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TO: Honorable Jon Riki Karamatsu, Chair
Honorable Ken Ito, Vice Chair
Members of the Committee on Judiciary

FROM: Serafin "Jun" Colmenares, Executive Director, Office of Language Access

RE: **Testimony in Support of the Intent of HB1784 HD1**
Hearing: Tuesday, February 24, 2009, 2:05 p.m., Conference Room 325

I. OVERVIEW OF CURRENT PROPOSED LEGISLATION

HB1784 HD1 proposes to improve health care by limiting damages for medical torts and allowing consumers to make informed decisions when selecting a health care provider. Specifically, the measure allows in medical tort cases the introduction of evidence on amounts payable as a benefit and likewise introduction of evidence of amounts paid by plaintiff; limits attorney fees for such cases; requires courts, if a party requests, to enter judgment ordering payment of monetary damages in periodic payments; limits non-economic damages in cases involving physician specialists to $250,000 per claimant and a cap of $3,000,000 in cases of gross negligence; allows for economic damages based on a proportionate percentage of negligence/fault; and sets a new timeline to bring medical tort actions. In addition, insurance providers for professional liability insurance for health care providers are required to lower their premium rates.

To protect consumers, this measure requires health care providers to notify patients of adverse events relating to their experience in providing medical treatment within 72 hours of the event and requires the Hawaii Medical Board to collect and publish information (including information about language access) about physicians licensed in the state.

II. CURRENT LAW

Chapter 671, HRS, does not address placing a limit on non-economic damages for medical torts involving physician specialists. In addition, although Chapter 453, HRS, addresses medical licensing and discipline, there is no requirement on the development and disclosure of physician

profiles as proposed here. The Hawaii Medical Board Newsletter describes Board actions taken against physicians over the past year. While the Board collects information about physicians, this does not include the extensive physician profile, including addressing language access.

III. HB1784 HD1

The Office of Language Access (OLA) supports the intent of HB1784 HD1.

The physician profile may include information on language access. The availability of language access through an interpreter or bilingual medical staff is a vital component for consumers seeking medical assistance. The OLA supports the intent of this measure to the extent that it furthers the goals of the state Language Access Law (enacted by the Legislature in 2006) to ensure meaningful access to state-funded services, programs and activities by persons with limited English proficiency.

LINDA LINGLE
GOVERNOR OF HAWAII

CHIYOME LEINAALA FUKINO, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
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In reply, please refer to:
File:

WRITTEN TESTIMONY

House Committee on Judiciary

H.B. 1784, H.D. 1 RELATING TO MEDICAL TORTS

Testimony of Chiyome Leinaala Fukino, M.D.
Director of Health

February 24, 2009; 2:05 p.m.

Department's Position: The Department of Health (DOH) supports this bill, but respectfully provides a recommendation to Part II of the current draft. Similarly, this suggested amendment also applies to H.B. 1514, H.D.1, Relating to Medical Torts.

Fiscal Implications: The inefficiencies of the medical tort system are costly– only about 40 cents of every dollar spent on malpractice insurance goes to compensate injured patients while the rest goes to legal fees, court costs, and insurance company administration (RWJF Research Highlights, Oct. 2006). The associated rise in medical malpractice insurance premiums has economically inhibited the ability of doctors to provide necessary services in rural areas and on the neighboring islands.

Purpose and Justification: Part II amends Chapter 321, Hawaii Revised Statutes, requiring health care providers to provide notification of harmful or life threatening adverse events to the patient or family. We suggest that the Hawaii Medical Board, charged with the development of rules and oversight, does not fall under the purview of the Department of Health and thus, the statutory citation should be reconsidered.

The Department of Health strongly supports the Legislature in its efforts to comprehensively consider the many related measures put forth this session to address this critical issue in health care.

The shortcomings of the medical tort system are widely acknowledged. First, few who sustain medical injuries actually receive compensation. Second, malpractice cases are lengthy and awarded compensation amounts are inconsistent. Indeed, the current medical tort system does not seem to effectively promote patient safety and may actually discourage accurate medical error reporting among health care providers. The Department of Health joins with the Office of the Governor, the Department of Commerce and Consumer Affairs and the Hawaii State Legislature as we work towards successfully realizing comprehensive medical tort reform this session.

Thank you for the opportunity to testify.

LINDA LINGLE
GOVERNOR

JAMES R. AIONA, JR.
LT. GOVERNOR

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LAWRENCE M. REIFURTH
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DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON JUDICIARY

TWENTY-FIFTH LEGISLATURE
Regular Session of 2009

Tuesday, February 24, 2009
2:05 p.m.

TESTIMONY ON HOUSE BILL NO. 1784, H.D. 1 – RELATING TO MEDICAL TORTS.

TO THE HONORABLE JON RIKI KARAMATSU, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is J.P. Schmidt, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Insurance Division ("Division") of the Department of Commerce and Consumer Affairs ("Department"). Thank you for hearing this bill. The Insurance Division supports the intent of this version of the bill, but prefers the Administration's bill, House Bill No. 1120.

The Division limits its comments to Part I of this version of the bill.

Both bills propose the establishment of limitations on noneconomic damages in medical tort actions, require the trier of fact to consider and assess the negligence of all parties, add a statutory definition of "economic damages", allocate economic and noneconomic damages in proportion to the provider's share of negligence, establish limits on contingency fees, and amend the definitions of "health care provider" and "medical tort" in Hawaii Revised Statutes ("HRS") § 671-1 and "joint tortfeasors" in HRS § 663-11.

Specifically, this version of the bill proposes a $250,000 limit per claimant for "physician specialists", which is defined as physicians in emergency medicine,

neurological surgery, obstetrics and gynecology, orthopedic surgery, or surgery. If gross negligence is shown, a $3 mil. limit would apply. The allocation of economic and noneconomic damages would apply for physician specialists.

This version of the bill requires a 25% premium rate rollback for physician specialists beginning January 1, 2010, provided that it does not either cause an insurer's insolvency or fail to provide a fair rate of return.

This bill also adds definitions for "future damages", "gross negligence", "periodic payments", and "recovered" in HRS § 671-1, and allows judgments for future damages exceeding $50,000 to be made by periodic payment, rather than by lump sum payment.

This version of the bill also requires the Department to submit a report to the Legislature prior to the convening of the 2013 regular session that identifies the benefits and detriments of Part I.

Since this version of the bill is limited to physician specialists, the Insurance Division prefers the approach in House Bill No. 1120, which is intended to stabilize the medical malpractice insurance market by allowing medical malpractice carriers to better predict the amount of claims and losses. Increased certainty will have the effect of decreasing or moderating premium costs. A study completed last year by the State of Hawaii's actuary, Martin Simon, determined that the reforms proposed last year would reduce medical malpractice insurance premiums by 12-18%. Every state that has passed reforms of non-economic damages has seen a reduction in premiums and a stabilized market. Numerous reputable studies have also supported this connection.

Because of the volatility of the medical malpractice insurance business, ALL for-profit malpractice insurers have left Hawaii. We have only two not-for-profit doctor-owned companies, MIEC and the Doctors Company, and a doctors' trust in Hawaii. If the Doctors Co. or MIEC find that their liability is less than what they had predicted, they refund any overage to the physicians.

Placing a limit on non-economic damages ends the litigation lottery, where there are no limits and no standards for these types of damages. The result of the current system is that doctors often will be sued whether they have committed an error or not.

As a result, doctors are leaving Hawaii. Four more doctors left the Big Island last year leaving only one full time and one part time orthopedist on the entire island.

We need doctors for our citizens. Kahuku Hospital stopped delivering babies, Wahiawa Hospital quit delivering babies, HMC West quit delivering babies. People with just a simple broken bone cannot find a doctor on the entire island of Maui or Hawaii and have to endure a flight to Queen's Hospital on Oahu with an 8 hour delay.

Queen's used to have over 20 orthopedists on call and now they have only 2. We need to keep or doctors and bring in new doctors. So the problem is not just in rural areas, even our hospitals in urban Honolulu are in crisis.

Many have said the problem is low reimbursements for doctors. Reimbursements probably do need to be adjusted to more appropriately compensate doctors. But we will never be able to match the pay in major urban areas like Los Angeles or Dallas where doctors can make two to four times what they make in Hawaii. New York and Miami can match those pay schedules, but they don't have legal and damages reform.

The doctors are going to the states that have enacted these reforms. We need to enact these reforms now, before our healthcare system is so broken it will take a generation to fix.

We thank this Committee for the opportunity to present testimony on this matter and respectfully request that the Committee pass a House Draft 2 with the contents of House Bill No. 1120 that includes all medical providers.

THE QUEEN'S MEDICAL CENTER

1301 Punchbowl Street • Honolulu, Hawaii 96813 • Phone (808) 538-9011 • Fax: (808) 547-4646

Representative Jon Riki Karamatsu, Chair
Representative Ken Ito, Vice Chair

Tuesday, February 24, 2009 – 2:05 p.m.
State Capitol, House Conference Room 325
HOUSE JUDICIARY COMMITTEE

HB1784 HD1 Relating to Medical Torts

Chair Karamatsu, Vice Chair Ito and Members of the Committee,

My name is Robin Fried. I am the Director of Risk Management at The Queen's Medical Center, the largest private tertiary care hospital in the State of Hawaii. I am testifying for The Queen's Medical Center **in opposition to Part II of HB1784 HD1, mandatory disclosure of adverse events.**

Queen's is committed to ensuring the safety and quality of care for its patients 24 hours a day, 7 days a week. While we support open communication and appropriate disclosure to patients and/or patient's personal representatives, we find this section of the bill to be unnecessary and duplicative of existing law and accreditation standards, as well as ambiguous in key aspects.

The proposed language is duplicative of existing law and accreditation standards as follows:

- HRS § 671-3(5) and longstanding case law holds that the treating physician has the duty to obtain informed consent. It follows that the physician has the duty of disclosure of any actual complications and is in the best position to address the medical issues.
- The Joint Commission currently requires accredited hospitals to ensure that the patient or surrogate decision-maker is notified about "unanticipated outcomes of care, treatment and services related to sentinel (major adverse) events".

The proposed language is ambiguous with regard to the following:

- The definition of provider includes both physicians and health care facilities. In situations where the physician is an independent practitioner, not a hospital employee, it is unclear who bears the responsibility for notification – the hospital or the physician.
- The definition of "adverse event" is overbroad and could include almost any complication that may occur.
- The bill provides that failure to comply may subject a health care provider to penalties, yet provides no clear standards for compliance, raising issues of due process.

The Queen's Medical Center urges you to delete Part II of HB1784 HD1. Thank you for the opportunity to testify.

Robin Fried, JD, MS

Castle Medical Center

Adventist Health

Exceptional Medicine
by Exceptional People

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February 23, 2009

To: Representative Jon Riki Karamatsu, Chair
Representative Scott Nishimoto, Vice Chair
House Judiciary Committee
Feb. 24th, Room 302, 2:05pm

From: Kevin Roberts, President and CEO
Castle Medical Center
Kailua, Hawaii

RE: SUPPORT for HB 1784, HD1 Relating to Medical Tort Reform

Dear Representatives Karamatsu, Nishimoto and committee members,

Through this bill, the Hawaii legislature has the opportunity to make a significant impact on the healthcare of Hawaii's residents for years to come. As a hospital administrator, I know with certainty what physicians are looking for when they make decisions about where to practice medicine. Though Hawaii is a great place to live, that is not enough for newly graduating physicians, or for those that have practiced here for many years. They must also know that their trade is welcome and respected in the place the choose to practice. Reasonable Medical liability reform has become the veritable "welcome mat" for recruitment and retention of existing physicians. Hawaii needs this change to become competitive with other states that are vigorously recruiting physicians in the midst of a national physician shortage.

Important attributes of this legislation include:

- It does not cost taxpayers any money
- It will save our state run hospitals money on malpractice premiums
- It will save on defensive medicine costs (ordering tests that are unnecessary)
- It will help to keep physicians in Hawaii and attract new physicians to Hawaii
- The public supports passage of medical tort reform.

We need this! Mahalo!

Sincerely,

Kevin A. Roberts
President and CEO
Castle Medical Center

NFIB
The Voice of Small Business®

Before the House Committee on Judiciary

DATE: February 24, 2009

TIME: 2:05 p.m.

PLACE: Conference Room 325

Re: HB 1784, HD1
Relating to Medical Torts
Testimony of Melissa Pavlicek for NFIB Hawaii

Thank you for the opportunity to testify in support of HB 1784, HD1. NFIB supports this measure.

The National Federation of Independent Business is the largest advocacy organization representing small and independent businesses in Washington, D.C., and all 50 state capitals. In Hawaii, NFIB represents more than 1,000 members. NFIB's purpose is to impact public policy at the state and federal level and be a key business resource for small and independent business in America. NFIB also provides timely information designed to help small businesses succeed.

NFIB agrees that limiting non-economic damages in medical tort actions is an important issue, with the potential to affect many businesses. We have long supported legislation that would tend to reduce additional financial or administrative burden on business, particularly small businesses.

841 Bishop Street, Suite 2100 Honolulu, Hawaii 96813

Tuesday, February 24, 2009, 2:05 p.m. CR 325

To: COMMITTEE ON JUDICIARY
Rep. Jon Riki Karamatsu, Chair
Rep. Ken Ito, Vice Chair

From: Hawaii Medical Association
Gary A. Okamoto, MD, President
Philip Hellreich, MD, Legislative Co-Chair
Linda Rasmussen, MD, Legislative Co-Chair
April Donahue, Executive Director
Richard C. Botti, Government Affairs
Lauren Zirbel, Government Affairs

Re: HB 1784 RELATING TO MEDICAL TORTS

In support.

Chairs & Committee Members:

Hawaii's patients need better access to quality medical care. Hospitals and physicians are teetering on the brink of insolvency because of low reimbursements, high malpractice liability insurance premiums, and their inability, due to prohibitions in their provider agreements, to pass on ever increasing costs. HMSA, Medicare, Health Quest, and the Workers' Compensation Fee schedules control physicians' fees. The only way to increase revenues is to see more and more patients with less and less time given to each, resulting in burn out for physicians and a lower quality of care for patients.

Hawai'i Island Health Workforce Assessment of 2008 states that the Big Island would benefit from an additional 45 physicians. This same **workforce assessment listed implementation of tort reform legislation to improve the medical malpractice environment as one of the study's conclusions on how to recruit these 45 needed physicians**.[1]

Tort reform will increase reimbursements and lower malpractice premiums, and a major reason why is the factor of defensive medicine. Defensive medicine is defined as providing medical services that are not expected to benefit the patient but that are undertaken to minimize the risk of a subsequent lawsuit. The study quoted most often is by Daniel P. Kessler and Mark B. McClellan. To really understand actual costs, Kessler and McClellan analyzed the effects of malpractice liability reforms using data on Medicare beneficiaries who were treated for serious heart disease. They found that liability reforms could reduce defensive medicine practices, leading to a 5 percent to 9 percent reduction in medical expenditures without any effect on mortality or medical complications.

If the Kessler and McClellan estimates were applied to total U.S. health care spending in 2005, the defensive medicine costs would total between $100 billion and $178 billion per year. Add to this the cost of defending malpractice cases, paying compensation, and covering additional administrative costs (a total of $29.4 billion). **Thus, the average American family pays an additional $1,700 to $2,000 per year in health care costs simply to cover the costs of defensive medicine.**[2]

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[1] Withy, Kelly, MD PhD. *Hawaii Island Health Workforce Assessment 2008.*
[2] Weinstein, Stuart. "The cost of defensive medicine."

Premium rates are partially based on the amount of malpractice cases in the area and caps on damages coincide with fewer lawsuits. **The inefficiencies of the medical tort system are costly – only about 40 cents of every dollar spent on malpractice insurance go to compensate injured patients while the rest go to legal fees, court costs, and insurance company administration** (RWJF Research Highlights , Oct. 2006). **The associated rise in medical malpractice insurance premiums has economically inhibited the ability of Hawaii physicians to provide necessary services, particularly in rural areas and on neighbor islands.**

Limits on non-economic damages have been proven to stabilize the claims market, making underwriting more predictable and insurance rates far cheaper. This table of Hawaii claims closed with indemnity paid (cwip) from MIEC, Hawaii's largest malpractice insurer, shows the extreme volatility in claims payment in Hawaii.

Yr closed	Paid		Average	Total #	
Indem & expense	CWIP		paid indemnity & expense	closed	pct CWIP
1995	$ 3,094,175	18	$ 171,899	121	14.9%
1996	$ 4,828,295	19	$ 254,121	159	11.9%
1997	$ 3,291,993	14	$ 235,142	129	10.9%
1998	$ 9,871,478	72	$ 137,104	167	43.1%
1999	$ 5,817,043	25	$ 232,682	204	12.3%
2000	$ 8,413,556	22	$ 382,434	189	11.6%
2001	$ 5,149,495	14	$ 367,821	122	11.5%
2002	$ 2,770,392	16	$ 173,150	145	11.0%
2003	$ 6,259,413	23	$ 272,148	185	12.4%
2004	$ 9,521,142	18	$ 528,952	196	9.2%

The total paid ranges from $2.77 million to $9.87 million. Typically 11-12% are closed with a payment for indemnity (1998 was unusual at 43%). The other 88-89% of cases incurred legal defense payments, which are not included here, even though no indemnity is paid. The amounts paid rise and fall from year to year. The average amount paid trends generally upward. MIEC returned $34 million in dividends to its policyholders in the 1990s.

As reported by the Hawaii Insurance Commissioner, there are a limited number of insurers specializing in medical malpractice and two of the major writers of medical malpractice insurance in Hawaii are not traditional for-profit stock insurers. St. Paul Insurance stopped selling medical malpractice insurance coverage nationwide a few years ago. Farmers Insurance stopped providing medical malpractice coverage last year in Hawaii and across the nation. He reports that if reasonable profits could be made in medical malpractice insurance, traditional insurance companies would be writing it. If excessive profits could be made, we would have many companies seeking to get this type of business.

Instead, Hawaii has mostly doctor-owned non-profit reciprocals or risk purchasing groups. These are groups of doctors who have banded together to form a non-profit entity to try to provide reasonable coverage for their fellow doctors. If they do make a profit, they either retain the funds to rebuild surplus depleted in unprofitable years or when feasible they refund those funds to their members.

The Insurance Commissioner reports further that medical malpractice carriers are in crisis due to the volatility of the market. Judgments, settlements, and costs to defend medical malpractice lawsuits have risen at an unpredictable rate. Also, for some years, there may not be many claims or lawsuits and profitability looks pretty good. Then the next year or so, there may be many very large claims and lawsuits and the company suffers significant losses. It is impossible to predict.

It is also important to note that using one year of medical malpractice insurers' profits to describe the current situation is incomplete and misleading. Profits and losses are viewed over many years, because medical malpractice claims have what is known as a "long tail", meaning a person may suffer an injury, but the claim is not brought until a long time later, sometimes many years later. This is another factor that makes medical malpractice insurance unpredictable.

This bill will help stabilize the market by providing reasonable standards for medical malpractice lawsuits. California, Texas, Mississippi, and Oklahoma have passed similar laws and seen a reduction in premiums. Nevada and Florida have recently passed similar laws.

The following information from the National Association of Insurance Commissioners shows the profitability of Hawaii medical malpractice carriers based on several different measures from 1994 to 2004. The figures indicate that the carriers are not making even reasonable profits.
Table A below shows Underwriting Profit over a ten-year period. Underwriting profit is essentially the profit a company makes from operations. **In 1995, 1996, 1998, 1999, 2001, and 2004, medical malpractice insurers in Hawaii suffered losses. In only four out of ten years did they show a profit, and none of the profits were as big as the losses in the other six years.**

Table A
2004 Profitability Report for Medical Malpractice Insurance in Hawaii
Percent of Direct Premiums Earned; Underwriting Profit

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	AVG
(31.4)	(29.3)	26.6	(53.1)	(89.9)	1.2	(85.0)	3.7	8.9	(40.6)	(28.9)

Table B below shows Profit on Insurance Transactions. Profit on insurance transactions is underwriting profit plus investment income. Again, there is extreme volatility, with losses in 6 years and some profit in 4 out of 10 years.

Table B
2004 Profitability Report for Medical Malpractice Insurance in Hawaii
Percent of Direct Premiums Earned; Profit on Insurance Transactions

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	AVG
(5.6)	(1.8)	32.2	(20.6)	(47.9)	15.2	(41.4)	11.5	16.2	(14.6)	(5.7)

Table C below shows Return on Net Worth. Return on net worth is profits after taxes divided by capital and surplus, or profitability of the medical malpractice line of insurance. This table shows volatility over the ten-year period and an average return on net worth over ten years of only 1.7%. This is far lower than any other line of insurance and almost breakeven, which is untenable in a high risk (volatile) market.

Table C
2004 Profitability Report for Medical Malpractice Insurance in Hawaii
Percent of Net Worth; Return on Net Worth

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	AVG
0.9	3.5	19.7	(4.7)	(16.6)	11.8	(18.7)	11.1	15.5	(5.5)	1.7

These tables show that no one is making excessive profits in the medical malpractice insurance business in Hawaii. It is a constant challenge to simply stay in business.

As reported by the Insurance Commissioner, there were three licensed medical malpractice insurers in Hawaii with $1 million or more in medical malpractice insurance premiums written during CY2004. The top two, Medical Insurance Exchange and The Doctors Co., an interinsurance exchange, insure physicians. The third, Executive Risk Indemnity, Inc., insured hospitals. Executive Risk notified the Insurance Division that it will not be renewing hospital policies in 2005. It should be noted that the two insurance exchanges are owned by doctors who are also the insureds.

