as Doctor 43--settled with malpractice victims for $600,000 in 1986, $391,000 in 1989, and $105,000 in 1992. Yet the patients of Doctor 46 have no right to that information.

9. Doctors grossly misperceive the threat of malpractice suits.

10. HB 346 will not reduce "defensive medicine" which results from doctors' exaggerated, persistent misperceptions about legal liability.

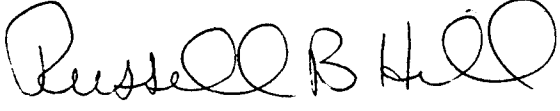
11. The proposals contained in HB 346 differ significantly from statutes in California, Colorado, and other states. The proposals in HB 346 have not reduced medical liability premiums or payments to malpractice victims, restrained overall health care costs, or improved access to medical care in other states.

12. Montana has already enacted numerous so-called tort reform proposals at the request of health care providers, including drastic reductions in the statutes of limitations applicable to children (1987 and 1989); mandatory screening panels which require victims to await action by an administrative panel before filing suit (1977); immunity for negligent providers when the victim happens to be the patient of a direct-entry midwife (1989); and immunity for providers who render negligent emergency care in emergencies without compensation (1987). The proponents of HB 346 weren't satisfied by <u>these</u> so-called tort reforms. They ignore the absence of similar "reforms" in California, Colorado, and other states. And they won't be satisfied with HB 346.

Despite the accompanying materials, which demonstrate terrible problems with HB 346, MTLA recognizes that legislators may nevertheless enact some version of the bill. Although unalterably opposed to the bill, and without presuming to bargain away the rights of future victims, MTLA suggests that any version of HB 346 ultimately approved by this Legislature should incorporate the accompanying amendments.

Thank you for considering these comments and the accompanying materials. If I can provide additional information, verification, or assistance, please contact me.

Respectfully,



Russell B. Hill, Executive Director

HOUSE BILL 346: HOW IT DOESN'T WORK

Section 1: Capping Non-Economic Damages in Medical Malpractice Cases

* Imposes a complex and arbitrary $500,000 cap on non-economic damages
* Ignores the recommendation of Governor Stephens' Health Care for Montanans Committee that such a cap exclude physical impairment and disfigurement
* Applies a single $500,000 cap regardless of how many victims result from "a single incident of malpractice" and regardless of how many health care providers (hospitals as well as doctors and nurses) are responsible for "a single incident of malpractice"
* Applies the cap on non-economic damages first, then applies such other mandatory reductions as apportionment for joint and several liability, contributions from collateral sources, set-offs and credits
* Prevents a jury from being told about the cap or how it will operate in the specific case which they are considering

Sections 2 and 4: Capping Contingency Fees in Medical Malpractice Cases

* Arbitrarily limits contingency fee percentages to 40 percent, 33.3 percent, 25 percent, and 15 percent, with no possibility of intermediate arrangements which are mutually agreeable to victims and their attorneys
* Arbitrarily bases contingency fee limits on threshold amounts of recovery--$50,000, $100,000, and $600,000--with no explanation of the significance of those amounts
* Imposes no limits on the fees paid by insurance companies to defense attorneys, despite the fact that those fees--unlike fees paid by victims to their attorneys--contribute directly to higher premiums
* Ignores differences in attorney involvement between negotiated settlements, jury trials, and appeals
* Ignores the substantial financial investment of $50,000, $100,000 or more that contingency-fee attorneys must make in catastrophic medical malpractice cases
* Contains no definition of "contingency fee"
* Applies to indemnity and subrogation claims arising out of medical malpractice cases as well as medical malpractice cases themselves

Section 3: Mandating Periodic Payment of Future Damages in ALL Cases

* Applies to all types of cases--not just those involving medical malpractice, not even just those involving personal injury--when periodic damages exceed $100,000
* Applies to all future damages, economic as well as non-economic
* Ignores the current discretion of a judge to order periodic payments when they are in the best interest of the victim and requires that judge, at the request of a losing defendant, to order future damages be paid by annuity or similar periodic payments
* Imposes impossible burdens on judges to calculate and reverse any reductions to present value which a jury applied to future damages
* Releases a defendant from responsibility when the insurance company providing the annuity breaches its obligations to a victim because of insolvency, intervention by state regulators, carelessness, or any other reason
* Requires a plaintiff who has already successfully proven his or her claim to endure a new, additional mini-trial on the issue of periodic payment

HB 346: Damage Caps

Damage caps punish only the most severely injured victims, especially those who are paralyzed, brain-damaged, or otherwise incapacitated. The more severe the injury, the greater the likelihood that damage caps will leave the victim financially dependent upon society.

Caps on non-economic damages impact women, children, and poor people most severely, since these victims generally earn lower wages, live longer, and suffer more mental and emotional trauma from such non-economic injuries as sterilization, disfigurement, loss of unborn children, and physical impairment.

Victims rarely recover the full amount of their economic damages. Because of inadequate reimbursements, injured victims themselves pay 38 percent of the total economic losses associated with nonfatal traumatic injuries in the U.S. Nearly two-thirds (64 percent) of all wages lost due to injury are never reimbursed and thus are borne exclusively by victims. (Deborah R. Hensler, "Compensation for Accidental Injuries in the United States," The Rand Corporation, Institute for Civil Justice, 1991)

The Montana Medical Association, in its extensive 1988 reports on obstetrical care in Montana, concluded that a flat-dollar limit on damages is "misguided for a number of reasons. It doesn't work, is often held unconstitutional, and impacts more severely on the people who are injured the most." ("Who's Going to Deliver Your Baby: The Loss of Obstetrical Services in Montana--Revised," June 1988, p. 19.)

Montana's Supreme Court has declared caps on damages unconstitutional (*White v. State of Montana* (Mont. 1983), 661 P.2d 1272, 40 St. Rep. 507; *Pfost v. State* (Mont. 1985), 713 P.2d 495, 219 Mont. 206) and it would do so again. Such caps violate Montana's constitution on several grounds. They deny equal protection by discriminating (1) against victims who are most seriously injured and in favor of victims who are less seriously injured victims; (2) against victims of medical malpractice and in favor of victims of other negligence; and (3) against victims who suffer non-economic damages and in favor of victims who suffer economic damages.

Numerous other states have declared caps on medical malpractice damages unconstitutional, including Florida (*Smith v. Department of Insurance,* 507 So.2d 1080 (1987), holding that caps violate right of access to courts); Illinois (*Wright v. Central DuPage Hospital Assn.,* 347 N.E.2d 736 (1976), holding that caps violate prohibition against special privileges); Kansas (*Kansas Malpractice Victims Coalition v. Bell,* 757 P.2d 251 (1988), holding that caps violate right to jury trial, adequate remedy and due course of law); New Hampshire (*Carson v. Maurer,* 424 A.2d 825 (1980), holding that caps violate equal-protection guarantees); North Dakota (*Arneson v. Olson,* 270 N.W.2d 125 (1978), holding that caps violate equal-protection guarantees); and Texas (*Lucas v. U.S.,* 757 S.W.2d 687 (1988), holding that caps violate right to open courts.) Most recently, Ohio's Supreme Court last August declared a $200,000 medical-malpractice cap on non-economic damages similarly unconstitutional, and in the course of that opinion cited a 1987 claims study by the Insurance Service Organization (ISO), the statistical arm of the insurance industry. The ISO study concluded that savings from various tort "reforms"

including a $250,000 cap on non-economic damages were "marginal to non-existent." (*Morris v. Savor,* No 89-1807 (Ohio Supreme Court, August 27, 1991).)

A study of medical negligence legislative limits passed in various states from 1974 to 1978 concluded that the changes, either individually or collectively, did not reduce or stabilize insurance rates. (Frank Sloan, "State Responses to the Malpractice Insurance 'Crisis' of the 1970s: An Empirical Assessment," *Journal of Health, Politics, Policy and Law,* Winter 1985)

Missouri capped non-economic damages in medical-negligence cases at $350,000 in 1986. But the average medical-negligence award against Missouri doctors increased 51 percent between 1990 and 1991, to $149,000. The average medical-negligence award against hospitals rose 11 percent in the same year, to $122,000. (*St. Louis Business Journal*, September 28, 1992)

Indiana capped all damages in medical-negligence cases in 1975. Yet medical-negligence payments in Indiana exceed those in neighboring Michigan by 40 percent and those in neighboring Ohio by 33 percent. Neither Michigan nor Ohio has enacted caps on damages. Moreover, 27.9 percent of medical-negligence claimants in Indiana received the $500,000 maximum, while only 13 percent of claimants in Michigan and Ohio got as much as $500,000. Why? Because in Indiana, where the maximum liability of insurance companies in medical-negligence cases is $100,000, the defense of those cases is less vigorous and "the ceiling becomes the floor." (Indiana University law professors Eleanor D. Kinney and William P. Gronfein, as reported in the *National Law Journal*, November 16, 1992, p. 34)

Wisconsin capped non-economic damages in medical-negligence cases at $1 million in 1985 and abandoned caps at the end of 1991 after six years of unsatisfactory results (*National Law Journal*, November 16, 1992, p. 37)

Aetna Life & Casualty calculated that capping non-economic damages at $450,000 would have no measurable impact on future liability premiums when it filed rate information required by Florida's "tort reform" legislation in 1986. (Rate filings with Florida Department of Insurance.)

