# WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

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## Committee on Insurance (AC-In)

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**(2005 documents)**

# The Potential Impacts of Caps on Non-Economic Damages in Medical Malpractice Insurance in Wisconsin

*September 2005*

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**EXHIBITS**

# The Potential Impacts of Caps on Non-Economic Damages in Medical Malpractice Insurance in Wisconsin

## *Executive Summary*

For states struggling with medical malpractice insurance affordability and availability crises, the state of Wisconsin has long been viewed as a model state. This is due to the ability of the state's broad set of legislative reforms to provide stable and affordable premiums for healthcare providers and a stable environment for insurers. One of the foundational elements of Wisconsin's reforms, the cap on non-economic damages, was recently found to be unconstitutional. The Wisconsin Supreme Court in *Ferdon vs. Wisconsin Patients Compensation Fund* found that the cap violates the state's equal protection guarantees. The court also stated that the ruling does not impact the state's damage cap in wrongful death cases. This decision has led to questions regarding the impact the elimination of the caps may have on coverage availability, affordability and market stability.

Through a review of both publicly available and proprietary data sources, Pinnacle Actuarial Resources, Inc. (Pinnacle) has come to a number of key conclusions regarding the impact of the presence or absence of caps on non-economic damages on the Wisconsin medical malpractice liability environment. The highlights of our findings as regard the various issues include:

- While all caps on non-economic damages reduce losses, the impact diminishes as the size of the cap increases. A cap of $250,000 eliminates approximately 25% of unlimited losses, a $550,000 cap eliminates about 15% and a $1 million cap eliminates about 7%.

- States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have significantly better insurance company loss ratios and combined operating ratios.

- States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have more competitive

insurance markets as measured by the number of insurance companies providing coverage in the state.

- States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have medical malpractice insurance premiums that are much lower than the premiums in states that do not have effective caps.

- The Wisconsin medical malpractice insurance market has significantly outperformed most states in terms of both the affordability of medical malpractice rates and insurance company operating results.

In summary, states with damage caps are more attractive to both current and prospective insurers. This is due in part to the cap on one of the least predictable and most volatile elements of medical malpractice claim costs (i.e. the non-economic portion of high severity, permanent disability claims). This makes losses and therefore rates more predictable.

Similarly, states with damage caps are more attractive to current and prospective health care providers. This is because providers in states with effective caps:

1. have current rates lower than providers in states without effective caps,
2. have had more stable rate levels over the last several years, and
3. more insurance carriers competing for their business

This suggests that healthcare providers find medical malpractice insurance costs more affordable and coverage more available in states with effective caps.

## ***Background***

Pinnacle Actuarial Resources, Inc. (Pinnacle) has been retained by the Wisconsin Hospital Association (WHA) and the Wisconsin Medical Society (WMS) to perform analyses of the impact of the presence or absence of caps on non-economic damages at various levels. Specifically, they would like assistance evaluating the impact of:

1. Caps on non-economic damages on claims data from states without caps, and
2. Experience of other states based on the type of cap applicable in the state.

Pinnacle is an Illinois corporation that has been in property and casualty actuarial consulting since 1984. Our 14 consultants make Pinnacle one of the 10 largest property/casualty actuarial consulting firms in the U.S. We specialize in insurance pricing, loss reserving, alternative markets, legislative costing and market analysis and financial risk modeling. Our headquarters are located in Bloomington, IL.

Pinnacle has established a reputation as a provider of unbiased, independent, actuarially sound analyses and reports. This reputation is demonstrated in the variety of clients that have engaged us for projects similar to this one. Clients that have engaged Pinnacle in legislative costing and market evaluation assignments have included insurance industry associations (e.g. NAII, AIA), insurance departments and governmental panels (e.g. Connecticut, Maine, Ohio, Oregon), government insurance programs, (e.g. Virginia), trade associations (e.g. Oregon Medical Association, Illinois Hospital Association) and insurance companies. Pinnacle may be unique in the breadth of parties involved in the medical malpractice insurance system that have engaged us. A list of relevant research and client-related publications follows.

### *Relevant Pinnacle Reports and Research*

- "A Report on Factors Impacting Medical Malpractice Insurance Availability and Affordability", Oregon Professional Panel for Analysis of Medical Professional Liability Insurance, October 2004 (www.pinnacleactuaries.com/pages/publications/files/saiffinalreport.pdf)

- "Final Report on the Feasibility of an Ohio Patients Compensation Fund", Ohio Department of Insurance, May 2003 (www.ohioinsurance.gov/Legal/REPORTS/FinalReportOhioPatientComp.pdf)
- "Preliminary Report on the Feasibility of an Ohio Patients Compensation Fund", Ohio Department of Insurance, February 2003 (www.ohioinsurance.gov/Legal/Reports/Prelim_Patient_Compensation_Report_03-03-03.pdf )
- "The Case of the Medical Malpractice Crisis: A Classic Who Dunnit", Casualty Actuarial Society Discussion Paper Program, Spring 2004 (http://casact.org/pubs/dpp/dpp04/04dpp393.pdf)
- "The Impact of Medical Malpractice Litigation On the Health Care Consumer", A Report to The PLUS Foundation, Summer 2004

## Data Sources

A number of data sources were used in the development of this analysis. The data sources relied upon included the following categories:

1. Oregon, Maine, and Florida Closed Claims Database
2. Medical Malpractice Rates and Rate Filings
3. Insurance Company Financial Statements
4. State Statutory and Regulatory Provisions for Medical Malpractice

A brief description of the data sources utilized in each area along with a description of the key data elements and potential limitations of the data follows for each category.

***Closed Claims Databases***

Statewide closed claim databases are valuable resources for the development of legislative costing estimates in medical malpractice. For this analysis, Pinnacle has relied on databases from the states of Oregon, Maine, and Florida. These databases were selected because the data was readily available, easily accessible and robust in the sense that several years of data for the vast majority of a state's medical malpractice claims experience was available. The use of these databases has enabled us to develop a range of estimated impacts of caps on non-economic damages at various levels which reflect some differing judicial systems and at the same time demonstrate a significant consistency in the estimated reductions in expected losses created by the caps.

In a previous study on behalf of the Oregon Professional Panel for Analysis of Medical Professional Liability Insurance, Pinnacle worked with a number of medical malpractice insurance companies in the state and the Oregon Medical Association to develop an independent, Oregon medical malpractice closed claims database. With these parties' permission Pinnacle has used this database to evaluate the impact of several of the proposed legislative changes. For more information on the specifics of this database, please refer to Pinnacle's earlier report for the Oregon Professional Panel. (www.pinnacleactuaries.com/pages/publications/files/saiffinalreport.pdf)

As a result of the 1977 Maine Health Security Act, "Every insurer providing professional liability insurance in this State to a person licensed by the Board of Licensure in Medicine or the Board of Osteopathic Licensure or to any health care provider shall make a periodic report of claims made under the insurance to the department or board that regulates the insured." This data has been compiled and provided in an electronic format for Pinnacle's analysis by the Maine Bureau of Insurance. For more information on the specifics of this database, please refer to Pinnacle's earlier report for the Maine Bureau of Insurance.

The Florida Department of Insurance has been collecting data on individual medical malpractice claims since 1975. This data contains tremendous descriptive detail about the claim damage amounts, but also about the characteristics of the claim itself. We have chosen to examine claims in the state of Florida that closed during the period from January 1, 1993 through March 1, 2003. This produced 21,639 individual claim records. For more information on the specifics of this database, please refer to Pinnacle's earlier report for the Ohio Department of Insurance.

In all three cases, losses were trended at an annual rate of 7%. The trend factor was selected after a review of recent rate filings from a variety of leading insurers in a variety of jurisdictions, including Wisconsin. In many cases, medical malpractice closed claim data does not contain a split between economic and non-economic damages. We reviewed the closed claim information that is publicly available from the Texas Department of Insurance which does contain the split between economic and non-economic. Based on this data approximately 65% of the total claim amount is due to non-economic damages for claims that closed for amounts between $250,000 and $2 million. For claims greater than $2 million the portion of the claim representing non-economic damages was 50%. Additional data sources such as the Florida Closed Claim database and other industry studies indicate that non-economic damages range from 50% to nearly 70% of the total claim amounts. Unless specific claims detail was available, we have assumed that 60% of claims values, excluding allocated loss adjustment expenses are non-economic damages.