An Analysis of Medical Malpractice reforms for the Insurance Division of the State of Hawaii released in February of 2008 states that based on an analysis of facts and data from Hawaii and other states, typical medical liability reforms would result in reductions in premiums of 12 to 18%.[3]

[3] Simons, Martin. Analysis of Medical Malpractice Reforms for the Insurance Division of the State of Hawaii.

Texas exemplifies how caps result in decreased malpractice insurance rates, increased desirability of practice, and an influx of specialists to all areas including rural counties. Thirty-three rural Texas counties have added at least one emergency medicine physician since the passage of Proposition 12 five years ago, including 24 counties that previously had none. Seventy-six Texas counties have seen a net gain in emergency physicians since the passage of reforms. Twenty-four rural counties have added at least one obstetrician since the passage of Proposition 12, including twelve counties that previously had none.

These statistics are confirmed by 4 sources including the Office of Rural Community Affairs, the Texas Department of State Health Services, the Texas Medical Board and the Texas Alliance for Patient Access. The trial attorneys have presented conflicting statistics; it is unclear where their information was obtained.

In Texas, once tort reform passed, malpractice insurance companies cancelled planned increases and began slashing rates. Shortly after the passage of Prop. 12, The Doctors Company cancelled a planned 20% increase and in February 2005 announced a 14% cut.[4]

Three years after Prop. 12 every single carrier in Texas had cut its rates, most by double digits. New carriers have started coming to Texas and today insure some 13% of the market.[5] Many hospital systems have saved $10 million or more on their liability premiums since the passage of Prop. 12.[6]

A dramatic illustration of the reasons for these reductions can be seen in analyzing the number of medical liability filings in the state's most populous county, Houston's Harris County. After a mad rush on the part of the trial bar to file before the vote on Prop. 12 in the summer of 2003, the number of filings plummeted to less than half the previous norm: from 550 the year before passage to 204 the year after.[7]

Laws capping non-economic damages have been enacted in a number of states. Milliman USA, Inc. provided an analysis of caps for the Pennsylvania legislature in 2003. Milliman looked at the effect of caps in states that had passed such laws and states without caps. In California MICRA reduced costs, medical malpractice losses per physician to 52% of the countywide average. Other states with caps have also reduced costs: Colorado 69%, Indiana 86%, and Maryland 64% of countrywide averages. Conversely, states without caps have higher than average malpractice costs: Pennsylvania 171%, Illinois 144%, New Jersey 131%, New York 156% and Washington, D.C. 144% of countrywide averages. Milliman estimated a reduction of 18% in medical malpractice premium rates if reforms were enacted in Pennsylvania in 2003. In a study in 2004, Milliman estimated a 15% reduction in rates in Wyoming if reforms were enacted.

Premiums are affected by numerous factors, but clearly lower costs will result in reduced premium rates. Again the experience of California shows that premiums have been stabilized at a lower level than similar states without caps (see graph).

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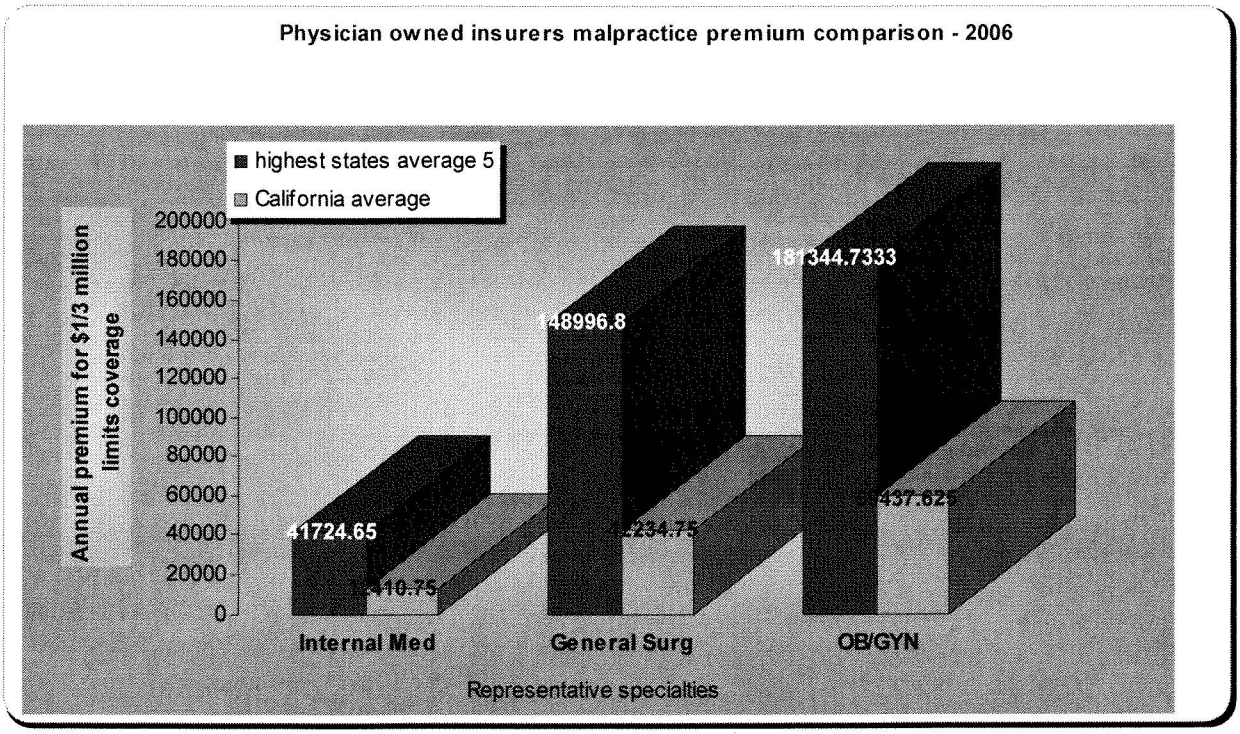
[4] "Proposition 12 Produces healthy Benefits; A Recap: Three Years after Its Passage," Texas Alliance for Patient Access.
[5] Ibid.
[6] Ibid.
[7] Ibid.



In Texas, hospitals report that they are having greater success recruiting physicians. And they are now spending the money saved on insurance premiums to update medical equipment, expand emergency departments, improve outpatient services, increase the number of on-call physicians, raise nurses' salaries, launch patient safety programs and expand uncompensated care.

West Virginia, Mississippi, Florida and Missouri have also passed tort reform statutes this decade, which have helped reduce rates by as much as 10 to 25% for some physicians.[8]

Although each state is different and Hawaii is comparatively much less litigious than Texas, California and Mississippi, the situation is exasperated because Hawaii is such a small state and by the fact that the number of practitioners in a specific field is extremely limited. As shown in the tables above, just one or two claims against a few practitioners has a damaging affect on all within the net. The resulting premiums based on actuaries can be staggering.

The fact that MIEC rates in Hawaii are in some cases comparable to California with its extremely excessive litigious environment is in and of itself proof of how effective tort reform is. In fact, a 2004 study published by the *Los Angeles Times* showed that California's MICRA savings for Los Angeles County when compared to similarly litigious counties netted malpractice savings of $52,000 per Emergency Medicine physician, $123,000 per General Surgery physician, $180,076 per Neurosurgery physician, $120,000 per OB/GYN physician and $112,686 per Orthopaedic surgeon.[9]

If trial lawyers are still unconvinced, the HMA is willing to support a trial period of 5 years where data can be obtained and the case for tort reform can be proven as applicable to Hawaii's unique situation. HMA is also willing to support accountability measures to ensure that savings resulting from decreased defensive medicine are passed on to doctors as well as the savings from reducing legal and

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[8] Lewis. (2009).

[9] SCPIE Indemnity Co. (Los Angeles, CA); Florida Physicians Insurance Company (Dade County, FL); Professional Liability Mutual Insurance Company (Long Island, NY); American Physicians Assurance (Wayne County, MI).

administrative fees to malpractice insurers such as MIEC and The Doctor's Company are passed on to physicians in the form of lower premiums.

Lawsuits are not an effective way to shield the general public from bad medical outcomes. In fact bad doctors shown in videos by trial attorneys do not have to pay any of the damages assessed against their negligence. It is the hospital system and community of doctors who pick up the tab in increased rates. As a side note, **the horrific medical situations depicted in the trial lawyers' videos would clearly fall under the category of gross negligence and there would be a 3 million dollar non-economic allowance under this bill on top of the millions of dollars these people would likely be awarded for economic damages, for which there is no limit.**

The bottom line is that your constituents deserve some sort of action from their legislature to address the failing health care system. Access to physicians has reached a critical juncture. Lowering the standard of medical care through measures such as allowing APRNs to become Primary Care Providers is a band-aid solution. Continually lowering the standard of care is resulting in a huge public safety crisis. Hawaii is a beautiful place to live and many physicians have held on for a long time because of this, but as access to specialists continues to worsen physicians in rural areas will continue to get sued and be charged ever increasing rates because they do not have colleagues to pick up the slack. Physicians are and will continue leave out of frustration and exasperation. Your constituents deserve better. A long overdue compromise must be brokered.

Tort reform costs nothing and will save the taxpayers millions. Eventually, the state will no longer need to subsidize the salaries of specialists when the market cannot create appropriate salaries. All other options to create a more attractive environment for physicians cost taxpayers money, money that we don't have at this point. We all know these cannot become reality at this time due to the massive budget deficit. And while it is sometimes stated that that we don't need tort reform, we just need to increase reimbursements, reimbursements are more often cut rather than increased. As a past example, the legislature greatly reduced workers' comp fee schedules by 54% in 2005, basing reimbursements on Medicare plus 10%. Hawaii's medical fee schedule fell to the fifth lowest in the nation.

Please recognize that the practice of medicine is also a business and therefore follows the same economic rules under which any business operates. You can increase payments by increasing reimbursements, and it is correct that this would be part of the solution. However, it is not happening, in fact the opposite is. Another solution is to decrease costs, namely the cost of malpractice insurance. This bill addresses decreasing costs.

Increasing patient caseloads cannot solve the problem without threatening patient safety. Defensive medicine is practiced daily in all physician offices, emergency rooms, and hospitals, which greatly increases costs to employers, patients, and government.

In a perfect world, injured patients would have no limitations in what they can recover in lawsuits, and this would have no effect on the delivery of vital health care services, or malpractice insurance premiums that physicians, hospitals, and JABSOM have to pay each year. In an imperfect world such as ours, society must impose some limitations on such awards, if the sick and injured are to continue to obtain the obstetrical, neurological, trauma, orthopedic, general surgery and emergency medical care they need.

Thank you for the opportunity to provide this testimony.

PRESENTATION OF THE
HAWAII MEDICAL BOARD

TO THE HOUSE COMMITTEE ON JUDICIARY

TWENTY-FIFTH STATE LEGISLATURE
REGULAR SESSION of 2009

Tuesday, February 24, 2009
2:05 p.m.

WRITTEN TESTIMONY ONLY

TESTIMONY ON HOUSE BILL NO. 1784, H.D. 1, RELATING TO MEDICAL TORTS.

TO THE HONORABLE JON RIKI KARAMATSU, CHAIR,
AND MEMBERS OF THE COMMITTEE:

The Hawaii Medical Board ("Board") thanks you for the opportunity to provide written testimony on H.B. No. 1784, H.D. 1, Relating to Medical Torts. The purpose of this bill is to limit the amount awarded in medical tort cases; set the award limit for non-economic damages in cases of gross negligence; require a health care provider to disclose to patients adverse events relating to their medical treatment; and require the Hawaii medical board to collect and publish information about physicians licensed in the state to allow consumers to make informed decisions in selecting physicians.

While the Board takes no position on the issues relating to medical torts, we do have strong concerns with respect to collecting and publishing information. Although we support and continue to strive, within the capabilities of our resources, to provide information to consumers to make informed decisions, for the reasons stated below we oppose this bill as it places data collecting and publishing responsibilities that we cannot bear without additional resources, and it requires collection of information that is not related to licensing. It further, inappropriately and harshly, authorizes sanctions against

a licensee if the physician fails to comply with furnishing information as well as failing to timely report updates to information.

We first would like to point out that DCCA's web sites already furnish a significant amount of information required by H.B. No. 1784, H.D. 1.

H.B. No. 1784, H.D. 1, however, proposes substantially more data be published and the effect of this is that it will require us to input information that we currently do not post to our database but is otherwise available in hard copy form (for any online publishing, the source of information must come from a database), and to collect and publish information for licensure that we currently do not collect.

On the matter of requiring us to publish information that will result in inputting information that we currently do not post to our database but is otherwise available in hard copy form, this is a workload issue. To manage this task would require additional staff and funding which, in the current economic situation, appears unlikely.

On the matter of requiring us to collect and publish information that we currently do not collect, we object to collecting information which does not have a direct nexus to a physician's competence and qualifications to practice medicine. We license in order to protect the public. Section 26H-2, Hawaii Revised Statutes, relating to policy, states in part that "the purpose of regulation shall be the protection of the public welfare..." To this end, information required of a physician should have (and currently does have) a direct nexus to the physician's competence and qualifications to practice medicine safely.

On the other hand, some of the information required of physicians by this bill has no nexus to qualifications, is not required to obtain or maintain a license, and is not currently collected.

To facilitate discussion and to help understand which enumerated items contained in H.B. 1784, H.D. 1 (PART III, pages 15 -19) fall into the categories described above, we set forth below by subject matter and the corresponding enumerated items from the bill, what information is currently posted on our web sites, what information we collect but is not in our database and thus is not information that can be extracted to post on an online system and to do so would require additional resources, and what information we do not currently collect (because it has no nexus to licensing purposes).

Information currently posted on our web sites:

(1) The full name of the physician; *This information is in the form of first name, middle initial (if provided), and last name.*

(3) A description of any final disciplinary action by the board against the physician, including fines, penalties, probation, suspension, or revocation of license;

(12) Status of compliance with continuing education requirements; *This information is not posted in our database but if a licensee has a current and active status as disclosed on our online service, that would mean compliance with continuing education requirements have been met.*

For the Committee's information, we also publish the license number of the physician, current license status, original date of licensure, expiration date of the license, any

conditions and restrictions placed on the license, prior license name (in the case of name changes), complaint history (the Regulated Industries Complaints Office website), and final disciplinary actions, including settlement agreements (the Office of Administrative hearings website).

Information we collect but is not posted to our database (additional resources needed to do so):

(2) A description of any criminal convictions for felonies and serious misdemeanors, as determined by the board, including convictions reported to the board pursuant to section 329-44;

(4) A description of any final disciplinary action taken by any other licensing jurisdiction in other states against the physician within the last five years;

(5) A description of revocation or involuntary restriction of hospital privileges for reasons related to competence, character, or substance abuse that have been taken by the hospital's governing board or administrative officer, or resignation from or nonrenewal of medical staff membership or restriction of privileges at a hospital taken in lieu of or in settlement of a pending disciplinary action. Adverse decisions reported to the board pursuant to section 663-1.7 shall be included in the profile;

(6) All medical malpractice court judgments or awards in which a payment was awarded to a complainant, including those reported to the board pursuant to sections 453-8.7, 671-5, and 671-15;

(7) Name of medical school attended, dates of attendance, and date of graduation;

(8) Name of graduate medical education program, dates of attendance, and date of completion; *We have this information for the majority of licensees. The exception would be those residents applying for licensure after their first year of residency training. As they would not have completed residency training, we would only have information with respect to the first year.*

(10) State or jurisdiction in which the physician is licensed, date of licensure; *This information is disclosed only with the application for licensure but is not collected at any point thereafter.*

(11) Names of hospitals where the physician has privileges; *This information is disclosed only with the application for licensure but is not collected at any point thereafter.*

SECTION 11, amendments to Section 453-7.5, Hawaii Revised Statutes relating to: (3) The board shall include in the physician profile under section 453- a statement that an adverse decision has been reported to the board.

For the Committee's information, enumerated items 2, 4, 5, 6, and the last item relating to amendments to Section 453-7.5 are the bases for complaints against licensees through the Regulated Industries Complaints Office of DCCA or as complaints initiated by the Board's Office. Therefore, underlying reasons for such actions by a physician do result in a complaint that would be available through the web site on complaint history on a licensee.

Information we do not currently collect (no nexus to licensing):

(1) The address and telephone number of primary practice office, and electronic mail address;

(9) Specialty board certification. The toll free number of the American Board of Medical Specialties shall be included to verify current board certification status;

(10) Current status of licensure of the State or jurisdiction in which the physician is licensed; *This information is disclosed only with the application for licensure but is not collected at any point thereafter.*

(13) Name of the professional liability insurance carrier or self-insured and status of compliance with financial responsibility provisions;

(14) Indication of whether the physician participates in the Medicaid program, health plans, or accepts workers' compensation cases;

(b) The physician may elect to include the following information: professional and community memberships, community activities, publications in peer reviewed medical literature, appointments to medical school faculty, language access, and any specialized areas of treatment.

In light of the above, we cannot support PART III (pages 15-19) of this bill should it move forward with requiring collection and publication of information unrelated to licensing. Should the Committees want us to publish information that we collect but is not posted to our data base, it will require support of positions and funding. If the funding mechanism is to be by way of increased fees to physicians to subsidize the additional staffing, we would have concerns on increasing fees.

Thank you for the opportunity to provide written testimony on H.B. No. 1784, H.D. 1.

Memo

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To: Chair, Judiciary Committee

From: Marty Fritz

Date: February 24, 2009, Tuesday at 2:05 p.m.

Re: **HB 1784, HD1 (HSCR505)**

Honorable Chair and Committee Members. My name is Marty Fritz. I am a lawyer who represents a limited number of medical malpractice victims who suffer horrific injuries or death from doctors errs.

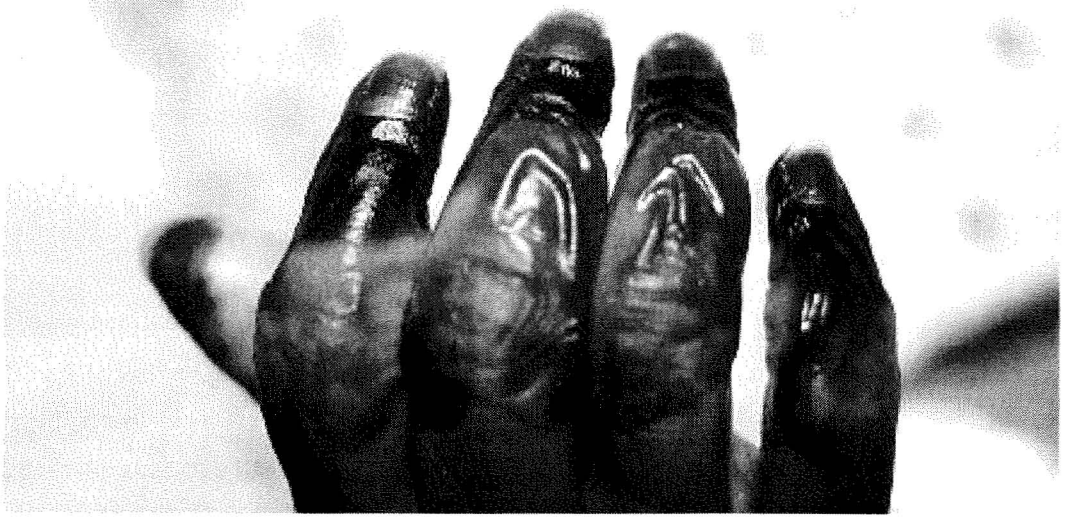
The bills your committee is hearing relating to tort reform have one basic assumption-- there is a need for some change. The arguments I have heard supporting these bills are primarily that there is an explosion in medical malpractice verdicts in the State of Hawaii which is leading large numbers of physicians to leave the state. There are no specifics presented, rather emotional non specific allegations of the negative effects of the current system. The reason why these arguments are non specific is because they are unable to be supported by relating on evidence and analysis.

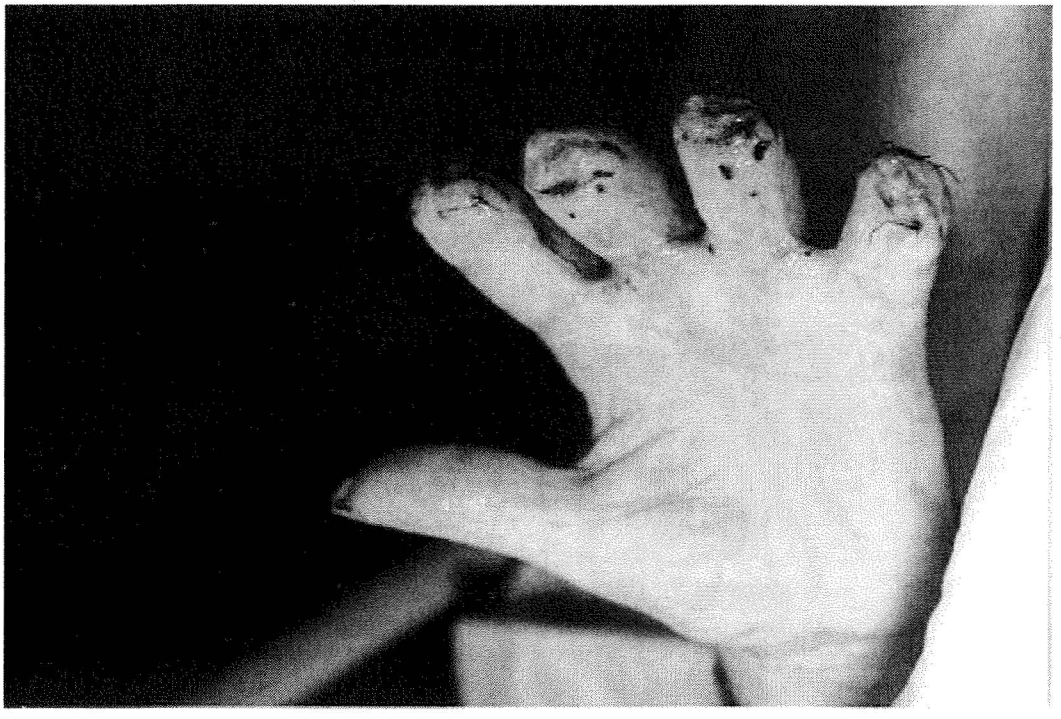
As a former member of the bipartisan committee appointed by the legislature in the late 1990's to make a two year study of the tort system, I am quite aware of how faulty perceptions combined with emotions and publicity can powerfully impact the legislative process. In the 1990's there was a perception that the costs of the tort system were out of control. The study, which thoroughly reviewed actual cases and filings, found to nearly everyone's surprise that just the opposite was true i.e. *there had been a significant drop in accidents and court filings.*

Un-needed restrictions like those proposed including caps on non-economic damages can have devastating impacts on people injured as a result of medical negligence. Although arguments are made that economic damages are sufficient to ensure adequate awards this is clearly incorrect in my experience especially for specific groups such as housewives and non-working women, retirees, and youngsters, and those with little or no wage earning history or capacity. With caps as those proposed many of these people will obtain tiny awards for injuries that are crippling and literally make their lives hell on earth.