State Farm Fire and Casualty Company estimated that a cap on non-economic damages in Kansas would impact premiums less than one percent. (Letter from Robert Nagel, vice president, to Kansas Insurance Department dated October 21, 1986)

A 1991 report by Washington's insurance commissioner Richard Marquardt to that state's legislature denied that "tort reform" changes were responsible for stabilizing rates and increased availability of coverage. To the contrary, a 1989 law requiring insurers to consider investment income in setting rates was projected to have a much greater impact on insurance rates than changes in the tort system. ("A Study of the Effect of Tort Reform on Insurance Rates and Availability and Its Impact on the Civil Justice System," Report to the Washington State Legislature, January 1991).

HB 346: Mandatory Periodic Payments

HB 346 mandates that all future damages totalling more than $100,000--not just those awarded in medical malpractice cases--be paid in installments upon request. Thus, a farmer who buys defective seed which causes $200,000 in damages to his soil for the next five years or a business owner who suffers lost sales in that amount could also be forced to accept compensation over the span of decades.

Montana law already allows the parties in a medical-negligence case to agree on periodic payments, and it allows the presiding judge to enforce such payments when they're in the interest of the victim, Sec. 25-9-403, MCA. HB 346, however, would force presiding judges to order periodic payments requested by a losing party.

Despite the fact that they have been authorized to do so since 1987, Montana judges have rarely--perhaps never--ordered periodic payments in the best interests of the claimant. In a society which values the right of individuals to make decisions for themselves, victims are entitled and best equipped to determine their own best interest.

Mandating periodic payments presumes that victims will squander their compensation and insurance companies will wisely manage it. The elitist presumption that ignorant, undisciplined victims will "blow their money on whiskey and Cadillacs" insults working men and women.

HB 346 completely shifts the risk of non-payment onto the victim: If a defendant or insurance company over the decades-long period of mandated payments becomes unable for any reason to continue those payments, the victim is unalterably deprived of compensation. And insurance companies frequently do go bankrupt.

Jury awards represent the damage already done to victims because of the fault of defendants. But mandated periodic payments permit those defendants to retain possession and control of victims' money, in effect making those victims dependent and further depriving them of dignity. Essentially, HB 346 replaces jury awards with welfare.

Montana laws favor finality of judgements and discourage continuous litigation. But by mandating periodic payments without defining "the best interests of the claimant" or specifying criteria for periodic payments, HB 346 will actually increase litigation. Victims who dispute a judge's determination of their best interest will be forced to challenge that determination by exploring uncharted legal territory. Judges who customize periodic payments to the best interests of the claimant risk similar legal challenges from defendants. Judges who customize periodic payments to the best interests of the claimant also risk the prospect that such customized annuities will be unavailable in the private insurance market.

The Alabama Supreme Court recently ruled that state's attempt to require periodic payments of future damages unconstitutional. In *Billy Ray Clark and Halliburton Industrial Services Division v. Container Corp. of America*, 589 So.2d 184 (1991), the court said the Legislature lacked the authority to require structured payments of future damages exceeding $150,000 in personal injury suits.

HB 346: Contingent-Fee Caps

Montana's legal Code of Professional Responsibility already adequately governs attorney fees, including contingent fees. (Rule 1.5, Montana Rules of Professional Conduct; also *Wight v. Hughes Livestock Co. Inc.* (Mont. 1983), 664 P.2d 303, 312.)

Contingency fees provide access to justice for injured Montanans who--unlike wealthy insurance companies and corporations--can't afford to hire an attorney otherwise. Contingency fees shift the risks of non-recovery in an expensive, complex medical malpractice case onto an attorney and away from victims. Proponents of contingent-fee caps don't--and can't--explain how attorneys should be compensated when they lose.

Sliding-scale contingency fees target the most catastrophic injuries, precisely those which are likely to be most vigorously contested, most complex, and most expensive to prove. These are the very cases requiring the attorney to advance the greatest investments of time and money and assume the greatest risks of loss. Defense attorneys, meanwhile, assume no such risk in the service of insurance companies and defendants with enormous financial resources. Clients actually complain much more frequently about attorneys' hourly fees than about contingency fees.

Contingency fees are paid, not by physician-defendants or insurance companies, but by victims from their recoveries. Yet physicians and insurance companies, not clients, are advocating sliding scale contingency fees. The real goal behind contingent-fee caps is to reduce the amount that victims and their attorneys can spend to prove medical-negligence cases in court.

An American Medical Association task force concluded that regulating contingency fees "may not reduce the number or severity of suits." ("Do Contingency Fees Really Cause Malpractice Suits?" in *Medical Economics,* October 21, 1985.)

Contingency fees weed out "frivolous" lawsuits. When an attorney's compensation is contingent on the outcome of legal action, he or she will avoid cases with little or no chance of success. Contingency fees impose strong incentives on attorneys to thoroughly and accurately review the prospects for success before filing suit. The U.S. Department of Health, Education and Welfare, for instance, found that average attorney involvement in "zero recovery" malpractice cases was 440 hours. It also found that 60 percent of medical-malpractice cases which go to trial result in no recovery at all. (See "Report of the Secretary's Commission on Medical Malpractice," U.S. Department of Health, Education and Welfare, Pub. No. 73-88 (1973), p. 33.)

In complex personal injury litigation such as medical negligence, attorneys generally agree to represent only 1 out of every 9 or 10 injured people who seek legal counsel. Why? Because they determine (1) that the injuries of their clients were not caused by malpractice or (2) that the high costs of pursuing such a complex claim will exceed any recovery. (Andrea Darvas, "Fundamentals of Medical Negligence Practice: Screening the Case," *Trial News*, October 1990)

Amendments to House Bill 346: Noneconomic Damages
Third Reading Bill (Blue Copy)

Requested by Russell B. Hill
For the Montana Trial Lawyers Association

1. Page 1, line 18.
Strike: "action or actions"

2. Page 1, lines 19 and 20.
Following: "malpractice," on line 19
Strike: the remainder of line 19 through "awards" on line 20
Insert: "an award"

3. Page 1, line 21.
Following: "$500,000"
Insert: "per claimant"
Strike: the remainder of line 21 through "reduction" on page 2, line 13

4. Page 2, line 14
Strike: "For each claimant, further"
Insert: "Other required"

5. Page 2, line 15
Following: "order"
Insert: "prior to any reduction for noneconomic loss"

6. Page 2, line 22.
Following: line 21
Insert: "(3) The limit on noneconomic damages specified in (1) must be adjusted annually in accordance with the consumer price index defined in 15-30-101."
Renumber: subsequent sections

7. Page 3, line 10.
Following: "CHAPTER 8."
Insert: "In order to qualify as a health care provider for purposes of this section, a physician, dentist, health care facility, or nurse must maintain, after October 1, 1993, commercial professional liability insurance coverage with an insurance company authorized to do business in this state in a minimum indemnity amount of $500,000 per incident and $1.5 million annual aggregate per year."

8. Page 3, lines 11 and 12
Following: "Malpractice claim"
Strike: the remainder of line 11 through "27-6-103." on line 12
Insert: "means a claim based on a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate

cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or other health care provider."

9. Page 3, lines 15 and 16
Following: "inconvenience;"
Strike: the remainder of line 15 through "disfigurement;" on line 16

10. Page 3, line 18.
Following: "humiliation."
Insert: "Nothing in this section shall be construed to limit the recovery of exemplary damages or the recovery of compensatory damages for physical impairment or disfigurement."

Reason for amendments:

Amendments 1 through 3 simplify the $500,000 cap on noneconomic damages by applying it to each claimant rather than multiple claimants. The maximum recovery for noneconomic damages is still limited to $500,000 even when multiple health care providers were to blame for "a single incident of malpractice." The amendments conform HB 346 more closely to California and Colorado law. See Colorado Revised Statutes, Sec. 13-64-302; California Civil Code, Sec. 3333.2; *Atkins v. Strayhorn*, 223 Cal.App.3d 1380 (1990).

Amendments 4 and 5 impose the $500,000 cap on noneconomic damages after rather than before other statutory reductions such as comparative fault, the victim's own insurance payments, etc. The amendments conform HB 346 more closely to California law. See *Atkins v. Strayhorn*, 223 Cal.App.3d 1380 (1990).

Amendment 6 adjusts the $500,000 cap on noneconomic damages according to the same consumer price index used to adjust Montana taxes.

