MLC COMMENTARY

Vol. 2, No. 5 July 1975

MLC NEWS BRIEFS

The American Association of Clinical Urologists received approval of its application for Supporting Membership in the Medical Liability Commission by the MLC Executive Committee at the latter's meeting in Chicago on May 29. The AACU will become the twentieth Supporting Member Organization as soon as the Executive Committee approval is ratified by the full Board of Commissioners at its Fall meeting.

The AACU Commissioner to the MLC will be its President, Russell B. Carson, M.D., of Fort Lauderdale, Florida. He is expected to designate the AACU Alternate Commissioner in the near future.

* * *

The American Hospital Association's Board of Trustees, in action taken on May 16, granted stand-by authorization to establish an AHA captive professional liability insurance company. The triggering mechanism would require requests from at least two different state hospital associations involving at least 100 hospitals and $5,000,000 in premiums. The company would be financed through stock subscriptions by the AHA and is intended for operation only in the event of a lack of insurance availability.

* * *

A Florida orthopaedic surgeon has filed a $2,500,000 lawsuit against two former patients and their attorneys who had previously sued him for alleged malpractice.

John B. Sullivan, M.D., of Fort Pierce, Florida, alleges that the suits against him were "frivolous," but that they were directly responsible for the loss of his medical liability insurance in late 1971. He has since been able to acquire coverage.

The suit charges malicious prosecution of a civil suit, negligence, conspiracy, and abuse of the judicial process. Doctor Sullivan has received the endorsement of the Florida Medical Association, together with an FMA contribution for legal research. Ellis Rubin, Esq., of Miami, Doctor Sullivan's attorney, stated that the case is likely to be a landmark decision. "I think this case will have a definite effect on malpractice throughout the United States," Rubin said. "It will cause attorneys to reflect, before they file suit, whether or not they have a valid course of actions."

MLC EXECUTIVE COMMITTEE MEETS IN CHICAGO

The Executive Committee of the Medical Liability Commission held its second business meeting of the year at the O'Hare Hilton in Chicago, Illinois, on May 29. Presiding over the meeting was MLC Chairman Charles A. Hoffman, M.D.

In actions taken at the meeting, the Committee

* approved continued pursuit of an Internal Revenue Service 501(c)3 tax status for an auxiliary foundation to function as an educational and research arm of the MLC.

* empowered the Executive Director to invite representatives of the Pharmaceutical Manufacturers Association to the Fall Board of Commissioners' meeting as observers.

* requested that notice be sent to all Commissioners, Alternate Commissioners, and Executive Directors of Supporting Member Organizations announcing the compilation and availability of the MLC state legislative summaries.

* concurred with the proposal of Commissioners Robert J. McNeil, M.D., and Maurice M. Hoeltgen, M.D., to develop an official MLC "position paper" defining malpractice.

The Committee also heard staff reports on the progress of MLC COMMENTARY, the state legislative summaries, the proposed MLC national seminar on professional liability, and the committee staffing program.

MLC Chairman Hoffman, in his Chairman's Report, recounted his many speaking engagements nationwide during the past several months and reported on the improving visibility of the MLC among health-care providers throughout the country.

The Committee engaged in detailed discussion on several key topics. It reached a consensus that the MLC should endeavor to notify Commissioners, Alternate Commissioners, and Supporting Member organizations of important public hearings on Federal and state professional liability legislation. It also felt that additional position papers should be developed advocating mechanisms at the local levels to prevent non-meritorious nuisance suits, and to explain and affirm a position on proposed no-fault insurance. The Committee discussed several types of witness lists in court proceedings that are being circulated, which were brought to the Committee's attention by Commissioner Maurice M. Hoeltgen, M.D. Further, the Committee discussed the procedures of insurance companies in apportioning awards, disclosing claims, and clarifying the records of providers against whom claims have been made, and debated various ways and means of improving those procedures.

Attending the meeting were Chairman Hoffman, Vice-Chairman J. Gerard Converse, M.D., Secretary-Treasurer Jay H. Hedgepeth, Esq., Commissioner John H. Budd, M.D., Commissioner C. Rollins Hanlon, M.D., Commissioner Herbert A. Holden, M.D., and Commissioner Robert J. McNeil, M.D. Guests attending were Commissioner Maurice M. Hoeltgen, M.D., and Commissioner Walter W. Whisler, M.D.

NAIC MEETS IN SEATTLE

The National Association of Insurance Commissioners held its annual meeting in Seattle from June 9 to 12. The NAIC D-4 Subcommittee on Professional Liability also met at that time.

In action taken at the meeting, the D-4 Subcommittee, in cooperation with the Blanks Committee, has designed a new reporting form which is a revision of that contained on page fourteen of the Annual Statement of Insurance Carriers. The new form separates physicians from hospitals by breaking up premiums and losses into four classifications: (1) Physicians (2) Hospitals (3) Other Health-Care Providers and (4) Other Health-Care Institutions. Although no effective date for initiation of the form was determined, the NAIC urged that July 1 be made the effective date, while the insurance industry suggested January 1, 1976.

With regard to the closed-claim study now underway, the D-4 Subcommittee heard debate as to whether the NAIC, the U.S. Department of Health, Education, and Welfare (HEW), or an independent entity should be entrusted with management of the data bank. The NAIC expressed opposition to HEW involvement in that matter, while HEW felt that it ought to receive some control, particularly with regard to the form to be used, due to the fact that the General Accounting Office requires the monitoring of such projects wherein Federal funding is being employed.

The NAIC suggested that outstanding as well as closed claims be examined in the study; however, representatives of the insurance industry objected to the proposal. The Subcommittee agreed to eliminate outstanding claims from the study, but will include the suggestion again at the December, 1975 NAIC meeting unless good cause to the contrary is shown by carriers.

Mr. Warren Cooper of Chubb and Son, Chairman of the Industry Advisory Panel to the D-4 Subcommittee, stated that the closed-claim study may possibly permit both the industry and legislatures to more accurately evaluate proposed state legislation on professional liability.

Although no date has been established for the next meeting of the D-4 Subcommittee, the NAIC stated that it would not be held any earlier than mid-July. The next meeting of the full NAIC will be held in December in Puerto Rico.

STATE LEGISLATIVE ACTIVITY CONTINUES

States are continuing to adopt various types of legislation on professional liability while others are creating study commissions to recommend such legislation for upcoming legislative sessions.

In California, SB864 has been enacted. It creates a county-by-county joint underwriting association, changes the statute of limitations to toll for two years from date of occurrence, limits attorney contingency fees, limits recoveries to $208,000 payable periodically, eliminates provider liability for oral contracts, and presumes acceptance of all provisions by providers and patients by January 1, 1976.

American College of Surgeons
55 EAST ERIE STREET, CHICAGO, ILLINOIS 60611

June 21, 1975

Robert W. Tilney,Jr., MD, FACS
President, New Jersey Chapter - ACS
21 Perry Street
Morristown, NJ 07960

Dear Doctor Tilney:

Mr. Ellenberger called me on June 20 to discuss the proposed meeting of the Council of the New Jersey Chapter to discuss professional liability related matters. It is my understanding that you plan to review Chapter actions on the announced "work slow down" of the anesthesiologists; appropriate Chapter involvement in state legislative matters,and the possibility of taking a position on the concept of physicians' counter-suits against patients and legal counsel whose professional liability litigation is without merit.

The Board of Regents has not authorized any Chapter to formally take a position in support of any unified work slow down or stoppage of services to patients or to espouse any such actions by Fellows of the College. The Regents understand the seriousness of the problem, but they do not feel that surgeons can help ameliorate the nature of the problem by threats of strike or support of other medical disciplines who select to act in that manner. The public you serve will not provide you with the necessary support to seek appropriate remedies if your actions are those of a union rather than as the professional persons you are.

The Board of Regents has encouraged Chapters to coordinate their efforts in the legislative arena under the umbrella of the state medical society. Chapters are urged to maintain a close liaison with the state medical society for the purposes of seeking appropriate legislative relief as well as offering the services of the Fellows to the end that the public can be informed about the issues and the public's help requested in urging legislators to adopt remedial legislation.

Medical splinter groups espousing pet legislative reforms have not contributed to the needed unified medical approach to legislators. The California experience is a case which bears out this contention. The anesthesiologists of Northern California were mouse-trapped by agreeing to a legislative bill which was not adequately explained to the five anesthesiologists who agreed to return to work based on the legislator's explanation. It was only after the damage had been done - appearance before the news media - that these physicians learned from the medical society's legal counsel that they had agreed to provisions in the bill which the physicians had been fighting. No, the physicians had not asked anyone from the medical society to accompany them to this legislator meeting; they thought they could handle the negotiations without professional legislative assistance.

Legislative relief is not going to be passed encompassing all of the changes many physicians agree should be made to ameliorate the current crisis situation. Competent legislative counsel can acquaint you with those issues which may be addressed by a legislative body. A visceral reaction on the part of physicians will not get the job accomplished. Compromise is the way of doing business in legislative bodies; there isn't tolerated an all or nothing attitude.

Counter-suits by physicians have been tried in three different jurisdictions in the United States and all of those suits have been lost by the counter-suing physicians. There are very stringent rules established by the courts which have to be satisfied if a physician is to successfully charge a patient and his lawyer in a counter-suit. One would have to have written proof of actions by the patient and his counsel which damaged the physician in order to secure damages from them.