I have enclosed pictures of a person who have been injured by medical errs. This person had her fingers and toes amputated. She was of retirement age, there was no treatment for injuries so she therefore, had little or no economic damages for a life changing painful, crippling conditions.

Of Counsel:
Steven J. Trecker





Castle Medical Center

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Exceptional Medicine
by Exceptional People

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February 23, 2009

To: Representative Jon Riki Karamatsu, Chair
Representative Ken Ito, Vice Chair
House Judiciary Committee
Feb. 24th, Room 302, 2:05pm

From: Kevin Roberts, President and CEO
Castle Medical Center
Kailua, Hawaii

RE: SUPPORT for HB 1784, HD1 Relating to Medical Tort Reform

Dear Representatives Karamatsu, Nishimoto and committee members,

Through this bill, the Hawaii legislature has the opportunity to make a significant impact on the healthcare of Hawaii's residents for years to come. As a hospital administrator, I know with certainty what physicians are looking for when they make decisions about where to practice medicine. Though Hawaii is a great place to live, that is not enough for newly graduating physicians, or for those that have practiced here for many years. They must also know that their trade is welcome and respected in the place the choose to practice. Reasonable Medical liability reform has become the veritable "welcome mat" for recruitment and retention of existing physicians. Hawaii needs this change to become competitive with other states that are vigorously recruiting physicians in the midst of a national physician shortage.

Important attributes of this legislation include:

- It does not cost taxpayers any money
- It will save our state run hospitals money on malpractice premiums
- It will save on defensive medicine costs (ordering tests that are unnecessary)
- It will help to keep physicians in Hawaii and attract new physicians to Hawaii
- The public supports passage of medical tort reform.

We need this! Mahalo!

Sincerely,

Kevin A. Roberts
President and CEO
Castle Medical Center

TESTIMONY OF ROBERT TOYOFUKU ON BEHALF OF THE HAWAII ASSOCIATION FOR JUSTICE (HAJ) formerly known as the CONSUMER LAWYERS OF HAWAII (CLH) REGARDING H.B. NO. 1784, HD 1

February 24, 2009

To: Chairman Jon Riki Karamatsu and Members of the House Committee on Judiciary:

My name is Bob Toyofuku and I am presenting this testimony on behalf of the Hawaii Association for Justice (HAJ) in opposition to Sections 1 to 5 of Part I of this bill.

With regard to Section 6 of Part I of this bill, although we are opposed to the provisions of Part I, and especially the limitations set forth in 671-D of Section 2 of this bill, if this committee passes the other sections of Part I, then HAJ contends that it is necessary to pass Section 6, Part I of the bill relating to a mandated rollback of insurance rates and suggests that it be at least 35% of the lowest rate rather than 25% as stated in Section 3 and also contain a sunset provision applicable to all of Part I of this bill.

"In state after state, patients continue to be told that the silver bullet for improving healthcare is to enact severe and arbitrary limits on patient access to the legal system. The arguments made by insurance and medical industry lobbyists are that, in essence, allowing the epidemic of medical errors to go unchecked by legal accountability will improve the quality of healthcare." *See Texas Watch, Patient Justice, January 2008.*

I am presenting this written testimony in sections to first focus on the current issues at the forefront in this debate, then to set forth specific information to illustrate why this bill is harmful to the public and consumers who are injured or die due to medical negligence, and why it will not solve the problems facing our state and the health

care industry as proffered by this administration, the insurance commissioner and the Hawaii Medical Association among others.

ISSUES AND ALLEGATIONS

1. Extent of medical errors and malpractice
2. Capping Recoveries will hurt the victims
3. Allegations
    a. Too many Lawsuits and Frivolous Claims
    b. Medical Malpractice Insurance Premiums are too high
    c. Doctors are leaving the State
    d. Hospitals cannot get enough doctors to go on-call
4. Medical Malpractice "Reform" will not solve these problems
5. The Rollback of Insurance Rates
6. Attorney's Contingency Fees
7. The facts behind the Texas "situation"

The presentation below is not in the order listed above because of the priority of the allegations being made for "reform".

. I. THE ISSUE OF DOCTORS LEAVING THE STATE

The HMA has made statements that doctors, especially specialists, are leaving the state because of malpractice premiums and the risk of medical malpractice lawsuits in general. The implication is that they are leaving in droves and the health care system is on the verge of collapse.

Although HAJ has no specific information as to who is leaving and in what specialty of practice or the primary reason for any doctor leaving the state, we also

maintain that neither does the HMA or those who testify that this is true. However, the following data will at least give you an overview of the number of doctors currently with Hawaii addresses and the increase of physicians over the past few years. We used information gathered from the Hawaii Data Book and the DCCA.

The Hawaii data indicates that the number of physicians in Hawaii increased each year from 2000 to 2009. *See Attachment 1.* The information up to 2006 was determined from the resources mentioned above. The information obtained for the number of physicians for 2007 and 2009 was obtained from the DCCA Professional and Vocational Licensing Division on-line information for current licenses for physicians. The information is as follows:

Year	Physicians/Surgeons
2000	3,044
2001	3206
2002	3251
2003	3363
2004	3445
2005	3616
2006	3680
2007	3735
2008	3917
2009	3925

In 2006 during a hearing in the House on SB 3279, Relating to Medical Liability, a doctor who was leaving for the mainland testified that the high cost of living in Hawaii

and the costly medical malpractice insurance premiums were the reasons why she was leaving. One of the House Judiciary Committee members during the question portion of the hearing asked if she would consider staying in Hawaii if the state paid her insurance premium. The doctor said "No" because she had a unique opportunity to work with a renown physician on the mainland in her specialty.

There also have been several articles and letters to the editor where it has been mentioned by doctors that a major reason to relocate is the **low reimbursements** in Hawaii. In an article that appeared in the Honolulu Advertiser on December 21, 2008, Dr. Jordan Popper, a neurologist, stated that "This state is in serious, serious trouble. The reimbursement issue is killing us. Doctors will not come out here when they can make two to three times as much for the same work anywhere else and the cost of living is so high."

II. ISSUE OF DOCTORS MOVING TO RURAL AREAS IN HAWAII

The proponents of limitations on compensation for victims claim that tort reform will be an incentive to cause doctors, especially certain specialists, to move to rural areas and in particular, neighbor island locations. The Hawaii Medical Association (HMA) has more recently pointed to the situation in Texas in an attempt to argue that medical malpractice tort reform has created an influx of physicians into the rural areas in Texas. HAJ would like to set forth some of the facts that are not being presented to the public or to the legislature.

The HMA refers to this situation in Texas as an example of why Hawaii should pass medical malpractice tort reform. So let us first look at the specific information as to whether doctors moved to rural areas.

In an article written by freelance writer Suzanne Batchelor for the Texas Observer publication, she observed that the far-reaching change "was built on a foundation of mistruths and sketchy assumptions. The number of doctors in the state was not falling; it was steadily rising, according to Texas Medical Board data." She also observed that the population in Texas grew 12.7 percent between 2000 and 2006 compared with 6.4 percent in the country as a whole. Also, her research revealed that there were 152 counties in Texas that did not have an obstetrician prior to 2003, and that four years later, there are still 152 counties in Texas without an obstetrician. She then stated that "The campaign's promise, that tort reform would cause doctors to begin returning to the state's sparsely populated regions, has now been tested for four years. It has not proven to be true." Her article, entitled *Baby, I Lied,* is attached to this testimony for your reference as a resource as *Attachment 2.*

There is no established causal connection between "caps" and doctors moving to rural areas. The fact is that doctors generally prefer to live in urban rather than in rural areas because of greater professional opportunities, access to modern facilities and equipment, better schools for their children, availability of cultural, artistic, sports, shopping, dining, and other recreational activities, and of course, higher incomes.

I will now return to the other issues mentioned in the introduction to this testimony.

III. EXTENT OF MEDICAL ERRORS AND MEDICAL MALPRACTICE

It is undisputed that medical errors occur and there is medical malpractice committed where patients are injured or die. It occurs in every state in the country.

In 1999, a credible book published by the Institute of Medicine estimated that medical errors contribute to as high as 98,000 deaths per year, making it the eighth leading cause of deaths, higher than motor vehicle accidents, breast cancer, and AIDS. It went further to state that the annual cost to hospitals stemming from these errors has been estimated to range from 17 to 29 billion dollars. (The reference was to deaths and did not include other injuries). The obvious conclusion is that if the incidents of medical error and malpractice are reduced, the specific issue that health providers complain about, the cost of malpractice insurance premiums, would be substantially reduced.

Instead of focusing on patient safety or studying the medical system to prevent medical errors and medical malpractice and the resulting injuries to patients, the advocates of the so-called medical malpractice "reform" have always tried to: (1) Reduce potential recovery for the injured patient (cap damages); and (2) Reduce attorney's fees for the attorneys who represent these injured patients.

The primary question that faces legislators as the policy decision makers is **whether capping damages and limiting attorney's fees will solve the problems set out above**. The following information and arguments will shed light on why HAJ strongly feels that it will not.

IV. CAPPING DAMAGES WILL HURT VICTIMS

Two of the major purposes of tort law are compensation for the victim and deterrence of negligent behavior. The suggested cap on non-economic damages (i.e. – pain and suffering, loss of enjoyment of life), as evidenced in this bill, clearly will adversely impact the right to recover adequate compensation by the victims who suffer injury as a result of medical malpractice. **Caps are unfair, arbitrary, and unnecessary**

and unfairly punish the most severely affected victims, whose quality of life has been destroyed in many instances. The arbitrary nature of a cap also takes away the right of a jury to determine the proper damages for a particular injury. It should also be pointed out that where a victim has no economic damages, that injured person is clearly unfairly limited by an arbitrary cap.

Example: An elderly person who is no longer employed is injured because of medical malpractice. There is no wage loss as compared to a working adult and any recovery for medical expenses or long term care goes to third parties who provide these services. The devastation to this person and his or her family is enormous in terms of the grief experienced and the fact that they must live with this situation for the rest of their lives. Capping non-economic damages for this kind of victim is especially unfair.

Further, HAJ has always urged that before drastic changes are made to the civil justice system, it is necessary that the legislature be provided with good reliable data and information in order to properly analyze the need for "reform".

V. ARE THERE TOO MANY LAWSUITS AND FRIVOLOUS CLAIMS?

1. The Number of Claims Filed In Hawaii Have Declined

The number of medical malpractice claims filed in Hawaii fell from 173 in 2001 to 94 last year – about a 45% reduction.

The MCCP Annual Reports to the Legislature document the fact that the number of claims filed has steadily and dramatically dropped during the past eight years.

Year	Claims Filed
2001	**173**
2002	**166**

2003	**132**
2004	**128**
2005	**105**
2006	**123**
2007	**105**
2008	**100**

The MCCP data confirms that there is **no litigation explosion** in medical malpractice claims in Hawaii as the medical profession and the insurance industry would like you to believe. Consider this data in this way – out of the millions of instances where Hawaii residents have contact with physicians, hospitals and other medical personnel, only 100 claims were filed in 2008.

With the number of claims going down, the question is why premiums are supposedly escalating significantly. Proponents may say it is because the awards are increasing. Yet the data confirms that claims payments are significantly declining along with the number of claims. The current Report of the Insurance Commissioner shows a 19% decline in the amount paid for claims. This follows a 53% reduction in claims payments reported by the commissioner last year. The largest insurer for private practice doctors, MIEC, has reported a steady and dramatic drop in claims payments from $8.2 million in 2004 to $2.8 million. The Insurance Commissioner Reports list MIEC claims payments of $8.2, $4.8, $3.7, and $2.8 million respectively for the past four years since claimants have been required to consult with a doctor to determine the merits of their claims before filing with the MCCP.

While proponents continue to repeat the mantra that a litigation explosion is responsible for escalating premiums and only tort reform can rein in claims, they are unable to explain why both the number of claims and the amounts paid for claims have decreased significantly without any change in tort laws. Neither are proponents able to explain why premiums are so high when claims are so low.

2. The Myth of the Frivolous Lawsuit – the Medical Claims Conciliation Panel (MCCP) and Merit Screening Process

Hawaii was one of the first states to implement a claims screening process to prevent the filing of frivolous claims. Claims must first be submitted to the MCCP before a lawsuit can be filed.

Further, the Legislature enacted an additional merit screening procedure in 2003. Medical malpractice claims must first be reviewed by a doctor in the same specialty involved in the claim. The claim cannot be filed unless there is a certificate of consultation filed with the claim that the claim has merit. The measure was codified as HRS section 671-12.5 and applied to claims filed after 2003. The effectiveness of the procedure is reflected by the fact that only two of the claims heard during the past four years was found to be frivolous. The 2005 MCCP Annual Report, for the 2004 year, specifically states: "there were no claims in which the Panel found the underlying claim to be frivolous." The 2006 MCCP Annual Report states that "there was one claim in which the Panel found the underlying claim to be frivolous." The 2007 MCCP report found no frivolous claims filed, the 2008 MCCP report found one frivolous claim filed, and the 2009 MCCP report found no frivolous claims filed.

VI. IS MEDICAL MALPRACTICE INSURANCE TOO HIGH?

The Hawaii Medical Association (HMA) has always maintained that the premiums of physicians are too high and have increased tremendously over the past few years. What this committee needs are specific facts and information to make a reasoned decision on actually how costly the premiums are for individual doctors and for what specialties; for example: (1) What is the amount of the premiums and does it vary from physician to physician in Hawaii? (2) What is the amount of gross income that these physicians make? (3) What is their net income? (4) What percentage of their gross income is the premium cost? and (5) What is the net cost because these premiums are fully tax deductible so its impact is reduced considerably when it is deducted from both federal and state taxes?

1. Hawaii Insurance Premiums vs. California Insurance Premiums

We mentioned this situation in past legislative sessions but I thought it was important to reiterate what happened in a committee hearing. A chart was submitted to the Senate Judiciary Committee at a hearing held in March 2005 to show premiums in Hawaii as compared to other locations. However, it only showed a comparison between Hawaii and Northern California where it is indicated that the premiums in Hawaii were higher. Please keep in mind that these bills are proposing the adoption of basically the California model of medical malpractice tort reform, which was adopted in California in 1975 and found constitutional by the California Supreme Court in 1985.

During the question portion of the hearing, the chairperson of the Senate Judiciary committee asked whether MIEC insured physicians in Southern California to which the answer was "yes." The follow-up question inquired as to the rates in southern California

to which the answer was that it was higher than Northern California, and in fact about 40% to 70% higher. The chair noted that the substance of the bill before the committee was the California model (MICRA) of medical malpractice reform and their own data indicates that the California premiums would be equal to those in Hawaii or higher in some instances. The conclusion reached by the committee was Hawaii should not pass such a law because after 30 years since MICRA was passed in California, the premiums in California were not significantly lower, and in many instances were higher than in Hawaii which does not have a MICRA model of "reform."

Our recent research shows that the highest MIEC rates in Los Angeles in 2009 are much higher than the highest rates in Hawaii. Here are some examples:

Specialty	Hawaii	Los Angeles
Neurosurgery	$73,248	$107,936
OB/GYN	$58,600	$ 86,348
Orthopedic Surgery	$48,832	$ 71,956
Family Practice	$ 9.768	$ 15,832

Further, the rates in Hawaii are lower in 2009 than in 2007 but the Los Angeles rates remain the same with no reduction. Also, although the rates in Northern California are slightly lower than the rates in Hawaii, the average rates in California are higher than in Hawaii.

2. Tort Reform Has No Significant Impact on Malpractice Premiums

The insurance industry and independent studies on the impact of tort reform on medical malpractice insurance premiums confirm that there is no significant relationship.

Following the medical malpractice "crisis" of the mid 1970's in California, the doctors formed their own member insurance companies that insure about 60% of the doctors. The second largest of these was SCPIE (Southern California Physicians Insurance Exchange). After almost 30 years of experience with MICRA, the insurance company declared under oath in connection with its contested rate filing:

> "While MICRA was the legislature's attempt at remedying the medical malpractice crisis in California in 1975, it **did not substantially reduce the relative risk of medical malpractice insurance** in California."

VII. WHY HOSPITALS CANNOT GET ENOUGH DOCTORS TO GO ON-CALL

Pursuant to Senate Concurrent Resolution No.150 (2006), the report of the task force stated, in summary, that it identifies "reimbursement" as the principal cause of the on-call crisis.

VIII. COLLATERAL BENEFITS

The provisions in Section 2 regarding collateral benefits bars subrogation by the government for benefits provided under the Social Security Act and federal workers compensation. Federal Law preempts state law so this is illegal and unenforceable. Likewise, the provisions bar subrogation by health insurers. Much of the health insurance is provided by employers under ERISA which preempts state law and therefore this is also not permissible.

This provision also bars subrogation by non-ERISA health insurance and this will shift the cost to employers including the state. Likewise it bars subrogation by the worker compensation insurance carriers so it shifts the cost to employers.

IX. PERIODIC PAYMENTS

The provision allows party, claimant or doctor, plaintiff or defendant, to request that the damages be paid by periodic payments. The current system where the parties in a lawsuit can agree to a structured settlement works well and gives either party the flexibility to have periodic payments tailored to the circumstances of the case and especially the plaintiff. There is an obvious difference in circumstances when the plaintiff is a child or an elderly person and where the amount of damages may be large or not. It would not be fair to just have one party make a request and the court is then forced to mandate periodic payments.

Mandating periodic payments has several significant problems. First, there is no way to accurately predict the cost of future treatments. If current medical expenses are $10,000 a year and future payments are mandated at $10,000 a year, the patient will be unable to pay for treatment if the patient suffers complications that require additional treatment. The patient will be unable to get the benefit of new treatments that have not yet been discovered because no provision for payment can be made today for treatments that are unknown today.

Second, there is no way to predict the effects of inflation and rise in the cost of medical treatment. If the cost of treatments increases unexpectedly, the patient will be unable to afford necessary treatment. If the cost of living goes up unexpectedly, the patient will not be able to survive on payments mandated based on today's circumstances. Inflation is at its lowest rate in decades right now. It can only go up in the future. Mortgage rates today are as low as 4.5% but were as high as 18.5% in the 1980s. Higher inflation in the future will result in the unfair situations where a patients have been

awarded sufficient amounts of total wage loss, but find themselves unable to access the wage loss because the amount mandated annually becomes inadequate because of inflation.

Third, periodic payments cannot predict and account for changes in future lifestyle circumstances. Periodic payments established today when a patient has a spouse present to help care for them will be inadequate if the spouse divorces the patient, becomes disabled or dies. The same is true of children who are being helped by their parents. There is no way to predict when a parent may die or become disabled.

If periodic payments are to be required, they should be adjustable to require the defendant to pay additional amounts if it turns out that future treatment or the future cost of living increases. Defendants oppose future adjustments because it injects an element of uncertainty to the total amount that will be paid in the future, yet seek to subject patients to that same uncertainty and shift the risk of unpredictable future circumstances totally to the patients.

There are many good reasons that mandated periodic payments are not required in Hawaii.

X. THE ROLLBACK OF INSURANCE RATES

Section 6 of Part I also provides for a rollback of medical malpractice insurance rates to 25% of the lowest rate in effect between January 1, 2003 and December 31, 2009. The Hawaii Medical Association and the Insurance Commissioner has testified that the high cost of medical malpractice insurance premiums are the reason doctors are leaving the state or refuse to move to the rural areas and that limitations on non economic damages will reduce insurance premiums. HAJ has argued that there will be no

substantial reduction in rates. Therefore, the question for you as policy makers is what will the savings be to the physicians and will the specialists then move to underserved areas, volunteer to be on-call physicians at hospitals, and make quality health care more accessible to all of our citizens?. If implemented, the reduction of the rate should be tied to a percentage of the current premiums. If the medical profession is so certain that capping damages will reduce premiums then the provision in this bill calling for a rollback should be at least 35% to 40% of the lowest rates between 2003 and 2009. Further, a sunset provision should be included as to the other sections in Part I of this bill if the mandated reduction is not implemented.

XI. ATTORNEY'S FEES LIMITATION

1. Contingency fees

It appears that the proponents of medical malpractice reform are again trying to restrict lawyer's fees. The contingency fee mechanism provides access to the courts by relieving the injured victim and the family of the necessity of paying legal fees and expenses up-front which is often impossibility for one who is injured, unemployed and beset with medical and family expenses. It is important to note that the contingency fee is negotiated between the attorney and the client. If the client is unhappy with the handling of the fee arrangement, disciplinary action can be taken. Further, proponents are trying to put up obstacles for injured persons who have legitimate claims against a health care provider.