The American Academy of Actuaries has provided guidance on the limitations of using closed claims databases. This guidance can be found at www.actuary.org/pdf/casualty/medmal_042005.pdf. Readers of this report are advised to be aware of these limitations. In spite of these cautions,

closed claim databases such as those used in this analysis remain the most readily available source of large volumes of medical malpractice claims applicable for evaluating the impact of caps on non-economic damages and other legislative changes and are widely used and accepted. These data sources represent states with a variety of different approaches to medical malpractice liability law. While none of the states have a current medical malpractice environment perfectly identical to the climate that exists in Wisconsin subsequent to the *Ferdon* decision, the consistency of the analysis results between the various states suggests that closed claim data are valid for the purpose of estimating the impact of non-economic damage caps. One example of the differences between the states is Maine's mandatory medical review panels. Another is Florida's judicial system which has created a very difficult climate for medical malpractice liability claims that has resulted in a large number of high severity claims. Overall, it appears that the information available in Oregon is most suited to estimating the impact of caps on non-economic damages in Wisconsin. The Florida data may slightly overstate the impact of the damage caps due to the greater frequency and severity of large losses.

Coincidentally, Oregon is another state that has experienced a Supreme Court ruling finding that non-economic damage caps are unconstitutional. The significant rate increases, reduced coverage availability, deteriorating industry operating results and reduced competition in Oregon are troubling evidence of the impact removing damage caps can have on a stable medical malpractice insurance market.

***Medical Malpractice Rates and Rate Filings***

A tremendous resource for historical rate levels of key insurers in all states is the Medical Liability Monitor. This publication conducts an annual survey of the leading medical malpractice insurers in all 50 states. The information that is requested is mature claims-made rates with limits of $1 million/$3 million (occurrence/aggregate). The Medical Liability Monitor provides rate level information by state for three large physician specialties (internists, general surgeons, and OB/GYNs). Typically data from several insurers is available in a given state. This information is a widely recognized and accepted resource.

Pinnacle has performed an internal analysis of the last nine years of Medical Liability Monitor

data to create an assessment of current insurance industry rate levels by specialty and state as well as average annual rate changes over the period. We attempted to track the rate changes of the largest insurer in state that provided data to the Medical Liability Monitor over the entire nine year period as a measure of rate level changes over the period. Generally, this was the largest or second largest insurer by market share. In a few states, data for a single insurer was not available for the entire period and a judgmental adjustment to reflect the change in leading carriers was necessary. In states where the limits were not typically provided due to coverage from a patient compensation fund or other factors, an estimated adjustment to get the rates to a more "apples to apples" basis was made using available PCF rates and other information. This was used to evaluate the current affordability of medical malpractice coverage by state.

A couple of caveats about this approach to industry rate levels are necessary. First, the current rates for one leading writer of medical malpractice for three specialties in each state are not a precise measure of overall rate levels for the entire industry. Medical malpractice insurers do not move in concert with one another and a leading insurer may have rates that differ materially from other insurers in the state. However, the rate levels of one of the two largest insurers in the state does serve as a reasonable proxy for industry rate levels which are impractical to measure. One complicating factor in this assessment is that other rating factors, including limits purchased and self-insured retentions selected, movement from traditional insurance to self-insurance, and the impact of claims-free credits and experience rating changes are not measured in manual rate changes. Still, the most significant factor influencing health care provider premiums are manual rate level changes.

***Insurance Company Financial Statements***

In evaluating the relative profitability of both individual medical malpractice insurers and the medical malpractice insurance industry in various states, Pinnacle relied heavily on insurance company annual financial statement data compiled by the A.M. Best Company. Pinnacle examined premiums, losses, loss adjustment expenses and underwriting expenses by line and state. This information was aggregated across all insurers to produce industry composites.

One of the complications of using this data source is that it is limited to carriers that have an

A.M. Best rating. Several writers of medical malpractice insurance, including leading writers such as Northwest Physicians Mutual Insurance Company in Oregon, are no longer in the annual statement databases. For some significant insurers, Pinnacle added data directly from company annual statements to the A.M Best data to produce more accurate industry composite results.

***State Statutory and Regulatory Provisions for Medical Malpractice***

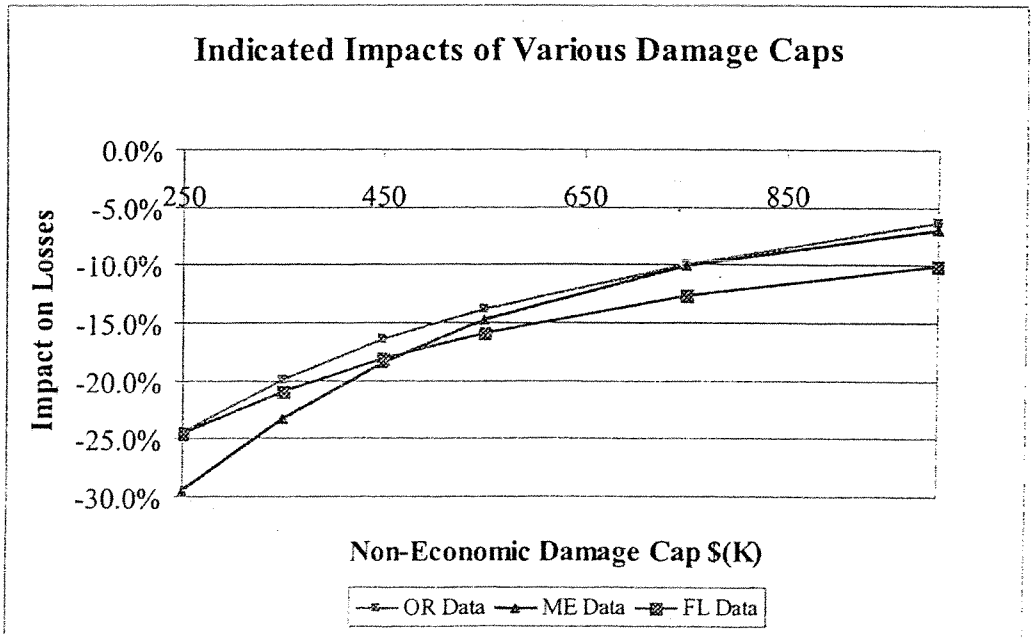
A thorough understanding of the current statutory caps on non-economic damages and any significant changes in these caps over the last decade by state was viewed as essential to providing a meaningful summary of both the presence or absence of damages caps in other states and also the impact these caps have had on the availability and affordability of premiums and insurer loss ratios and combined operating ratios. States with both non-economic damage caps and total caps, e.g. Colorado, were assigned to the state to which their non-economic cap belongs. States with only total damage caps, e.g. Indiana, were given judgmental assignments to the group that their caps most appropriately matched. Reassigning or removing the states with total caps did not materially impact the overall findings of the analysis.

We relied primarily on two resources in compiling information on applicable caps in each state over the last decade. One resource is the website of the law firm of McCullough, Campbell & Lane (www.mcandl.com) which provides a concise summary of many medical malpractice statutory features by state along with the relevant legal citations. The other resource is the website of the American Tort Reform Association (ATRA) which provides a detailed summary of Civil Justice Reforms by State. This information includes both currently active legislation and historical changes. We have followed categorizations of states by non-economic damage caps as Low ($250,000), Medium (between $250,000 and $550,000) and High (greater than $550,000) as they appear to provide reasonable groupings of states with comparable industry conditions. These groupings were recently published in an article in the September 2005 Best Review entitled, "Doctors' Orders", which utilized ATRA data. Pinnacle has used information from both of these resources as a reference in several previous projects and found them to be reliable and accurate.

## Discussion and Analysis

**While all caps on non-economic damages reduce losses, the impact diminishes as the size of the cap increases. A cap of $250,000 eliminates approximately 25% of unlimited losses, a $550,000 cap eliminates about 15% and a $1 million cap eliminates about 7%.** In order to estimate the impact of a cap on non-economic damages, Pinnacle's analysis started by trending the closed claims in the Oregon, Maine and Florida closed claims data set by an annual rate of 7% for indemnity payments and ALAE payments. As noted above, the trend factor was selected based on a review of recent rate filings from leading insurers in a variety of jurisdictions, including Wisconsin. Losses were trended assuming that the non-economic damage caps would begin to apply on January 1, 2006. Exhibit 1 summarizes the results of this analysis.

The results of applying non-economic damage caps ranging from $250,000 to $1,000,000 are remarkably similar for all three databases. A cap on non-economic damages of $250,000 results in an estimated reduction in losses and allocated loss adjustment expenses (ALAE) of between 24.5% and 29.5%. This steadily decreases as the cap increases until the $1 million cap only eliminates 6.3% to 10.1% of total loss and ALAE. We also believe the results in Florida may overstate the likely impact of this high of a cap in Wisconsin due to significant differences in the judicial systems in the two states. The results of this analysis are shown graphically below.