Amendment 7 requires a health care provider to obtain liability insurance before benefitting from the protection provided by a cap on noneconomic damages. The amendment conforms HB 346 more closely to Colorado law. See Colorado Revised Statutes, Sec. 13-64-301.

Amendment 8 replaces the definition of "malpractice claim" contained in Sec. 27-6-103, MCA, with statutory language copied from California's provision capping noneconomic damages. The amendment recognizes the important differences between a definition designed to encourage non-binding arbitration before the medical-legal screening panel and a definition designed to deny damages awarded by a jury to a successful claimant. The amendment caps noneconomic damages only in cases of negligence and not in cases of intentional acts, gross negligence, or flagrant disregard for license restrictions. See California Civil Code, Sec. 3333.2; see also Colorado Revised Statutes, Sec. 13-64-202(5).

Amendments 9 and 10 exempt noneconomic damages resulting from physical impairment or disfigurement from the statutory $500,000 cap. The amendments conform HB 346 more closely to Colorado law, the recommendations of Gov. Stephens' Health Care for Montanans Committee, and the Legislative Council's draft bill incorporating those recommendations. See Colorado Revised Statutes, Sec. 13-21-102.5(5).

Amendments to House Bill 346: Attorney Fees
Third Reading Bill (Blue Copy)

Requested by Russell B. Hill
For the Montana Trial Lawyers Association

1. Page 1, line 8.
Strike: "PLAINTIFF'S CONTINGENCY"

2. Page 3, line 20.
Strike: "contingency"

3. Page 3, line 21.
Strike: "contingency"

4. Page 3, line 22.
Strike: "for representing a claimant"

5. Page 4, line 1.
Following: "(a)"
Strike: remainder of subsection (1)
Insert: "on a contingent-fee basis:
(i) 40% of the first $250,000 recovered;
(ii) 33.3% of the next $250,000 recovered;
(iii) 25% of the next $500,000 recovered; and
(iv) 20% of any recovery above $1,000,000.
(b) on an hourly-fee basis, $95 per hour, not to exceed $500,000."

6. Page 4, line 11.
Strike: "less"
Insert: "different"

7. Page 4, line 12.
Following: "section"
Insert: "upon a showing of good cause."

8. Page 4, line 14.
Following: "recoveries"
Insert: "and combined fees"

9. Page 4, line 16.
Strike: "claimants"
Insert: "parties"

10. Page 4, line 18.
Following: line 17

Insert: "(4) The dollar amount limits in subsection (1) must be adjusted annually in accordance with the consumer price index defined in 15-30-101."
Renumber: subsequent sections

11. Page 4, line 25.
Strike: "Claimant"
Insert: "Party"

12. Page 5, line 5.
Strike: "or"

13. Page 5, line 6.
Strike: "."
Insert: "; a defendant in any such claim or action; or an insurer of any such defendant."

14. Page 5, line 13
Following: line 12
Insert: "(5) Every attorney representing a party in a malpractice claim must disclose upon request the amount of fees received as a result of that claim."

Reason for amendments:

Amendments 1 through 4, 8, 9, and 11 through 13 modify the current language of HB 346 to accomodate Amendment 5, which applies fee limits to both claimant attorneys and defense attorneys.

Amendment 5 applies two types of attorney-fee limits. For contingent fees, it retains the first three percentages in HB 346 (40%, 33.3%, and 25%), raises the final percentage from 15% to 20%, and applies them to higher thresholds ($250,000, $500,000, $1 million). The amendment also limits hourly fees to $95 (compared to typical hourly fees of $110 in medical malpractice cases) and imposes a maximum fee of $500,000 (i.e., 5,263 hours) on attorneys charging hourly rates in a medical malpractice claim. By comparison, a contingent-fee attorney charging the maximum allowed by this amendment would need to recover $1,958,750 in order to collect $500,000. The amendment discourages protracted litigation on both sides while preserving the risk and flexibility of contingent fees as well as the safety and certainty of hourly fees.

Amendments 6 and 7 authorize a court to approve attorney fees greater or less than those prescribed by subsection (1) in exceptional circumstances.

Amendment 10 adjusts the contingent-fee threshhold amounts and the hourly-fee limits according to the same consumer price index used to adjust Montana taxes.

Amendment 14 requires all attorneys involved in medical malpractice claims to disclose their fees upon request.

Amendments to House Bill 346: Periodic Payments
Third Reading Bill (Blue Copy)

Requested by Russell B. Hill
For the Montana Trial Lawyers Association

1. Page 6, line 23.
Following: "bond."
Strike: remainder of line 23 through "discharged" on page 7, line 1
Insert: "The judgment is not satisfied and the judgment debtor is not discharged until all periodic payments have been made. As a condition to ordering periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor. Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security given shall revert to the judgement debtor."

Reason for amendment:

The amendment conforms HB 346 more closely to California law, which imposes a continuing obligation on judgment debtors and contains no provision discharging them from those obligations upon the purchase of inflation-indexed annuities. See California Code of Civil Procedure, Sec. 667.7.

Amendments to House Bill 346: Disclosure
Third Reading Bill (Blue Copy)

Requested by Russell B. Hill
For the Montana Trial Lawyers Association

1. Page 1, line 11.
Following: "CONDITIONS;"
Insert: "REQUIRING DISCLOSURE OF MEDICAL MALPRACTICE CLAIMS AND RECOVERIES;"

2. Page 1, line 12.
Following: "25-9-403"
Insert: ","
Strike: "AND"
Following: "25-10-301,"
Insert: "AND 27-6-103"

3. Page 7, line 22.
Following: line 21
Insert: "**Section 5.** Section 27-6-103(5), MCA, is amended to read:

"Malpractice claim" means any claim or potential claim of a claimant against a health care provider for medical or dental treatment, lack of medical or dental treatment, or other alleged departure from accepted standards of health care which proximately results in damage to the claimant, whether the claimant's claim or potential claim sounds in tort or contract, and includes but is not limited to allegations of battery or wrongful death. A health care provider must disclose, upon request, the number of malpractice claims resolved against the provider by payment to a claimant and the amount of payment involved in each such resolution.

Reason for amendments:

Amendments 1 and 2 modify the current language of HB 346 to accomodate Amendment 3.

Amendment 3 provides the only corresponding protection in HB 346 to health-care consumers who are forced to surrender their rights to full compensation, to control that compensation themselves, and to freely contract for legal services. The amendment enables health-care consumers, when they select a health-care provider, to detect and avoid those providers most likely to injure them.

Amendments to House Bill 346: Sunset
Third Reading Bill (Blue Copy)

Requested by Russell B. Hill
For the Montana Trial Lawyers Association

1. Page 13, line 19.
Following: line 18.
Insert: "NEW SECTION. **SECTION 7.** [This act] terminates October 1, 1995."

Reason for amendment:

This amendment recognizes the lack of objective data presently supporting HB 346 and the likely mandate in Senate Bill 285 to analyze these same three measures: caps on noneconomic damages, mandated periodic payment of future damages, and reverse sliding scale limits on contingency fees. By adding a sunset provision, the amendment challenges proponents of HB 346 to demonstrate that the bill has actually benefitted health-care providers, and it challenges opponents to demonstrate that the bill has actually victimized consumers.

The Evolution of HB 346

HEALTH CARE FOR MONTANANS COMMITTEE

Recommendation: $250,000 cap on non-economic damages (excluding physical impairment and disfigurement)

LEGISLATIVE COUNCIL BILL DRAFT #LC0124

NEW SECTION. **Section 6. Medical malpractice non-economic damages limitation.** A medical malpractice award of non-economic damages for injuries other than physical impairment, physical disfigurement, or both, may not exceed $250,000.

MMA RECOMMENDED SUBSTITUTE LANGUAGE

NEW SECTION. Section 6. Medical malpractice non-economic damages limitation. (1) In any action against a health care provider based on a malpractice claim, any award of future damages for noneconomic loss shall not be discounted to present value and the combined award or awards of past and future damages for noneconomic loss, whether by one or more claimants in the same or in separate proceedings or whether based on the same or separate acts, shall not exceed two hundred fifty thousand dollars ($250,000), except as otherwise provided in subsection (5).

(2) The limit on the award of damages provided for in this section shall not be disclosed to a jury and an award of damages for noneconomic loss in excess of $250,000 shall be reduced to $250,000 by the court after an award of damages is rendered at trial and before the entry of judgment or by amendment of the judgment after entry.

(3) Where more than one claimant is involved in an action where the combined award of damages for noneconomic loss exceeds $250,000, the court shall reduce the combined awards to $250,000 and apportion the $250,000 among the claimants. If separate proceedings are brought on the same malpractice claim, no claimant shall recover an amount as damages for noneconomic loss which, when added to the damages for noneconomic loss previously recovered by another claimant or claimants, exceeds $250,000.