2. Limitation Applicable only to Patient (Claimant)

The provision is applicable only to the attorney's fees on behalf of the patient-claimant but allows unlimited defense attorney's fees for the doctors. This creates an unfair advantage for the defense and creates an unlevel playing field.

Finally, Hawaii law already provides that contingency fees may be reviewed by the court for reasonableness. HRS section 607-16 currently provides that both plaintiffs' and defense attorney fees shall be limited to reasonable amounts subject to court review for both judgments and settlements of tort claims. If there are situations where the reasonableness of plaintiffs' attorneys' fees are questioned, then the court should be asked to review those fees.

XII. DUTY TO NOTIFY OF ADVERSE EVENTS

Testimony Regarding Section 8 of Part II

The purpose of this section of the bill is to require health care providers to notify patients or their representatives of any adverse events that result in serious harm or death to the patient within 72 hours of discovery of the adverse event. The notification is not admissible as evidence of liability.

In 2007, the Legislature passed HB 1253 (Act 88) that made statements of sympathy inadmissible to prove liability. (HRS section 626-1, Hawaii Rules of Evidence Rule 409.5) In the context of medical errors, this bill takes the next step toward encouraging full disclosure of adverse medical events. This bill carefully balances two important and often conflicting interests: protecting a patient's right to know about any unexpected medical consequences that may harm them and the health care provider's concern that disclosure of an adverse medical event may be an admission of liability.

Background for "Sorry" Laws with Disclosure Requirements

In 1999, a report by the Institute of Medicine, "To Err is Human," indicated that up to 98,000 deaths occur each year in the United States as a result of medical errors. Since then, there has been a steady movement focused on patient safety and improving communication between health care providers and patients to create a more transparent environment to avoid triggering an automatic adversarial situation.

Two significant organizations support disclosure of medical errors. The American Medical Association Code of Medical Ethics describes standards of professional conduct that includes disclosure to the patient of facts necessary to ensure understanding of what has occurred, without concern about legal liability.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that hospitalized patients and their families be told of "unanticipated outcomes" of care (Standard - Ethics, Rights, and Responsibilities (RI) 2.90, 2005) and that clinicians and health care organizations inform patients and families of adverse events.

At least 29 states have adopted "sorry" laws as a means to reduce medical malpractice claims. These laws encourage full disclosure of mistakes or errors in judgments by eliminating a physician's fear that the admission will be used against them. Over the past several years, many of these states have added mandatory notification requirements that impose a duty on health care providers to inform patients of adverse medical outcomes. These states include Florida, Nevada, New Jersey, Pennsylvania, Vermont, Colorado and Illinois. This bill is patterned after the Colorado and Illinois statutes.

"Sorry" Laws and Disclosure of Medical Errors Reduces Medical Malpractice Claims and Malpractice Insurance

The Veterans Affairs Medical Center at Lexington, KY is a pioneer in adopting a full disclosure policy. The Lexington program requires immediate notification to the patient of a possible mistake, face to face communication of details, an apology, and if it is determined that the hospital was at fault, restitution is offered. A study of the success of the Lexington Program was conducted by Kraman and Hamm, "Risk Management: Extreme Honesty May be the Best Policy," Annals of Internal Medicine, Vol. 131, No. 12, 12/21/99, which concluded that in comparison with other Veterans Affairs medical facilities, Lexington had lower payments than 30 other facilities, averaged payment of $15,000 versus $98,000 average of other facilities, quicker case closure than the average, in general, more positive economic outcomes.

Other medical centers, such as University of Michigan and University of Illinois, which have adopted policies of disclosure, also report reduction in malpractice claims and litigation expenses. See, attached New York Times article, "Doctors Say 'I'm Sorry' before 'See You in Court'," for a discussion of the success of disclosure policies in reducing malpractice claims.

Many insurance companies are also offering incentives for premium discounts for insured physicians who participate in the insurer's risk management and education program. For example, Med Pro offers a 5% discount. (as reported in www.sorryworks.net/article 44)

Disclosure of Medical Errors Leads to Improved Patient Safety as "lessons learned"

Health care providers have operated under the "deny and defend" model for too long. Unfortunately, when mistakes are covered up, no one learns from the mistakes or takes steps to correct practices and protocols that could prevent future errors. This bill will stop the "deny and defend" practice immediately and shift to the "lessons learned" approach to medical treatment. While most conscientious health care providers take risk management very seriously, this bill puts patient safety as the highest priority for health care providers, without regard to concerns over liability.

Conclusion.

Our experience is that many clients come to attorneys because they simply don't know why something bad has happened in their medical treatment. They complain that no one has given them reasons, and worse, some have told them that they can't talk to them. One physician whose wife was seriously injured due to malpractice would not have initiated litigation if only the hospital had been candid, admitted its mistake and offered to help out with the additional medical costs necessitated by the malpractice. Patients deserve full disclosure when mistakes are made. This bill will lead to improved patient safety procedures, reduce medical errors, which in turn will lead to reduced malpractice claims and costs of insurance.

XIII. PHYSICIAN PROFILES

Testimony Regarding Sections 9, 10 and 11 of Part III

This section of the bill calls for greater transparency of information collected by the DCCA Board of Medical Examiners (BME) on Hawaii's physicians and requires

publication of the information on their website. The categories of information include standard facts such as contact information and status of licensure, biographical facts such as medical education and academic appointments, business-related facts such as insurance carrier, hospital affiliations, medical practice specialty areas, and malpractice awards, and profession-related data such as disciplinary actions and criminal convictions.

The Patient's Right to Know

This bill is aptly called the "Patient's Right to Know Act." In Hawaii, very little information is readily accessible to the public about the 7400 physicians who treat our residents and visitors. Our body is so important that we require food manufacturers to list ingredients, nutrition, and the identity of the manufacturer on packaging so that consumers can decide whether to ingest the food product. Yet, when it comes to choosing a doctor to heal our body, we ask patients to take their qualifications on faith. We don't require doctors to provide even the most basic information about themselves, such as how long they've practiced medicine and whether they are certified in a medical specialty!

Hawaii residents are starved for information about physicians so that they can make informed decisions about medical providers. It is no wonder that the "Best Doctors" edition of the Honolulu magazine is one of the most sought after and widely read publication. For patients, there is some comfort in selecting a doctor because his/her name appears on a "best" list even if no other data is provided in the article. And doctors must also believe there is a need to provide information about themselves because their advertisements include biographical facts, years of experience, medical specialties, and personal attributes such as hobbies and community activities.

DCCA Board of Medical Examiners Collects, But Does Not Publicly Release, Essential Physician Data

Currently, the BME provides two pieces of information on its website: status and dates of current license and cryptic descriptions of disciplinary action. If a patient can figure out how to access license information by clicking on an obscure label called "online services," the patient will eventually be rewarded with a screen that describes that information. (See, sample Attachment 1) And if a patient is savvy enough to click on the label "Office of Administrative Hearings" the patient may discover a list of 39 disciplinary decisions published between 1995 and 2007.

Despite the dearth of available public information, doctors and other private and governmental entities are required to submit certain information to the BME, which collects the data but does not release it. Specifically, the following data is submitted and collected:

Physician's license application: medical education and training, hospital affiliation, licensed in other jurisdictions, disciplinary action in other jurisdictions, malpractice claims, denial of malpractice insurance, criminal convictions. Physician has a continuing duty to update information and report new events to the BME, including malpractice settlements, claims, and awards.

Affiliated Hospitals: confirmation or denial of staff privileges, disciplinary actions taken in a training program, actions relating to safe practices, adverse decisions of peer review committees (HRS §453-7.5).

Court system: certain criminal convictions (HRS §329-44) and malpractice judgments (HRS §453-8.7).

Insurance carriers: medical malpractice settlements, judgments and awards (HRS §671-5).

MCCP: malpractice awards (HRS §671-15).

This bill simply requires the BME to publish the information that it already collects.

Hawaii's Physician Information System Doesn't Work is and Inadequate

Most patients are given a doctor's name by a friend or family member or by a referring physician. However, for serious illnesses or sensitive conditions, patients should not have to rely on the word of another. Instead, before a patient is forced to sign an "informed consent" form, the patient should also make an "informed decision" about the medical provider. That's why this bill is necessary. Under Hawaii's current system, it is not sufficient to know that a doctor has a current license to practice medicine. Even though cryptic disciplinary action information appears to be provided, a patient cannot rely on the absence of disciplinary information as assurance that the doctor is competent to deliver services.

Here are two cases on point.

First, a check of the licensure status of Richard Bost. MD, indicates that his license is "current, valid & in good standing" and expires on 1/31/2010. Any patient reading that information would have no reason to look further by clicking on the standard language "complaint history" link. Yet, the complaint history reveals two disciplinary actions taken, in 2003 and 2006, both for failure to disclose disciplinary action in another jurisdiction or agency. The 2003 action is not reported as one of the 39 published disciplinary decisions. The 2006 action placed Dr. Bost on probation for 1095 days, with

a compliance date of 11/03/09. The actual disciplinary order reveals that he was disciplined in Florida and failed to report that disciplinary action to Hawaii BME, resulting in a three year probation. Based on the disciplinary order, it appears that Dr. Bost should still be on probation until November 30, 2009. Yet the license status is "current, valid & in good standing." (See, Attachment 1 to HB 1514, HD1)

Second, Robert Ricketson, MD, is the doctor who implanted a screwdriver rod instead of medically appropriate titanium rods, during spinal surgery on Arturo Iturralde at Hilo Medical Center in February 2001. The rod broke, and Iturralde suffered intense pain and loss of certain bodily functions as he underwent several surgeries to correct the problems. Iturralde died in June 2003. In March 2006, a jury found that Dr. Ricketson committed malpractice. During the 2006 trial, evidence emerged that Dr. Ricketson had a history of drug abuse, was disciplined in the late 1990's by Oklahoma for writing false prescriptions for drugs which he took, and his medical license was revoked by Texas in 2000 for unprofessional conduct likely to deceive or injure the public. Dr. Ricketson testified that he was re-credentialed by Hilo Medical Center even though it knew about his prior disciplinary actions and drug abuse. Further, trial evidence revealed that Dr. Ricketson's file at Hilo Medical Center contained eight complaints of malpractice.

While Dr. Ricketson's malpractice is shocking, his disciplinary history in Hawaii tells a troubling story of a system that protects the doctor, not the public. Dr. Ricketson fled to Hawaii and obtained a license to practice here in 1998. In May 1999, he entered an agreement with the Hawaii Medical Association (HMA) to refrain from taking illegal drugs. Eighteen months later, in November 2000, after being charged with failure to report disciplinary action by another jurisdiction, Dr. Ricketson entered into a settlement

agreement with BME to be placed on probation for 4 years, and to abide by the same terms as his prior agreement with HMA. Six years later, in July 2006, (four months after the widely publicized malpractice trial returned a verdict against Dr. Ricketson), the BME initiated disciplinary action against Dr. Ricketson for violation of probation in 2002 when he ingested cocaine in an attempt to commit suicide. Over one year later, the BME revoked Dr. Ricketson's medical license.

The published records on his disciplinary actions are vaguely described on the website "complaint history" page as three complaints, but only the 2007 revocation action is posted as a disciplinary decision. (See, Attachment 2 to HB 1514, HD1) Neither the settlement agreement with HMA nor the probationary action appears to have been publicly disclosed at the time; these facts were described in the 2007 revocation decision. Clearly, the system protected Dr. Ricketson from public disclosure of his disciplinary history, both here in Hawaii and in other states. In this case, the system failed to protect the patient and the public.

This transparency bill addresses the deficiencies identified by the Bost and Ricketson cases, and properly puts patient safety first.

Hawaii Needs to Keep Up with Transparency Laws Enacted in Other States

Many states recognize that patient safety and preventative practices will do more toward reducing the high costs of health care, litigation, and malpractice insurance than tort remedies designed to close the courthouse door to victims of medical malpractice. These states have enacted transparency laws that require physician profiles be published on the agency's website.

A sampling of physician profiles from other states is attached to the testimony to HB 1514, HD 1 for the committee's review and is not attached to this testimony. For reference purposes, they are:

Massachusetts – Attachment 3

California – Attachment 4

Rhode Island – Attachment 5

Connecticut – Attachment 6

Colorado – Attachment 7

Maine – Attachment 8

Conclusion

Patient's rights and patient safety must be Hawaii's highest priority in the delivery of health care services. The pendulum has swung from the policy of "buyer beware" to "buyer be aware" as the consumer protection movement has grown over the years and consumers demand more information before making a choice. This bill gives licensing and enforcement agencies an opportunity to play an important role in building patient confidence that there is reliable information about doctors available for them to make informed decisions on medical

XIV. CONCLUSION

HAJ opposes much of this bill (Part I) because it is a radical change in social policy and I urge this committee to do a thorough analysis before you vote to strip away consumer rights. With regard to Part II and Part III, HAJ supports these concepts and these provisions.

Thank you for the opportunity to testify on this measure.

ATTACHMENT

1

Medical Malpractice Data – Licensed Physicians

Place of Address	2000 Physicians/ Surgeons (Hawaii Data Book) DCCA	2001 Physicians/ Surgeons (Hawaii Data Book) DCCA	2002 Physicians/ Surgeons (Hawaii Data Book) DCCA	2003 Physicians/ Surgeons (Hawaii Data Book) DCCA	2004 Physicians/ Surgeons (Hawaii Data Book) DCCA	2005 Physicians/ Surgeons (Hawaii Data Book) DCCA	2006 Physicians/ Surgeons (Hawaii Data Book) DCCA	2007 Physicians (MD) (Geographic Report) DCCA – Current License	2008 Physicians/ Surgeons Geographic Report) DCCA – Current License
Total Licensed	5,481	6,118	5,970	6,483	6,413	7,073	6,869	7,073	7,564
Total Hawaii Addresses	3,044	3,206	3,251	3,363	3,445	3,616	3,680	3,735	3,917
Hawaii	278	291	303	313	327	338	369	370	382
Maui	233	238	251	262	272	277	285	287	315
Lanai	2	2	2	2	2	2	2	2	2
Molokai	6	5	7	8	10	10	10	10	11
Oahu	2,414	2,556	2,566	2,652	2,697	2,852	2,870	2,919	3,049
Kauai	111	114	122	126	137	137	144	147	158
Mainland U.S. Addresses	2,384	2,860	2,672	3,067	2,918	3,394	3,126	3,275	3,573
Foreign Addresses	53	52	47	53	50	63	63	62	158
Total Not Hawaii Addresses	2,437	2,912	2,719	3,120	2,968	3,457	3,189	3,337	3,731
Other	n/a	n/a	n/a	n/a	n/a	n/a		1	
Percentage of Licensed – Not Hawaii Addresses	44%	48%	46%	48%	46%	49%	46%	47%	49%

TABLE 3

STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
CURRENT LICENSES AS OF JANUARY 28, 2009

Board, License Type	Location	Total	Individual	Corporation, Partnership	Sole Owner	Other
EMTP		424	424			
	OAHU	230	230			
	HAWAII	86	86			
	MAUI	42	42			
	KAUAI	20	20			
	MOLOKAI	5	5			
	LANAI					
	MAINLAND	41	41			
	FOREIGN					
	OTHER					
MD		7515	7515			
	OAHU	3069	3069			
	HAWAII	375	375			
	MAUI	315	315			
	KAUAI	153	153			
	MOLOKAI	11	11			
	LANAI	2	2			
	MAINLAND	3523	3523			
	FOREIGN	67	67			
	OTHER					
MDG		4	3		1	
	OAHU	2	1		1	
	HAWAII					
	MAUI	1	1			
	KAUAI					
	MOLOKAI					
	LANAI					
	MAINLAND	1	1			
	FOREIGN					
	OTHER					
MDR		456	456			
	OAHU	330	330			
	HAWAII	1	1			
	MAUI					
	KAUAI					
	MOLOKAI					
	LANAI					
	MAINLAND	97	97			
	FOREIGN	2	2			
	OTHER	26	26			

ATTACHMENT

2

The Texas Observer

Baby, I Lied

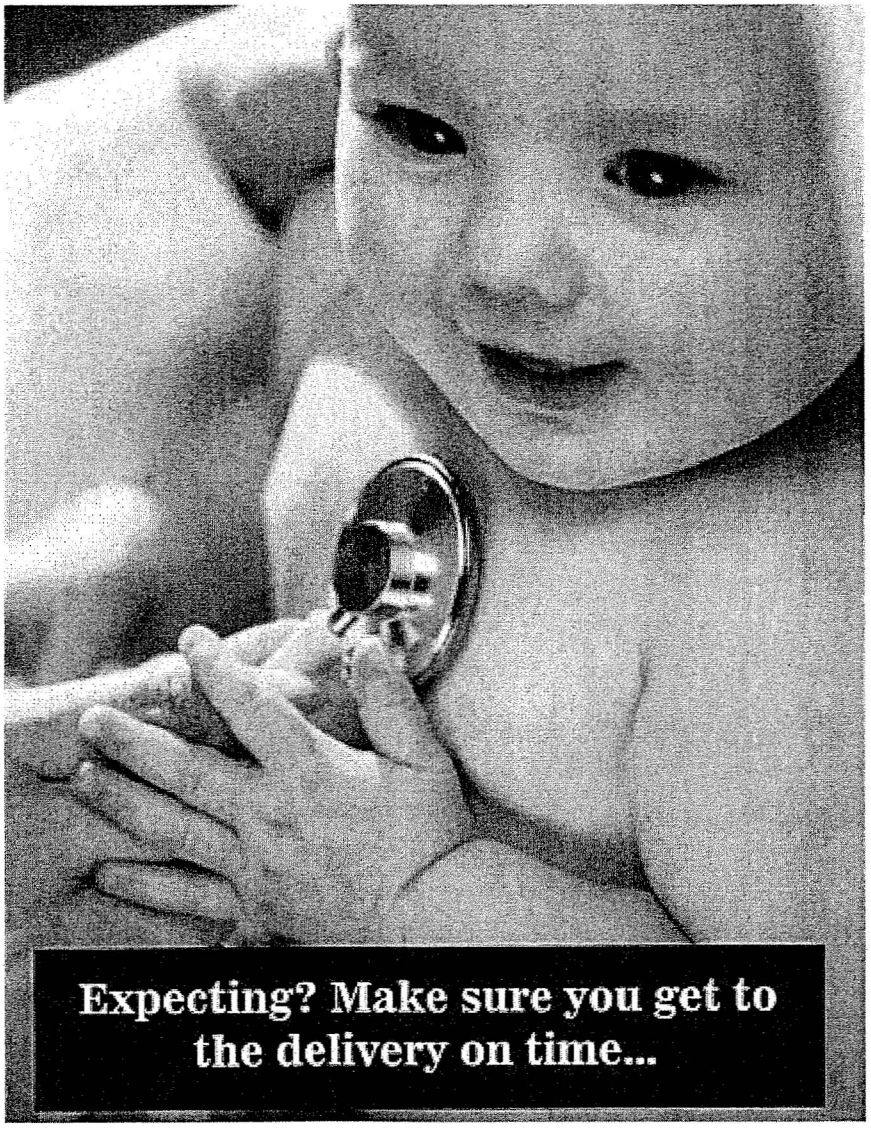
Rural Texas is still waiting for the doctors tort reform was supposed to deliver.

Suzanne Batchelor | October 19, 2007 | Features

The flood of beguiling baby photographs began cascading into mailboxes across Texas as the 2003 fall election drew near. Gracing the cover of a slick brochure, the infant smiled as a stethoscope—held by an unseen but presumably kind physician—was pressed to its chest. "Who Will Deliver Your Baby?" the mailer asked.

The direct-mail pitch was one of many churned out by insurance and medical interests as they spent millions urging voters to pass Proposition 12, a constitutional amendment that would limit the amount of money patients or their survivors could recover in medical malpractice lawsuits.

Swaddled in the glossy brochures was a dire threat. Greedy lawyers were besieging doctors with unwarranted lawsuits that were making malpractice insurance rates skyrocket. Doctors were fleeing Texas, leaving scores of counties with no obstetricians to deliver babies, no neurologists or orthopedic surgeons to tend to the ill. Without Proposition 12, the ad campaign warned, vast swaths of rural Texas would go begging for health care.



Choosing between greedy trial lawyers and cuddly babies was no contest for most Texas voters. Proposition 12 passed. Four years later, vast swaths of rural Texas are going begging for health care.

Proposition 12, and the far-reaching changes in Texas civil law that it dragged behind it, was built on a foundation of mistruths and sketchy assumptions. The number of doctors in the state was not falling, it was steadily rising, according to Texas Medical Board data. There was little statistical evidence showing that frivolous lawsuits were a significant force driving increases in malpractice premiums.

Perhaps the most insidious sleight of hand employed by Proposition 12 backers was their repeated insistence that medical malpractice insurance rates were somehow responsible for doctor shortages in rural Texas.

"Women in three out of five Texas counties do not have access to obstetricians. Imagine the hardship this creates for many pregnant women in our state," Gov. Rick Perry told a New York audience in October 2003 at the pro-tort-reform Manhattan Institute for Policy Research. "The problem has not been a lack of compassion among our medical community, but a lack of protection from abusive lawsuits."

The campaign's promise, that tort reform would cause doctors to begin returning to the state's sparsely populated regions, has now been tested for four years. It has not proven to be true.

Since Proposition 12 passed, insurance companies—many grudgingly—have lowered their rates. More doctors are coming to Texas, as a recent *New York Times* article trumpeted. That is proof, say Proposition 12's backers, that so-called tort reform is working.