The reverse of this finding is also true. That is we expect that the removal of the Wisconsin caps on non-economic damages which were at approximately $450,000 are likely to increase expected losses by between 18% and 22%. Because of the role played by the Wisconsin Injured Patients and Families Compensation Fund (IPFCF) as the excess coverage provider in the state we expect it will bear a significant portion of the increase losses created by the elimination of the caps. Our analysis suggests that insurance company rates will need to increase by between 12% and 15% while IPFCF assessments may need to more than double. Note that this will reduce the impact on primary insurance company rates but not on health care provider costs as they are responsible for IPFCF assessments as well as their insurance premiums.

This increase in medical malpractice insurance costs will likely involve a single rate correction or potentially a single rate change followed by additional adjustments as the impact is better understood and more data is collected. However, the potential for increased variability in insurance company loss results and increases in loss severity inflationary trends also present the risk of additional rate increases and deterioration of industry loss results. This behavior has been manifested in a number of states without effective caps on non-economic damages and will be discussed later in the report.

The extent to which these estimated cost reductions will be realized depends on a number of issues. The cost reductions do not reflect the potential impact of judicial challenges of damage caps which could delay or reduce the realization of the potential savings. In addition, there is a potential for the migration of some non-economic damages to economic damages. For example, damages paid to the family of a deceased mother who had no outside income can be broadly awarded as pain and suffering, or non-economic damages. If caps are put in place, the costs of the services that can be replaced may be more fully itemized and listed as economic damages. Furthermore, there is no consideration in this analysis of indirect effects such as reductions in claim frequencies due to the cap or reductions in ALAE due to reduced settlement delays created by the caps. These indirect effects are quite difficult to quantify and generally would lead to our estimates being somewhat conservative, i.e. potentially understating the impact of the caps.

This inability to quantify indirect effects of non-economic damage caps based on closed claims data suggests that an additional approach is also needed. Therefore, Pinnacle has compiled industry rate, premium and loss data by state so that state experience by different categories of damage caps can be compared.

**States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have significantly better insurance company loss ratios and combined operating ratios.** Exhibits 2 through 4 summarize three important measures of the health of an insurance market: loss and defense and cost containment expense (DCC) ratios, combined ratios and market concentrations by the type of damage cap that exists in a state. Loss and DCC ratios are the ratio of losses and defense and cost containment expenses as a percentage of premium earned. The combined ratio starts with the loss and DCC ratio and adds ratios of both other loss adjustment expenses and underwriting expenses to premium. When these ratios are above 100% an insurance company or state insurance market is paying out more than they are collecting in premiums and can signal a need for rate increases or the potential for reduced access to coverage. Note that this metric does not reflect the investment income that insurers can earn between the time premiums are collected and losses and other expenses are paid.

As shown on Exhibit 2, Wisconsin's five year loss and DCC ratio is lower than even the average for states with low noon-economic damage caps. In fact, it is one of the lowest of any state. The statewide combined ratio is also one of the lowest in the nation. As you can see in Exhibits 2 and 3, the states with low or medium caps demonstrate loss and DCC ratios and combined ratios that are much lower than states with high caps or no caps. The five year average combined ratios of over 135% shown by the states without effective caps have led to voluntary company exits from the marketplace, company liquidations and dramatic rate increases by insurers remaining in these states.

**States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have more competitive insurance markets as measured by the number of insurance companies providing coverage**

**in the state.** An important measure of the availability of insurance coverage is the degree of competition between insurers to provide coverage in a state. One way to measure the degree of competition is the level of market concentration. A more competitive market will tend to be less concentrated. We have examined medical malpractice market concentrations over time and by state. This type of analysis is widely used in insurance and many other markets to measure the competitiveness of a market.

The metric we used to measure market concentration is the Herfindahl-Hirschman Index (HHI). HHI is computed as the sum of the squares of the market shares of the firms competing in a market. The HHI can range from a minimum of close to 0 to a maximum of 10,000. The U.S. Department of Justice considers a result of less than 1,000 to be a competitive marketplace, a result of 1,000 - 1,800 to be a moderately concentrated marketplace, and a result of 1,800 or greater to be a highly concentrated marketplace. In insurance, it is common to sum the data for statutory insurance companies that operate within a single group in terms of their ownership structure and pooling of financial results. Exhibit 4 shows the HHI results by the state categories by damage cap type for 2004 and a five year average (2000-2004) for the medical malpractice market in total.

Wisconsin's marketplace, which ranked 27$^{th}$ in total premium volume, is slightly less concentrated (HHI=1,656) than most states. Generally, states with caps are much more competitive as reflected in significantly lower HHI statistics. The high average HHI for states with medium caps is heavily influenced by a few states with dominant domestic mutual insurers founded by state physicians groups.

**States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have medical malpractice insurance premiums that are much lower than the premiums in states that do not have effective caps.** It is noteworthy that not only are loss ratios lower in states with effective damage caps ($250K to $550K), signifying better insurance company results and thus the potential for a more competitive market and greater availability of coverage; but, these states also have significantly lower premiums on average suggesting more affordable coverage. The

results of this rate comparison are summarized in Exhibits 5 through 7. States with small ($250K) and medium caps on non-economic damages have average rates of $11,600 to $13,800 for the internal medicine specialty while state with no caps or caps that were found to be unconstitutional have average rates in excess of $18,000. Similar differences of 25% to 35% exist for the General Surgery and OB/GYN specialties. This results in average OB/GYN rates in states with effective caps being over $25,000 lower than rates in states without caps. Wisconsin rates are among the lowest in the nation in all three specialties.

Similarly, average rate levels over the last six years in states with effective caps have increased between 8% and 12% while rates in states without caps have increased between 14% and 19% annually. This means that for states without caps, many medical malpractice premiums have more than doubled in six years. Wisconsin annual rate increases over the period have been less than 5%.

**The Wisconsin medical malpractice insurance market has significantly outperformed most states in terms of both the affordability of medical malpractice rates and insurance company operating results.** Exhibits 2 through 7 show that the state of Wisconsin has significantly outperformed most states in all of the categories presented. Market concentration is lower than average suggesting better than average insurer competition. Industry loss and ALAE ratios and combined operating ratios are much lower than national averages. Leading company rate levels and average annual rate changes over the last six years have typically been among the ten best states in the country. These metrics suggest that the state of Wisconsin's broad approach to medical malpractice reform which includes the IPFCF, caps on attorney contingency fees, recognition of collateral sources, mandatory periodic payments, and damage caps, have led to a market with better than average availability and affordability of coverage for health care providers and an environment that encourages competition for insurers while still offering an opportunity to generate reasonable operating results in a stable loss environment.

It appears based on both the expected impact of the removal of the state of Wisconsin's previous non-economic damage cap and the current conditions in other states that Wisconsin's balanced environment is now in jeopardy without meaningful caps. It appears that either a low cap such

as California's $250,000 cap or a medium cap of less that $550,000 are essential to maintaining the current availability, affordability and stability of medical malpractice coverage in the state of Wisconsin.

## Disclosures

*Distribution and Use*

This report is being provided for the use of the Wisconsin Hospital Association and the Wisconsin Medical Society who commissioned the study. It is understood that this report may also be distributed to makers of public policy and various stakeholders in the healthcare industry in the State of Wisconsin. Distribution to these parties is granted on the conditions that the entire report be distributed rather than any excerpts and that all recipients are made aware that Pinnacle is available to answer any questions regarding the report.

These third parties should recognize that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the data, computations, interpretations contained herein that would result in the creation of any duty or liability by Pinnacle to the third party.

*Reliances and Limitations*

Judgments as to conclusions, recommendations, methods, and data contained in this report should be made only after studying the report in its entirety. Furthermore, Pinnacle is available to explain any matter presented herein, and it is assumed that the user of this report will seek such explanation as to any matter in question. It should be understood that the exhibits, graphs and figures are integral elements of the report.

We have relied upon a great deal of publicly available data and information, without audit or verification. Pinnacle reviewed as many elements of this data and information as practical for reasonableness and consistency with our knowledge of the insurance industry. As regards the legislative costing elements of this report, it is possible that the historical data used to make our estimates may not be predictive of future experience in Wisconsin. We have not anticipated any extraordinary changes to the legal, social or economic environment which might affect the size or frequency of medical malpractice claims beyond those contemplated in the proposed legislative changes.

Loss and loss adjustment expense estimates are subject to potential errors of estimation due to the fact that the ultimate liability for claims is subject to the outcome of events yet to occur, e.g., jury decisions, judicial interpretations of statutory changes and attitudes of claimants with respect to settlements. Pinnacle has employed techniques and assumptions that we believe are appropriate, and we believe the conclusions presented herein are reasonable, given the information currently available. It should be recognized that future losses will likely deviate, perhaps substantially, from our estimates.

Pinnacle is not qualified to provide formal legal interpretations of state legislation. The elements of this report that require legal interpretation should be recognized as reasonable interpretations of the available statutes, regulations, and administrative rules. State governments and courts are also constantly in the process of changing and reinterpreting these statutes.