(4) If separate awards of damages for past and future noneconomic loss are rendered in the same action, and the combined awards exceed $250,000, the award of damages for future noneconomic loss shall be reduced first and the award of damages for past noneconomic loss shall not be reduced unless it exceeds $250,000.

(5) An award of damages for noneconomic loss in excess of $250,000 shall be reduced to $250,000 before accounting for any other reduction in

damages required by law, and the order of further reduction shall be: first, pursuant to 27-1-702 and 27-1-703, the claimant's percentage of negligence and the percentage of liability attributed to any other party; and second, setoffs or credits against damages for noneconomic loss to which a defendant is entitled. For purposes of comparative negligence and a settling person, a setoff or credit shall be apportioned to damages for noneconomic loss in the same amount as the settling person's percentage of liability, applied to either the award of noneconomic damages at trial or $250,000, whichever is less.

(6) Separate acts of professional malpractice by one or more health care providers shall not result in liability for more than a total of $250,000 as damages for noneconomic loss, unless damages are awarded for separate noneconomic loss caused by separate injuries sustained by a claimant during separate courses of treatment. The burden of proving such separate noneconomic loss, separate injuries, and separate courses of treatment shall be on the claimant.

(7) As used in this chapter, the following definitions apply:

(a) "Health care provider" means a dentist, health care facility, and physician as defined in 27-6-103(1)(b), 27-6-103(2), and 27-6-103(7)(b).

(b) "Malpractice claim" means a malpractice claim as defined in 27-6-103(5).

(c) "Noneconomic loss" means subjective, non-monetary losses including, but not limited to, pain, suffering, inconvenience, physical impairment, disfigurement, mental suffering, emotional distress, loss of society and companionship, loss of consortium (other than loss of household services), injury to reputation, and humiliation.

(d) "Claimant" includes, but is not limited, to one or more individuals suffering bodily injury, an individual claiming on behalf of or as a result of bodily injury to another, the representative of the estate of a deceased individual, and a beneficiary of an action for wrongful death.

St. Paul Fire And Marine Insurance Company
Proposed Physician and Surgeon Average Rates
On An Annual Basis After July 1, 1992

(Based on Class 3 doctor/mature claims-made rates primarily at $1 million/$3 million limits)

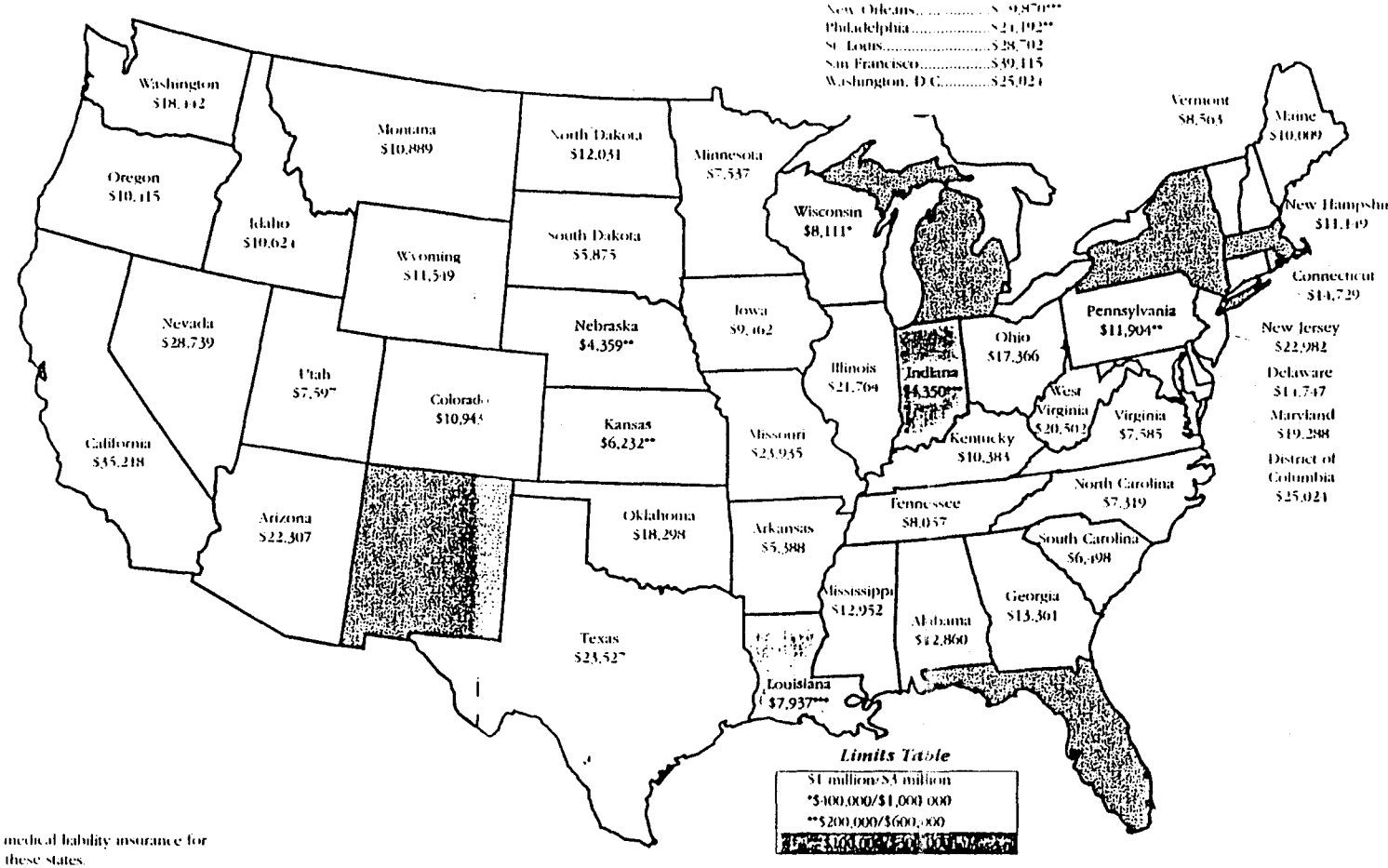
Comparison of Medical Liability Insurance Rates

Currently, average annual premiums range from $5,388 in Arkansas to $48,718 in Chicago for a Class 3 physician purchasing liability limits of $1 million/$3 million at mature claims-made policy rates. The Class 3 rate reflects the average premium paid by physicians and surgeons insured with The St. Paul.

The map shows average rates for $1 million/$3 million limits of liability except in states where lower limits are mandatory. Selected metropolitan areas established as separate rating territories from the remainder of their respective states are listed separately.

Individual premiums are determined by a physician's specialty or rating class, the state or territory where a physician practices, the limits of liability selected and the number of years insured under claims-made coverage.

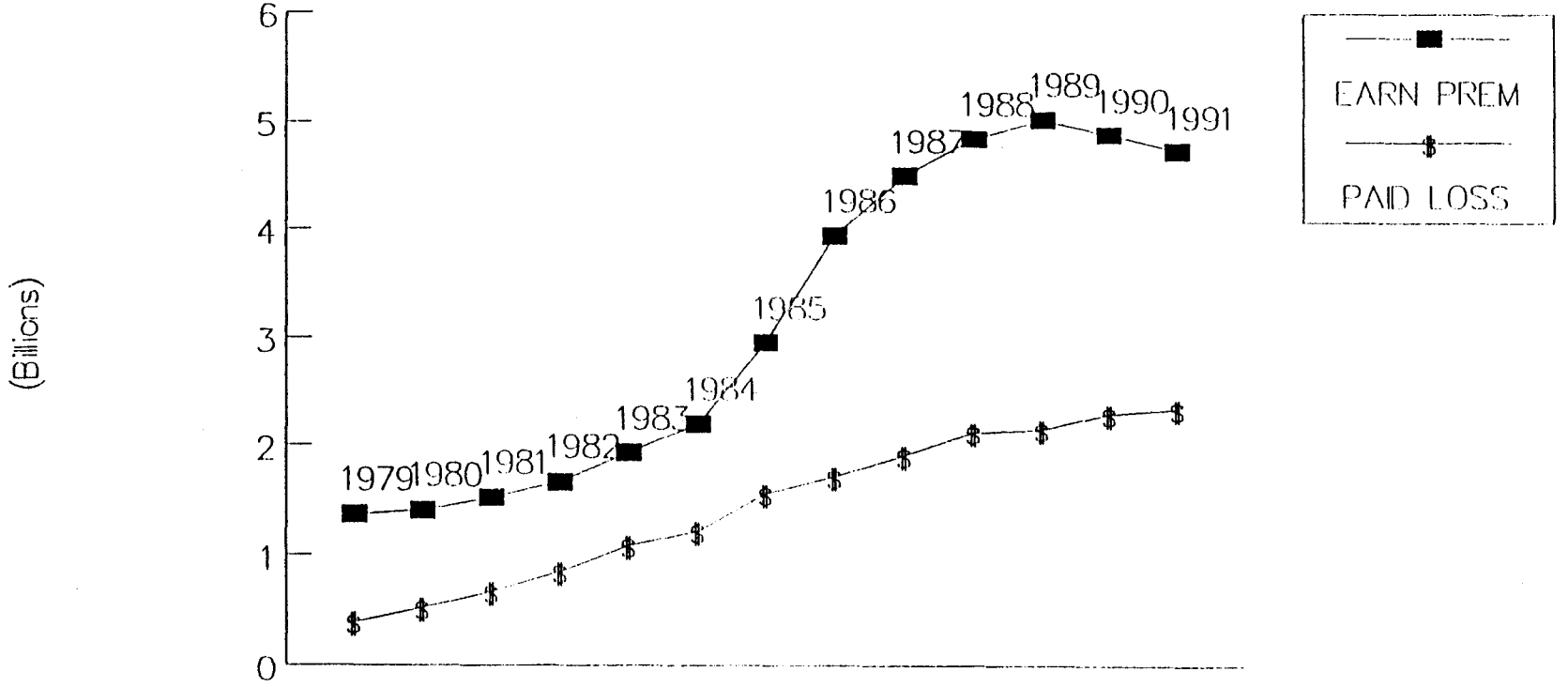
This comparison of rates for Class 3 physicians purchasing $1 million/$3 million limits on a mature claims-made policy provides an overview of rates countrywide. **To determine your exact premium, please consult with your independent insurance agent.**