Another negative which makes it unwise to seek to publicize a Chapter's action encouraging counter-suits by its members is the public reaction. On one hand you are trying to enlist the public to help you secure legislative relief and on the other hand you are saying to the public physicians will sue if you bring an action which is judged to be without merit. The plaintiff's lawyers would have a field day with such an action making physicians look very bad in the eyes of the public and in the eyes of the legislators from whom you are trying to get legislative relief.

Although these are trying times, do not react in a manner which ultimately will destroy what credibility you as physicians have by taking actions which will be twisted and turned against you. Permit me to offer you and your colleagues more than twenty years of experience in the political and legislative arenas before you take any action which may be contrary to College policies or affect your professional posture in New Jersey.

Best wishes.

Sincerely,

John W. Pompelli
Department of Organization

JWP:j

cc: Elmer L. Grimes, MD, FACS
Peter J. Guthorn, MD, FACS
C. Rollins Hanlon, MD, FACS
Mr. Arthur R. Ellenberger

AMA "Forum For Medical Affairs" June 15, 1975

"Malpractice - Just Whose Baby is it?"

Roger O. Egeberg, M.D., Special Assistant to the Secretary of HEW for Health Policy: Dr. Egeberg addressed his remarks to where he thought we could cut the incidence of suit. This statistical analysis shows that the most common occurrence which starts a suit is a fall. Situations conducive to injury in hospitals or offices must be corrected. The patient that has fallen elsewhere and reports for treatment must be recognized as a potential suit and handled with care. Statistics next show that many doctors have had no suits and some have had three or more. There is indication that some personalities antagonize patients and the simple answer is to be nice. The third factor is "false expectation" and this goes beyond informed consent. Many now feel that since they are in the hands of a specialist they expect excellent results. This problem will continue until we convince the public of a more realistic approach. Not too long ago if a patient had his leg broken in twenty places, he was satisfied with the result of walking again. Now he will sue if the leg turns out one half inch shorter. We cannot hope for an immediate change which completely rules out juries. Both lawyers and judges do not want to see the dueling ground of the courtroom lost. Insurance companies only halfheartedly want some change because they still desire to handle large premiums. Insurance Commissioners are not interested in doing anything to assist the situation. Dr. Egeberg believes that a large part of the mechanics of the problem is in the Statute of Limitations and Res Ipsa Loquitur. State Legislation can do much here. But beyond the mechanics, Doctors are expected to have a thousand batting average and these unrealistic expectations do not plague the lawyers or other professions. There is some sentiment for limiting the number of cases which go before the jury system, but most people will not go for abandoning our current liability system. We

must all work toward a realistic, pragmatic and useful method of using our courts.

James J. Stewart, Esq., Counsel for Indiana State Medical Association and Author of the Indiana Physicians' Compensation Act: Mr. Stewart stated that Indiana felt they must solve the problem with new radical surgery. They did not get all they sought but aimed for the following:

1) Removal of malpractice action from the jury system.
2) Create a cap or limitation on awards -- combined with a catastrophic injury fund.
3) Outlaw actions based on where the result was expected to be perfect.
4) Reduce Statute of Limitations to two years for adults and six years for minors.
5) Reduction of contingency fee.
6) Financial responsibility for all health care providers.
7) Retain most of tort law including Res Ipsa Loquitur and Informed Consent.
8) A comprehensive reporting system.
9) Effective peer review which would eliminate the bad doctor.
10) That all work be done constitutionally without expense to taxpayer.
11) Form a risk pool for those who cannot get insurance at reasonable rates.

Gilbert M. Wilhelmus, M.D., President, Indiana State Medical Association: Dr. Wilhelmus stated that the people of Indiana passed the legislation which the Doctors suggested after everything was explained to the public through an extensive campaign. He stated that it was a mistake to start any solution to this problem with a Doctor-Lawyer or Doctor-Insurance Company fight, and people don't care how much you pay until you explain exactly how much the cost is to them. He was given one man decision power on this campaign and he hired a dynamic lawyer. He also hired two lobbyists, one Republican and one Democrat.

One of them was a past speaker of the House and had much influence. Dr. Wilhelmus stated they developed a "Health Care Provider Bill". They even provided Chiropractors to The Medical Society Office because they wanted all health providers to influence their legislators. They were then faced with the joint problem of educating their doctors and educating the public. They got much free TV time and made sure that all their speakers told a simple true story backed by facts, and presented the problem of the public paying the bill. Placards were placed in each doctor's office with pamphlets urging the people to write legislators for action. They hired a PR firm and tried advertising on TV, but this campaign backfired with commentators stating that physicians were buying public opinion, and they stopped this advertising. There was no strike or slowdown in Indiana and not even a mention of it, and Dr. Wilhelmus stated that we got the, "people and unions behind us." The UAW did nothing to help, but the steelworkers did. He urged that the physicians get to know their legislators. He complimented Dr. Egeberg for coming to Indiana from his HEW offices in Washington to assist them as a speaker and with their legislators. Indiana increased its membership dues $10.00 per member and this provided an additional $20,000 but they spent $60,000 and must go to their membership for further dues increase. At the height of the campaign they sent two or three letters or information Bulletins to each physician in the State each week. One of the direct results of the campaign is that claims incurred insurance is now available to all including new residents and interns who could not obtain this.

John J. Coury, Jr., M.D., Past-President, Michigan State Medical Society: Dr. Coury stated that they are in the midst of a campaign similar to the one in Indiana but they do not have a conservative legislature like Indiana.

They are attempting to:

1) Limit contingency fees (their current limitations are not as good as the New Jersey limitation.)

2) They are stressing to the public that there are "no guarantees".

3) They are seeking legislation which requires all insurance carriers to report their statistics rapidly.

4) Their Good Samaritan Act now applies in hospitals with the exception of the emergency room, and unless there is "gross neglect". They are working on an insurance pool as insurance is currently available, but not at a reasonable cost.

5) They are attempting through legislation to have the medical society take over the insurance fund.

6) They are seeking legislation to insure that the State Licensing Board receive all registration fees instead of their going into the General State Treasury.

7) They are attempting to put through a new licensing act.

8) They are reducing their Statute of Limitations to two years but could not include minors. (This Bill has passed one house)

9) They have introduced a bill for an arbitration panel (This Bill has passed one house)

10) They went directly through the public and through Media as did Indiana.

11) They fought the Senator Kennedy approach at the national level as the "carrot and stick approach."

Dr. Coury ended his remarks by stating that he listened to retired Chief Justice Weintraub of the New Jersey Courts who seems to expect that a Professor expert should solve the entire matter. Dr. Coury believes that this is not realistic and that you must involve the public, and through them the legislators at the state level.

Ralph Emerson, M.D., of the Medical Society of the State of New York: Dr. Emerson stated that they hired a PR firm and they generated 200th petitions and letters sent to Senators and Assemblymen. They had to answer a volume of correspondence from legislators and the public and they appeared on many

TV shows. Physician popularity peaked immediately prior to the "job slowdown". e public and the legislators started reacting adversely when people began losing their jobs, and the unions who had been with us were turned off when their union personnel at hospitals could not work.

They achieved New York State Legislation which allows them to set-up their own insurance company. This insurance company is licensed and ready to operate on July 1, 1975. The Governor set-up a Blue Ribbon Panel on Professional Liability to make specific recommendations of the Senate and members of the Assembly. There are two doctors on this panel. New York did not get either a limitation of contingency fees or a top limit on awards. Dr. Emerson felt that if awards continue to spiral upwards as in the last few years, they will shortly equal the gross national product. The physicians in New York are working with the State Hospital Association. They have an arbitration board to which a patient can bring his own lawyer but this lawyer before the Board is paid on a per diem, not on a contingency basis. They have set-up a panel to work closely with the Bar and have lawyers, consumers and physicians on the panel. Dr. Emerson reported that, with the exception of the work slowdown period, public acceptance of their programs has been good. They feel that more adequate peer review will help their situation and they are working on this.

The New York delegation has introduced Resolution #20 to the AMA House of Delegates on the subject of "Voluntary Malpractice Arbitration". (note Resolution #20 was debated in Reference Committee H and the House decided to refer this Resolution to the AMA Board of Trustees for implementation.)

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 20
(A-75)

Introduced by: New York Delegation

Subject: Voluntary Malpractice Arbitration

Referred to: Reference Committee H
(Ralph H. Riggs, M. D., Chairman)

Whereas, Malpractice insurance premium costs are becoming prohibitive and malpractice insurance is becoming increasingly unavailable; and

Whereas, State legislatures have frequently exhibited reluctance to restructure the malpractice system and have been caught in the suction of inactivity; and

Whereas, The public interest is not served by pass-on increased costs or a decrease in physicians' services; therefore be it

Resolved, That the American Medical Association recommend to its state societies that they urge their members to institute voluntary arbitration under the auspices of the American Arbitration Association; and be it further

Resolved, That the American Medical Association, together with the American Arbitration Association, recommend prototype agreements; and be it further

Resolved, That the American Medical Association urge the American Hospital Association and its state associations and member hospitals to develop appropriate voluntary arbitration agreements with the American Arbitration Association.

Fiscal Note: Meeting costs, fees to the American Arbitration Association and support costs are estimated to total $10,000 for a one-year period

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Past House Action: C-74:131-142; A-74:361

June 27, 1975
Vol. XVI - LR 23

Legislative Roundup

A Weekly Report on National Medical Legislation

Congressional Recess Begins.....The Senate and House have recessed for an Independence Day break of eleven days leaving crucial health issues including health manpower, national health insurance, termporary health insurance for the unemployed and HMO amendments pending. Upon the return of Congress July 9, action on certain of these subjects is expected to begin immediately, although an anticipated month-long Congressional recess in August may prevent final action until autumn.