## *Exhibits*

Exhibit 1. Impacts of Various Caps on Non-Economic Damages

Exhibit 2. Rate and Loss Experience by Predominant State Damage Caps

Exhibit 3. Premium and Loss Experience by State

Exhibit 4. State Rate Histories

## Wisconsin Hospital Association/Wisconsin Medical Society

### Impact of Various Caps on Non-Economic Damages

Exhibit 1

I. Indicated Impact Based On Oregon Closed Claim data

| Trended Size of Loss | Trended Loss & ALAE Uncapped | Indicated Reduction in Overall Loss and ALAE | | | | | |
|---|---|---|---|---|---|---|---|
| | | $250K Cap | $350K Cap | $450K Cap | $550K Cap | $750K Cap | $1M Cap |
| 0-25 | 15,882,386 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 25-50 | 16,393,941 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 50-100 | 26,406,073 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 100-150 | 19,480,715 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 150-200 | 19,237,755 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 200-250 | 14,575,199 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 250-350 | 27,434,350 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 350-500 | 38,874,756 | -2.2% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 500-1000 | 101,772,269 | -22.8% | -10.0% | -2.5% | -0.3% | 0.0% | 0.0% |
| 1m-2m | 123,309,631 | -42.2% | -35.4% | -28.6% | -21.8% | -10.3% | -1.9% |
| 2m+ | 177,954,398 | -37.3% | -34.9% | -32.4% | -30.0% | -25.2% | -19.2% |
| Overall | 581,321,472 | -24.5% | -19.9% | -16.4% | -13.9% | -9.9% | -6.3% |

II. Indicated Impact Based On Maine Closed Claim data

| Trended Size of Loss | Trended Loss & ALAE Uncapped | Indicated Reduction in Overall Loss and ALAE | | | | | |
|---|---|---|---|---|---|---|---|
| | | $250K Cap | $350K Cap | $450K Cap | $550K Cap | $750K Cap | $1M Cap |
| Overall | 199,784,402 | -29.5% | -23.3% | -18.6% | -14.8% | -10.1% | -7.0% |

III. Indicated Impact Based On Florida Closed Claim data

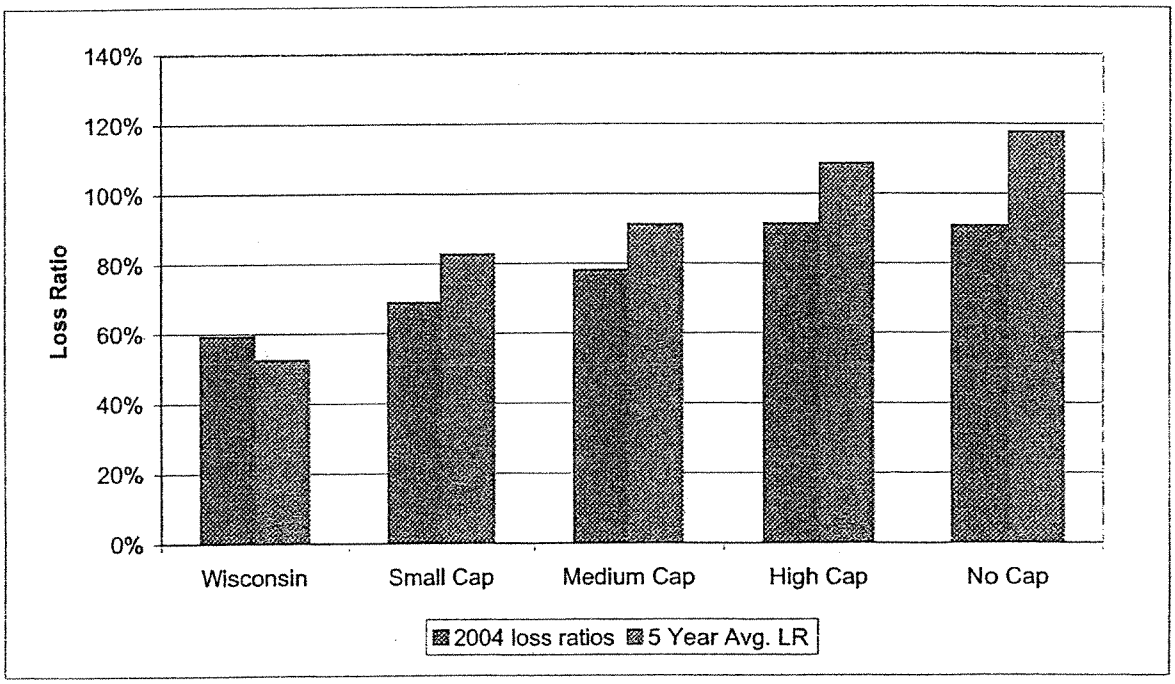
| Trended Size of Loss | Trended Loss & ALAE Uncapped | Indicated Reduction in Overall Loss and ALAE | | | | | |
|---|---|---|---|---|---|---|---|
| | | $250K Cap | $350K Cap | $450K Cap | $550K Cap | $750K Cap | $1M Cap |
| Overall | 11,219,742,990 | -24.6% | -21.0% | -18.1% | -15.8% | -12.7% | -10.1% |

Assumes Medical Malpractice Loss Inflation of 7.0% for Indemnity and ALAE.

# Wisconsin Hospital Association/Wisconsin Medical Society
## Loss Ratios

### Industry Experience by State Predominant Damage Cap

| Category | 2004 Loss Ratio | 5 Yr. Average Loss Ratio |
|---|---|---|
| **Wisconsin** | **59.32%** | **52.53%** |
| Small Cap | 68.91% | 82.75% |
| Medium Cap | 78.14% | 91.32% |
| High Cap | 91.50% | 108.69% |
| No Cap | 90.94% | 117.72% |
| Premium Weighted Average | 87.40% | 110.82% |




Source: AM Bests' Aggregates and Averages

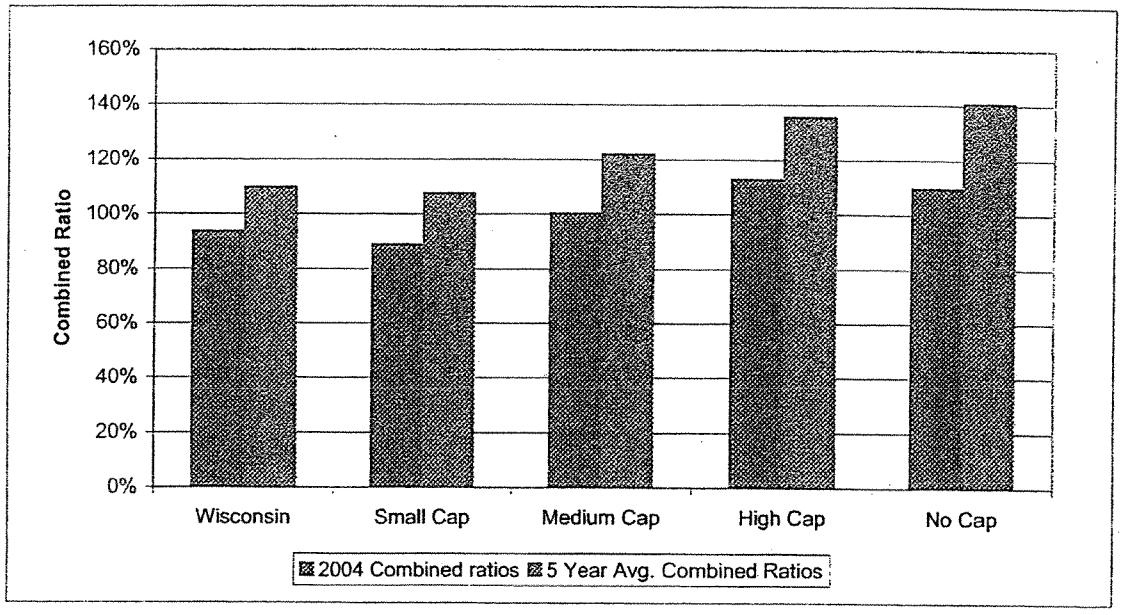
Predominant State Groups are:

| | |
|---|---|
| Small Cap - | CA,CO, KS, MT, UT |
| Medium Cap - | AK, HI, ID, IN, MA, MI, ND, OK, SD, WI |
| High Cap - | MD, MO, NM, VA |
| No Cap - | AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY |

## Wisconsin Hospital Association/Wisconsin Medical Society
### Combined Ratios

### Industry Experience by State Predominant Damage Cap

| Category | 2004 Comb. Ratio | 5 Yr. Average Comb. Ratio |
|---|---|---|
| **Wisconsin** | **93.89%** | **109.86%** |
| Small Cap | 88.92% | 107.65% |
| Medium Cap | 100.34% | 121.93% |
| High Cap | 112.89% | 135.64% |
| No Cap | 109.84% | 140.77% |
| Premium Weighted Average | 106.90% | 135.04% |



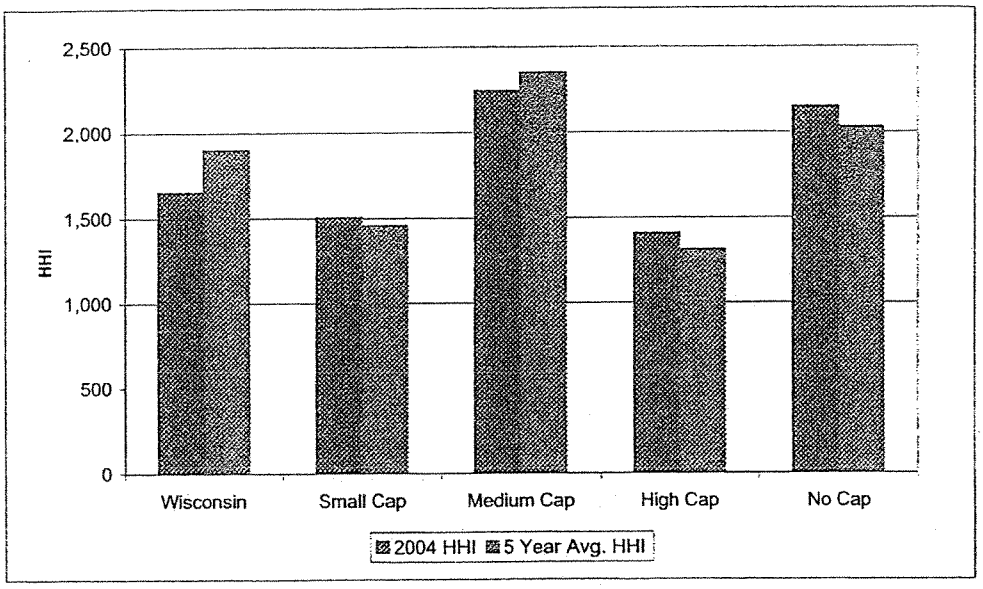

Source: AM Bests' Aggregates and Averages

| | |
|---|---|
| Small Cap - | CA,CO, KS, MT, UT |
| Medium Cap - | AK, HI, ID, IN, MA, MI, ND, OK, SD, WI |
| High Cap - | MD, MO, NM, VA |
| No Cap - | AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY |

# Wisconsin Hospital Association/Wisconsin Medical Society
# Market Concentration by State by Year

## Comparison by Damage Cap

| Category | 2004 HHI | 5 Year Avg. HHI |
|---|---|---|
| **Wisconsin** | **1,656** | **1,904** |
| Small Cap | 1,507 | 1,459 |
| Medium Cap | 2,246 | 2,353 |
| High Cap | 1,409 | 1,312 |
| No Cap | 2,150 | 2,028 |
| Written Premium Weighted Average | 2,033 | 1,941 |




Data Sources: 2004 Direct Written Premium: A.M. Best Page 15 data.

Comments: HHI (Herfindahl-Hirschman Index) is calculated by squaring the market share of each firm competing in a market, and then summing the resulting numbers. The index can range from 0 to 10,000. The U.S. Department of Justice considers a result of less than 1,000 to be a competitive marketplace, a result of 1,000-1,800 to be a moderately concentrated marketplace and a result of 1,800 or greater to be a highly concentrated marketplace.

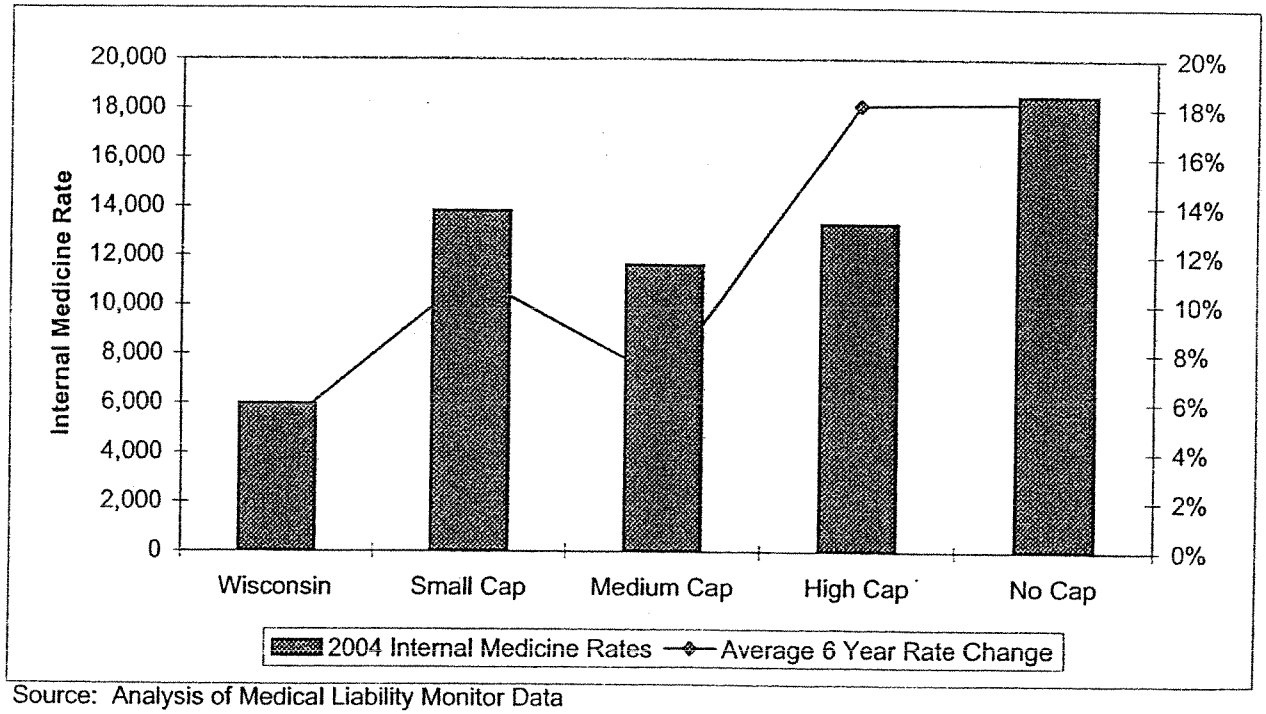
Predominant State Groups are:

| | |
|---|---|
| Small Cap - | CA,CO, KS, MT, UT |
| Medium Cap - | AK, HI, ID, IN, MA, MI, ND, OK, SD, WI |
| High Cap - | MD, MO, NM, VA |
| No Cap - | AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY |

# Wisconsin Hospital Association/Wisconsin Medical Society
## Internal Medicine Rates and Rate Levels

### Comparison by Damage Cap

| Category | 2004 Rate | Average 6 year Rate Change |
|---|---|---|
| **Wisconsin** | **5,973** | **4.85%** |
| Small Cap | 13,834 | 11.17% |
| Medium Cap | 11,615 | 6.98% |
| High Cap | 13,292 | 18.11% |
| No Cap | 18,514 | 18.24% |
| Physician Weighted Average | 16,587 | 15.78% |