The St. Paul does not offer medical liability insurance for physicians and surgeons in these states.

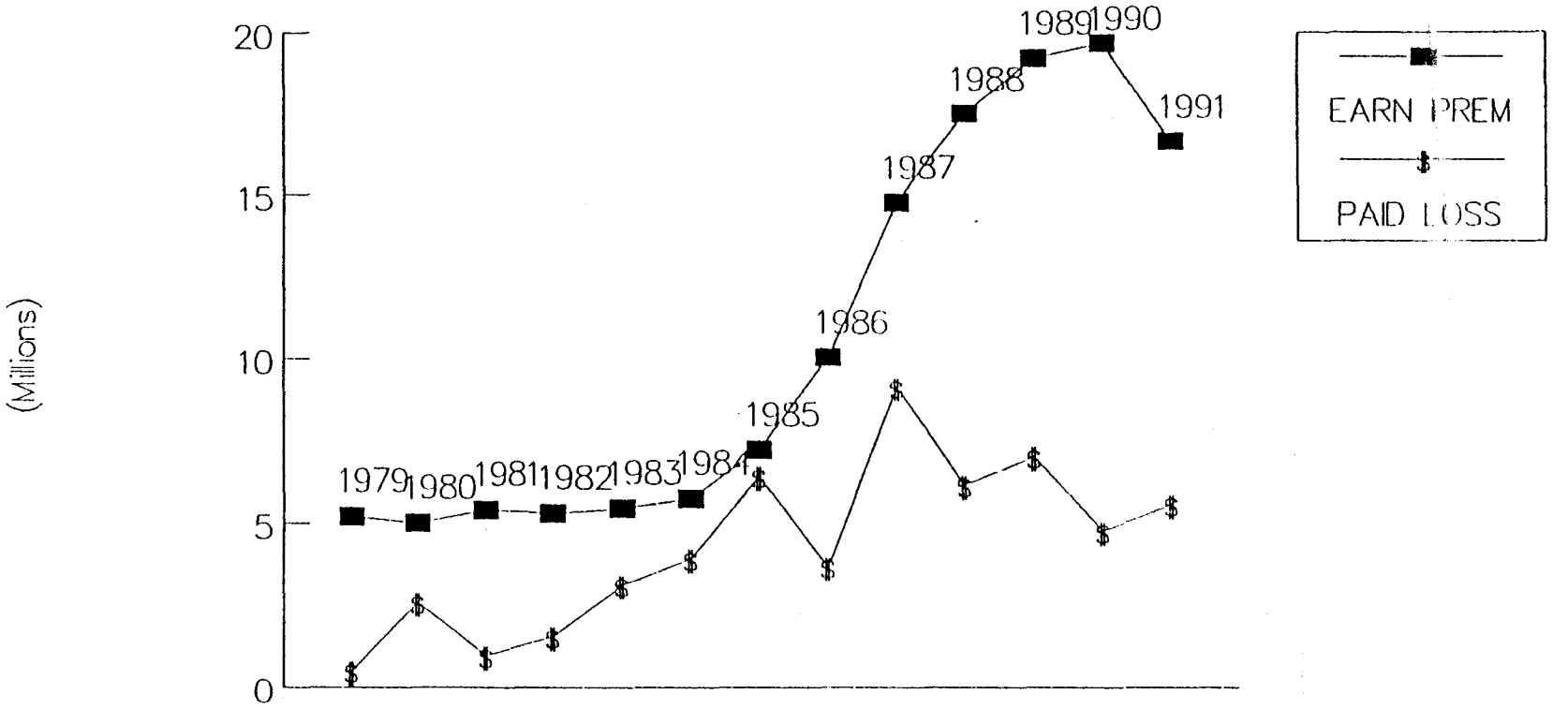
MEDICAL MALPRACTICE PREMIUMS

U.S. TOTAL 1979–1991



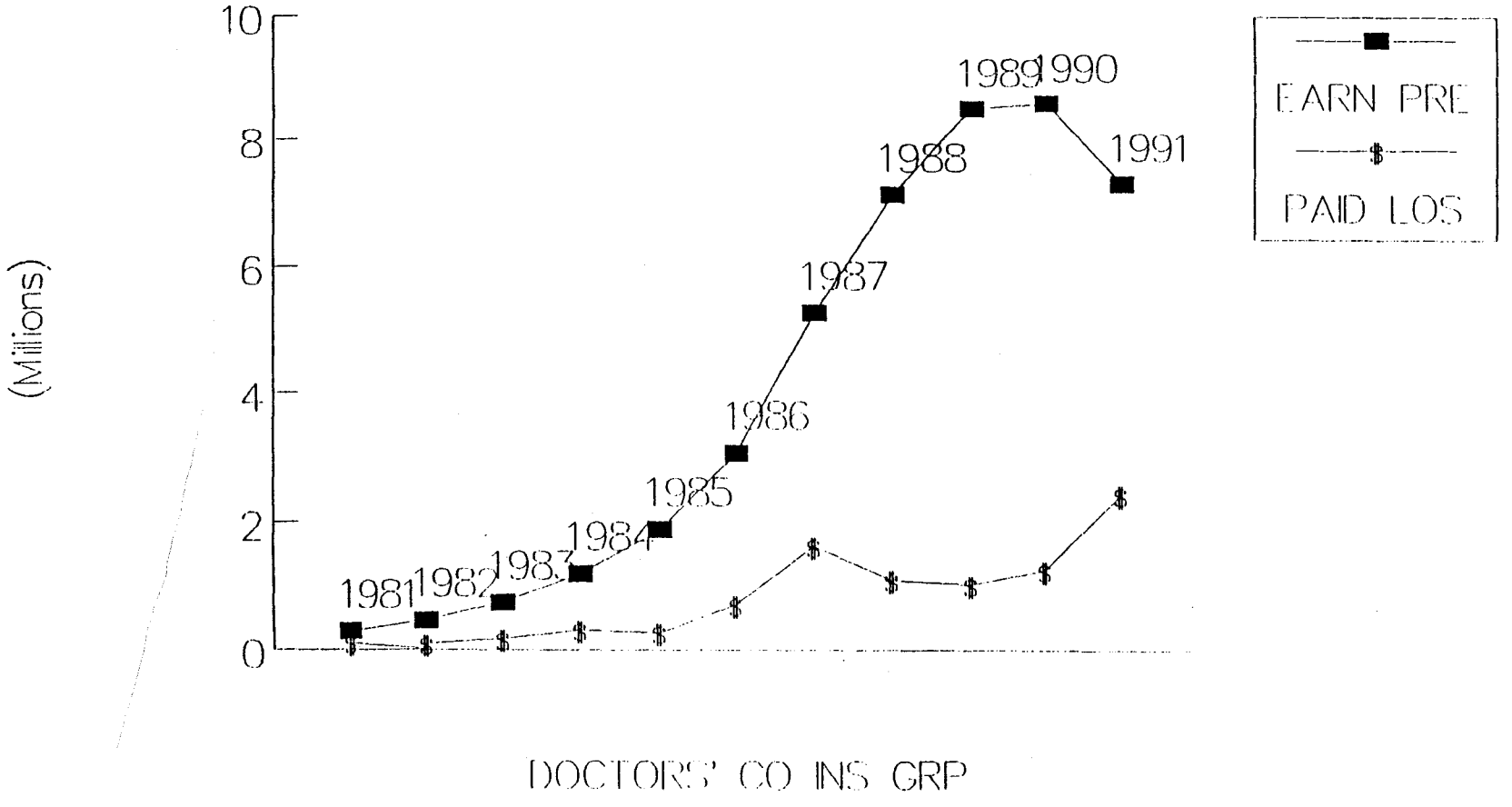
MEDICAL MALPRACTICE PREMIUMS

MONTANA 1979-1991



MEDICAL MALPRACTICE PREMIUMS

MONTANA 1979–1991



To the Senate Judiciary Committee
Honorable William Yellowtail, Chairman

ATE JUDICIARY
BIT NO. 6
E 3-24-93
NO. HB 346

Re: HB 346 Medical Malpractice Tort Reform

Recommendation: That you table the bill now and wait to consider any medical malpractice reform as part of an overall plan for medical reform.