"Texas has seen a tremendous success in luring doctors to practice in our state thanks to tort reform passed in 2003," says Krista Moody, Perry's deputy press secretary. Moody noted that the Texas Medical Board is having to add staff to handle a backlog of doctors applying for state licenses.

Those doctors are following the Willie Sutton model: They're going, understandably, where the better-paying jobs and career opportunities are, to the wealthy suburbs of Dallas and Houston, to growing places with larger, better-equipped hospitals and burgeoning medical communities.

On a Texas map inside the beguiling-baby mailer, blood red marked the 152 counties in Texas that did not have obstetricians in 2003. Rural doctor shortages were kept front and center as the state's physicians, led by the Texas Medical Association and the Texas Association of Obstetricians and Gynecologists, campaigned for Proposition 12.

A flier printed by the TMA in English and Spanish and posted in waiting rooms across the state told patients that "152 counties in Texas now have no obstetrician. Wide swaths of Texas have no neurosurgeon or orthopedic surgeon. ... The primary culprit for this crisis is an explosion in awards for non-economic (pain and suffering) damages in liability lawsuits. ... vote "YES!" on 12!"

As of September 2007, the number of counties without obstetricians is unchanged—152 counties still have none, according to the *Observer*'s examination of county-by-county data at the state Medical Board.

Nearly half of Texas counties—124, or 49 percent—have no obstetrician, neurosurgeon, or orthopedic surgeon. Those specialists aside, 21 Texas counties have no physician of any kind. That's one county worse than before Proposition 12 passed, when 20 counties had no doctor.

The TMA counts 186 new obstetricians in Texas since Proposition 12 passed, and President Dr. William Hinchey offers that as proof of tort reform's effectiveness.

No independent study has shown what caused the increase, though Texas medical schools have graduated increasing numbers, by the hundreds, of physicians every year since 1997, the earliest year for which TMB posts data. And the state's growth probably played some part. According to the U.S. Census Bureau, Texas' population grew 12.7 percent between 2000 and 2006, compared with 6.4 percent for the country as a whole. The number of obstetricians in Texas increased only 4.27 percent over the same six years, including three years under tort reform.

More telling is where the new obstetricians—and neurosurgeons and orthopedic surgeons—decided to go.

The Medical Board's latest obstetrician data for the 254 Texas counties reveals that several counties led the gains.

Collin County, the Dallas suburb that is the wealthiest in Texas in terms of per capita income, gained the most obstetricians. Its 34 new ones increased its obstetrician ranks by an impressive 45 percent since Proposition 12 passed.

In second place is Montgomery County, Houston's northern neighbor along the booming Interstate 45

corridor, and the state's fourth-fastest growing county, according to the U.S. Census 2006 estimate. Montgomery gained 19 obstetricians. Tarrant County followed with 17.

Next, at 12 each, are Galveston and Hidalgo counties. Among the rest, a few counties gained in single digits, a few lost, and the majority of counties—two thirds—remained the same.

With well-equipped, well-staffed hospitals, plenty of colleagues, and insured patients, it's not hard to see why Collin County would attract the most obstetricians or offer them the most jobs. Collin's population grew 42.1 percent from 2000 to 2006; the county encompasses Plano, Carrollton, and a small part of Dallas.

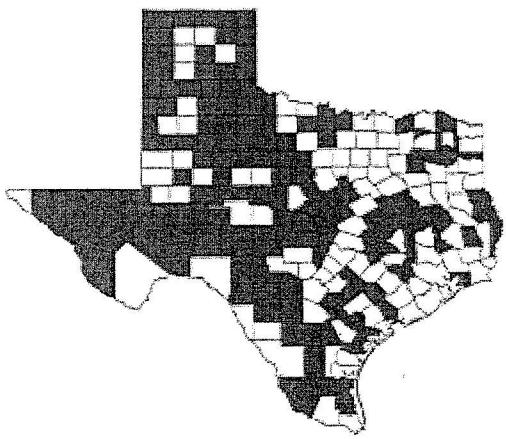
The county's Presbyterian Hospital of Plano alone has 73 obstetricians and 30 neonatologists for newborns. Two allied hospitals serve nearby Allen and Dallas, and the three are far from Collin's only hospitals.

Margot and Ross Perot gave $6 million last October to the Presbyterian Hospital of Plano for maternal and infant care. The Margot Perot Center for Women and Infants has been named "Best Place to Have a Baby" by *DallasChild* magazine 11 years in a row. The Presbyterian system has even been honored locally for its baby sign-language classes.

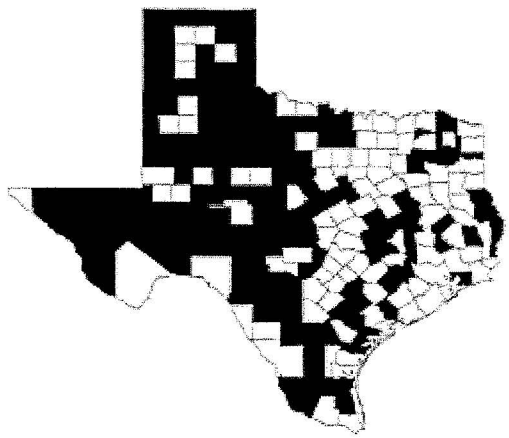
The pattern of doctors' opting to practice in more affluent, urban areas holds true for Texas' overall gains in neurosurgeons (36) and orthopedic surgeons (185) since 2003.

The number of neurosurgeons statewide increased 8.8 percent in the past four years. The biggest share, again, went to Collin County, which gained seven. Bexar and Harris counties each gained five, while Lubbock gained four, and Tarrant, three. At last count 216 counties, or 85 percent, have no neurosurgeon.

Texas has added 185 orthopedic surgeons since 2003, a 10.3 percent increase. Harris County gained the most with 25, followed by Dallas County with 21, Tarrant County with 19, Travis County with 16, and Collin County with 15. There are no orthopedic surgeons in 169 Texas counties.



Texas counties without obstetricians in 2003 before Proposition 12 passed.



Texas counties without obstetricians four years after Proposition 12 passed.

Source: Texas Medical Board

Surely, state leaders and the TMA knew that tort reform wouldn't deliver doctors and specialists to rural Texas.

The persistent struggle to get rural, underserved Texans care by obstetricians, brain surgeons—any specialists—has little to do with lawsuits or high premiums.

Rural health care has been strained by a steady, decades-long migration of Texans from rural to urban areas. Rural areas have fewer hospitals and facilities, and tend to have higher concentrations of patients on Medicaid. "The enormity of Texas ... can serve as a great obstacle for those seeking and providing health care," TMA's own Web site notes. "Approximately 15 percent of Texas' population lives in rural counties, yet only 9 percent of primary care physicians practice there."

It's hard for an obstetrician to make a living in Deaf Smith County in the Panhandle, or Pecos County out west. Understandably, most specialists choose financial security over scraping anxiously by—if for no other reason than to pay back medical school loans. They like to practice near a large community of colleagues, have access to more elaborately equipped hospitals, and treat patients with private insurance coverage.

Yet some of those who pitched Proposition 12 as a cure for rural health care woes now seem surprised that doctors aren't surging into the countryside.

"You limited your line of questioning to a single issue we have not yet revisited," said an e-mail sent by Jon Opelt, spokesman for the pro-Proposition 12 Texas Alliance for Patient Access, when asked about the rural obstetrician situation. The alliance represents more than 200 insurance companies, hospitals, medical clinics, doctors' associations, and nursing homes. It donated $500,000 to the political action committee, Yes on 12, in 2003, according to the *Houston Chronicle*.

Dr. Charles W. Bailey Jr., a plastic surgeon who was TMA president during the Proposition 12 campaign, said he wonders if perhaps new doctors aren't out there and the Medical Board simply hasn't been able to keep up its count. "They have a lot of stuff to do, and maybe they haven't really reassessed all the counties," Bailey said. "We have to realize that many of these counties have so few people in them, they won't support a specialist. They'll have family practice physicians delivering babies. Like many towns won't support a neurosurgeon or plastic surgeon or cardiologist. I would just, I don't know if they've really, with all the applications they're processing, if they have the time and manpower to really determine, to do another head count. From all I've heard, they can be hard pressed to keep their head above water."

Medical Board spokeswoman Jill Wiggins expressed confidence in the agency's count. Fortunately, she said, the 2003 Legislature boosted its funding and allowed the agency to add staff. When the board's license applications became backlogged in 2006, Wiggins said, the agency received even more new funding and now has about 142 full-time employees, compared with 101 seven years ago, a 41 percent increase.

Dr. Ralph Anderson, a University of North Texas obstetrics and gynecology professor and legislative adviser in 2003 with the obstetricians and gynecologists association, said the overall statewide increase in obstetricians might still yield a trickle-down effect in rural areas.

"If you bring more obstetricians to the state, a portion of those are going to go into the underserved areas, the Rio Grande Valley. If you have a lot of personalities coming in, they will disperse themselves to the area where they feel comfortable," he said. "The more people interested, the more chance you'll find somebody who's looking for that kind of opportunity. Those communities have benefited because of the increased numbers of people coming into the state."

So how did doctors become poster children for the sweeping tort-reform agenda pushed by the business

and insurance lobbies in 2003?

Former TMA lobbyist Kim Ross recalled his firing just before the 2003 legislative session. Ross, who now runs his own public relations firm for national and regional medical clients, said he was canned in December 2002 by the TMA under pressure from Perry.

"There was a strongly held belief that I was personally responsible for TMA endorsing (Democratic nominee) Tony Sanchez over Rick Perry," said Ross. "I definitely took the fall on that."

The doctors' Democratic endorsement had resulted from Perry's earlier, unexpected veto of a bill they had supported requiring prompt payment from health maintenance organizations. "Perry vetoed that in an ambush without any warning. There was a huge response from physicians," Ross said. The governor also was unhappy, Ross said, because he and other TMA staff were then negotiating with trial lawyers over what they would and would not support in 2003 tort-reform legislation.

Though they fired him under political pressure, Ross said, he doesn't believe TMA supported tort reform's claims of bringing health care to rural areas just to gain Perry's favor. "There's always been an article of faith, even among OB-GYNs themselves and family practitioners, who are the mainstay of rural practice, that if we just had some liability relief and less fear of lawsuits, that would translate into a restoration of access," Ross said. He characterized that belief as an "urban myth. "

Yet "the cost of liability is a relative fraction of rural healthcare cost—it's a high part of trauma [emergency] costs—but access is driven by reimbursement," Ross said. "Reimbursement from Medicare, Medicaid, commercial managed care ... You need some liability stability, but the primary driver is the economics of reimbursement. For all its emotional charge of fairness, liability cost for the most part is not the issue."

Why did physicians readily believe it when insurance companies blamed greedy, out-of-control plaintiff's lawyers for high liability rates in 2003? One reason may be that the largest malpractice insurer in Texas is their own.

The TMA and the Legislature created the Texas Medical Liability Trust in 1978 as a self-insured trust solely for TMA members. The trust's doctor-insureds elect a board of directors via mail-in ballot every three years. Besides insurance, the trust provides defense attorneys to doctors who are sued, and pays doctors' expenses when the investigators of the Medical Board fine them.

The trust is not regulated by the Texas Department of Insurance. As former Insurance Department Associate Commissioner Birnie Birnbaum noted, the trust can charge what it chooses, while regulated companies must charge the rates they file with the department. (The trust isn't Texas' only unregulated malpractice insurer; "risk retention" insurers are also free of state oversight. There's no federal regulation of insurance companies.)

Since 2003, the trust has reduced its insurance premiums: 12 percent in 2004; 5 percent in 2005; 5 percent in 2006; 7.5 percent this year; and 6.5 percent for 2008. In 2008, the trust will charge doctors 68.7 percent of the charge before tort reform.

Dr. Donald A. Behr, head of TMA's rural physician group, speaks enthusiastically about his rural practice in Graham, seat of Young County in North Central Texas. Behr and his wife, a nurse, left Fort Worth six years ago and say they love treating the smaller community of neighbors and friends, "not just insurance cards."

Graham's hospital is better off than most rural facilities, said Behr, a general surgeon. An old oil town, Graham was flush with millionaires 25 years ago; their philanthropy keeps the hospital afloat.

Of the five counties bordering Young, only one has an obstetrician. Graham has one, but no neurosurgeon, orthopedic surgeon, or cardiologist. Specialists ride in weekly or monthly, like pioneer circuit riders, from Wichita Falls, Mineral Wells, and Abilene.

Graham Regional Medical Center draws from Jack, Stevens, Throckmorton, and Archer counties. "Part of that is because of our obstetrician, part probably because of me," Behr said.

A frantic edge comes to Behr's otherwise confident voice when he describes the hospital's financial fragility despite philanthropy.

"Most of the obstetrics patients in rural Texas are Medicaid," which pays rural physicians less than urban ones, he said. Just to offer obstetrics, Graham's hospital has to jump through a few hoops.

First, the hospital has to have a minimum of two doctors who deliver babies and accept Medicaid, Behr said. Fortunately, Graham has three family practice physicians who also provide obstetrics to back up its lone obstetrician.

"A little hospital with one doctor doesn't fly," Behr said. "You've got to have anesthesia, and if you don't have enough volume for a full-time anesthetist, you can't have obstetrics, basically."

Graham's hardworking obstetrician sees patients six days a week, traveling to five towns, and his nurse-practitioner sees the women at other times.

In an interview, Behr scarcely mentions liability insurance as a factor facing rural health care. Adequate reimbursement—getting paid—by Medicare, Medicaid, and private insurers to cover costs topped Behr's concerns, expressed in a long conversation.

"The only way to keep doctors in rural Texas and anyplace is, somehow we have to find a way to practice medicine cheaper," he said. "We spend too much, yet there's a lot of doctors who can't make a living."

Tort reform may have failed to brighten health care for rural Texans, but two state agencies are trying to lure physicians and other health care professionals to underserved areas.

The seven-year-old Office of Rural Community Affairs gives doctors stipends of up to $15,000 a year for residency practice after medical school in underserved areas. A separate program in the state office uses $112,500 a year in interest from the state's share of the massive tobacco lawsuit settlement to recruit and retain licensed nonphysicians, such as nurses and physical therapists, in underserved areas. Another $2 million in tobacco money is distributed by the office to small rural hospitals.

The 2007 Legislature increased funding for a doctor education-loan repayment program administered by the Texas Higher Education Coordinating Board. For the current biennium, the program will hand doctors $1 million annually.

Loan program Director Lesa Moller said doctors willing to practice in underserved areas can receive up to $9,000 for each year they complete. After two years, the doctor becomes eligible for federal matching funds of up to $18,000.

"Unfortunately, there's been way more applicants than there's been dollars," said TMA lobbyist Helen Kent Davis of the assistance programs, adding that the TMA has advocated for the rural programs at the Legislature for many years.

TMA does not fund any rural doctor programs, Davis said.

The irony that tobacco-settlement money is put to work year after year sustaining rural health care professionals and hospitals should not be lost on Texas physicians who campaigned for Proposition 12.

The massive tobacco settlement was the work of trial lawyers, the very folks TMA leaders demonized in their quest for cheaper insurance and fewer lawsuits.

Suzanne Batchelor is a freelance writer in Austin.

February 24, 2009

The Honorable Jon Riki Karamatsu, Chair
The Honorable Ken Ito, Vice Chair

House Committee on Judiciary

Re: HB 1784 HD1 – Relating to Medical Torts

Dear Chair Karamatsu, Vice Chair Ito and Members of the Committee:

My name is Rick Jackson and I am President of the Hawaii Association of Health Plans ("HAHP"). HAHP is a non-profit organization consisting of seven (7) member organizations:

AlohaCare
Hawaii Medical Assurance Association
HMSA
Hawaii-Western Management Group, Inc.
MDX Hawai'i
University Health Alliance
UnitedHealthcare

Our mission is to promote initiatives aimed at improving the overall health of Hawaii. We are also active participants in the legislative process. Before providing any testimony at a Legislative hearing, all HAHP member organizations must be in unanimous agreement of the statement or position.

HAHP appreciates the opportunity to testify on HB 1784 HD1 which seeks to lower medical malpractice insurance premiums by adopting legislation that directly affects elements impacting medical malpractice insurance rates. HAHP supports the intent of this bill as a good first step toward helping to contain the spiraling cost of medical malpractice insurance.

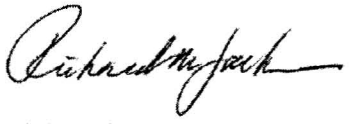
We do agree with statements made by local physician organizations that the current medical tort system drives significant "defensive medicine" costs and has led to Neighbor Island shortages in key surgical specialties such as neurology. The members of HAHP see these facts daily in our medical claims costs and in limitations in the numbers and types of our contracted physicians on neighbor islands.

We believe, however, that the language in Section 6 could set a dangerous precedent for entities providing any type of insurance coverage. This section would legislatively mandate a 25% "rollback" of premium rates for specific provider types. Entities providing insurance coverage take many factors into account when setting rates and legislatively mandating a premium in statute may prevent carriers from being able to offer coverage at all. This could have the unintended

consequence of limiting choices for coverage rather than expanding it. Therefore, we would respectfully request the removal of this language from the measure.

Thank you for the opportunity to offer comments today.

Sincerely,



Rick Jackson
President

karamatsu3-Leanne

From: F. Don Parsa [fdparsa@yahoo.com]
Sent: Sunday, February 22, 2009 8:50 PM
To: JUDtestimony
Subject: RE: SUPPORT for HB 1784, HD1 Relating to Medical Tort Reform

Please **deliver to room 302 for the hearing at 2:05pm on February 24, 2009 House Judiciary Committee.**

To: **February 22,2009**

Representative Jon Riki Karamatsu, Chair
Representative Scott Nishimoto, Vice Chair
House Judiciary Committee
Feb. 24th, Room 302, 2:05pm

RE: SUPPORT for HB 1784, HD1 Relating to Medical Tort Reform

Dear Representatives Karamatsu, Nishimoto and committee members,

Representative Jon Riki Karamatsu, Chair
Representative Scott Nishimoto, Vice Chair
House Judiciary Committee
Feb. 24th, Room 302, 2:05pm

I have been in practice for the past three decades as the chief of Plastic Surgery at the Queen's Medical Center and as Professor of Surgery at the University of Hawaii, John A. Burns School of Medicine.

I strongly support HB 1784, HD1 relating to Medical Tort Reform. This will not const taxpayers any money and will save our state run hospital money on malpractice premiums. It certainly will save on the enormous cost of practicing defensive medicine such as ordering costly and unnecessary tests and last but not least it will keep physicians in Hawaii and attract more doctors to the islands.
and attract new physicians to Hawaii.

Sincerely,

F.Don Parsa, M.D.,F.A.C.S.
Professor of Surgery,
Chief,Division of Plastic Surgery,
University of Hawaii,
John A. Burns School of Medicine.
Chief of Plastic Surgery,
Queen Medical Center.

karamatsu3-Leanne

From: John Bellatti [johnbellatti@gmail.com]
Sent: Sunday, February 22, 2009 9:27 PM
To: JUDtestimony
Subject: SUPPORT for HB 1784, HD1 Relating to Medical Tort Reform

Representative Jon Riki Karamatsu, Chair
Representative Scott Nishimoto, Vice Chair
House Judiciary Committee
Feb. 24th, Room 302, 2:05pm

RE: SUPPORT for HB 1784, HD1 Relating to Medical Tort Reform

Dear Representatives Karamatsu, Nishimoto and committee members,

I have met with Mr Karamatsu and also have testified in front of the Senate Health Committee. I praise your leadership in championing Medical Tort Reform. We have discussed the proven record of Medical Tort reform in Texas and Mississippi -- both recently done, and both with decisive increases in the number of physicians, especially critical sub-specialties of OB,Orthopedics,Neurosurgery. There was a dramatic increase in the number of these physicians working in previously under served areas. There is no reason not to expect similar results in Hawaii. Our own rural areas are in need of Obstetricians, Orthopedist, Neurosurgeons and General Surgeons. In addition we need a good Samaritan like protection for physicians helping patients in emergent situations.

The plaintiff's attorney's will parade one or two egregious cases from 4-5 years ago in front of you. Do not be deceived. The one regarding an infant involved a NON PHYSICIAN employee of the US government who carelessly asphyxiated a new-born. Tragic, but not demonstrating a need for our current medical tort system. In fact the great miscarriage of justice is that the attorney pleaded for and received a 4 million dollar pain and suffering award, and then too ALL OF IT for himself! This is reported in the newspapers at that time. So clearly the non-economic damages are mostly to keep the attorneys fees from damaging the patient even more. None of this money benefited the patients of Hawaii in any greater way.

The case of the "screw-driver-in-back" took up 30 minutes of the Senate Health committee even though it was not in any way representative of physicians working in Hawaii. A drug addicted physician with a bad malpractice record elsewhere was granted a Hawaii License. A hospital desperate for another Orthopedic surgeon, accepted him on the staff. The man performed foolishly and tragically injured his patient. That doctor would not have been there but for the shortage of physicians in Hilo. The plaintiff's attorneys will tell you that there needs to be a way to punish gross negligence. Well apparently this was not an example of that. This doctor paid nothing out of his pocket (pocket empty), and did not lose his license for some time after. When I tried to explain these two cases to the Senate Health Committee, Mr Ige, and Ms Baker left the room, so as to remain ignorant of the facts.

Our current system benefits Plaintiff's Attorneys and , and , and, -- I cannot think of anyone else, unless it in some way benefits legislators who keep acting of the attorneys behalf.

So please vote favorably on Tort Reform, and please defend it vigorously on the House Floor and in conference with the Senate. This bill is for patients.