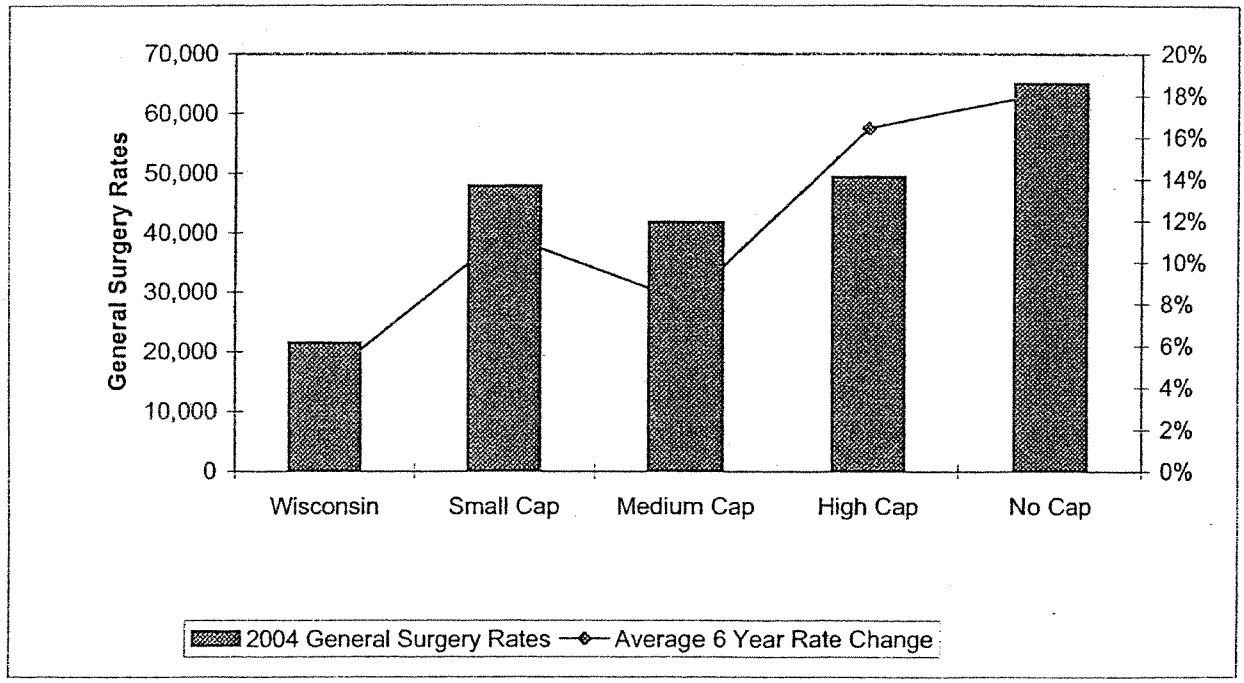

Source: Analysis of Medical Liability Monitor Data

| | |
|---|---|
| Small Cap - | CA, ID, KS, MT, UT |
| Medium Cap - | AK, CO, HI, IN, LA, MA, MI, MS, ND, OK, SD, WI |
| High Cap - | MD, MO, NM, VA |
| No Cap - | AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY |

# Wisconsin Hospital Association/Wisconsin Medical Society
## General Surgery Rates and Rate Levels

### Comparison by Damage Cap

| Category | 2004 Rate | Average 6 year Rate Change |
|---|---|---|
| **Wisconsin** | **21,504** | **4.44%** |
| Small Cap | 47,862 | 11.33% |
| Medium Cap | 41,819 | 8.13% |
| High Cap | 49,446 | 16.45% |
| No Cap | 64,974 | 18.21% |
| Physician Weighted Average | 58,470 | 15.81% |



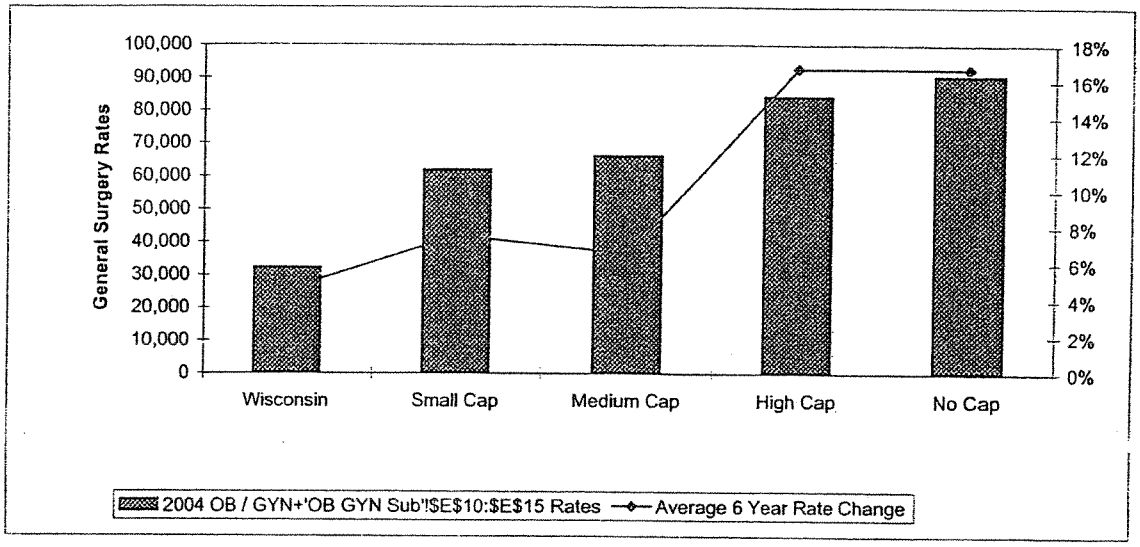

Source: Analysis of Medical Liability Monitor Data

| | |
|---|---|
| Small Cap - | CA, ID, KS, MT, UT |
| Medium Cap - | AK, CO, HI, IN, LA, MA, MI, MS, ND, OK, SD, WI |
| High Cap - | MD, MO, NM, VA |
| No Cap - | AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY |

## Wisconsin Hospital Association/Wisconsin Medical Society
### OB / GYN Rates and Rate Levels

### Comparison by Damage Cap

| Category | 2004 Rate | Average 6 year Rate Change |
|---|---|---|
| **Wisconsin** | **32,255** | **4.61%** |
| Small Cap | 61,999 | 7.58% |
| Medium Cap | 66,241 | 6.59% |
| High Cap | 84,354 | 16.72% |
| No Cap | 90,753 | 16.72% |
| Physician Weighted Average | 83,223 | 14.15% |




Source: Analysis of Medical Liability Monitor Data

| | |
|---|---|
| Small Cap - | CA, ID, KS, MT, UT |
| Medium Cap - | AK, CO, HI, IN, LA, MA, MI, MS, ND, OK, SD, WI |
| High Cap - | MD, MO, NM, VA |
| No Cap - | AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY |

TO: Assembly Insurance Committee

FROM: Kim and David Zak

DATE: October 18, 2005

RE: Testimony against caps on damages

We are Kim and David Zak from Crivitz, Wisconsin. We are here today to speak against caps on damages because we have been impacted in a very deep and personal way by malpractice. I want to tell our story.

David is an auto mechanic and was at work flushing out a cooling system, when hot anti-freeze burned his right forearm. The burn was cleaned, but unknown to us, the burn drove Group A Strep bacteria, which is on our skin, into David's bloodstream.

That night David woke up in the middle of the night with chills. He took a Benadryl and went back to sleep. Five hours later he awoke with the shakes. He called me at work and asked that I come home and drive him to the hospital. This was a very unusual request.

I came home and we drove to Green Bay, on the way we stopped and grabbed all the bottles that David had used that day and took with us to the ER. It took about an hour and half to drive. We arrived about 9 a.m.

During the next 3 and half hours, they treated David's burn and did blood work-up, including a CBC. His temperature spiked to 103.9 degrees and his blood pressure was low. They said it would take 24-48 hours for the cultures to grow and prescribed Ibuprofen and Tylenol for the pain and fever, alternatively. We were advised that if conditions didn't worsen to come back in two days.

David spent the rest of the day resting and didn't present any new symptoms. He took a cool bath and his temperature went down a bit.

The hospital called back at 10 p.m. and said something was growing in the cultures and to return to the ER that night or in the morning. We decided to return that night. On the way to the hospital, David started experiencing diarrhea. By the time we reached the hospital, his blood pressure was very low and he was already septic. I could see blood coming out of the penis.

David's organs started shut down – liver, kidneys, and bladder. His lungs were bleeding. He spent three weeks in the hospital on antibiotics. Everything came back, but his bladder. He was required to have tubes inserted into his back, so his urine could drain into bags on his legs. They had to be cleaned everyday and bandaged.

We went to an urologist at the Mayo Clinic to have his bladder removed and a new bladder rebuilt. The new bladder is a neobladder made from his appendix, colon and intestines.
What happened? During the course of our trial we learned that the Physicians Assistant (PA) had done an analysis of the blood called a wet analysis. The result said to do it manually, which would have taken an hour. The PA also told the doctor that David was already septic, yet the doctor said it was April and he had the flu and sent him home without any antibiotics.

What is our life like? We are constantly watching for infections. He is required to use a catheter every time he goes to the bathroom and he is very susceptible to infections.

David must take liquid medication and antacids for metabolic acidosis. He is fatigued.

He suffers from erectile dysfunction. To have an erection he must inject himself with Triple agent. If it doesn't work right and the erection doesn't subside, he must go to the hospital and have it cut and drained.

We had an eight-day trial in Marinette County that gave us $1 million for our pain, suffering and disability. David received $750,000 and I received $250,000. The cap cut down our award over 55%. The compensation recognizes what we will have to go through for the rest of our lives.

Also, I want to point out, if David and I hadn't brought this lawsuit, workers' comp would not be repaid. To date, our case is still on appeal and we haven't received any money to date.

I hope that none of you in this room ever have to be sitting in this place that we are today. A mistake was made that changed our lives forever. It could have happened to anyone here... It still could happen to you.