Slated for action July 9 in the House Rules Committee is H.R. 5546, the Health Manpower Act. If given favorable action by the Rules Committee, as is expected the controversial proposal will be scheduled for debate on the House floor. In the Senate, the Labor and Public Welfare Health Subcommittee has rescheduled its hearings on S. 1737, the Clinical Improvement Act of 1975, for July 16-17.

NHI Hearings.....Representative Dan Rostenkowski (D-Ill) Chairman of the Subcommittee on Health of the Committee on Ways and Means has announced the second stage in the Subcommittee's consideration of national health insurance. This stage will involve small panel discussions on the broad issues regarding NHI. The Subcommittee will form these small panels from members of the Advisory Panel on National Health Insurance which it established earlier this year. The four days of hearings are set to begin July 10, 1975, and are to be continuted on July 11, 17, and 24.

In addition, on July 31, the Subcommittee will meet to consider aspects of Medicare it will address in public hearings held after the August recess. Included in the discussion will be possible action on recent DHEW Medicare regulations which were the subject of a public oversight hearing on June 12, 1975.

Weinberger Resigns.....HEW Secretary, Caspar W. Weinberger, has formally announced his long anticipated resignation which will be effective Autust 10, 1975. As his successor, President Ford has nominated David Mathews, President of the University of Alabama. Mathews, 39, has been President of the University since 1969, at which time he was the youngest President of a major American university. He holds undergraduate and master's degrees from the University of Alabama and a doctorate in the History of American Education from Columbia University.

Labor-HEW Appropriation Passes House.....By a 368-69 vote Thursday the House passed H.R. 8069, the fiscal year 1976 appropriations bill for federal health and labor programs. The bill was passed despite Administration opposition to the total appropriation figure of $45 billion, exceeding by $870 million the amount requested by President Ford. The House accepted an amendment offered by Representative Edward Roybal (D-Cal) adding $30.9 million for maternal and child health programs and rejected an amendment that sought to prohibit federal funding of abortions.

The next edition of Legislative Roundup will be published July 11, 1975.

Council On Legislation, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610

MSNS 1975

A

COLLATERAL SOURCE LAW

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1) Measure of Damages-Special Damages-Actual Economic Loss -- In any action for damages for personal injury in which liability is admitted or established, the damages awarded may include actual economic losses suffered by the claimant by reason of the personal injury, including, but not limited to cost of reasonable and necessary medical care, rehabilitation services, and custodial care, loss of services and loss of earned income, but only to the extent that such costs are not paid or payable and such losses are not replaced, or indemnified in whole or in part, by insurance, or governmental employment or service benefit programs or from any other source except the assets of the claimants or of the members of the claimants immediate family.

2) Evidence-Admissibility Damages-Actual Economic Loss -- In any action for damages for personal injury where it is alleged that the claimant suffered economic loss by reason of such injury, including but not limited to the cost of medical care, custodial care or rehabilitation services, loss of services, and loss of earned income, evidence shall be admissible on the issue of damages which tends to establish that any such cost or expense.

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was paid for or payable by or any such economic loss was replaced or indemnified, in whole or in part, by insurance or governmental, employment or service benefit programs or from any other source except the assets of the claimant or the claimants immediate family.

This act shall take effect immediately.

MSNJ

B

RES IPSA LOQUITUR

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

Evidence-Medical Negligence-Proof of Injury -- No liability for personal injury or death shall be imposed against any provider of medical care based on alleged negligence in the performance of such care unless expert medical testimony is presented as to the alleged deviation from the accepted standard of care in the specific circumstances of the case and as to the causation of the alleged personal injury or death, except that such expert medical testimony shall not be required and a rebuttable inference that the personal injury or death was caused by negligence shall arise where evidence is presented that the personal injury or death occurred in any one or more of the following circumstances: (1) A foreign substance was unintentionally left within the body of a patient following surgery, and (2) A surgical procedure was performed on the wrong patient or the wrong organ, limb or part of a patient's body.

This act shall take effect immediately.

MSNS

C

STATUTE OF LIMITATIONS

AN ACT to amend Title 2A:14-21 of the Revised Statutes limitation of actions and extension of periods by reason of infancy or other matters.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1) If any person entitled to any of the actions or proceedings specified in sections 2A:14-1 to 2A:14-8 or sections 2A:14-16 to 2A:14-20 of this title or to a right or title of entry under section 2A:14-6 of this title is or shall be, at the time of any such cause of action or right or title accruing, under the age of 21 years, or insane, such person may commence such action or make such entry, within such time as limited by said sections, after his coming to or being of full age or of sane mind.

2) However, any action at law for an injury to the person caused by the wrongful act, neglect, or omission of another must be brought within 10 years after the date that the act, omission, or occurrence alleged to have caused injury to the person occurred or by age 23, whichever is sooner.

3) This act shall take effect immediately.

MSNS

D

STATUTE OF LIMITATIONS

AN ACT to amend Title 2A:14-2 of the Revised Statutes limitation of actions for injuries to the person by wrongful act.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1) Every action at law for an injury to the person caused by the wrongful act, neglect, or default of any person within this State shall be commenced within 2 years next after the cause of any such action shall have accrued.

2) A cause of action shall accrue under this act on the date that the act, omission, or occurrence alleged to have caused injury to the person occurred.

3) Any action for damages as the result of injury to the person brought after the period of limitations contained in this act shall be barred from hearing by the courts of this State.

4) This act shall take effect immediately.

MSNS from Joseph C. Lucci Jan 23, 1975 A

COLLATERAL SOURCE LAW

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1) Measure of Damages-Special Damages-Actual Economic Loss -- In any action for damages for personal injury in which liability is admitted or established, the damages awarded may include actual economic losses suffered by the claimant by reason of the personal injury, including, but not limited to cost of reasonable and necessary medical care, rehabilitation services, and custodial care, loss of services and loss of earned income, but only to the extent that such costs are not paid or payable and such losses are not replaced, or indemnified in whole or in part, by insurance, or governmental employment or service benefit programs or from any other source except the assets of the claimants or of the members of the claimants immediate family.

2) Evidence-Admissibility Damages-Actual Economic Loss -- In any action for damages for personal injury where it is alleged that the claimant suffered economic loss by reason of such injury, including but not limited to the cost of medical care, custodial care or rehabilitation services, loss of services, and loss of earned income, evidence shall be admissible on the issue of damages which tends to establish that any such cost or expense

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was paid for or payable by or any such economic loss was replaced or indemnified, in whole or in part, by insurance or governmental, employment or service benefit programs or from any other source except the assets of the claimant or the claimants immediate family.

This act shall take effect immediately.

MSNS

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This act shall take effect immediately.

MSNS

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2) However, any action at law for an injury to the person caused by the wrongful act, neglect, or omission of another must be brought within 10 years after the date that the act, omission, or occurrence alleged to have caused injury to the person occurred or by age 23, whichever is sooner.

3) This act shall take effect immediately.

MSNJ

D

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2) A cause of action shall accrue under this act on the date that the act, omission, or occurrence alleged to have caused injury to the person occurred.

3) Any action for damages as the result of injury to the person brought after the period of limitations contained in this act shall be barred from hearing by the courts of this State.

4) This act shall take effect immediately.

AMERICAN HEALTH SYSTEMS, INC.

215 MARKET STREET · SAN FRANCISCO, CALIFORNIA 94105 · TELEPHONE (415) 391-5074

May 30, 1975

John J. McGuire, M.D.,
President
Medical Society of New Jersey
315 W. State St.
Trenton, N.J. 08618

Dear Dr. McGuire:

This letter is in response to your recent request regarding our suggested approach to assisting the Medical Society of New Jersey in formulating an effective strategy to deal with the professional liability insurance problem. Recently, Sherry Huff of our firm conducted a national survey of medical society activity in this area. She observed after conversation with MSNJ staff that the Society appeared content with the services of both Chubb and the Joseph A. Britton Agency. The Medical Defense and Insurance Committee has also organized what appears to be a successful Loss Control Program which utilizes the local society Medical Review and Advisory Committees.

It seems to me that these are indeed excellent programs but, by themselves, are no talisman to ward off the increasing number of suits and more generous settlements and jury awards. Perhaps a more accurate assessment of your situation is that you are in the eye of the storm and should take advantage of the calm to prepare yourself for the demands of the future. I suggested that we would be interested in providing technical assistance and research services to assist MSNJ to prepare a new professional liability posture.

In looking at the malpractice crisis around the country, certainly California is no exception, one quickly concludes that no single source has enough information (or motivation) to speak authoritatively with respect to the size or nature of the problem, or the long term social, medical or economic implications of the many proposed solutions to the problem. With this in mind, I propose that American Health Systems undertake a series of studies on the malpractice issue which would prepare your decision makers to formulate an enlightened and comprehensive response which would be protective of both the public and the doctor's interest. Such an undertaking might consider several different study topics simultaneously, for example:

1. The direct and indirect costs of malpractice claims:

   a. for the population at large

   b. for federally supported programs (the Federal government closely associates PSRO and malpractice)

2. Alternative classifications of institutions and practitioners for rate making purposes.

3. Recommended methods of minimizing the cost of litigation

4. A contingency plan for a physician owned professional liability carrier with a residual risk back up (JUA) for high risk practitioners. This plan should be prepared in the event the traditional market-place fails.

5. Conduct studies and evaluate alternatives to the settlement of malpractice disputes such as no fault, compensation panels, pre-litigation screening, arbitration and mediation, including performance evaluation of the Loss Control Program.