Thank you

John Bellatti MD
Orthopedic Surgeon, formerly working in Kona

karamatsu3-Leanne

From: Pete Crackel [petelind222@yahoo.com]
Sent: Monday, February 23, 2009 11:38 AM
To: JUDtestimony
Subject: HB 1784 re: medical tort reform

2/23/09

From: Pete Crackel
105H Kailua Road
Kailua, Hawaii 96734

ATTN: Rep Jon Riki Karamatsu, Chair
Rep Scott Nishimoto, Vice Chair

I strongly support HB 1784 in favor of medical tort reform.
Please support it as well.

We need this bill to bring Hawaii into the new century.
The bill costs taxpayers nothing.
It protects doctors from meritless suits.
It will, as it has in other states, attract doctors to Hawaii.

The present situation is near chaos and has already resulted in rationed health care. We do not want to go down that road.

Please support this bill

Thank you

Pete Crackel

karamatsu3-Leanne

From: Linda J. Rasmussen [lindamd1@juno.com]
Sent: Monday, February 23, 2009 1:02 PM
To: JUDtestimony
Subject: Fw: Hearing Tues. 2:05pm House Judiciary HB 1784, HD1 room302

JUDtestimony@capitol.hawaii.gov
Deliver to room 302 for the hearing at 2:05pm

Linda J. Rasmussen, MD
Past President Hawaii Medical Association
Co-chair Legislative Committee, Hawaii Medical Association
President, Western Orthopedic Association

Feb. 23, 2009

Representative Jon Riki Karamatsu, Chair
Representative Scott Nishimoto, Vice Chair
House Judiciary Committee
Feb. 24th, Room 302, 2:05pm

RE: SUPPORT for HB 1784, HD1 Relating to Medical Tort Reform

Dear Representatives Karamatsu, Ito and Committee Members,

Medical malpractice is a serious problem in Hawaii. Physicians are leaving practice and the State as a result of being sued or the high risk of being sued and the associated stress. The numbers speak for this. Dr. Helen Ing, Internal medicine physician in Kailua, stopped practicing due to the risk of malpractice after two suits against her physician husband. Dr. Jeffrey Ryan, Family pracitce physician in Kailua, left Hawaii for California last fall. Dr. Michele Shimizu, family practice physician and the the only physician delivering babies on the North Shore left in November. Dr. Kerry Hubbs, orthopedic surgeon in Kailua, left practice. Dr. Michael Hahn, orthopedic hand surgeon left for Texas 2 years ago. Dr. Richard Rose, orthopedic surgeon who left practice here for California. Dr Terrance Teruya, vascular surgeon who left practice here for California. Dr. Sharon Lowrie, ER physician who stopped practicing, retired, in her early 50's due to the stress of a malpractice case. Dr. Neil Katz, orthoepdic surgeon on the North Shore who left for California. Dr. Cindy Mosbrucker, ob/gyn who left for Washington State. Dr. Sarah Schutte and Dr. Heather Awaya are both ob/gyn physicians in Kailua who are leaving practice in July. Dr. Schutte is moving to Colorado and Dr. Awaya is going to stop practicing.

This is just the last 2 years Windward Oahu. The neighbor islands would fill pages.

Something needs to be done this year.

In Texas, they have found that with caps on pain and suffering, when something happens, both sides agree to the economic damages and a settlement is easier to reach. This results in more money for the injured person and earlier without the 5-7 years it takes to go to trial. It is a GOOD thing for the injured patient!!! Don't let the lawyers tell you otherwise.

With Aloha,

Linda J. Rasmussen

karamatsu3-Leanne

From: Tracy Janowicz [tracy@halekipa.org]
Sent: Monday, February 23, 2009 3:05 PM
To: JUDtestimony
Subject: HB 1784, HD1 - Testimony in Support

February 23, 2009

TO: Representative Jon Riki Karamatsu, Chair
Representative Ken Ito, Vice Chair
Judiciary Committee Members

FROM: Theresa "Tracy" J Janowicz
1666A Walea Street, Wahiawa, HI 96786
(808) 622-6952

RE: HB 1784, HD1 Relating to Medical Torts
JUDICIARY COMMITTEE HEARING
Tuesday, February 24, 2009, 2:05 p.m.

Aloha Chair Karamatsu, Vice Chair Ito and Committee Members:

I strongly support medical tort reform in the State of Hawaii and House Bill 1784.

I cannot speak professionally to what it means to be in the medical profession, nor can I speak to what it means to litigate a medical malpractice claim, but what I can speak to is how Hawaii's current medical malpractice laws affect Hawaii's residents – patients and/or consumers of health care. More specifically - my family, friends and me.

In the past ten years I have lost five doctors – two chose to retire (at what would be considered "in their prime") because the cost of medical malpractice insurance was prohibitive in this State and the threat and stress of malpractice claims was unbearable; and three who left Hawaii to practice medicine on the mainland and/or abroad because medical malpractice insurance was affordable and medical tort reform allowed these physicians to practice medicine the way they were trained.

Allow me to talk about me. Just over ten years ago I was diagnosed with a rare blood disorder, basically my blood randomly clots; it turns out this is genetic. I ended up in the Intensive Care Unit twice within a three year timeframe with pulmonary emboli (blot clots in my lungs). Every doctor I have seen since the first incident stated as a matter of fact that I should have died; both times. Initially (after the first incident) I had a primary care physician in the Wahiawa/Mililani area which was very convenient since I am a resident of Wahiawa. After three months under his care for the disorder he announced he would be leaving at the end of sixty days to practice medicine abroad. When I asked why he told me his malpractice insurance rate was too much for him. He explained that it was his desire to be "a country doctor" and although he was born and raised in Hawaii and graduated from the University of Hawaii Medical School he would have to experience his dream someplace else. To make matters worse he referred me to five other doctors in Central Oahu, none would take me as a patient...I am too high risk. Out of desperation I contacted a doctor I had seen before in Kailua, she agreed to review my medical record and then accepted me as a patient. Dr. Helen Ing saved my life. Not only did she accept me as her patient she researched everything she possibly could about my blood disorder and then educated and supported ALL of my other doctors including my dentist. I finally felt confident in my medical care, even if I had to drive from Wahiawa to Kailua. At least that was true until about two years ago. I received a thirty day notice from Dr. Ing that she was closing her practice because her husband, my cardiologist, was being sued

and the stress on her and her family had taken its toll. When I spoke with Dr. Ing I asked her if she would ever consider returning to medicine. Her statement was very matter-of-fact, "not until this state embraces medical tort reform." Dr. Ing is smart, caring and very much the kind of doctor Hawaii needs. She retired before she was 50 years old! Just to finish my personal story it took me months to find a primary care doctor. Thank goodness Dr. Ing was meticulous in her notes and willing to bring my new doctor up-to-speed on my blood disorder. Nonetheless, I still travel from Wahiawa to Kailua to see my doctors.

Those are two of my five stories. What is unfortunate is when I talk with friends and acquaintances I find that although the details are different they too have lost doctors due to high malpractice insurance rates and the stress of being sued. What I believe is that some doctors should not be allowed to practice medicine and we have the system in place to reveal and review these doctors. What the State of Hawaii must do is setup the system to retain and recruit the best and brightest physicians. We can't even seem to hold on to doctors who are educated and trained in Hawaii. I believe medical tort reform is the beginning of that setting up that system.

I urge you to pass HB 1784, HD1 Relating to Medical Torts.

Thank you for hearing this matter.

Tracy Janowicz
Director of Quality Improvement, Property & Purchasing
Chief Privacy Officer
Hale Kipa, Inc.
Office: (808) 589-1829 x111
Fax: (808) 589-2610
Cell: (808) 754-7864

karamatsu3-Leanne

From: Oswald Stender [oswalds@oha.org]
Sent: Monday, February 23, 2009 3:26 PM
To: JUDtestimony
Subject: HB 1784, HD1, Relating to Medical Tort Reform;

Dear Rep. Jon Riki Karamatsu, Chair and Rep. Ken Ito, Vice Chair and Committee Members: My name is Oswald K Stender, a resident living at 1056 Maunawili Loop, Kailua, Oahu, Hawaii, 96734 and I write in support of HB 1784, HD1 relating to Medical Tort Reform. I have been concerned with this matter for some years and have discussed the matter with my insurance counselor, my doctor and other doctors in practice in Kailua. In reflecting on the concerns of my personal physician and other doctors, I have come to the conclusion that this bill is vital to retain good doctors in Hawaii and to control awards for "emotional" pain and suffering which cannot be reasonably measured. It Is these awards that drive up the cost of insurance that the doctors must have. If this problem is not addressed, the good doctors will leave Hawaii and Hawaii will be left with doctors that should not be practicing medicine at all. Instead of having the best doctors for Hawaii, we will have to live with what is left. This bill does will not cost the State any money; without it, the cost of medical care will continue to skyrocket, especially for our citizens who can least afford it. Mahalo for you considereation of this bill. Aloha. Oswald K. Stender

TESTIMONY OF KAREN KOHL IN OPPOSITION TO HB 1784 AND 1514

House Committee on Judiciary, Hearing February 24, 2009

To: Chair Jon Riki Karamatsu and Members of the House Judiciary Committee

My name is Karen Kohl and I submit this testimony because I feel that the current system makes it very difficult for victims to seek a fair resolution for medical malpractice. Further, arbitrary caps on noneconomic damages for medical malpractice are unfair because no one can predict what the future will hold for the patient and family.

I'd like to take a few minutes of your time to tell you my story. In April 2003, my husband Darius joined the army and in October, my son Tyson (who is now 11) and I moved to Hawaii to be together. Parker Benjamin Kohl was born on December 18, 2003 at Tripler Army Medical Center. He was a healthy 8 lb. ½ oz. 21 ½ in long baby boy. Despite a heart defect Parker was happy and met all of his developmental milestones. He was rolling over, babbling and even briefly standing next to furniture. He loved his daddy, playing in his "Johnny Jumper", and sitting outside with his big brother and his friends.

On May 3rd, 2004, five month old Parker was admitted into Tripler Army Medical Center for what we would later find out was an upper respiratory virus. He was moved up to the PICU and intubated (inserted a respiratory tube) on May 4th. Eight days later, the doctors did a trial extubation (removed the respiratory tube). Parker was unable to breathe and the doctors failed to respond to his distress properly. Due to gross negligence in the care of Parker by the doctors, he suffered 2 pulmonary-cardio arrests.

Since May 13th, the date of the first arrest, our lives have never been the same. **Due to Parker's arrests he had cortical blindness, hypothyroidism, severe encephalopathy, spastic quadriplegia, a tracheotomy, seizure disorder and used a feeding tube.** He took

11 daily medications. Parker spent six months in the hospital. Seven weeks were spent at Lucille Packard Children's Hospital in Palo Alto, CA. During this time, my husband and I lived in a motel while our other son stayed with grandparents. Being separated from one another during such a scary time was horrible for all of us. Once back in Hawaii we prepared for another move to Ft. Lewis, WA where they had more services for Parker and more home nursing care.

Over the next four years, our family life revolved around caring for Parker. I don't think people realize how a disabled child affects the entire family. Our oldest son Tyson had to deal with some very adult issues. He was fearful of going to the doctors. He felt as the 'big brother' it was his job to 'take care' of Parker, so often he didn't want to go to school. He didn't get to do lots of things that we used to because I had to take care of Parker and Parker was pretty much home bound. Also, because I could no longer work outside the home, we couldn't afford to give Tyson those extras that he was used to.

As for myself, I suffered a lot of health issues since Parker got sick, including gaining 100 pounds and the resultant stress on my body due to the weight gain. All my time was spent focusing on Parker and his needs while my own needs took the back burner. This is the same with our marriage.

We had to fight to give Parker the care he deserved and to keep him at home. It took three years for the court to find that the hospital had committed negligence. In 2007, Judge Ezra found the hospital negligent when it:

Failed to monitor and respond to Parker's deteriorating condition;

Failed to reattach Parker's breathing tube;

Failed to take a blood gas test that would have indicated Parker's respiratory failure;

Failed to initiate intravenous access;

Failed to wean Parker off narcotic medication.

And even after that ruling, there were more delays while the hospital pursued its legal rights. During those four years, we struggled to care for Parker and to keep our family going.

Parker died on April 17, 2008.

We will never see Parker off to Kindergarten, learn to read or write, go on his first date, play sports, graduate, get married or have kids. Not to mention the smaller things like learn to tie his shoe, open Christmas presents, or say "I LOVE YOU!!" Those things are priceless. We will NEVER get those things.

No amount of money will ever change what happened.

Despite all that has happened we remain a strong family. It is only by the grace of God that we get through each day because we certainly couldn't do it on our own accord. Parker brought so much joy and happiness to everyone who knew him. We feel truly blessed that the Lord trusted us to be his parents.

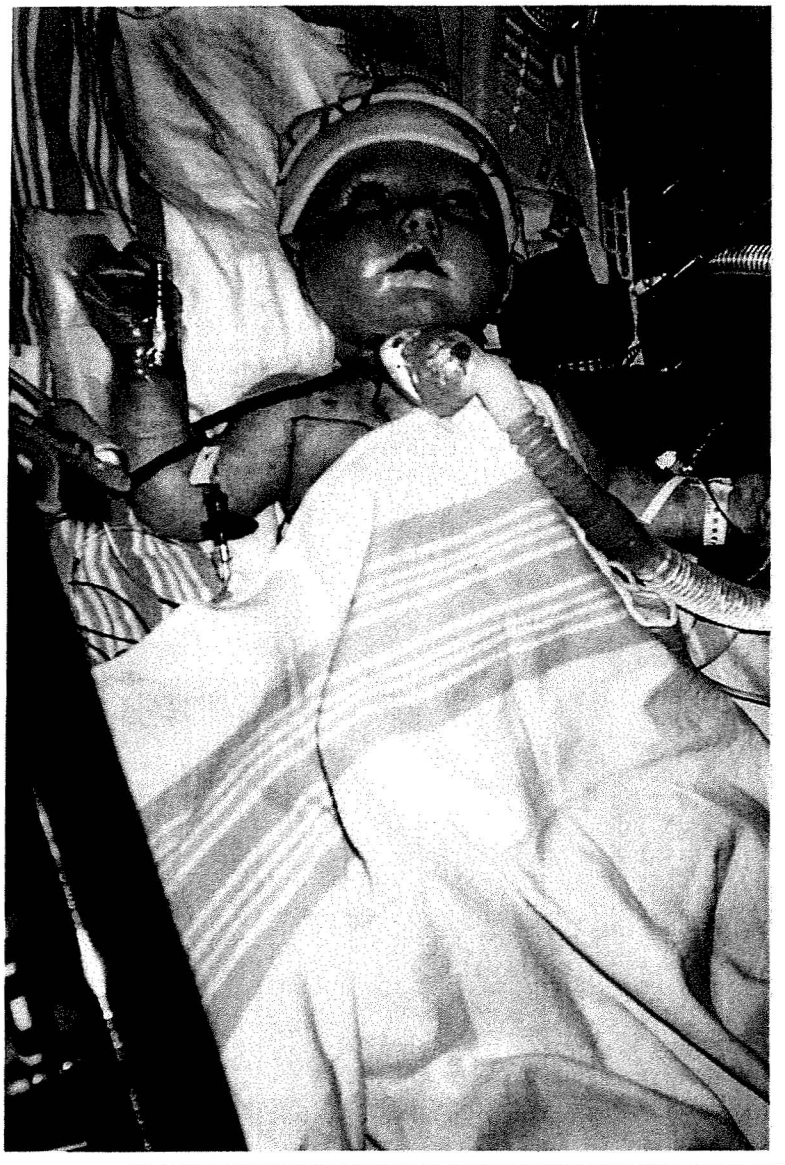
I am attaching photos of Parker and our family. Thank you for the opportunity to testify.

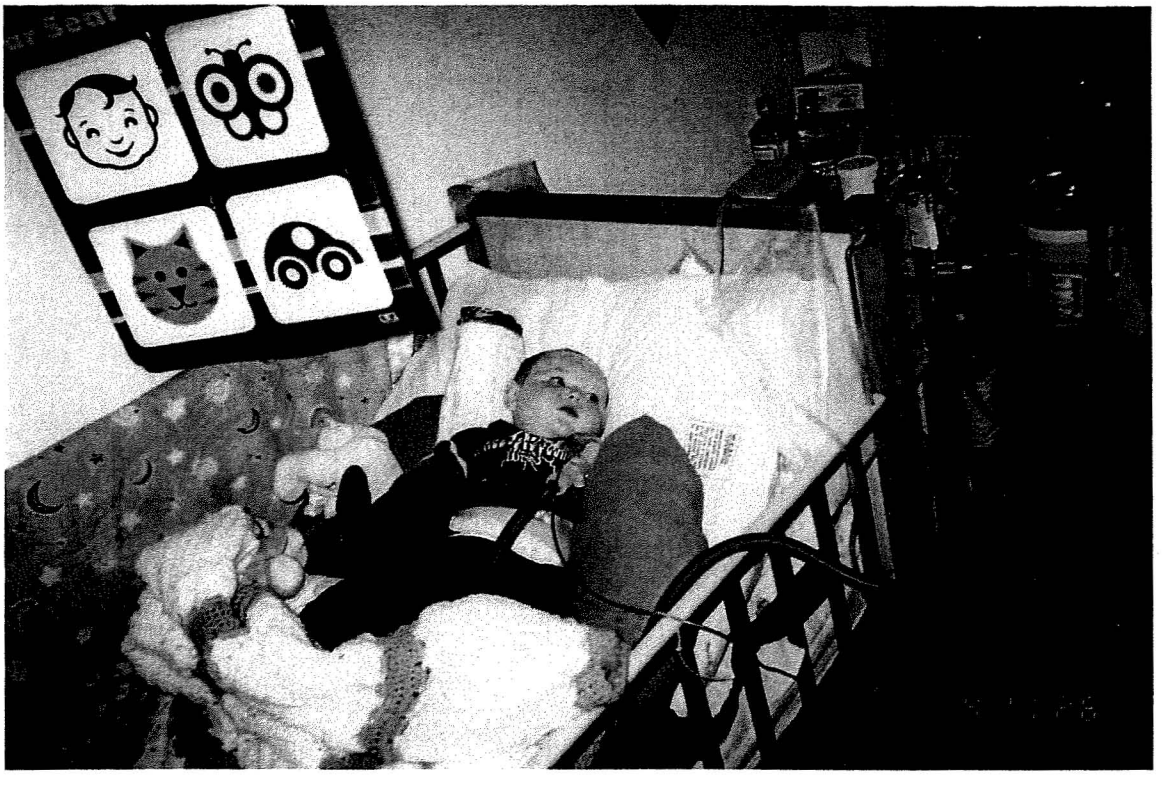
Karen Kohl

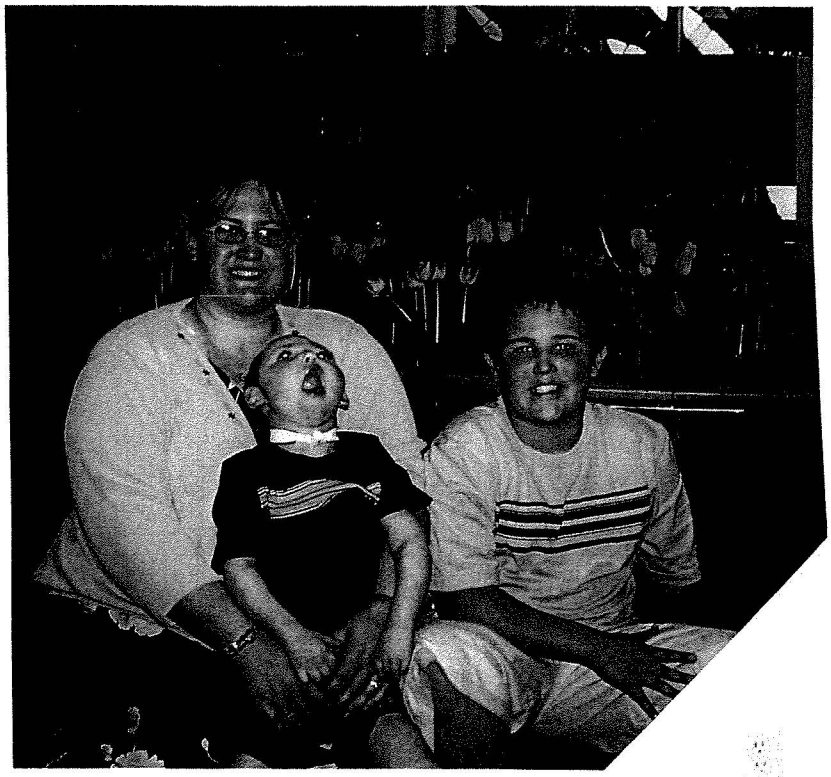
Karen Kohl

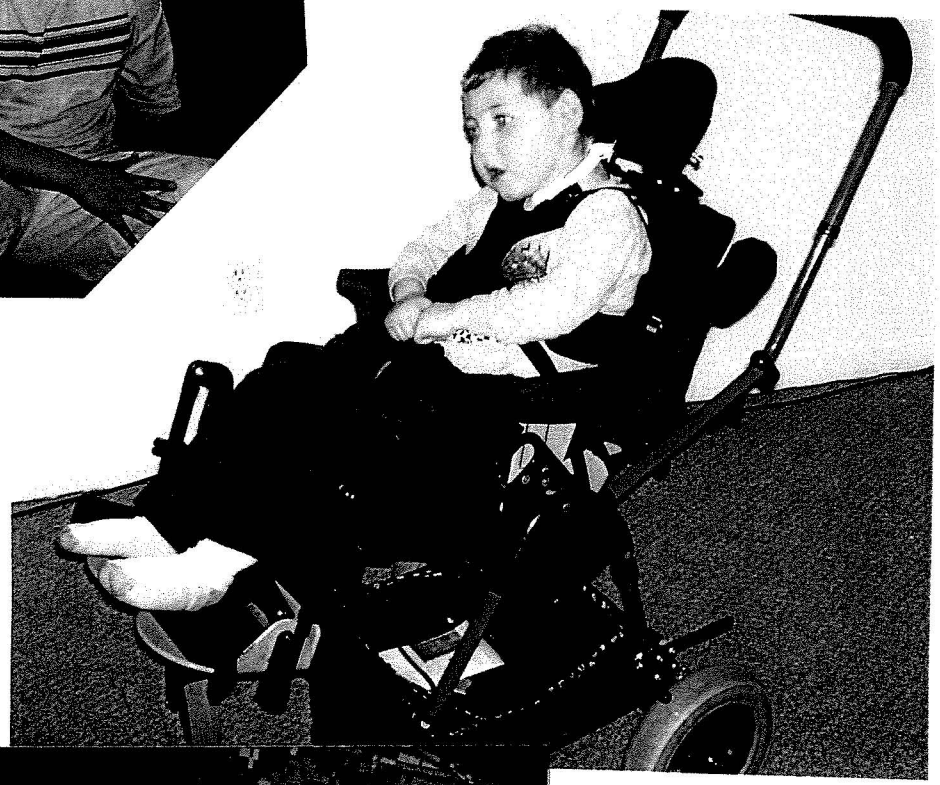
Raymond, Nebraska

February 22, 2009










KOHL

karamatsu3-Leanne

From: Robin Pilus [gardenbird@hawaii.rr.com]
Sent: Monday, February 23, 2009 4:40 PM
To: JUDtestimony
Subject: SUPPORT FOR HB1784

Robin Pilus
40 Ohia Lehua Place
Makawao, HI 96768

Date

Representative Jon Riki Karamatsu, Chair
Representative Scott Nishimoto, Vice Chair
House Judiciary Committee
Feb. 24th, Room 302, 2:05pm

RE: SUPPORT for HB 1784, HD1 Relating to Medical Tort Reform

Dear Representatives Karamatsu, Nishimoto and committee members,

Please support HB1784.