I am concerned with the way certain legislation in this session has taken on the landslide effect--once the ball gets rolling nothing can stop it, and regardless of the merits of the legislation. Anything that stands in the path of the landslide is crushed.

We have addressed ourselves to the wrong problem. The real problem is that we, the American public, we, the Montana public, have deified the medical profession. We have made gods of them--------and we are paying the price.

Lets put the American medical profession in a historical perspective of what the medical profession has inflicted on the American public through their arrogance and exalted position of the American deity, and the ignorance of the medical profession that has been foisted on an even more ignorant American public.

Case # 1. THE RUSH OF THE MEDICAL PROFESSION DURING THE 1940's, 1950's and even 1960's, TO EXCISE FROM OUR BODIES OUR OUR TONSIL"S, OUR ADENOIDS, OUR APPENDIXES, ETC.

During those years millions of Americans were deprived of some very important organs of our immune systems because of the arrogant belief of the medical profession that these organs had little if any function. Now it is known that these organs play an essential role in our immune defenses. As a youth growing up in Butte, I can remember it to be almost a status symbol to have had these organs severed from our bodies. So many of the young people were so victimized by an arrogant and ignorant medicall profession.

Case #2. THE VIRTUALLY UNIVERSAL PRACTICE DURING THE 1930's, THE 1940's, THE 1950's, AND EVEN INTO THE 1960's, TO ENCOURAGE MOTHERS NOT TO NURSE THEIR BABIES, THE RESULT BEING THAT PROBABLY THE VAST MAJORITY OF AMERICAN MOTHERS DURING THOSE DECADES DID NOT NURSE THEIR BABIES.

Undoubtedly the medical students were taught by the medical schools that mother's milk was bad for their babies, and that instead the infant formulas pushed by corporate America through their influence on the medical schools, was the only acceptable way of feeding the newborn.

Now, of course, we know how wrong the medicall profession was, and we know that we, the American public, was duped by the medical profession and its corporate baby food sponsors.

How many millions of American mothers were deprived of suckling their young; how many millions of Americans were deprived of the sustenance of life from their mother's breasts?

Case #3: THE AMERICAN WAY OF BIRTH: HOW MANY HOSPITALS,FOR DECADES AND DECADES, HAVE VIRTUALLY DEPRIVED MOTHERS FROM SEING THEIR NEWBORN OFFSPRING EXCEPT FOR FEEDING TIMES?

For the past several decades millions and millions and millions of mothers have not been able to keep their newborn in their rooms with them, and in fact have seen them rarely except primarily for feeding. How many hospitals in the world have the practice of separating the newborn infants from their mothers?

Yet these have been the practices and procedures inflicted on the American public, on the Montana public, by an ignorant and arrogant medical profession. And let us not deceive ourselves, the hospitals do not act independently from the doctors. For all practical purposes it is the doctors who control the policies of the hospitals.

I could go on with other examples, but time and circumstances do not permit. I conclude by attaching to my recommendation that you table HB 346, an article by a highly respected physician who is also highly respected for his views and knowledge and belief in alternative health care. The article by Dr. Andrew Weil, M.D, appears in the Sewptember/October 1992 issue of Natural Health Magazine. This article not only warns us all, but should frighten us all about the excesses of the practice of medicine in the United States and yes, even in our own state of Montana. No matter how you vote on this bill, please read the article. It may even save your life or the life of a loved one.

Respectfully,

Daniel J Shea

Daniel J. Shea
Respresenting only an independent point of view
Helena, Montana

WARNING:

11 Medical Practices to AVOID

Andrew Weil alerts readers to widely used medical procedures that he considers obsolete.

If you grew up in a big American city in the 1950s, you were at risk of having your thymus destroyed by the medical profession. The thymus is a pyramid-shaped gland located just behind the breastbone at the level of the heart. In those days, doctors did not understand its function as the master gland of the immune system. In fact, they taught that it had no function, that it was a "vestigial" organ. The dictionary defines *vestigial* as, "occurring or persisting as a rudimentary or degenerate structure." (Other vestigial organs included the adenoids, tonsils, and appendix, all now recognized as functioning components of the immune system.)

One of the main arguments medical scientists used to justify their low opinion of the thymus was that it shrank at puberty. The technical term for this shrinking is the "involution of the thymus," and I must say that I have difficulty grasping the logic by which it translates into "vestigial organ." In fact, the thymus is most active, and consequently most massive relative to body weight, during fetal life and early childhood, when it serves as a training ground for lymphocytes that will carry and pass on vital information about antigens to other immune cells for the rest of a person's life. This function of the thymus is mostly completed by adolescence, but the gland remains active in other ways for life.

Like all structures of the immune system the thymus has a high rate of cell division and so is sensitive to the effects of ionizing radiation, which can kill dividing cells by damaging their DNA. Doctors in the 1950s knew that they could cause the thymus to shrink prematurely by bombarding it with X-rays, and since they had decided it was a degenerate body part, not worth the space it took up, why shouldn't they knock it down early instead of waiting for nature to do the job? To justify this course of action, they invented a disease that every child had: thymic hypertrophy or excessive development of the thymus. The treatment was a course of X-rays directed at the gland. Parents, especially educated, informed parents, were urged to bring children in to leading university medical centers to correct their uncontrolled thymic hypertrophy by means of modern medical technology.

BY ANDREW WEIL, M.D.

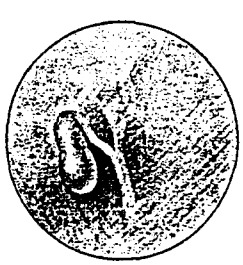
The full consequences of these treatments are still not known. We do know that many cases of thyroid cancer resulted years later in these children, which is not surprising since the thyroid is sensitive to the carcinogenic effects of radiation directed toward the upper chest. There is also strong evidence of an increased incidence of breast cancer among women who had their thymuses irradiated as children.

I commented on this episode in American medical history in my book *Health and Healing:*

"I cannot excuse such activity as simple ignorance. It is more an arrogant disregard of the wholeness and holiness of the human body. To label an organ useless because you do not understand its function and then to injure or destroy it with a technological weapon is the antithesis of good medicine and concern for health. Only allopaths are guilty of atrocities of this sort. No homeopath, chiropractor, acupuncturist, herbalist, or shaman would ever dream of treating the body in such a fashion."

One of the many reasons not to let people forget about the Thymic Hypertrophy Disaster of 40 years ago is that it might encourage them to ask this pointed question: What medical procedures are orthodox doctors doing today that we will look back on 40 years from now with equal disbelief and horror? Recognizing that hindsight is infinitely clearer than foresight, I will nonetheless attempt to warn readers about 11 common treatments that I believe are now or should soon be either obsolete or severely restricted in their use.

1.
Cholecystectomy (removal of gallbladder) by open abdominal surgery



Removing gallbladders is a popular pastime of surgeons, so much so that it is one of the most widely abused operations, frequently performed when unnecessary. It is easy to do, and the body does get along quite well without this organ. The gallbladder is a storage sac for bile, which is secreted by the liver and required for digestion of fats. Not infrequently, and more often in women than in men, stones form in the gallbladder, irritating it and sometimes blocking its outflow. This condition can lead to attacks of abdominal pain and digestive disturbances. Most asymptomatic gallstones and even many that cause symptoms can be managed by adjustments in diet (particularly by drastically cutting down on dietary fat) and by drugs, but when severe damage to or obstruction of the gallbladder results, it should be removed to prevent worse problems. Until recently, the only way to remove a gallbladder was to make an incision through the abdomen, dissect the gallbladder away from the liver, and take it out through the cut.

A new procedure, called laparoscopic cholecystectomy, renders the conventional operation obsolete in most cases. The new method is to insert a thin imaging tube connected to a video camera along with several grasping and cutting tools through tiny punctures in the navel and along the rib cage. As surgeons monitor their progress on a video screen, they take hold of the gallbladder, free it, drain it, and slip it out through one of the tiny holes. Without an open abdominal incision, patients suffer far less pain and recover much faster. Some have been out of the hospital in 24 hours and back to work in a few days compared to a four- to six-week recovery from standard surgery.