Please don't enact new caps on damages. It only serves to hurt someone like us.

**Testimony**

**Against Legislation for Re-establishment of Caps for Pain and Suffering Resulting from Medical Malpractice [Room 412E]**

**by**
**Dr. Eric E. Rice**
**Wisconsin Family Justice Network**
**Middleton, WI**

**18 October 2005**

There are many significant medical malpractice issues that need to be resolved to help patients and their families to: gain disclosure of information, have equal rights and legal protection under the law, and seek accountability for medicine that is well below the standard of care. I submit to you that the medical insurance industry is the route of the medical malpractice problems in this country and that is where reform is needed. We should not do more harm to the effected patients by putting caps back. Caps on non-economic damages are a hindrance to finding out the truth and gaining accountability for our citizens.

The Rice Family of Middleton, Wisconsin experienced a medical crisis and loss of our 20-year old daughter, Erin Elisabeth Rice at UW Hospital on April 19, 1999 due to gross misdiagnosis of her illness. This ordeal has identified many significant medical and legal issues that need to be fixed by this legislature. The Wisconsin Family Justice Network, of which I am involved, was formed to fight for all of us, fight for the rights of all patients and our families.

[1] The Network does not support medical malpractice caps and we believe that judges and juries should make those decisions just like in any other civil action.

[2] The Network supports the passage of the Family Justice Bill [ sponsored by Senators Plale, Hansen, and Erpenbach, and Representatives Ott, Sheridan, and Zephick ] that will put all patients on an equal basis and prevent discrimination based on age and marital status.

[3] The Network supports the Repeal of the 180-day Notice Rule [SB-74 - Sponsored by Senator Risser, and Representatives Jenson, Hines, Pocan, Berceau, and Lehman] that UW physicians and lawyers have used to unfairly discriminate against patients that use UW physicians.

Patients/Families that have suffered or died require the right to litigate against physicians, hospitals, HMOs, insurance companies in a standard equal and fair way. The same standards must be utilized for any medical provider within a given state. No unfair advantage must be afforded to one medical provider over another when it comes to the provision or need for malpractice insurance, limits of liability, and notice of claim rules.

The recent low $350,000/$250,000 [with inflation] cap on malpractice/wrongful death non-economic damages limit (in Wisconsin and elsewhere) is totally unconstitutional should not be approved by our legislature. The Wisconsin Supreme Court will declare its flaw once again, if passed; however, I expect that Governor Doyle will veto it.

Until recently, the State of Illinois had no cap on medical malpractice, as the previous caps were declared unconstitutional by the Illinois Supreme Court. The Judges and Juries made those determinations. With no caps, healthcare in Illinois has improved, physicians practiced better medicine, the cost of medicine only increased by 1%, there is much less indirect pain and

suffering, and there is much less indirect adverse economic cost to the people. The bad doctors moved to states with caps! In states where lower caps exist (like Indiana, for example), the quality of medicine is poor, and the greater is the pain and suffering and greater is the unmeasured economic loss of patients and their families. This lower cap may result in patients not being treated with the smartest or heroic measures because it is cheaper for the medical system to simply go through the motions and let the patient die and pay the limited claim in or out of court.

Any cap - at any level - on medical malpractice provides tremendous advantages to the medical practitioner and the insurance company and does a terrible injustice to a victimized patient in either the negotiation of a fair settlement or trial action, if taken. Reinstatement of Caps will only reduce the quality of healthcare that patients receive in this state. If there are problems of frivolous lawsuits, let the juries and judges make the fair decisions. Provide these institutions the tools they need to foster fairness to both the patients and doctors!

The Patient's Compensation Fund is for Patient Compensation. It has ballooned to a whopping $750M and still the insurance companies complain. Even after significant reductions in physician premiums, the fund still grew by $20M last year. The fund is meant to try to make "whole" the patient and families that have been harmed or killed by medical errors and failures.

For cases, usually involving young or older victims, there may be no likely economic claim, the caps on non-economic damages will prevent an action from making it to the court room. I'll explain why. To gain legal representation, a client's case must make sense, economically. If there is a plaintiff win probability of 25% and there is a cap of $400K, that means that the likely economic win would be 25% of $400K which would be a $100K probable result. However, to put on a trial, the out of pocket costs for depositions, testimony of medical experts, travel, etc., will easily reach $100K. Also, the Wisconsin jury trial plaintiff win probability last year was 17% [4 out of 23] in WI. The Lawyer will not take the case because there is not enough likelihood of getting paid any thing for his or her labor. This means that patients like these will never get to the court room to find out what happened. No accountability will ever be achieved.

Just think what you would do if your older parent or your young child died of medical malpractice and no attorney could take the case because of caps, and you could never find out what happened. That's why the caps need not be put back. And that is why the Medical Society and Insurance Company Lobbyists support Caps. Medical Malpractice in this country accounts for less than 0.46% of the total cost of the health care delivery system. Wisconsin had the lowest rate in the nation at less than 0.4%. Who has the correct facts here? We do.

Vote No for Caps

Vote Yes for Family Justice

Vote Yes for repeal of the 180-day Notice Rule.

That's my input -- Thanks for listening!

# FACTS AND REASONS WHY

# THE WISCONSIN FAMILY JUSTICE BILL (SB-467) MUST BE MADE INTO LAW --

# AND

# THE 180-DAY NOTICE RULE FOR MEDICAL MALPRACTICE FOR STATE RUN INSTITUTIONS AND STATE PHYSICIANS MUST BE REPEALED RETROACTIVELY (SB-70)

**3 March 2004**

# FACTS AND REASONS WHY THE WISCONSIN FAMILY JUSTICE BILL (SB-467) MUST BE MADE INTO LAW -- A FACT SHEET FOR THE LEGISLATURE March 3, 2004

**Madison, WI.** Did you know that if your single son or daughter is 18 or older and experiences medical malpractice and dies in Wisconsin that you, as a parent or sibling, will not be able to bring a claim for wrongful death against the wrong doers. Also, did you know if your single parent experiences medical malpractice and dies as a result in Wisconsin, that you as an adult child of that parent will not be able to bring a claim for wrongful death against the wrong doers. You will never find out what really happened, you will never get accountability, you and your family will never see justice. It will be tough to gain closure. Wisconsin law currently discriminates against two classes of people, single young and single elderly.

In this time of "family values", it is totally unbelievable that Wisconsin law does not recognize the life-long, and growing with age, bond between parent and child, regardless of the child's or parent's age and regardless of whether the parent is widowed or divorced. Up until now, the state law has been based on the bottom-line values of the health care providers, insurance companies, physicians' organizations and manufacturers and other big campaign contributors, not the family values held by the majority of Wisconsin citizens.

Wisconsin, of all states, you would think would be supportive of its citizen's rights. Not currently so. Six other states/districts in the US also have discriminating laws like this one, namely, Indiana, Florida, Maine, New Jersey, Maryland, and DC. Victims in these states are also fighting to change the law there to allow equality under the law. Forty-four states do not discriminate!

Wisconsin families who have suffered the loss of a family member due to apparent medical negligence have found the courthouse door slammed shut in their faces. In response, they have formed the Wisconsin Family Justice Network (WFJN).

A group of Wisconsin families, made up of both Republicans and Democrats from all walks of life, who suffered the loss of a family member due to apparent medical negligence, have been fighting to change the Wisconsin law back to what it was prior to 1995. We are a small group of families who now understand what the law means. The rest of the public still doesn't understand. We have few resources, but we must get the message out to the unsuspecting public, voters, media, and work with our legislators to get the law changed! The current WFJN members, their home towns, and their victimized family member are:

Jeanine & Lauren Knox
Milwaukee (mother)

Jim & Donna Harvey
Waterford (mother)

Sandy Gunwaldt
New Berlin (mother)

Stephanie O'Connell
Green Bay (father)

Sherry Ellis
Oak Creek (mother)

Dan & Kim Leister
Mukwonago (daughter)

Roger Fransway
Chippewa Falls (sister)

Bernice Watts
Brown Deer (daughter)

Lonny & Rhonda Brown
Chippewa Falls (son)

Willie Davis
Milwaukee (mother)

John Zachar
Greendale (mother)

Judy Demeuse
Germantown (father)

Carolyn Walasek
Park Falls (mother)

Helen Szurovecz
Milwaukee (mother)

Pam Vertanen
Manitowoc (mother)

Susan Czapinski
Madison (mother)

Patty Schey
Wauwatosa (father)

Steve Janasik
Park Falls (mother)

Harriet Yancey
Milwaukee (father)

Sheryl Holdmann
Milwaukee (mother)

Jake Budrick
Saukville (mother)

Lee Davis
Menomonee Falls (brother)