6. An evaluation of existing incident prevention and risk management techniques and recommended claim prevention models to be implemented and the development on on-going evaluation methodology

These are highly complex issues which, to my knowledge, have not been suitably addressed anywhere in the country. Even if they were, each area of the country represents a distinct underwriting and risk management problem requiring individual assessment. I propose to address these issues in a highly specific way making use of all pertinent data. In order to secure these data, the study must have official sanction of the Society and its authorization to secure from the present carrier pertinent claims and membership data. Perhaps I can best illustrate our specific approach by suggesting some of the sub-topics or techniques which would be used to address the major issues, for example:

a. A study of claims processed to determine the characteristics and disposition of claims and the character of the injury. The study would include an evaluation of the nature and size of the award in comparison to the injury, the patient, the doctor, the practice setting and the geographical location.

b. A study of carrier expenses and premium to determine whether increases in premium are justified, and if so, the characteristics of the classes of insureds that necessitate the increase. Much of this information would come from the claims study and tables would be prepared distributing claims exposure in categories such as setting of the procedure, the procedure itself, educational background of the physician, age or experience, or Board certification status, etc. An express distribution of the premium dollar would result. How much ultimately goes to the patient, attorney, court costs, administration, etc.

c. An assessment of the carrier's claims reserve methods, distribution of investment income, level of administration expense, adequacy of record keeping, etc.

d. A consideration of alternative ways and means of compensating defense attorneys including the scheduling of contingency fees. I understand you presently have a contingency fee schedule in New Jersey.

e. An analysis of the capability and continuing responsibility of the providers licensing board with respect to professional liability and competence. Should the board have disciplinary responsibility including the right to censor, to place on probation, to suspend or revoke based on incompetence demonstrated in professional liability experience. Should the Board become a central data repository on malpractice settlements by maintaining a file which would include, for example, the nature of claim, damages asserted, injuries alleged, attorney's fees and expenses incurred.

f. An estimate of the social and actuarial consequences of reducing the statute of limitations to various levels.

g. An analysis of methods of achieving reasonable limits on the amount of recovery. What are the components of recovery? What criteria can be established to determine reasonableness? Who establishes the criteria? Should cost and fees be considered separate from the award? Should collateral attack by health and accident carriers on the malpractice settlement be permitted? What is the impact of collateral attack on the cost or size of the award? Should the construction of the award be compartmentalized, for example, a specific award

for past medical expenses, future medical expenses including rehabilitation, lost income, court costs, attorney's fees, etc. What is the impact of ad damnum on settlements?

h. Lastly, an estimate of the universe of iatrogenic injuries in an effort to determine how many meritorious small claims never reach the system because of the bias to potentially large awards. The basic question is, of course, the impact of various malpractice proposals on this reservoir of unreported claimants. In a no fault system, perhaps, the introduction of these claimants might overwhelm the savings brought on by restricting the size of the award on the high end of the scale.

Clearly, the point I am attempting to underscore is there is much work to be done before an organization such as yours can take an enlightened approach to the malpractice problem. Not only must these studies be undertaken for the first time, they must be continually updated so that the professional liability program is truly responsive to the changing environment in which it functions. These are issues that should have been explored long ago by the carrier or broker. Although they have the incentive for concern, they often do not share the objectives of the Society as long as there is a continuing opportunity to balance the system through rate increases. Nor do they typically have a sufficiently broad view of the problem, that is to say, a total system view. I believe AHS can bring these attributes to the problem. We are exclusively concerned with the objectives of medical societies and Foundations. We have the appropriate technical, legal, financial, actuarial and business administration skills to conduct the work. As a corporate group, we are committed to the systems approach to problem solving. We are not selling insurance - we are interested in assisting your organization to formulate a long term and comprehensive policy on an important medical and social problem.

I propose for AHS to undertake this task for the Society on a fee basis to be generated out of future premium payments. We will begin the task immediately on agreement. A society steering committee will be established which will control our work plan and schedule. We will prepare our first reports not later than 90 days from commencement. By definition some of the issues will be considerably longer tasks and we will work out an appropriate schedule with the staff or steering committee. We will prepare and maintain an on-going professional liability history file for the organization and periodically report on it. The services of independent consulting actuaries and accountants are included within the scope of our service.

Our fee for this service will be 1% of each year's malpractice premium. I propose to assist you in negotiating this fee from the existing commissions paid to the broker of record. Therefore, it should cost the membership no additional dollars but merely represent a redistribution of fees that are presently being expended. I hope you will agree with me that it makes a sounder use of existing resources. It is important to note that we are not competing with the insurance company or the broker. We do not wish to receive an insurance commission. Rather, I propose that Chubb pay the society an annual allowance for the services I have described. The society then contracts with AHS - we work for you since that is your best assurance of where our loyalty lies.

I would be pleased to expand our discussion into a more formal proposal or to meet with the appropriate members of the Society.

Sincerely,

John P. Norris
President

JPN:meh

The Medical Society of New Jersey

EXECUTIVE OFFICES

315 WEST STATE STREET, TRENTON, NEW JERSEY TELEPHONE 394-3154

REPLY TO P. O. BOX 904, TRENTON, NEW JERSEY, 08605

VINCENT A. MARESSA, EXECUTIVE DIRECTOR
Public Hearing -- Medicaid Regulations
August 20, 1975

I am Vincent A. Maressa, Executive Director of The Medical Society of New Jersey, and am appearing here on behalf of the 8,800 members of The Medical Society of New Jersey. I take no pleasure in this appearance and am quite frankly distressed to find that necessity dictates that The Medical Society of New Jersey must lodge a vigorous and formal protest with a State agency and at the same time admonish that agency for a cavalier and shabby disregard for the statutory law of our State. Apparently, abuses by the executive branch of government are neither restricted to the Federal bureaucracy nor with our former President and his staff..

<u>In Regard to the 10% Reduction in Reimbursement</u>

Consider:

1. On July 10, 1975, a notice appeared in 7 N.J.R. 317(b) entitled "Proposed Temporary Fee Reduction Concerning Medicaid" That notice declared a September 1, 1975 effective date and established a July 30, 1975 response date.

2. The Medical Society of New Jersey statement of opposition was sent pursuant to the notice to the Department on July 28, 1975, along with a demand for a public hearing.

9. You allege the cut is temporary and restricted to 10%. We believe actions speak louder than words and history does repeat itself. The Federal income tax was a temporary measure. (It sure has demonstrated outstanding durability.) Hitler's occupation of Czech territory, Stalin's occupation of Eastern Europe, and every tyrant's declaration of martial law from Alexander through Castro and Mrs. Ghandi has been under the guise of "temporary".

Strangely enough, these temporary cuts which were enacted in California, Illinois, Maryland, and Florida all had the proclivity for durability and expansion. There is little doubt that the Division has the same goal in mind.

10. Instead of cutting providers why not cut the administrative expenses? The GAO day after day releases information indicating that the cost benefit ratios of governmental service programs are dismal and disheartening. In some programs as little as $.16 per thousand dollars appropriated reaches the ultimate consumer and in certain "well run" government enterprises only 40% of the appropriation is lost to administration. The time has come for the State to open the books and let the public know what is really occurring. Charges of fraud and overutilization are distributed by the State with reckless abandon. Indictments, however, are few and far between. Civil service employees are laid off, but "exempt professional employee" hirings are at an all-time high.

should be ready to accept that fact.

This Society is currently considering withdrawing endorsement of the program and advising its members that their decision to participate or not is a personal one as long as no person in New Jersey is denied emergency care.

<u>In Regard to the Proposals Dealing with Generics, The Medical Society of New Jersey Offers the Following Comments in Opposition</u>

1. State statutes do not allow the Department of Institutions and Agencies to effect an amendment of statutory law by the adoption of an ill-conceived regulation. The law requires pharmacists to dispense the medication that the physician prescribes, not that which the State, totally incapable of practicing medicine, has decided he should prescribe to save money. The Medical Society of New Jersey has determined that in this regard it will pursue all remedies available to protect the citizens and the physicians of New Jersey.

2. Most importantly, however, is the fact that the Federal government has spent millions of dollars studying the issue of bioavailability and therapeutic equivalency and, contrary to common opinion, has reached the conclusion that bioavailability and therapeutic equivalency of generic products cannot be assured with an acceptable degree of certainty at this time.

The result is that the effectuation of these proposals will produce an increased risk to the Medicaid patient because of exposure to drugs which are of unproven quality.

In closing, I would like to advance a personal observation concerning the administration of Medicaid nationally and, in New Jersey in particular, as opposed to Medicare.

Medicare (Title XVIII) is effectuated by the Federal government in conjunction with the use of "fiscal intermediaries".

Medicaid (Title XIX) is effectuated by the Federal government in conjunction with the State government in conjunction with "fiscal intermediaries". Thus, there are three agencies performing services that could essentially be provided by two.

While the State has a right and obligation to be involved, we question their involvement to the extent currently experienced since many of the Division's functions are duplicative of those of the Federal government and the "fiscal intermediaries". Beyond the sphere of needless duplication, we also have observed a certain degree of confusion and chaos which has created an administrative "sink hole" which costs all taxpayers a great deal of money.

Rather than having the "axe of the efficiency experts" pierce the service benefits and delivery segment of the program, we would urge the Department of Institutions and Agencies to apply it to that portion of the program where it can be most productive financially and least destructive to the health of the Medicaid population -- that is the administrative component.

Thank you.