Open-abdominal cholecystectomy has been a bread-and-butter operation for many general surgeons, and since laparoscopic surgery requires special training, many are reluctant to give up the old procedure. If you know anyone who needs to have gallbladder surgery, urge them to hold out for the new operation. Also caution them to put themselves in the hands of a surgeon who has much experience with the new technique since inexperienced operators are likely to botch it, and the complications can be serious.

Laparoscopic surgery is a wave of the future that will probably eventually replace standard procedures for removing appendixes, kidneys, and bowels and repairing hernias and ulcers.

2.
Prophylactic appendectomy

For many years it has been common practice for surgeons to remove the appendix if they happen to have the

patient's abdomen open for some other reason. The idea is to prevent the possibility of future appendicitis. Since the notion that the appendix is a vestigial organ is still with us to some degree, its expendability is seldom questioned. Many patients never consented to the removal, and some only learned of it when they got their hospital bills.

The appendix is a functioning organ of the immune system. It is filled with lymphatic tissue whose job is to meet and recognize potentially pathogenic organisms that are likely to inhabit the lower end of the digestive tract. Do not let anyone take your appendix out for no good reason. If you must have abdominal surgery, tell your doctor to keep his or her knife away from your appendix.

3.
Hysterectomy for uterine fibroids

Surgical removal of the uterus is another bread-and-butter operation performed to great excess, especially in the United States. Rates of hysterectomy are much lower in some other countries, especially France, where greater value is attached to a woman's womb. In her excellent book, *Medicine & Culture* (Henry Holt & Co., 1988), Lynn Payer reports that the rate of hysterectomy in France is less than one-half that in the U.S., where 1 percent of women ages 25 to 34 and 2 percent of women 35 to 44 have hysterectomies each year. According to Payer, "Most French gynecologists say there are only two indications [for hysterectomy] in young women: cancer and abnormal uterine bleeding that cannot be controlled in any other way." By contrast, American gynecologists regard this operation as the final solution for most persistent female problems. One of the most common indications for it here remains the occurrence of fibroid tumors

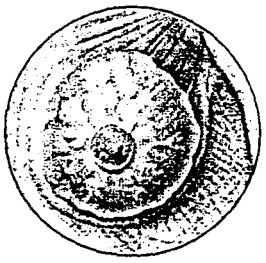
of the uterine musculature.

Fibroids are benign, estrogen-dependent growths that can attain large size, can distort the shape of the uterus, and can cause painful periods with heavy blood loss. There are many ways to treat them without taking out the whole uterus.

In the first place, it is worth trying to halt or reverse their growth by lowering estrogen levels in the blood. A woman can do this by increasing aerobic activity, cutting way down on dietary fat, and eliminating outside sources of estrogen by avoiding commercially raised meats and poultry as well as certain plant sources of estrogenic activity (soy products, licorice, ginseng, dong quai, and others). If she is near menopause, a woman with fibroids should simply try to hang on, treating any symptoms of the fibroids, until naturally declining estrogen levels at the change of life cause the tumors to shrink and disappear. Of course, she must avoid estrogen replacement therapy.

If these methods do not succeed, new techniques of laser surgery can remove the fibroids themselves while sparing the uterus. I see many women patients with fibroids who are told by (usually male) gynecologists that there is no alternative to hysterectomy. That is emphatically not true.

4.
Radical mastectomy



At the end of the 19th century, the great American surgeon William Halsted invented the definitive surgical treatment for breast cancer: the radical mastectomy. A contemporary Harvard surgeon, Oliver Cope, in *The Breast: Its Problems Benign and Malignant and How to Deal with Them* (Houghton Mifflin, 1977), describes this operation as:

> . . . the removal of the entire breast containing the cancer, the lymph nodes of the axilla to which the cancer might have spread, and the major pectoral muscle, which lies between the breast and the axilla. . . .The smaller pectoral muscle (*pectoralis minor*) was also severed at one end and retracted to open access to the nodes. The nipple and the major portion of the skin over the breast were removed. Only enough skin on the sides of the breast was left to bring the edges of the skin together and thus close the wound over the chest wall. . . . To get rid of the primary tumor, the breast was removed. To get all of the nodes of the axilla, the muscle was removed. The removal of both left not only a hideous defect in the upper chest, but a significant handicap to the motion of the arm as well.
>
> The operation was also frequently followed by pain since it cut across many sensory nerves. . . . Furthermore, with the removal of the highest nodes of the axilla, the lymph flow from the arm is always blocked to an extent and some swelling of the arm is common.

This horribly disfiguring operation for breast cancer began to fall out of fashion only with the rise of the women's movement. Research has demonstrated that it offers no greater likelihood of long-term survival over simple removal of the breast without removing underlying muscle or lymph nodes (simple mastectomy) or removal of the tumor (lumpectomy) with follow-up treatments such as local radiation, chemotherapy, or hormonal blockade. Women with breast cancer should never consent to radical mastectomy. The procedure is obsolete.

5.
Back surgery for slipped discs and chronic pain

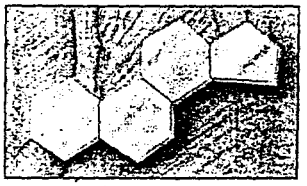
If you take a hurting back to a neurosurgeon or an orthopedic surgeon, they will likely recommend surgical treatments for your pain. The most common operations—laminectomy and spinal fusion—are routine procedures in most hospitals, and they are rarely necessary. Laminectomy means removal of part of the bony ring around the spinal sac in order to remove herniated disc material that is pressing on a nerve root. Spinal fusion unites two separate bones in order to eliminate motion between them. The procedure involves grafting bone chips from other parts of the spine or from the hip onto scraped surfaces of two adjacent vertebrae; the chips serve as a framework on which new bone cells grow, bridging the two vertebral bodies.

The two operations may be done simultaneously. Back pain may recur after surgery.

If there is one clear fact to emerge from the confused mass of information about chronic back pain, it is that little correlation exists between the subjective experience of pain and objective assessments of the spine by X-ray, CAT-scan, and other sophisticated imaging techniques. It is easy to find people with perfectly normal looking spines who are disabled by pain [illegible] who walk around free of symptoms although the images of their spines look so bad that you would think they would be confined to beds. Yet it is the abnormal images that are used as justification for drastic surgical interventions.

The vast majority of cases of chronic back pain will respond sooner or later to nonsurgical treatments, including mental interventions (hypnosis, counseling), rest, exercise, stress reduction, and so forth, whether or not structural abnormalities are present. Great numbers of patients with back pain are sent to operating rooms. Try not to be among them.

6.
Long-term corticosteroid treatment



Corticosteroids are derivatives and relatives of cortisone, a hormone produced by the outer layer (cortex) of the adrenal gland. Cortisone has a distinctive molecular structure, called the steroid nucleus, that is shared by a few other natural hormones and many synthetic drugs with powerful effects on the metabolism. Synthetic steroids, like prednisone, are widely used in medicine today because they cause allergies and inflammation to disappear as if by magic.

Steroidal magic is actually direct suppression of immune function. It is sometimes necessary to give these strong drugs for severe, life-threatening prob-

lems, but they should be limited to short-term use: no more than two to three weeks. When used over longer periods, steroids cause devastating toxicity: weight gain, depression, ulcers, weakened bones with resulting compression fractures of the spine, increased susceptibility to infection (from weakened immunity), eye cataracts, and more. I see many patients who have been maintained on these drugs for years; they are often walking illustrations of steroid toxicity. Moreover, steroids do not cure the diseases they are usually prescribed for (asthma, rheumatoid arthritis, ulcerative colitis, lupus, for example). They suppress them and may result in worsening of the diseases over time, despite initial improvements. The longer you use these drugs, the harder it becomes to break dependence on them for control of symptoms.

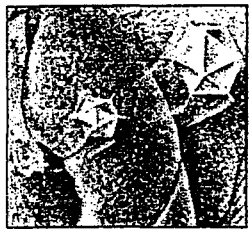
Try to avoid using steroids in any form until you have exhausted all other possible treatments. If you must take a steroid for a severe problem, try to limit its use to a few weeks at most.

7.
Long-term treatment with Valium, Halcion, and other benzodiazepines

Benzodiazepines are a class of depressant drugs widely prescribed as antianxiety agents and nighttime sedatives. Some common examples are diazepam (Valium), chlordiazepoxide (Librium), alprazolam (Xanax), triazolam (Halcion), lorazepam (Ativan), temazepam (Restoril), oxazepam (Serax), and chlorazepate (Tranxene). All of these drugs are highly addictive, and the addiction is one of the hardest of all drug addictions to break. In addition, they interfere with memory and intellectual functioning. These effects are the rule rather than the exception.