We need to do reasonable things to attract and keep doctors in our community. HB1784 will not cost taxpayers money and will in fact save money on malpractice premiums. It will also save on defensive medicine costs as doctors will not order as many unnecessary tests.

The public is very supportive of medical tort reform, as it is one step to solving the healthcare crisis we are experiencing...particularly on our outer islands.

Mahalo -

Robin Pilus

TESTIMONY OF RUTH ALONI IN OPPOSITION TO HB 1514 HD1 AND HB1784 HD1

February 24, 2009 Hearing
Committee on Judiciary
House of Representatives

Chair Jon Riki Karamatsu and Members of the House Judiciary Committee:

My name is Ruth Aloni and I am a victim of medical malpractice. I oppose HB 1514 HD1 and HB 1784 HD1 that sets caps for noneconomic damages for persons injured by medical malpractice. My doctor failed to diagnose my cancer for two years. Since then, I have suffered through many medical procedures as I have fought against the cancer that has spread through my body. The process of compensating persons injured by malpractice must be fair and not restricted by an arbitrary amount.

Thank you for allowing me the opportunity to testify.

Ruth Aloni
Honolulu, HI

karamatsu3-Leanne

From: Curt Carson [curtcarson@gmail.com]
Sent: Monday, February 23, 2009 6:31 PM
To: JUDtestimony
Subject: Support for HB 1784, HD1 Medical Tort Reform

Curt Carson, MD
419 Atkinson Dr #1206
Honolulu, HI 96814

2/23/09

Representative Jon Riki Karamatsu, Chair
Representative Scott Nishimoto, Vice Chair
House Judiciary Committee
Feb. 24th, Room 302, 2:05pm

RE: SUPPORT for HB 1784, HD1 Relating to Medical Tort Reform

Dear Representatives Karamatsu, Nishimoto and committee members,

I am a physician in Honolulu, and I would like to give my support to HB 1784. I am the vice-president of TAMGI, the largest anesthesiology group in the state. I also do a significant amount of the recruiting for our group. As you know, it is extremely difficult to get good doctors to come out to Hawaii, which is due at least in part to the lack of tort reform in this state. In fact, one of my partners left Oahu to go back to the mainland this past October after he was named in a frivolous lawsuit. He stated that with the low reimbursement and high liability here, it just did not make sense for him to stay.

There are no losers with tort reform. There is no additional cost to your taxpaying public. State hospitals will save on their malpractice premiums. The ordering of unnecessary "defensive" tests will be reduced. Better physicians will be attracted to Hawaii due a more doctor-friendly climate. Finally, injured patients will still be able to receive reasonable and adequate reimbursement to cover their medical costs, as these will not be affected.

Thank you for your time and support in the passage of HB 1784

Curt Carson, MD

karamatsu3-Leanne

From: frannie haws [frannieh@prodigy.net]
Sent: Monday, February 23, 2009 6:45 PM
To: JUDtestimony
Subject: Medical Tort Reform
Attachments: stat1199.jpg

Dear Rep. Ken Ito and members of the Judicial Committee.

It is now even more imperative to make sure our Doctors and future Doctors come and stay in Hawaii. We are desperately short of Doctors now. What is going to happen when thousands of new Medicaid patients need care? Please make sure the Tort Reform bill is passed or every community in Hawaii will have even bigger problems then they have already. You all must realize by now the crisis we are in.

Thank you for your time,

Frances P Haws

February 24, 2009

TO: Representative Jon Riki Karamatsu, Chair
Representative Ken Ito, Vice Chair
Judiciary Committee Members

FROM: Kathy F. Campbell
1046 Lunaai Street
Kailua, HI 96734
261-5049

RE: Medical Malpractice Reform

I strongly support medical malpractice reform. These bills will reduce medical malpractice premiums paid by physicians and, in turn, increase patient's access to physician care in Hawaii.

I have attended many malpractice hearings and heard all the comments about Doctors vs. Attorneys in this issue. However, the third group comcerned about this issue is the Patients. I feel we are the forgotten group in this issue. We are the endangered species in this issue. When doctors leave, as many have in the past couple of years, we are the ones who take the hit. We are the ones who get left behind and are hurt. So as you consider this issue today I hope you will keep us, the patients, foremost in your mind and do the right thing to help us keep our doctors and improve the access to care in this state.

I am a volunteer advocate for this third group, and probably the most important, concerned with the medical malpractice issue. PATIENTS!!! I am voluntarily representing thousands of patients in this state who have lost their doctors or have not been able to get timely medical care. The Save Our Doctors coalition is composed of consumers, patients and constituents who have all had doctors close their practice while we were their patients. We have all had trouble finding new doctors. Many of us are patients and/or senior citizens who are on medication. When a doctors closes their practice where do we get our medications?

I lost two of my doctors last year. My internist closed her practice with one month notice. Her husband is a cardiologist and has been sued twice. They have young children and my Doctor told me she could not sleep at night due to the stress these suits have caused in their family. She was worried about getting sued herself and she told me this caused her to close her practice. She has been doing paper work for her husband in his practice and in a note she sent me she said, "now he can come home and have dinner with the family two nights a week instead of only one." This is insane! Doctors should be able to have lives too.

My other Doctor was Dr. Michael Hahn, a board certified orthopedic hand specialist. He also left due to high malpractice premiums. He went to Texas where they have passed major malpractice reform legislation. He e-mailed his former partner here and said he can now practice medicine as he was trained to do in medical school. He no longer orders unnecessary tests for patients to protect himself from malpractice suits. He doesn't have to practice defensive medicine. His stress is gone and he enjoys going to work each day. In February 2006 Dr. Hahn diagnosed me with carpal tunnel in both of my hands and was treating me for this problem. In the summer of 2007 I read in the paper that he had gone to Texas. I was upset! In October 2007 my right thumb went to sleep. It didn't wake up. I went to see a new Doctor and decided to have surgery on November 28, 2007. My new Doctor is an orthopedic surgeon but not a board certified hand specialist. I had to take my chances because there wasn't anyone else to help me. I couldn't just wait until my whole hand went to sleep, never woke up and I had permanent nerve damage. My current doctor is originally from Hawaii and recently returned. His wife is a radiologist and the only way they could come home was if she could keep her practice. So she continues her practice to the mainland via the internet as a radiologist..

This is the reason I volunteered to become involved in this issue. This is not a partisan issue. This is not a doctor vs. attorney issue. THIS IS NOT EVEN A MONEY ISSUE. The state doesn't have to pay for anything. That's the best news I've heard all year! THIS IS A PEOPLE ISSUE. THIS IS A PATIENT ISSUE. Since I have been involved I have heard one horror story after another from patients and your constituents. Story after story from neighbor island people who have lost an eye, lost a foot, lost a leg because it took 10 or more hours to medevac them to Oahu. Every time I talk to someone they tell me about losing their doctor. My good friend was also Dr. Hahn's patient. Another friend had arthoscopic surgery by another doctor who went back to the mainland. My surgery nurse lost two doctors. A couple I met at a windward legislative meeting both went to my internist. My internist had 3,000 patients. Where are 3,000 patients going to go in Kailua? The couple has been unable to find a new doctor. Every doctor they call said they are not taking new patients and/or will not take Medicare patients. Senior citizens are usually on some kind of medication, and if you stop it on a moments notice it can be life threatening. This happened to me. I had to get my OB/Gyn to refill my prescriptions from my internist.

This issue is not about eliminating the option to obtain damages for negligence in catastrophic cases. When definite malpractice and permanent damages/disabilities occur people have the right to remuneration. My son was born with cerebral palsy. He is spastic quadriplegic, has never walked one step and has spent his entire life in a wheelchair. There were malpractice issues when he was born. That was 42 years ago before machines and monitors. I did not sue anyone. I have lived with his disability for 42 years so I know how hard it can be. I have walked the walk.

In answer to the attorneys arguments against this reform this bill DOES NOT deny anyone the right to sue when there is definite malpractice involved and life changing injuries occur. Of course, those kinds of damages should be compensated. Also, I have heard attorneys say that doctors won't relocate to the neighbor islands and other rural areas. An article in the Honolulu Star Bulletin, October 7, 2007 stated, ".....doctors are responding as supporters predicted, arriving from all parts of the country to swell the ranks of specialists at Texas hospitals and bring professional health care to some long-underserved rural areas." I'm sure that rural areas on the neighbor islands are much more appealing than rural areas in Texas!

The following Doctors from the windward side of Oahu have closed their practice and/or left Hawaii in the past two years: Dr. Kerry Hubbs, orthopedic surgeon; Dr. Terry Smith, the only orthopedic back surgeon; Dr. Neil Katz, orthopedic surgeon; Dr. Richard Rose, orthopedic surgeon; Dr. Michael Hahn, the only board certified orthopedic hand surgeon; Dr. Helen Ing, internist; Dr. Jeffrey Ryan, family practice; Dr. Cynthia Mosbrucker, OB/Gyn; Dr. Theodore Teruya, vascular surgeon; Dr. Sam Smith, anesthesiologist, only here six months. Dr. James F. Pierce, a neurologist at Queens, retired November 30, 2007. In his Star Bulletin notice of retirement he said, "I tried unsuccessfully for 1 1/2 years to find someone to continue my practice. Cost of living in Hawaii, ever-rising costs in the medical practice and inadequate reimbursements..... do not cover these needs" The Doctors who have left have relocated to states that have passed malpractice reform.

OB/Gyn is in chaos in the state right now. There is not a hospital Ewa of Queens and Kapiolani that delivers babies. That is where the majority of young families who are of child bearing age live on Oahu. An OB/Gyn who practices in Wahiawa sends his patients to Kapiolani as soon as they begin contractions. He says if they wait and there are traffic problems they won't make it. There is only one OB/Gyn delivering babies on Maui. Molokai and Lanai have NONE. A mother cannot give birth on these islands. These patients have to come to Oahu 1-2 weeks before their due date and stay here until they give birth to make sure they are here when they go into labor. Once you are in labor the airlines won't let you on an airplane. You're not suppose to fly in your last month of pregnancy either. The OB/Gyn in the Kahuku area has discontinued delivering babies. She said she can no longer drive back and forth between Kahuku and Castle Medical Center to do the deliveries. Kahuku Hospital closed its obstetrics department. When mothers are forced to deliver babies in unsafe circumstances the chances of developmental disabilities increases drastically and developmental disabilities becomes another cost to the state.

We must embrace change and forget the politics. Malpractice insurance must be changed in such a way to reduce the malpractice premiums so that our Doctors will stop leaving the state and we will have quality of care. The Texas model is an excellent example for us to follow. It has solved Texas' problem with malpractice. I hope you will create change in the malpractice area and improve our lives.

The health care situation is scary, really scary. In fact it scares me to death. However, it might be a good thing if we all got scared to death, because that would solve our crisis. Seriously, it's not just about us patients, it's about you legislators also. You are being affected the same as us. If you haven't felt the impact of the malpractice problem yet, your turn will come, it's only a matter of time. You are the only ones who can help us and yourselves. I am putting my trust in you to solve the physician shortage in our state this session. I have heard Doctors testify that the system is broke, in crisis and chaos. By passing malpractice reform this year it will be a big step in solving the health crisis in this state. Will you please help because this is a situation in which we can not help ourselves. Again this is not a partisan issue, nor an attorney vs. doctor issue. The Legislature needs to take care of their constituents by solving this problem NOW. Please help us and thank you for listening.

Leolinda L. K. Parlin

2604 Pauoa Road
Honolulu, HI 96813

Phone: (808)282-6348 **leolinda@resqconsultants.com** **Fax: (808)531-3595**

Date: February 23, 2009

To: COMMITTEE ON JUDICIARY
Representative Jon Riki Karamatsu, Chair
Representative Ken Ito, Vice Chair

Fr: Leolinda Parlin, Private Citizen

Re: **OPPOSE:** HB1784, HD1 - RELATING TO MEDICAL TORTS

Thank you for this opportunity to provide testimony on HB1784. I am providing testimony today on behalf of myself and my family in opposition of this measure. I have silently studied the testimony submitted on this and other similar proposed measures over the last two years and find myself compelled to speak directly to this committee. When I think of the role of the Judiciary, I see this committee as the fortress that insures that statutes protect, not harm, our lives, liberty and property. It is for this reason, I ask this committee, the fortress, to protect the lives and liberty of my family to hold this bill in committee. I ask this for the following reasons:

Contention 1: <u>The process of obtaining input has alienates key stakeholders</u>
In the analysis of the testimony previously submitted for this measure the voice of the victim, or in our case survivors of a loved one whose life was ended tragically due to malpractice, is noticeably absent. How can, in good conscience a measure move out without having input from the consumers themselves who are directly affected by this measure? There is no other class of stakeholders of any other subject area, who have an inherent barrier to providing and participating in the traditional legislative hearing. Typically, victims involved in malpractice claims are subject to confidentiality agreements which are very general and at times vague. As such, victims are intimidated with the potential of violating those agreements and losing their awards for speaking out, not to mention, the emotional drain from the conflict of wanting to tell a story which is forbidden to tell and insuring that the legislative committee has enough information to make the best decision it can. Until such time, victims can be protected to engage fully, HB1784 will be tainted as a measure that never received input from the constituency of which it must protect.

Contention 2: <u>The cap on non-economic damages devalues the victim</u>
It is a false assumption that the families of victims are fully compensated through economic damages in the wrongful death or injury of a loved one. I will share our family's story. I met the man of my dreams twenty years ago. He was my soul mate, partner, and wind beneath my wings. We were quickly married because "we knew" we were meant for each other and didn't understand the purpose of waiting. After 5 years of marriage we had our son and then daughter. By the time our son was 21 months old he was diagnosed in the Autism Spectrum. This turned our lives around. My husband selected less desirable work to insure that my son could be taken to the various appointments and therapies he would need. In one year, he took him to 89 speech therapy appointments during the work day. He worked nights and weekends so he could be there during the day to facilitate the

necessary services our son would need. This arrangement allowed me to focus on my work to become the primary income earner. Once both children were in elementary school, I began a lucrative consulting practice which took me off island and out of state several times a year. He was then able to return to school to study to become a network engineer. When my father died, my husband unbeknownst to me invited my frail mother to move from Hilo to live with us. He vowed to take care of her in the same manner that he had cared for the kids and me. He was a full partner in raising the children, caring for my mom, and being my support system. Because of deferring his career, he had not amassed the large salary one would expect at his age. Yet, his value to our family was priceless. His ability to nurture our children, comfort my mother, assist our elderly neighbors with everyday tasks as they coped with their dementia and how he touched everyone's life is his legacy. If you think about our family as being a system or an organization, he was the "key man" to our system. That value is by no means quantifiable. There is no rubric, algorithm, matrix or formula that will be able to measure the value of the loss of his presence in our lives, as he died tragically in 2002.

Colloquially, we tend to think of non-economic damages as an award for "pain and suffering". For our family, it is a vehicle to obtain relief from the overwhelming burdens we must endure. On a daily basis since 2002, my son talks about the loss of his father. Imagine hearing day in and day out, "My dad died. I miss my dad. I wish he were here. Why did he have to go?" Imagine, not only hearing it every day, but having to respond to it every day, especially on days you don't want to.

If I can find one less thing in my life each day to not worry about, then I am relieved. So, if I don't have to worry about how I am going to pay for my daughter's braces or for tutoring to help her cope with her dyslexia, it's makes the other burdens of trying to keep our family intact and running smoothly more manageable, which ultimately makes it easier to get up the next day and keep trying. There are days I can find relief and other I can't. The fact remains, that for the rest of our lives there will be many days when our loss supersedes what we have.

I humbly ask this committee to hold this bill as it is apparent the consumers of whom this committee is charged to protect, would be adversely impacted by the cap. Thank you for your time and consideration.

karamatsu3-Leanne

From: Dr. Bobby C. Baker [BB@cancerMD.net]
Sent: Tuesday, February 24, 2009 4:15 AM
To: JUDtestimony
Subject: Support for HB 1784, HD1 Related Medical Tort Reform

Bobby C. Baker, MD
President
Pacific Cancer Institute of Maui
227 Mahalani Street
Wailuku, HI 96793

February 23, 2009

Representative Jon Riki Karamatsu, Chair
Representative Scott Nishimoto, Vice Chair
House Judiciary Committee
Feb. 24th, Room 302, 2:05pm

RE: SUPPORT for HB 1784, HD1 Relating to Medical Tort Reform

Dear Representatives Karamatsu, Ito and committee members,

I have been a practicing physician for 15 years in Maui. I am the director of the Cancer Institute of Maui and have served as the Chief of Staff of Maui Memorial Medical Center in 1999 and 2000. I can honestly tell you that I have never seen our system as fragile as it is today. Our ability to recruit new physicians has been extremely difficult while at the same time, we are watching our colleagues move away to other states.

This HB 1784 will save our "state ran" hospitals, including Maui Memorial Medical Center, the high cost of malpractice premiums while not costing the taxpayers a cent. It will also help stop the defensive medicine that is becoming the standard. So often, expensive tests are ordered only out of the fear that malpractice may be lurking around. When I was training in medicine, we were taught to diagnosis medical problems with the least amount of tests. We were actually counted off on our grades in some classes if we ordered to many tests to get the correct diagnosis. The wanted us to learn to think as doctors. With our current defensive approach, we are ordering tens of thousands of dollars in expensive tests to often confirm what we already often know. If this were the approach in my classes 25 years ago, we would have received an "F" in the class.

This plan will help us retain good doctors in Hawaii and stop them from leaving for better states to practice in like Texas, which has adopted similar laws as those being proposed this year in Hawaii. I have talked to many of my patients and members of the community and it is obvious that there is overwhelming support for this legislation.

I applaud the legislature for taking on the task of saving our health care system in Hawaii. This bill will make our rescue one step closer. When the word gets out in the national medical community that these changes have been made, Hawaii will be a much more attractive place for good doctors to relocate.

Sincerely,

Bobby C. Baker, MD

Sincerely,

Bobby C. Baker, MD | President
Pacific Cancer Institute of Maui
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HOUSE OF REPRESENTATIVES
THE TWENTY-FIFTH LEGISLATURE
REGULAR SESSION OF 2009

COMMITTEE ON JUDICIARY
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Rep. Ken Ito, Vice Chair

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karamatsu3-Leanne

From: Linda J. Rasmussen [lindamd1@juno.com]
Sent: Tuesday, February 24, 2009 5:59 AM
To: JUDtestimony
Subject: HB1784, HD1 hearing 2/20, room 302

Please deliver the following testimony for House judiciary hearing today, room 302 at 2:05pm
wdbhiller@hotmail.com>
Date: Tue, 24 Feb 2009 04:19:46 +0000
Subject: FW: Tort Reform
Message-ID: <BAY144-W2F01C920E486C4F8D757DA8AF0@phx.gbl>

From: wdbhiller@hotmail.com
Subject: Tort Reform
Date: Tue, 24 Feb 2009 04:16:00 +0000

Representative Jon Riki Karamatsu, Chair
Representative Ken Ito, Vice Chair
House Judiciary Committee

Support for HB1784 Relating to medical tort reform.

Dear Representative Karamatsu and Ito,

I am an orthopedic surgeon who grew up in Hawaii, came home to practice -- and have left again.
Big Island patients frequently have NO ORTHOPEDIC SURGEON ON CALL to take care of them.
Why?
Lawyers and the current abusive tort system.
Three years ago I stopped taking ER call on the Big Island , as did Dr. Bellatti. We both quit because of the tort system, and in fact one lawyer is actually responsible for 170,000 people having zero orthopedic emergency coverage.

Tell me if you would sign up for this deal: 1)You agree to leave your familiy for an unlimited amount of time at any time of the day or night, 2) if you don't arrive in the ER quickly enough you agree to pay a $50,000 fine, 3) You agree to do all of this for free, and 4) for this 'privilege' you agree to accept unlimited liability!