RE-RE-ENGROSSED

HB 1267

ENROLLED

AS PASSED BY THE LEGISLATURE

A bill to be entitled

An act relating to medical liability insurance and civil law revisions concerning medical malpractice actions; providing a short title; creating s. 627.352, Florida Statutes, relating to the creation of a medical liability insurance study commission; creating s. 395.18, Florida Statutes, authorizing certain hospitals to establish internal risk management programs; amending subsection (1) of s. 627.355, Florida Statutes, to allow total self-insurance by a group or association of physicians or health care facilities organized for any purpose; creating s. 768.133, Florida Statutes, providing for the establishment of medical liability mediation panels in each judicial circuit; providing for the filing, hearing and disposition of claims, and providing a filing fee; providing for legal proceedings subsequent to the decision of the mediation panels; amending s. 95.11(4), Florida Statutes, 1974 Supplement, relating to the statute of limitations, to provide that actions for medical malpractice shall be commenced within two years from the time the incident occurred or the injury is discovered but not to exceed four years from the date the incident occurred; providing exceptions for fraud and misrepresentation; creating s. 768.042, Florida Statutes, to prohibit the stating of the amount of general damages in any complaint for recovery of damages for personal injury or wrongful death; amending s. 725.01, Florida Statutes, to provide that medical guarantees shall be governed by the Statute of Frauds; creating s. 768.132, Florida Statutes, entitled the "Florida Medical Consent Law"; covering consent in all cases not covered by s. 768.13, Florida Statutes, entitled the "Good Samaritan Act"; setting standards for information necessary for consent; providing a presumption where a valid consent was given; amending s. 458.1201(1)(m), Florida Statutes, and adding paragraphs (o) and (p) to said section; providing that the State Board of Medical Examiners determine standards of acceptable and prevailing medical practice; authorizing board action in medical malpractice cases and certain disciplinary cases; providing for a civil penalty; adding paragraphs (c) and (d) to s. 458.1201(2), Florida Statutes; providing for appointment of licensed physicians to act for the board; providing for immunity from liability for investigations conducted pursuant to this act; amending s. 458.1201(3)(a), Florida Statutes; authorizing board to require physicians to participate in continuing education programs; authorizing board to require physicians to practice under the direction of a physician in certain locations; adding s. 458.1201(5), Florida Statutes; requiring the board to report to the legislature; creating s. 395.065, Florida Statutes, providing for hospital disciplinary powers; adding subsection (8) to s. 627.351, Florida Statutes, to provide for a joint underwriting plan offering medical malpractice insurance coverage to be set up by

insurers writing casualty insurance as defined in s. 624.605(1)(b), (j), and (p), Florida Statutes, and self-insurers authorized under s. 627.355, Florida Statutes; creating s. 627.353, Florida Statutes, to provide for the limitation of liability when certain provisions are met for any licensed hospital, physician, physician's assistant, osteopath or podiatrist for the amount of any settlement approved by the joint underwriting association established under s. 627.351(8), Florida Statutes, or any judgment exceeding $100,000 for any claim arising out of the rendering of medical care or services; creating a patient's compensation fund to be administered by said joint underwriting association subject to supervision by a board of governors to provide coverage for the amount of any such settlement or judgment affected by said limitation of liability; providing for fees to support the fund including an assessment against participants for deficits; providing for costs in administering or defending the fund; providing claims procedures; providing an effective date.

WHEREAS, the cost of purchasing medical professional liability insurance for doctors and other health care providers has skyrocketed in the past few months; and

WHEREAS, it is not uncommon to find physicians in high-risk categories paying premiums in excess of $20,000 annually; and

WHEREAS, the consumer ultimately must bear the financial burdens created by the high cost of insurance; and

WHEREAS, without some legislative relief, doctors will be forced to curtail their practices, retire, or practice defensive medicine at increased cost to the citizens of Florida; and

WHEREAS, the problem has reached crisis proportion in Florida, NOW THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. The short title of this act shall be "The Medical Malpractice Reform Act of 1975".

Section 2. Section 627.352, Florida Statutes, is created to read:

627.352 Medical Liability Insurance Commission.--

(1) The Florida Medical Liability Insurance Commission is hereby created, consisting of the following members: the Insurance Commissioner, the Secretary of the Department of Health and Rehabilitative Services, and twelve members to be appointed. The Governor, the President of the Senate, and the Speaker of the House of Representatives shall each appoint four members to the commission. Each shall appoint a member of the legal profession, a provider of health services, a lay citizen and a representative from the insurance industry.

(2) The Insurance Commissioner shall be the chairman of the commission and shall provide records management for the commission. A majority of the commission members shall constitute a quorum for the transaction of any business or the exercise of any power or function of the commission. The affirmative vote by a majority of the quorum present at a duly called and noticed meeting shall be required to exercise any power or function of the commission. Each member shall be entitled to one vote on all matters which may come before the commission. The commission may delegate to one or more of its members such duties as it deems proper.

(3) The Insurance Commissioner and the Secretary of the Department of Health and Rehabilitative Services may designate a representative from his agency to exercise his power and perform his duties, including the right to vote on the commission.

(4) Members of the commission serving as representatives of the general public shall receive mileage and $20 per diem for attending meetings of the commission. Each member of the commission shall be allowed the necessary and actual expenses which he shall incur in the performance of his duties under this section.

(5) On or before January 1, 1976, the commission, in cooperation and consultation with appropriate state and federal agencies, the medical and legal professions, the insurance industry and representatives of the general public, shall prepare and submit to the Governor and the legislature its report and recommendations.

(a) The goal of the plan shall be to recommend a medical liability insurance system which can be operated at reasonable cost for the purpose of providing prompt, equitable compensation to those sustaining medical injury.

(b) Primary consideration shall be given, but not limited to, establishing an insurance system which can be underwritten by private insurers on a self-supporting basis using actuarially sound rates.

(c) If the commission finds that no insurance system meeting the goal of the plan can be underwritten by private insurers on a self-supporting basis using actuarially sound rates, it shall specify the needed changes in the statutes to create a viable market for medical liability insurance, or self-insurance.

(d) The comprehensive report shall include recommendations to the legislature for reducing the incidence of medical injuries, including establishing standards of care and procedures for peer review; reducing the cost of prosecuting and defending claims and administering the insurance mechanism, changes in existing law governing the eligibility of injured persons for compensation and the amount of compensation, including limitations on the time within which claims may be brought and the elements of loss for which compensation may be recovered and any other matters or procedures which the commission considers relevant to the medical liability insurance problem.

(e) The commission is authorized and encouraged to make interim reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives concerning specific legislative proposals, which need immediate consideration.

Section 3. Section 395.18, Florida Statutes, is created to read:

395.18 Internal risk management program.--Every hospital licensed pursuant to this chapter, having in excess of 300 beds, as a part of its administrative functions, shall establish an internal risk management program which shall include the following components:

(1) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients; and

(2) The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients through the cooperative efforts of all personnel; and

(3) The analysis of patient grievances which relate to patient care and the quality of medical services.

The risk management program shall be carried out either through a person on the administrative staff of a hospital, as part of his administrative duties; or by a committee of the

hospital board of trustees or directors, or by the medical staff in a manner deemed appropriate.

Section 4. Subsection (1) of s. 627.355, Florida Statutes, is amended to read:

627.355 Medical malpractice insurance; purchase.--

(1) A group or association of physicians or health care facilities, composed of any number of members, organized for purposes other than the purchase of medical malpractice insurance which has been in continuing existence for a period of at least 2 years, is authorized partially to self-insure against claims of medical malpractice upon obtaining approval from the Department of Insurance and upon complying with the following conditions:

(a) Establishment of a medical malpractice risk management trust fund to provide coverage against professional medical malpractice liability.

(b) Employment of a professional staff and consultants for loss prevention and claims management coordination under a risk management program.

Section 5. Section 768.133, Florida Statutes, is created to read:

768.133 Medical liability mediation panel.--

(1) The chief judge of each judicial circuit shall prepare a list of persons to serve on medical liability mediation panels, whose purpose shall be to hear and to facilitate the disposition of all medical malpractice actions arising within the jurisdiction of the circuit. The number of persons on the list shall be determined by the chief judge but shall be in sufficient numbers to efficiently carry out the intent of this section. All hearings, as hereinafter provided for, shall be before a three-member panel hereinafter referred to as the panel, mediation panel or hearing panel composed as follows: a judicial referee who shall be the presiding member of the hearing panel,

shall be a circuit judge. Such appointments shall be made by a "blind" system. The other panel members shall be selected in accordance with the following procedure:

(a) A list of physicians licensed to practice under chapters 458 or 459 shall be prepared by the chief judge. In making the list, the chief judge may accept the recommendations of recognized professional medical societies. The list shall be divided into lists of physicians according to the particular specialty of each if possible.

(b) A list of qualified attorneys shall be prepared by the chief judge. In making the list the chief judge may accept the recommendations of recognized professional legal societies.

(c) Names of physicians and attorneys may be added to or taken off the panel list at any time by the chief judge at his discretion, provided, however, that all names added to the list shall be placed at the bottom of the list.

(d) A physician or attorney selected to be on the hearing panel for a particular case may disqualify himself or be challenged for cause.

(e) A filing fee not to exceed $25 shall be established by the chief judge in each circuit and shall be paid to the clerk of the circuit court. The filing fee shall be used to meet such incidental expenses as the panel may incur.