It is all right to take benzodiazepines on occasion to deal with situational anxiety or insomnia due to such stresses as a death in the family or an intercontinental flight, but it is risky to take them for more than a couple of days or nights in a row. Most physicians are unaware of the risk, being poorly educated about the dangers of prescribing psychoactive drugs and strongly influenced by the promotional efforts of the drug manufacturers. As a result, some of the benzodiazepines have been among the most frequently prescribed drugs in the world.

8.
Antibiotic treatment for viral respiratory conditions



Most common respiratory infections, including colds, flus, sore throats, and bronchitis, are caused by viral infections. Antibiotics work against bacteria, but have no antiviral activity. Nonetheless, patients commonly want antibiotics when they have respiratory ailments, and doctors frequently give in to their demands. Although doctors should know that antibiotics are useless in these instances, they justify their prescriptions by saying they are preventing secondary bacterial infections or treating probable associated bacterial infections. For example, patients with bronchitis who develop productive (that is, mucus-producing) coughs usually get antibiotics on the assumption that this type of cough is a sign of bacterial activity.

In fact, studies do not support these assumptions. In most cases the infections are purely viral, and the use of antibiotics is bad medicine. Not only do antibiotics have some toxicity, they may also weaken immunity and encourage the development of resistant strains of bacteria that make trouble for everyone. Do not take antibiotics for acute respiratory ailments unless there are clear signs of bacterial infection and a laboratory test, such as a throat swab or sputum culture, confirms the presence of susceptible organisms.

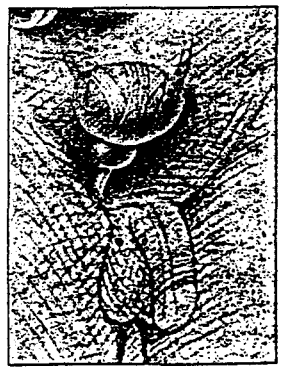
9.
Sinus surgery

Chronic sinusitis is a miserable disease, causing recurrent episodes of pain, headache, nasal discharge, and post-nasal drip, and impairment of breathing and hearing. Doctors treat sinusitis with many drugs—antibiotics, decongestants, antihistamines, and steroids—and sometimes with surgery. Sinus surgery is expensive, painful, and rarely effective. I have never seen it solve the problem, and I have dealt with many patients who, to their great regret, have had it done to them more than once.

In this operation, surgeons scrape out the unhealthy tissue lining the sinuses. This procedure does nothing to correct the underlying causes of chronic sinus inflammation, which may be rooted in tobacco smoking, allergy, food sensitivity, or stress. Almost always sinusitis returns full-blown. It is possible to moderate the condition by changing your lifestyle and exploring alternative methods of controlling symptoms. For example, I have helped patients overcome sinusitis by teaching them to go on milk-free diets to decrease mucus production, to eliminate respiratory irritants from their lives, to pay scrupulous attention to nasal hygiene (by inhaling a saline solution every day), and by using medical treatments like antibiotics only when they are clearly indicated.

While on this subject, I might mention my low opinion of long-term treatment with antihistamines as well. These drugs are suppressive, expensive, and toxic, especially in their effects on mood and mental state. Newer forms like terfenadine (Seldane) that do not cross the blood-brain barrier are even more expensive and produce uncomfortable side effects, like headaches, in a large percentage of users.

10.
Prostatectomy



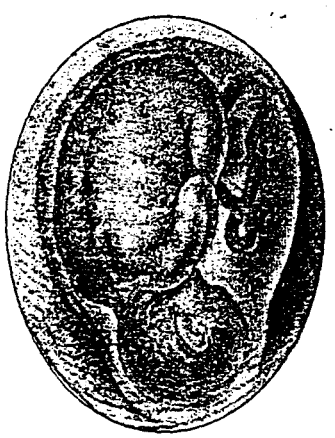
Countless men undergo surgical removal of the prostate gland. This operation is expensive and painful, and frequently results in impotence and urinary dysfunction. It is used to treat two common conditions: benign prostatic hypertrophy (BPH) and early stages of prostate cancer.

BPH afflicts most men as they get older. It is an enlargement of the gland under hormonal influence. As the prostate swells, it often interferes with urination, causing a decrease in the strength of the stream and dribbling. Partial or total surgical removal of the gland is a crude treatment that is on the verge of becoming obsolete as new nonsurgical treatments become available. Two herbal medicines (*Serenoa repens* or saw palmetto, and *Pygeum africanum*) help control BPH, and some new pharmaceutical drugs may reverse the condition.

Prostatectomy is equally unjustified in many cases of early prostate cancer. The problem is to distinguish between those cancers that are aggressive and will probably metastasize, threatening general health and life, and those that will follow an indolent course for years, never leaving the gland. At the moment, few urologists try to make that distinction, and all glands with cancer come out.

Most physicians are unaware of the risk of prescribing psychoactive drugs, being poorly educated about their dangers and strongly influenced by the promotional efforts of the drug manufacturers.

11.
Delivery by cesarean section



The rate of cesarean delivery in the U.S. now approaches 25 percent of all births. That's up from 5 percent in less than 20 years. Those figures are an outrageous indictment of American birthing practices. A c-section is more expensive and more dangerous than vaginal delivery in most cases and may deprive the newborn of a normal birth experience, with consequences that we do not yet understand. There are clear indications for cesarean delivery, which can be lifesaving for both baby and mother, but these are present in only a small fraction of cases. Most c-sections today are done as "defensive medicine," to avoid perceived threats of malpractice actions.

I am a strong advocate of midwifery and home birth, which pose little risk of defensive practice. If you are an expectant mother planning a hospital birth, you should learn the c-section rates of various hospitals in your area and choose the one with the lowest rate. Also choose your obstetrician with this same consideration in mind.

There are many other conventional procedures to be wary of, but the arguments against them may not be so clear cut. I believe, for example, that our present cancer treatments, especially the use of chemotherapy and radiation, will not only be obsolete within 40 years, but also that we will look back on them with the same astonishment with which we now regard the idea of destroying normal thymus glands in children. At the moment, however, safe and effective alternatives to those treatments are not available for most kinds of cancer.

Medical students learn little of the history of medicine in the course of their education. If doctors were more aware of the failures of the past, they might be more aware of questionable practices of the present. ◆

ANDREW WEIL teaches at the University of Arizona College of Medicine, has a private medical practice, and is the author of *Natural Health, Natural Medicine* (Houghton Mifflin, 1990) and *Health and Healing* (Houghton Mifflin, 1988).

NECESSARY PROCEDURES?

PROCEDURE	NUMBER PERFORMED ANNUALLY IN U.S.
Radical & modified radical mastectomy	105,000 *
Delivery by cesarean section	945,000
Prostatectomy	364,000
Disc surgery	305,000
Hysterectomy	591,000
Cholecystectomy	522,000
Sinus surgery	82,000
Benzodiazepine prescriptions	61,000,000 **

Figures are not available for prophylactic appendectomy, corticosteroid prescriptions, antibiotic prescriptions. Statistics provided by National Center for Health Statistics.

* Surgery may not have included removal of chest muscle.

**Source: Task Force Report, American Psychiatric Association, 1990.

SENATE JUDICIARY
EXHIBIT NO. 7
DATE 3-24-93
BILL NO. HB 346

TESTIMONY ON HOUSE BILL 346

My name is Fran Marceau, I am the State Legislative Director for the United Transportation Union. I am here today to speak in opposition to House Bill 346.

Under provisions of this bill if a doctor or other medical provider is drunk or otherwise negligent and causes, for example, a person to be rendered paraplegic, his liability for non-economic damages would be limited to $500,000.00.

This bill also limits the amount of contingent attorneys' fees which can be charged, which could limit a person's ability to find a lawyer who would present his case in court.

The bill also provides that, in an action for damages in excess of $[illegible]00,000.00, the defendant may request the court to order that the judgment for future damages be paid in whole or in part by periodic payments rather than a lump sum payment. The period of time payment could be stretched out over is unspecified, and additional interest payments to an injured person who is required to accept periodic payments is not adequately addressed. In many cases, the injuries to the members I represent are severe enough to prohibit them from ever returning to their jobs. Wise investment of a lump sum payment will guarantee a monthly income to a disabled person. With periodic payments they would not have that security.

Railroaders are governed by a federal law which treats all injured employees equally. There is no reason for the state of Montana to interfere with the federal law with the resulting effect that Montana residents, or people injured in Montana, would receive less damages for the same injury than someone injured in another state. The bill also provides that the court shall order future periodic payments to be made during the life of the injured party, or during the continuance of the compensable injury or disability period. The injured person would continue to have to prove his disability over the remainder of his life. The Federal Employers' Liability Act, and the general tort law in the state of Montana, have worked well for over one hundred years and should not be tampered with so as to remove economic benefits from victims of railroad negligence or medical malpractice.

I urge a <u>do not pass</u> recommendation for HB 436.

Thank you for the opportunity to give testimony before this committee.