Would you, or any sane person do this?
That is what we as physicians have done forever.
No more.
We have been accused of every evil act imaginable as reward for our service: the huge majority of all cases brought -- of the order of 90% including MCCP and lawsuits --- are utimately deemed without merit.

There is never any compensation for this abuse. A failed 'frivilous lawsuit' is in reality a foiled extortion attempt. The MCCP does not even require an expert to support the frequently grossly inadequate and always self serving allegations of the plaintiff's attorneys.

The public is getting swindled by this system: There is absolutely no evidence that 1) huge awards are actually associated with real malpractice 2) malpractice is in fact affected at all by this system 3) that people with small, real claims benefit at all from the system 4) that healthcare is improved in any way by this system. There is in fact excellent evidence that this all occurs at huge public and private expense, that the only real beneficiaries are attorneys, that the system generates billions of dollars of unnecessary costs, and that many people cannot find legal assistance.

While rich Honolulu attorneys cry crocodile tears for the supposed 'poor patients who won't be represented', a Honolulu Advertiser poll shows that EIGHTY PERCENT of local middle and lower income people were denied legal representation. The legal community, with the spotlight on them, raised money to 'solve the problem'. Presumably these were the same attorneys who refused to see these poor folks to

begin with! This is shocking and self serving hypocrisy.
You can see doctors in the ER, or you can see them in court..... make your choice.
If the legislature fails to pass meaningful tort reform, it is the legislature's fault every time a patient can't get the care she needs.
And the voters will know this, and vote accordingly.... Josh Green got amazing electoral support. Tommy Waters was smart enough to not run again.

Please support tort reform.
Thank you
Doug Hiller, MD
Waimea/Wyoming.

TO	:	**Jon Riki Karamatsu, Chairperson** **House Committee on Judiciary**
FROM	:	**Michael K. Livingston**
SUBJECT	:	**H.B. 1514 H.D.1; H.B. 1636; H.B. 1784 H.D.1**
HEARING DATE	:	**Tuesday, February 24, 2009, 2:05 p.m.** **Room 325**

TESTIMONY OF MICHAEL LIVINGSTON IN OPPOSITION TO
H.B. 1514 H.D. 1; H.B. 1636; H.B. 1784 H.D. 1

To the House Committee on Judiciary:

My name is Michael Livingston. I represent patients who are injured through the negligence of health care providers and failures in our health care delivery system.

I would like to bring to your attention a case handled by my law firm involving an orthopedic surgeon, Dr. Ricketson, who was permitted to perform spinal surgery on our client, Arturo Iturralde, in 2001, despite having had his medical license suspended by Oklahoma in 1999 and revoked by Texas in 2000 (with a finding that he engaged in unprofessional conduct that is likely to deceive or defraud the public or injure the public). This doctor implanted a steel screwdriver in our client's spine instead of a titanium surgical rod. The screwdriver broke inside his back only days after the surgery, requiring three more surgeries and leaving our client completely disabled and in constant pain until his death from related complications several years later.

Dr. Ricketson stopped practicing medicine in Hawai'i after we filed suit against him in 2003. Our investigation discovered that, in addition to having had his medical license suspended in Oklahoma and revoked in Texas, he had been denied a medical license in Kansas in 2002, he had been sued for malpractice at least seven times in several states, and he had admitted to addiction to narcotics and use of crack cocaine. Yet it was not until July 17, 2007, more than six years after Dr. Ricketson implanted a screwdriver in our client's back, that the State of Hawai'i finally revoked Dr. Ricketson's Hawai'i Medical license.

This case demonstrates that neither the hospital credentialing process nor the State medical licensing and review process is capable of providing adequate protection to the public against incompetent practitioners. Simply put, the Hawai'i public was only protected from Dr. Ricketson by Arturo Iturralde's malpractice lawsuit. This case also highlights the commonsense notion that our efforts should be addressed at preventing malpractice instead of limiting recoveries of those who are injured. Efforts to limit recoveries unfairly penalize the injured patient, detract from the real solution of preventing malpractice, and have unintended and undesired consequences. Reduce malpractice and you reduce malpractice claims, while preventing unnecessary injury and improving patient safety.

Michael K. Livingston

Testimony of Bert Sakuda
In Opposition to H.B. No. 1784, H.D. 1

Chair Jon Riki Karamatsu and Members of the House Committee on Judiciary:

Thank you for the opportunity to testify in Opposition to H.B. No. 1784, H.D. 1.

The limitation on patients' recoveries is opposed because it is fundamentally unfair and poor public policy to shift the burden of medical errors from the health system to the injured patient. Insurance now spreads the cost of medical errors among participants in our health care system. No single doctor, hospital, nurse, pharmaceutical company, medical device manufacturer or patient pays the entire cost of major medical errors. Everyone shares in the cost through insurance, including the patient who pays for health insurance (the cost of which reflects the cost of providing medical services including malpractice insurance). The measure would cap damages and shift the entire burden on any amount in excess of the cap solely to the patient.

There is no data to support the claim that capping non-economic damages will cause doctors to remain in Hawaii, let alone move to a neighbor island, take call at hospitals, or significantly reduce the cost of malpractice insurance. The recent LRB study completed in 2006, at the legislature's request, concluded that data regarding the connection between limiting damages and significantly reducing premiums were "at best inconclusive."

The Texas experience is now offered as conclusive proof that a $250,000 cap on non-economic damages will solve the neighbor island and on-call doctor shortage, significantly reduce malpractice premiums and keep doctors from leaving Hawaii. The data and facts, however, do not support the claim of a Texas miracle.

Texas Has Not Solved Its Rural Doctor Shortage

The Texas Medical Board maintains and publishes data on the number of physicians (by specialty) for each of the 215 counties in Texas. It is therefore a simple matter of comparing the data from years before Texas adopted a limitation in damages with the data from subsequent years. The data plainly show that there is no increase in doctors moving to rural Texas.

Texas Medical Board reports for 2003 and 2008 show the following:

	Counties with No OB/GYN	Counties with No Orthopedic
2003	57%	63%
2008	57%	63%

The Texas Academy of Family Physicians reported on the Texas rural physician shortage in its journal, Texas Family Physician Vol. 59 No.3 Fall 2008, stating:

> "The national average for direct-care physicians to every 100,000 people is 220, but Texas averages 157 for every 100,000 people. In primary care, 114 Texas counties are Considered full primary care health professional shortage areas (HPSA designated by the U.S. Department of Health and Human Services) and 47 counties are considered partial HPSAs. Twenty-five counties have no physician."

The number of Texas HPSAs increased to 117 by the end of 2008 according to the Texas Department of State Health Services which publishes a county by county listing of Texas HPSAs. There were 116 Texas HPSAs in 2006, so the supply of physicians in rural and underserved Texas counties has not increased significantly over the past several years.

The Texas Department of State Health Services published a report in June 2007 confirming that Texas had a "persistent geographic maldistribution of the supply of pediatricians in rural and inner city communities." The study confirmed that the rural pediatrician supply increased from 16.9 per 100,000 children to 17.9 - - an increase of just 1. Urban counties however saw a pediatrician increase of 42.5 per 100,000 children to 47.4 - - an increase of 5. The Texas department of Health data proves 1) Texas has an overwhelming maldistribution of pediatricians in urban areas with 47.4 per 100,000 versus just 17.9 in rural counties, and 2) the increase in Texas pediatricians was going to urban not to rural counties.

Texas Has Not Experienced a Dramatic Increase in Physicians

The Texas Medical Board publishes data on licensed physicians annually. Unlike Hawaii, however, the Texas Medical Board keeps separate data for doctors practicing in Texas and doctors licensed in Texas, but practicing elsewhere. The data shows that there was no dramatic increase in the number of doctors practicing in Texas after tort reform went into effect. Instead, the data shows that the increase in Texas doctors has been steady and consistent from well before tort reform to the present.

Here is the data from the Texas Medical Board for the years May 1997 through May 2008:

Texas Doctors
(In State)

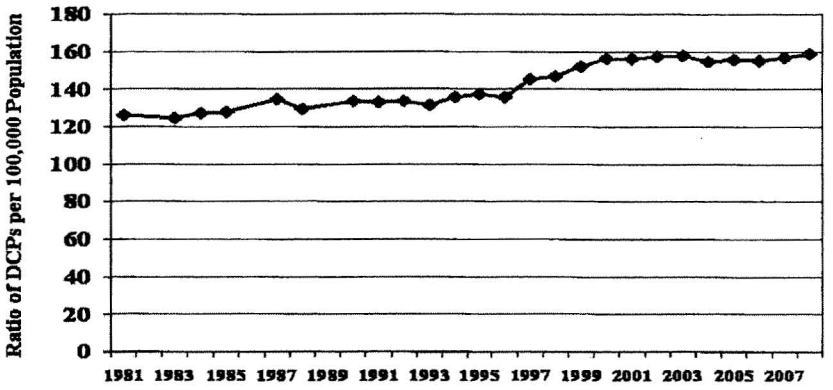
Year	Number	Increase Over Prior Year	Percent Change
1997	29,360		
1998	30,115	755	2.6%
1999	31,164	1,049	3.5%
2000	32,082	918	2.9%
2001	32,946	864	2.7%
2002	34,556	1,610	4.9%
2003	35,723	1,167	3.4%
2004	37,420	1,697	4.8%
2005	38,461	1,041	2.9%
2006	39,605	1,144	3.0%
2007	41,227	1,622	4.1%
2008	42,608	1,381	3.3%

Annual increases before tort reform ranged between 2.6% to 4.9%; while they varied between 2.9% to 4.8% after tort reform. The single largest increase of 4.9% occurred in 2001 well before tort reform. The second largest increase of 4.8% took place between May 2003 and May 2004. Because tort reform did not even take effect until September 2003, it is unlikely that it was the reason for that year's increase given the time required to move to Texas and take the licensing examination. If anything, the following year of 2005 should have seen a big increase, but instead the increase dropped to 2.9%, then increased marginally to 3.0% in 2006. The rate of increases both before and after tort reform is essentially the same.

In addition to keeping separate data for doctors practicing in-state and out-of-state, Texas also maintains separate data for doctors that actually treat patients in contrast to those who do not. Texas refers to treating doctors as "direct patient care physicians." This does not include researchers, administrators, teachers or others who do not treat patients.

In December 2008, the Texas Department of State Health Services published data on physician trends for the years 1981 through 2007, including a graph charting the supply of direct patient care doctors.

Direct Patient Care Physician Trends



Data Source: Texas Medical Board
Prepared By: Health Professions Resource Center
Center for Health Statistics, Texas Department of State Health Services
December 11, 2008

The Texas Department of Health data shows a steady supply of 130 to 140 doctors per 100,000 residents between 1987 through 1996. The supply increases significantly between 1997 and 2000 when the supply jumps from about 140 to 160 doctors per 100,000. This increase all occurs well before tort reform then holds steady to the present with no increase at all after tort reform. The data plainly does not support the claim of a dramatic increase in the supply of doctors that treat patients in Texas after tort reform.

The Increase in the Number of Texas Doctors is Primarily Due to the Large Medical School Enrollment in Texas

Texas embarked on an expansion of medical school facilities and student slots in the mid-90s that has resulted in a current medical school enrollment of approximately 6,029 students.

Texas has eight (8) traditional medical schools and one (1) osteopathic medical school.

School	Enrollment
Baylor	750
Texas A&M	423
Texas Tech	584
UT Galveston	929
UT Houston	939
UT San Antonio	897
UT Southwestern	976
Texas College of Osteopathic Medicine	630

These 6,029 first through fourth year medical students are graduating at a rate of over 1,300 per year. As the Texas Academy of Family Physicians explains, this is important because "if you go to medical school here, you do your residency here, you have more than an 80-percent chance of retaining that person as a professional in Texas." Indeed, "Sixty to 70 percent of residents will stay within 60 miles of where they trained." It is obvious, therefore, that the most significant factor in the increase in doctors in Texas is due to the presence of its large medical school enrollment, not tort reform.

Texas implemented its Joint Admission Medical Program in 2003. This program provides students from rural and underserved communities who are economically disadvantaged with special admissions consideration, scholarships and stipends to pursue a medical education. All eight Texas medical schools participate in the program.

Six of the eight Texas medical schools have also implemented rural track programs that focus on skills needed for rural medical practices that are not necessary for urban practices and not included in traditional medical programs. The scope of rural practice is greater than urban practice because of a lack of specialists in rural areas. Medical school and residency rural track programs prepare doctors for the additional skills they will need and encourage them to establish rural practices.

Texas has an established loan repayment program for medical students who practice in rural communities. Loan repayment programs are proven incentives for encouraging the establishment of rural medical practices.

Texas Malpractice Premiums on Average Are Higher Than Hawaii's

The average malpractice insurance premiums for major Texas insurers reporting their rates are higher than premiums for Hawaii doctors in similar specialties. The average 2008 premiums for Texas insurers Medical Assurance Co. (ProAssurance), Texas Medical Liability Trust, and the Doctors Company for OB/GYNs is $76,790 compared to $61,684 for Hawaii insurer MIEC (Medical Insurance Exchange of California). The Hawaii premiums for doctors insured by HAPI is said to be about 40% lower than MIEC premiums.

Texas premiums vary widely by county. The Medical Assurance Co. (ProAssurance) OB/GYN premiums range from $82,677 for most counties to $97,682 for 40 counties and a high of $151,699 for 14 counties. The Texas Medical Liability Trust premiums vary from $33,744 to $63,432. Premiums for the Doctors Company range between $64,714 and $102,054.

The Texas Malpractice Crisis Was Caused By Insurance Market Dynamics, Not By Malpractice Claims

The Texas Insurance Department maintained a comprehensive database of medical malpractice claims. Professors at the University of Texas, University of Illinois and Columbia University conducted an extensive study of Texas medical malpractice data for the 15 years before Texas enacted medical tort reform based on the alleged explosion in malpractice claims that was blamed for skyrocketing insurance premiums.

The Texas database included "all closed claims, and provides detailed information about payments, defendants, trial outcomes, defense costs, and other matters" for the years 1988 through 2002. The study, entitled, "Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988 -2002," states:

> "This **evidence suggests that no crisis involving malpractice claim outcomes occurred**. It thus also suggests a weak connection between claims-related costs and short-to-medium term fluctuations in insurance premiums. If so, litigation reforms may not prevent future insurance crises."

The research article concludes, "**the more likely explanation is that the rise in premiums reflects insurance market dynamics, and not litigation dynamics**."

The fact that Texas insurance premiums are now decreasing is therefore due to the fact that the enormous increases in premiums before tort reform were not justified by any increase in claims and is now returning to a lower level more appropriate to the level of claims.

Texas Still has More Malpractice Claims Paid Than Hawaii

The Texas Insurance Department no longer maintains the comprehensive database of closed claims. Federal law however requires the reporting of paid malpractice claims to the National Practitioner Data Bank (NPDB). NPDB data published in September 2008 for the year 2007 reports that Texas had the fifth most malpractice claims paid in the nation with 538. Hawaii on the other hand had the ninth fewest with 25. Adjusted for the difference in population, Hawaii still had a significantly lower rate of claims paid than Texas (or California for that matter).

The Effect of Other Texas Reforms Are Ignored

While the Texas law is touted most for its limitation on non-economic damages, there are other aspects of Texas law that have the potential for greater effect that are ignored by the proponents. These include a requirement similar to Hawaii's certificate of merit and an apology exclusion from evidence.

Hawaii has experienced a significant drop in both the number of claims filed at the Medical Claims Conciliation Panel and the amounts of payments since claimants were required to consult with a doctor in the same specialty to determine whether the claim was meritorious before pursuing the claim. Texas instituted a similar requirement that claimants retain the services of a qualified doctor to review and certify the claim for merit at the outset before the case is permitted to proceed. Texas Civil Practice and Remedies Code section 74.351 requires that this consultation and certification occur within 120 days. There is no data that studies and separates the effects of this provision on the Texas experience from the effect, if any, of the damages cap. Absent any data to indicate otherwise, there is no reason to expect that this screening process does not have a similar effect on lowering claims in Texas as it did in Hawaii.

Texas also adopted an apology law similar to Hawaii's that makes apologies inadmissible in evidence in the event of any subsequent litigation. According to the Sorry Works Coalition, Texas physicians have apparently embraced the apology concept with greater enthusiasm than Hawaii's doctors. Sorry Works programs are proven to reduce the number of claims, reduce the amounts paid on claims that are made, and improve patient safety by allowing errors to be freely discussed and become lessons learned for the profession. There is no reason to expect that apology programs in Texas are any less successful than elsewhere.

Finally, Texas raised its Medicaid reimbursement rates significantly several times beginning in 2001. A Council of State Governments report, Physician Shortages and the Medically Underserved (Aug. 2008), suggests: "the most effective incentive to lure physicians to rural underserved areas might be for states to increase Medicaid reimbursement rates." This is because "rural practitioners tend to depend on Medicaid as payment for services more than their suburban and urban counterparts. Consequently, increasing Medicaid reimbursement rates is frequently cited as one of the most promising incentives to encourage physicians to locate in underserved areas.

There is no data on the impact that increased Texas Medicaid rates have had on the supply of rural doctors. This is an important factor in Texas because of the low percentage of rural residents covered by private insurance. The Texas Academy of Family Physicians reports that only one-third of rural citizens are covered by private insurance. Two-thirds are covered by Medicaid/Medicare or are uninsured. The impact of Medicaid rate increases is therefore significant in Texas.

It's the Economy, Stupid

Also ignored is the effect of the energy crisis in fueling the boom in the Texas economy since tort reform was passed in Texas. As the price of oil skyrocketed, so went the Texas economy. At its peak, the Texas economy became the seventh largest in the world with a gross state product in 2006 of $1.1 trillion, it had the most Fortune 500 company headquarters in the nation and was home to 33 billionaires.

The soaring economy was good for doctors as well. It still is in comparison to Hawaii. An HMA representative has testified on numerous occasions that Hawaii orthopedic surgeons make only $125,000 to $150,000 annually, but can easily make three to five times as much on the mainland. A review of Texas doctor want ads will easily confirm that the income of doctors there far surpass incomes of Hawaii doctors. A review of want ads for Texas orthopedic surgeons show numerous positions offering annual compensation of $400,000 to $1,000,000. It should come as no surprise to anyone that a state like Texas with high pay, cheap housing, low cost of living and no state income tax should attract doctors, while Hawaii with low pay, unaffordable housing, high cost of living, and high tax burden should lose doctors (and teachers, police officers, nurses, and all other types of workers).

There Is No Data From Texas (or elsewhere) That Shows That Capping Non-Economic Damages Had A Cause And Effect Relationship On Any Of The Claimed Events That Have Occurred In Texas Since 2003. The Actual Data Shows That Capping Non-

Economic Damages Will Not Cause Doctors To Move To The Neighbor Islands, Take Call or Remain In Hawaii.

Thank you very much for this opportunity to testify.

Testimony of John Yamane
In Opposition to HB No. 1784, HD1

To the House Committee on Judiciary:

There has been much said in the media about the shortage of doctors on the neighbor islands and the supposed need to cap damages to solve the shortage. The Hawaii Medical Association claims that capping damages will cause doctors to move to the neighbor islands. As a person who grew up on a neighbor island, I wish to comment on the reasons capping damages will not solve the problem and offer suggestions on better solutions.

If a doctor wanted to live on a neighbor island, they would already live there. Capping damages will not make the difference. Here's why. There aren't as many opportunities for better paying jobs. The population and economy is just too small to support expanding opportunities. It is harder to find a good job. When you find a job, you get paid less for the same work compared to Honolulu or the mainland. The cost of buying a house and the cost of living is much higher. Everything costs more.

I grew up on Lanai. Almost all of my classmates left as soon as they graduated from high school. I know of only a couple that went back and still live there. The only jobs available were in the pineapple plantation and later the hotels. There were no opportunities for my classmates who became dentists, lawyers and construction workers.

The quality of education is lower on the neighbor islands. Why is it lower? It's lower because it's hard to get good teachers to move to the neighbor islands. Many of those that try it leave after a short time for the same reasons as doctors. If you want a good education for your children, so they can go to a good college, you pretty much have to live in Honolulu. That is what happened to me. My parents realized that there were better opportunities for their children's education and moved us back to Honolulu at the first opportunity.

Unless you marry someone from a neighbor island who wants to go back home, your spouse is not likely to want to live on a neighbor island. There are very few good jobs for them. There are fewer cultural and educational events. Almost all of the musical performances, stage shows and cultural exhibits come only to Honolulu. There is a shortage of good restaurants, shopping, activities for the kids and entertainment options. The fact is that unless you really want to live there, it's just too expensive and boring. Costs more - - pays less.

Every summer my mom would bring my sister and I to Honolulu so we could see other things like plays and museums and go to summer school.

So what has a realistic chance of working? First, you need to target the people who really want to live there. Not the city folks who think they want to live the simple country life, but the students who grew up there, have family and roots there, and know they want to live there because they don't like the city life. The medical school needs sufficient slots dedicated to students from the neighbor islands.

Second, becoming a neighbor island doctor has to be economically feasible. Neighbor island students tend to come from families with modest means so grants and loan repayments for those who actually return home are needed. Tax credits and higher medicaid fees for neighbor island doctors will help.

Those are the kinds of solutions that work. You can't do anything about the quality of life factors to attract people who don't really want to live the neighbor island lifestyle so don't waste time and money trying.

Hawaii has had a difficult time recruiting and retaining doctors, teachers, policemen, nurses, and many other kinds of jobs for the same reasons. Living in Hawaii costs more and pays less. The main reasons doctors leave Hawaii is the same as everyone else. This goes double for the neighbor islands. It has nothing to do with capping damages.

Thank you for letting me testify.