(2) Any person or his representative claiming damages by reason of injury, death or monetary loss on account of the alleged malpractice by any medical or osteopathic physician, hospital, or health maintenance organization and against whom he believes there is a reasonable basis for a claim shall submit such claim to the appropriate panel before that claim may be filed in any court of this state. Claims shall be made on

forms provided by the circuit court and shall be filed initially with the clerk of that court, with copies mailed to the person against whom the claim is made and to the administrative board licensing such professional. Service of process shall be effected as provided by law. Constructive service of process may be effected as provided by law. All parties named as defendants in the claim shall file an answer to such claim within 20 days of the date of service. No other pleadings shall be allowed. If no answer is filed within such time limit, the jurisdiction of the mediation panel over the subject matter shall terminate, and the parties may proceed in accordance with law. Within 30 days after service of process, the parties shall file with the clerk a document designating the type of medical specialist who should hear the claim. In the event the parties do not agree on the specialist, the judicial referee shall make the determination. In no event shall more than one medical practitioner serve on a mediation panel.

(3) If both parties agree upon a doctor and an attorney to serve on the hearing panel, they may so stipulate. In the event that no agreement is reached within 10 days after determination of the specialty of medical practice involved, the clerk shall mail to the parties and the panel members hereinafter described the names selected at random of five attorneys who are members of the hearing panel and the names selected at random of five physicians of the designated specialty who are members of the hearing panel, or if it is impractical to designate the physicians by specialty, the names selected at random of five physicians without regard to specialty. Thereafter, the panel members so selected shall have 10 days within which to disqualify themselves and the parties shall have the same time in which to challenge panel members for cause. A decision on challenges for cause shall be made by agreement or by the judicial referee. If there are disqualifications or challenges for cause, the clerk shall appoint additional panel members as required. Thereafter, from the list of five attorneys and five physicians, the parties shall agree on one attorney and one physician to serve on the hearing panel. If the parties are unable to agree, each side shall then strike names alternately from the attorneys' list and from the physicians' list separately, with the claimant striking first, until each side has stricken two names from each list. The remaining attorney and physician shall serve on the hearing panel.

(4) The clerk shall, with the advice and cooperation of the parties and their counsel, fix a date, time and place for a hearing on the claim before the hearing panel, provided, however, that the hearing shall be held within 120 days of the date the claim is filed with the clerk, unless for good cause shown upon order of the judicial referee, such time is extended. Such extension shall not exceed six months from the date the claim is filed. If no hearing is held on the merits within 10 months of the date the claim is filed, the jurisdiction of the mediation panel on the subject matter shall terminate and the parties may proceed in accordance with law.

(5) The filing of the claim shall toll any applicable statute of limitations, and such statute of limitations shall remain tolled until the hearing panel issues its written decision, or the jurisdiction of the panel is otherwise terminated. In any event, a party shall have 60 days from the date the decision of the hearing panel is mailed to the parties or the date on which the jurisdiction of the panel is otherwise terminated in which to file a complaint in circuit court.

(6) All parties shall be allowed to utilize any discovery procedure provided for by the Florida Rules of Civil Procedure. Any motion for relief arising out of the use of such discovery procedures shall be decided by the judicial

referee. The judicial referee may in his discretion make reasonable limitations on the extent of discovery.

(7) The claim shall be submitted to the hearing panel under such procedural rules as may be established by the Supreme Court, provided that strict adherence to the rules of procedure and evidence applicable in civil cases shall not be required. Witnesses may be called, all testimony shall be under oath, testimony may be taken either orally before the panel or by deposition, copies of records, x-rays and other documents may be produced and considered by the panel and the right to subpoena witnesses and evidence shall obtain as in all other proceedings in the circuit court. The right of cross-examination shall obtain as to all witnesses who testify in person. Both parties shall be entitled, individually and through counsel, to make opening and closing statements. No transcript or record of the proceedings shall be required, but any party may have the proceedings transcribed or recorded. The judge presiding at the hearing shall not preside at any trial arising out of the claim or hear any application in the case not connected with the hearing itself. No other hearing panel member shall participate in a trial arising out of the claim either as counsel or witness.

(8) Within 30 days after the completion of any hearing, the hearing panel shall file a written decision with the clerk of the court who shall thereupon mail copies to all parties concerned and their counsel. The panel shall decide the issue of liability and shall state its conclusion in substantially the following language: "We find the defendant was actionably negligent in his care and/or treatment of the patient and we, therefore, find for the plaintiff"; or "We find the defendant was not actionably negligent in his care and/or treatment of the patient and we, therefore, find for the defendant". The

decision shall be signed by all members of the hearing panel; however, any member of the panel may file a written concurring or dissenting opinion.

(9) After a finding of liability, if the adverse parties agree, the panel may continue mediation for the purpose of assisting the parties in reaching a settlement. In such event, the panel shall also make a recommendation as to a reasonable range of damages, if any, which should be awarded in the case. The recommendation as to damages shall include in simple, concise terms some breakdown as to which portion of the damages recommended are attributable to past and estimated future health or custodial care expenses attributable to the alleged malpractice or any of the other elements of damage enumerated in s. 768.21, Florida Statutes, for wrongful death or recognized by the Florida Standard Jury Instructions as elements of damages in injuries due to negligence. However, the panel shall not have the right to determine punitive damages. Any findings of damages shall not be admissible in evidence in a subsequent trial.

(10) In the event any party rejects the decision of the hearing panel, the claimant may institute litigation based upon the claim in the appropriate court. Furthermore, in any civil medical malpractice action, the trial on the merits shall be conducted without any reference to insurance, insurance coverage or joinder in the suit of the insurer as a co-defendant.

(11) The conclusion of the hearing panel on the issue of liability may be admitted into evidence in any subsequent trial. However, no specific findings of fact shall be admitted into evidence at trial. Parties may, in the opening statement or argument to the court or jury, comment on the panel's conclusion in the same manner as any other evidence introduced at trial. If there is a dissenting opinion, the numerical vote of the panel shall also be admissible. Panel members may not

be called to testify as to the merits of the case. The jury shall be instructed that the conclusion of the hearing panel shall not be binding but shall be accorded such weight as they choose to ascribe to it.

(12) No member of the hearing panel shall be liable in damages for libel, slander or defamation of character of any party to the mediation proceedings for any action taken or recommendation made by such member acting within his official capacity as a member of the hearing panel.

Section 6. The provisions of section 5 of this act shall not be applicable to any case in which formal suit has been instituted prior to the effective date of that section, which shall be July 1, 1975.

Section 7. Subsection (4) of section 95.11, Florida Statutes, 1974 Supplement, is amended to read:

95.11 Limitations other than for the recovery of real property.--Actions other than for recovery of real property shall be commenced as follows:

(4) WITHIN TWO YEARS.--

(a) An action for professional malpractice, other than medical malpractice, whether founded on contract or tort; provided that the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence; provided, however, that the limitation of actions herein for professional malpractice shall be limited to persons in privity with the professional.

(b) An action for medical malpractice shall be commenced within two years from the time the incident occurred giving rise to the action, or within two years from the time the incident is discovered, or should have been discovered with the exercise of due diligence, provided, however, that in no event shall the action be commenced later than four years from the date of the incident or occurrence out of which the cause of action accrued. An action for medical malpractice is defined as a claim in tort or in contract for damages because of the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of health care. The limitation of actions within this subsection shall be limited to the health care provider and persons in privity with the provider of health care. In those actions covered by this paragraph where it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the injury within the four-year period, the period of limitations is extended forward two years from the time that the injury is discovered or should have been discovered with the exercise of due diligence, but in no event to exceed seven years from the date the incident giving rise to the injury occurred.

(c)~~(b)~~ An action to recover wages or overtime or damages or penalties concerning payment of wages and overtime.

(d)~~(c)~~ An action for wrongful death.

Section 8. Section 768.042, Florida Statutes, is created to read:

768.042 Damages.--In any action brought in the circuit court to recover damages for personal injury or wrongful death, the amount of general damages shall not be stated in the complaint, but the amount of special damages, if any, may be specifically pleaded and the requisite jurisdictional amount established for filing in any court of competent jurisdiction.

Section 9. The provisions of section 8 of this act shall not apply to any complaint filed prior to the effective date of this act.

Section 10. Section 725.01, Florida Statutes, is amended to read:

725.01 Promise to pay another's debt, etc.--No action shall be brought whereby to charge any executor or administrator upon any special promise to answer or pay any debt or damages out of his own estate, or whereby to charge the defendant upon any special promise to answer for the debt, default or miscarriage of another person or to charge any person upon any agreement made upon consideration of marriage, or upon any contract for the sale of lands, tenements or hereditaments, or of any uncertain interest in or concerning them, or for any lease thereof for a period longer than one year, or upon any agreement that is not to be performed within the space of one year from the making thereof, or whereby to charge any health care provider upon any guarantee, warranty or assurance as to the results of any medical, surgical or diagnostic procedure, performed by any physician licensed under chapter 458, Florida Statutes, osteopath licensed under chapter 459, Florida Statutes, chiropractor licensed under chapter 460, Florida Statutes, podiatrist licensed under chapter 461, Florida Statutes, or dentist licensed under chapter 466, Florida Statutes, unless the agreement or promise upon which such action shall be brought, or some note or memorandum thereof shall be in writing and signed by the party to be charged therewith or by some other person by him thereunto lawfully authorized.

Section 11. Section 768.132, Florida Statutes, is created to read:

768.132 Florida medical consent law.--

(1) This section shall be known and cited as the "Florida Medical Consent Law".

(2) In any medical treatment activity not covered by s. 768.13, Florida Statutes, entitled "the Good Samaritan Act", this act shall govern.

(3) No recovery shall be allowed in any court in this

state against any physician licensed under chapter 458, Florida Statutes, osteopath licensed under chapter 459, Florida Statutes, chiropractor licensed under chapter 460, Florida Statutes, podiatrist licensed under chapter 461, Florida Statutes, or dentist licensed under chapter 466, Florida Statutes, in an action brought for treating, examining, or operating on a patient without his informed consent where:

(a) The action of the physician, osteopath, chiropractor, podiatrist, or dentist in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community; and

(b) A reasonable individual from the information provided by the physician, osteopath, chiropractor, podiatrist, or dentist under the circumstances, would have a general understanding of the procedure and medically acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among other physicians, osteopaths, chiropractors, podiatrists, or dentists in the same or similar community who perform similar treatments or procedures; or

(c) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he been advised by the physician, osteopath, chiropractor, podiatrist, or dentist in accordance with the provisions of paragraphs (a) and (b) of this section.

(4)(a) A consent which is evidenced in writing and meets the requirements of subsection (3), shall, if validly signed by the patient or another authorized person, be conclusively presumed to be valid consent. This presumption may be rebutted if there was a fraudulent misrepresentation of a material fact in

obtaining the signature.

(b) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

Section 12. Subsection (5) of s. 458.1201, Florida Statutes, is renumbered as subsection (6), and a new subsection (5) is added to said section; paragraph (m) of subsection (1) of said section is amended and paragraphs (o) and (p) are added to said subsection; paragraphs (c) and (d) are added to subsection (2) of said section; paragraph (a) of subsection (3) of said section is amended to read:

458.1201 Denial, suspension, revocation of license; disciplinary powers.--

(1) The board shall have authority to deny an application for a license or to discipline a physician licensed under this chapter or any antecedent law who, after hearing has been adjudged unqualified or guilty of any of the following:

(m) Being guilty of immoral or unprofessional conduct, incompetence, negligence, or willful misconduct. Unprofessional conduct shall include any departure from, or the failure to conform to, the ~~minimal~~ standards of acceptable and prevailing medical practice in his area of expertise as determined by the board, in which proceeding actual injury to a patient need not be established; ~~or the committing by a physician of any act contrary to honesty, justice, or good morals,~~ when whether the same is committed in the course of his practice ~~or otherwise~~, and whether committed within or without this state;

(o) Being found liable for medical malpractice or any personal injury resulting from an act or omission committed or omitted by a person in his capacity as a physician licensed pursuant to this chapter.

(p) Being removed or suspended or having disciplinary

action taken by his peers within any professional medical association, society, professional standards review organization established pursuant to section 249F of Public Law 92-603, or similarly constituted professional body, whether or not such association, society, organization, or body is local, regional, state, national, or international in scope, or by being disciplined by a licensed hospital or medical staff of said hospital for immoral or unprofessional conduct or willful misconduct or negligence by a person in his capacity as a physician licensed pursuant to this chapter. Any body taking action as set forth in this paragraph shall report such action to the board within 30 days of its occurrence or be subject to a fine assessed by the board in an amount not exceeding $500.

(2)(c) In any proceeding under subsection (1) of this section the board may appoint one or more licensed physicians to act for the board in investigating the conduct or competence of a physician.

(d) There shall be no liability on the part of, and no cause of action of any nature shall arise against the board, its agents, its employees, or any organization or its members identified in paragraph (p) of subsection(1) of this section, for any statements made by them in any reports or communications concerning an investigation of the conduct or competence of a physician.

(3)(a) When the board finds any person unqualified or guilty of any of the grounds set forth in subsection (1), it may enter an order imposing one or more of the following:

1. Deny his application for a license;

2. Permanently withhold issuance of a license;

3. Administer a public or private reprimand;

4. Suspend or limit or restrict his license to practice medicine for a period of up to five years;

5. Revoke indefinitely his license to practice medicine;

6. Require him to submit to the care, counseling, or treatment of physicians designated by the board;~~.~~

7. Require him to participate in a program of continuing education prescribed by the board;

8. Require him to practice under the direction of a physician in a public institution, public or private health care program, or private practice for a period of time specified by the board.

(5) The board shall report to the President of the Senate and the Speaker of the House of Representatives, on February 1 of each year beginning February 1, 1976, the status of the actions taken by the board in carrying out its responsibilities assigned to it under this section.

(6)~~(5)~~ The provisions of this section are enacted in the public welfare and shall be liberally construed so as to advance the remedy.

Section 13. Section 395.065, Florida Statutes, is created to read:

395.065 Hospital disciplinary powers.--

(1) The medical staff of any hospital licensed pursuant to chapter 395, Florida Statutes, is authorized to suspend, deny, revoke, or curtail the staff privileges of any staff member for good cause, which shall include, but not be limited to:

(a) Incompetence;

(b) Negligence;

(c) Being found an habitual user of intoxicants or drugs to the extent that the physician is deemed dangerous to himself or others; or

(d) Being found liable by a court of competent jurisdiction for medical malpractice.

Provided, however, that the procedures for such actions shall comply with the standards outlined by the Joint Commission of Accreditation of Hospitals and the

Principles of Participation in the Federal Health Insurance Program for the Aged.

(2) There shall be no liability on the part of and no cause of action of any nature shall arise against any hospital, hospital medical staff or hospital disciplinary body, its agents or employees, for any action taken in good faith and without malice in carrying out the provisions of this act.

Section 14. Subsection (8) of s. 627.351, Florida Statutes, is created to read:

627.351 Insurance risk apportionment plan.--

(8)(a) The Department of Insurance shall, after consultation with insurers as set forth in paragraph (b), adopt a temporary joint underwriting plan as set forth in paragraph (d).

(b) Entities licensed to issue casualty insurance as defined in s. 624.605(1)(b), (j), and (p), Florida Statutes, and self-insurers authorized to issue medical malpractice insurance under s. 627.355, Florida Statutes, shall participate in the plan and shall be members of the Temporary Joint Underwriting Association.

(c) The joint underwriting association shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the joint underwriting association, an attorney to be named by the Florida Bar, a physician to be named by the Florida Medical Association, a hospital representative to be named by the Florida Hospital Association, and the Insurance Commissioner or his designated representative employed by the Department of Insurance. The Insurance Commissioner or his representative shall be the chairman of the board.

(d) The temporary joint underwriting plan shall function for a period not exceeding three years from the date of its adoption by the Department of Insurance and if still in existence

at the end of such three-year period, it shall automatically terminate. The plan shall provide professional liability or malpractice coverage in a standard policy form for all hospitals licensed under chapter 395, Florida Statutes, physicians licensed under chapter 458, Florida Statutes, osteopaths licensed under chapter 459, Florida Statutes, podiatrists licensed under chapter 461, Florida Statutes, dentists licensed under chapter 466, Florida Statutes, nurses licensed under chapter 464, Florida Statutes, and nursing homes licensed under chapter 400, Florida Statutes, or professional associations of such persons. The plan shall include, but not be limited to, the following:

1. Rules for the classification of risks and rates which reflect past and prospective loss and expense experience in different areas of practice and in different geographical areas.

2. A rating plan which reasonably recognizes the prior claims experience of insureds.

3. Provisions as to rates for insureds who are retired, semi-retired, the estate of a deceased insured, or part-time professionals.

4. Protection in an amount to be determined by the Insurance Commissioner and for those hospitals licensed under chapter 395, Florida Statutes, whose policies have been cancelled since April 1, 1975, that have not been able to otherwise secure coverage in the standard market shall provide continuous coverage at the limits available in the plan from the above date.

5. Rules to implement the orderly dissolution of the plan at its termination.

6. The Insurance Commissioner may, in his discretion, require that insurers participating in the joint underwriting association offer excess coverage.

(e) Premium contingency assessment.--

1. In the event an underwriting deficit exists at the end of any year the plan is in effect, each policyholder shall

pay to the association a premium contingency assessment not to exceed one-third of the annual premium payment paid by such policyholder to the association. The association shall cancel the policy of any policyholder who fails to pay the premium contingency assessment.

2. Any deficit sustained under the plan shall first be recovered through the premium contingency assessment. Concurrently, the rates for insureds shall be adjusted for the next year so as to be actuarially sound.

3. If there be any remaining deficit under the plan after maximum collection of the premium contingency assessment, such deficit shall be recovered from the companies participating in the plan in the proportion that the net direct premiums of each such member written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the association. Premiums as used herein shall mean premiums for the lines of insurance defined in s. 624.605(1)(b), (j), and (p), Florida Statutes, including premiums for such coverage issued under package policies.

(f) The plan shall provide for one or more insurers able and willing to provide policy service through licensed resident agents and claims service on behalf of all other insurers participating in the plan.

(g) The Department of Insurance, prior to termination of the plan, shall determine whether a need reasonably exists for continuing coverage for those who have been insured by the plan, as to claims solely for incidents which occurred during the existence of the plan. If such need is found, the Department of Insurance shall establish a plan for the purchase of such coverage for a reasonable time, prior to termination of the plan.

(h) All books, records, documents or audits relating

to the joint underwriting association or its operation shall be open to public inspection.

Section 15. Section 627.353, Florida Statutes, is created to read:

627.353 Limitation of liability and patient's compensation fund.--

(1) LIMITATION OF LIABILITY.--

(a) All hospitals licensed under chapter 395, Florida Statutes, shall, unless exempted under paragraph (c) of this section, and all physicians and physician's assistants licensed under chapter 458, Florida Statutes, osteopaths licensed under chapter 459, Florida Statutes, and podiatrists licensed under chapter 461, Florida Statutes, may, pay the yearly assessment into the patient's compensation fund pursuant to subsection (2) of this section prior to practicing during any

(b) Said licensed hospital, physician, physician's assistant, osteopath, or podiatrist shall not be liable for an amount in excess of $100,000 for claims arising out of the rendering of medical care or services in this state if at the time the incident occurred giving rise to the cause of the claim the hospital, physician, physician's assistant, osteopath or podiatrist:

1. had posted bond in the amount of $100,000, proved financial responsibility in the amount of $100,000 to the satisfaction of the Insurance Commissioner through the establishment of an appropriate escrow account, obtained medical malpractice insurance in the amount of $100,000 or more from private insurers or the joint underwriting association established under section 14 of this act, or obtained self-insurance

as provided in s. 627.355, Florida Statutes, providing coverage in an amount of $100,000 or more, and

2. Had paid for the year in which the incident occurred for which the claim was filed the fee required pursuant to subsection (2) of this section.

(c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to meet claims arising out of the rendering of medical care or services in this state shall not be required to participate in the fund:

1. Post bond in an amount equivalent to $10,000 for each hospital bed in said hospital not to exceed $2,500,000; or

2. Prove financial responsibility in an amount equivalent to $10,000 for each hospital bed in said hospital not to exceed $2,500,000 to the satisfaction of the Insurance Commissioner through the establishment of an appropriate escrow account; or

3. Obtain professional liability coverage in an amount equivalent to $10,000 or more for each bed in said hospital from a private insurer, from the joint underwriting association established under section 14 of this act, or through a plan of self-insurance as provided in s. 627.355, Florida Statutes; provided, however, no hospital shall be required to obtain such coverage in an amount exceeding $2,500,000.

(d) Any licensed hospital, physician, physician's assistant, osteopath, or podiatrist who does not meet the provisions of paragraph (b) of this subsection shall be subject to liability under law without regard to the provisions of this section.

(2) PATIENT'S COMPENSATION FUND.--

(a) The fund.--There is created a "Florida Patient's Compensation Fund" hereinafter referred to as the "Fund", for the purpose of paying that portion of any medical malpractice claim which is in excess of $100,000 as set forth in paragraph

(b) of subsection (1) of this section. The Fund shall be liable only for payment of claims against hospitals, physicians, physician's assistants, osteopaths and podiatrists in compliance with the provisions of paragraph (b) of subsection (1) of this section, and reasonable and necessary expenses incurred in payment of claims and fund administrative expenses.

(b) Fund administration and operation.--Management of the fund shall be vested with the joint underwriting association authorized by section 14 of this act, hereinafter referred to as the JUA. The JUA shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the JUA, an attorney to be named by the Florida Bar, a physician to be named by the Florida Medical Association, a hospital representative to be named by the Florida Hospital Association, and the Insurance Commissioner or his designated representative employed by the Department of Insurance. The Insurance Commissioner or his representative shall be the chairman of the board. In the event of termination or dissolution of said JUA with respect to providing professional liability or malpractice insurance, the JUA shall continue to operate for the purpose of fund management as provided in this subsection.

(c) Fees and assessments.--Annually, each licensed hospital, physician, physician's assistant, osteopath or podiatrist as set forth in subsection (1) electing to comply with paragraph (b) of subsection (1) of this section shall pay the fees established under this act for deposit into the fund, which shall be remitted for deposit in a manner prescribed by the Insurance Commissioner. The coverage provided by the fund shall begin July 1, 1975 and run thereafter on a fiscal year basis. For the first year of operation each participating licensed hospital, physician, physician's assistant, osteopath,

or podiatrist covered under the fund shall pay a fee for deposit into the fund in the amount of $1,000 for any individual and $300 per bed for any hospital. The fee charged after the first year of operation shall consist of a base fee of $500 for any individual and $300 per bed for any hospital. In addition, after the first year of operation additional fees shall be assessed based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state.

2. The prior claims experience of persons or hospitals covered under the fund.

3. Risk factors for persons who are retired, semi-retired or part-time professionals.

Said base fees may be adjusted downward for any fiscal year in which a lesser amount would be adequate and in which the additional fee would not be necessary to maintain the solvency of the fund. Said additional fee shall be based on not more than two geographical areas with three categories of practice and with a fourth category which contemplates individual risk rating for hospitals. The fund shall be maintained at not more than $25,000,000. Fees shall be set by the Insurance Commissioner after consultation with the JUA. Nothing contained herein shall be construed as imposing liability for payment of any part of a fund deficit on the JUA or its member insurers. If the JUA determines that the amount of money in the fund is not sufficient to satisfy the claims made against the fund in a given fiscal year, the JUA shall certify the amount of the projected insufficiency to the Insurance Commissioner and shall request the Insurance Commissioner to levy a deficit assessment against all participants in the fund for that fiscal year. The Insurance Commissioner shall levy such deficit assessment

against such participants in amounts that fairly reflect the classifications prescribed above and which are sufficient to obtain the money necessary to meet all claims for said fiscal year.

(d) Fund accounting and audit.--

1. Monies shall be withdrawn from the fund only upon vouchers approved by the JUA as authorized by the Board of Governors.

2. All books, records, and audits of the fund shall be open for reasonable inspection to the general public.

3. Persons authorized to receive deposits, withdraw, issue vouchers or otherwise disburse any fund monies shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of such bond shall be paid from the fund.

4. Annually, the JUA shall furnish an audited financial report to all fund participants and to the Department of Insurance and to the Joint Legislative Auditing Committee. The report shall be prepared in accordance with accepted accounting procedures and shall include income and such other information as may be required by the Department of Insurance or the Joint Legislative Auditing Committee.

5. Monies held in the fund shall be invested in short-term interest bearing investments by the JUA as administrator, provided that in no case shall said moneys be invested in the stock of any insurer participating in the JUA or in the parent company or company owning a controlling interest of said insurer. All income derived from such investments shall be credited to the fund.

6. Any person or hospital participating in the fund may withdraw from such participation at the end of any fiscal year; however, such person or hospital shall remain subject to any

deficit assessment pertaining to any year in which such person or hospital participated in the fund.

(e) Claims procedures.--

1. Any person may file an action for damages arising out of the rendering of medical care or services against a person covered under the fund provided that the person filing the claim shall not recover against the fund any portion of a judgment for damages arising out of the rendering of medical care or services against a person covered under the fund unless the fund was named as a defendant in the suit. If after reviewing the facts upon which the claim is based it appears that the claim will exceed $100,000, the fund shall appear and actively defend itself when named as a defendant in the suit. In so defending, the fund shall retain counsel and pay out of the fund attorney's fees and expenses including court costs incurred in defending the fund. The attorney or law firm retained to defend the fund shall not be retained or employed by the JUA to perform legal services for the JUA other than those directly connected with the fund. The fund is authorized to negotiate with any claimants having a judgment exceeding $500,000 to reach an agreement as to the manner in which that portion of the judgment exceeding $500,000 is to be paid. Any judgment affecting the fund may be appealed under the Florida Appellate Rules of Procedure as with any defendant.

2. It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a hospital, physician, physician's assistant, osteopath or podiatrist who is also covered by the fund to provide an adequate defense on any claim filed that potentially affects the fund with respect to such insurance contract or self-insurance contract. The insurer shall act in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding

$100,000, or any other amount which could require payment by the fund, shall be agreed to unless approved by the JUA.

3. A person who has recovered a final judgment or a settlement approved by the JUA against a hospital, physician, physician's assistant, osteopath or podiatrist, who is covered by the fund may file a claim with the JUA to recover that portion of such judgment or settlement which is in excess of $100,000 as set forth in paragraph (b) of subsection (1) of this section. In the event the fund incurs liability exceeding $1,000,000 to any person under a single occurrence the fund shall pay not more than $1,000,000 per year until the claim has been paid in full.

4. Claims filed against the fund shall be paid in the order received within 90 days after filing unless appealed by the fund. If the fund does not have enough money to pay all of the claims, claims received after the funds are exhausted shall be immediately payable the following year in the order in which they were received.

5. If a person or hospital participating in the fund has coverage in excess of $100,000, he shall be liable for losses up to the amount of his coverage, and he shall receive an appropriate reduction of his assessment for the fund. Such reduction shall be granted only after that person has proved to the satisfaction of the JUA that he has such coverage.

Section 16. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared severable.

Section 17. This act shall take effect upon becoming law.

The Medical Society of New Jersey

EXECUTIVE OFFICES

315 WEST STATE STREET, TRENTON, NEW JERSEY TELEPHONE 394-3154

REPLY TO P. O. BOX 904, TRENTON, NEW JERSEY, 08605

MEMORANDUM

TO: Presidents and Executive Secretaries
Component Medical Societies

FROM: Martin E. Johnson, Executive Assistant

DATE: August 21, 1975

The Medical Society of New Jersey registered a formal protest against the Department of Institutions and Agencies' proposed Medicaid regulation changes at the public hearing held in Trenton on August 20, 1975.

Mr. Vincent A. Maressa, Executive Director of The Medical Society of New Jersey delivered the Society's position to Mr. Gerald J. Reilly, Director, Division of Medical Assistance and Health Services, at the public forum attended by various interested groups.

The enclosed copy of Mr. Maressa's presentation will indicate that all areas were thoroughly covered.

The general reception to the speech was most enthusiastic and quite vocal. Not only was the problem "nailed down" in the proper area of fault but, MSNJ picked up an excellent piece of public relations.

You may care to advise your County Society that MSNJ is continuing to actively oppose this proposed regulation and all other regulations and legislation unfavorable to the practice of efficient medicine.

MEJ:lap
Enclosure