Ray & Betty Lange
Beaver Dam (son)

Rosemary Halvorson
Readstown (mother)

Peter Torgerson
Colfax (mother)

Anita Harris
Milwaukee (son)

James & Dottie Webb
Whitewater (daughter)

Eric & Linda Rice
Middleton (daughter)

Dimitri Jordan
Milwaukee (mother)

James Bollig
Cottage Grove (father)

Sharon Kind
West Bend (mother)

Jonna Fedie
Hammond (mother)

Mary McBride
Madison (father)

Mack Kirksey
Brown Deer (mother)

Mary Siedschlag
Argyle (mother)

Kathleen Sese
Kewaskum (son)

Lee Brown
Milwaukee (mother)

Taron Monroe
Milwaukee

Michelle Martin
Green Bay (mother)

Phil Tipke
Cottage Grove (son)

Jeanne Hanson
Neenah (son)

Sister of Jackie Hemenway
Twin Lakes (father)

Mark Lavalle
Twin Lakes (mother)

Lisa Jacobsen
Darlington

The focus of the Wisconsin Family Justice Network (WFJN)—growing since being formed five years ago to over 45 families across the state—is now turning to the State Legislature, where Network members are working to build bi-partisan support for the passage of the Wisconsin Family Justice Bill (SB-467) and other legislation. This is not a political issue! Republicans and Democrats together should recognize that this problem needs fixing as soon as possible. We will not stop our efforts until we get the Wisconsin Family Justice Bill passed by the legislature and signed by the Governor -- our motto is *"We Will Not Stop Until Justice and Accountably is Available to all Wisconsinites"*. The bill is aimed at closing loopholes in current state malpractice law. In 2002, this bill passed the Senate, but failed to be put up in the Assembly.

A barrage of "mis-information" by opponents of the Wisconsin Family Justice Bill may again be upon us. Those trying to protect the unfair status quo will claim that Wisconsin's insurance rates will go up and that we will see doctors leaving the state or refusing to practice in nursing homes. But, malpractice costs are about one-half of one percent (0.55%) of all medical costs, so the claims of skyrocketing medical costs were plain ridiculous. 44 other states allow all families to have legal rights in malpractice cases, and they have not suffered any loss of doctors willing to practice.

Private malpractice insurance carriers are very healthy. The loss ratios for malpractice insurers from 1995 to 2000 are very low. During this period, the average loss ratio is 18. That is only 18¢ of every dollar the insurance company estimates it will pay on all malpractice claims. In addition, private physicians are compelled by state law to pay into the patient's medical compensation fund every year (roughly $30 to 55M per year). The fund now has grown to over $678,000,000. Because it is so big, the Governor wants to take some of this surplus to help the state's budget problems. These insurance rates should be going down! But they are not – why?

The Wisconsin Family Justice Network suggests that once you, as a representative of the people of this great State of Wisconsin, honestly consider the thoughts below that you will be compelled to support the Wisconsin Family Justice Bill. Try answering the questions below and we think you will understand exactly what we are fighting for.

- Do you believe that the bond between you and your parent and you and your child is life-long, and not eroded by age or marital status, but actually grows with age? Ponder that thought for a minute.
- How would you deal with the awful prospect of the loss of your own 18-year old son or daughter due to gross medical errors? How would you react with the fact that you can't get any legal representation because you are not allowed to have a wrongful death case under current Wisconsin law?
- Consider the prospect of the loss of your mother or father due to medical errors in a simple medical procedure and you can't get answers, accountability or justice.
- How would you deal with the fact that you can't get any attorney to take your case because of the current law constraints and limits?
- Do you feel comfortable with Wisconsin being one of ***just 6 states of 50*** that make arbitrary distinctions in legal rights, based on the age and marital status of the victim?
- Think about this, do you have less love? less compassion? less affection? or less connection to your family members when they become 18 or even when they become 60 years old?
- And finally, was it really the intent of the Wisconsin State Legislature to implement an biased and discriminating law that denies equal protection that says your loving son or daughter, over 17 years old and your single mother or father has **ABSOLUTELY NO VALUE.**

The Wisconsin Family Justice Network and the rest of the citizens of this state simply want a single standard of access to the courts and accountability for all citizens. It is a fundamental matter of equity and equality; the current law is biased, discriminating and totally unfair and must be changed!

# FACTS AND WHY
# THE 180-DAY NOTICE RULE FOR MEDICAL MALPRACTICE FOR STATE RUN INSTITUTIONS AND STATE PHYSICIANS MUST BE REPEALED RETROACTIVELY (SB-70)
## March 3, 2004

**Madison, WI.** Did you know that if you are treated by physicians at UW Hospital & Clinics or UW Health/Physicians Plus and medical malpractice results in injury or death to your family member, you will not likely be able to bring a claim forward unless you have given notice to the state attorney general within 180 days after the event occurs? The current statute allows for discovery after this period; however, the most all the courts (case law) have made this tough to do. If you are late with your notice, not only will it be difficult or impossible to ever bring a case, but you may never find out what really happened, you and your family will never see justice, and the physicians won't talk and will never be held accountable for any of their errors/mistakes. Wisconsin law favors state physicians over private ones. Did you also know that state-employed physicians do not have to pay medical malpractice insurance? The state self-insures them. Private physicians and organizations remain outraged by this and the 180-day notice rule.

Again, Wisconsin families who have suffered the loss of a family member due to apparent medical negligence have found the courthouse door slammed shut in their faces.

A group of Wisconsin families, made up of both Republicans and Democrats, who suffered the loss of a family member due to apparent medical negligence have been fighting hard to fix Wisconsin law. We are a small group of families and we have few resources, but we must get the message out to the unsuspecting public, voters, media, and work with legislators to get the law changed!

The focus of the Wisconsin Family Justice Network (WFJN)—growing since being formed five years ago to over 45 families across the state—is now turning to the State Legislature, where Network members are working to build bi-partisan support for the passage of the Wisconsin Family Justice Bill and now, the repeal of the 180-day notice rule for medical malpractice by state healthcare employees. These are not political issues! Republicans and Democrats together should recognize that these problems need fixing as soon as possible. We will work to get the retroactive repeal of the 180-day notice bill passed by the legislature and signed by the Governor. Senator Fred Risser, a Democrat, has agreed with Dr. Eric Rice, a Republican constituent of Senator Riser, to again to whole heartedly sponsor this year's bill. Last year, it passed the Senate by voice vote, but never was introduced to the Assembly.

The Wisconsin Family Justice Network suggests that once you, as a representative of the people of this great State of Wisconsin, honestly consider the thoughts below that you will be compelled to support the repeal of the 180-day notice for medical malpractice claims for state healthcare employees.

- For example, how would you deal with the awful prospect of the loss of a loved one due to gross medical errors at UW Hospital? After much grief, you finally get around to talking with an attorney and then the attorney tells you how sorry he or she is, but you missed the 180-day notice deadline and your potential legal claim is now likely void! You, like almost everyone, thought you had 3 years to respond. This happens all the time to grieving families!

- How would you react to the fact that you can't get any legal representation because you are not likely to have a case under this current Wisconsin law if you are late with your notice of claim?
- Was it really the intent of the Wisconsin State Legislature to implement a biased law that denie Wisconsin citizens their rights for justice and accountability?
- How are you ever to know about the 180-day notice rule? Have you ever heard of it before? The public does not know. Check out your constituents – ask them if they know. We would bet that none do, except us and our close friends.
- If you loose a loved one at the UW Hospital, do they tell you have only 180 days to file a claim for malpractice with the Attorney General's Office? No. Of all the forms one has to sign in the hospital, is there a form that you sign in the hospital that says you have 180 days to file a notice of claim if the hospital were to perform malpractice? No!
- Private health care providers (HMO's etc.) and UW co-mingle their employees at the HMO and UW Hospital facilities. How do you really know which physician is a UW employee and which one is with the HMO private provider? Which ones do you give notice to, if you knew of the rule?
- If medical malpractice occurs, it seems to take forever to get a copy of the medical records. This cuts into your time to assess and decide if you have a claim or not with the 180-day rule. We don't need to be filing notices of claim if we are not sure! Time is needed to assess the medical records and have other expert physicians review what happened.
- For sure, the 180-day rule is likely never to be known by a grieving family.
- One should believe that there should be fairness and equal protection under the law for all Wisconsinites, regardless of what hospital they go to, but is not currently the case.
- It's obvious that this law is aligned to protect the insurance companies and the UW physicians; not the patients and their families. The law is biased to benefit state employees and state-run medical facilities.
- Private physicians are outraged by this discrimination and that the State self insures them at no cost.

The Wisconsin Family Justice Network and the rest of the citizens of this state simply want a single standard of access to the courts and accountability for all citizens. It is a fundamental matter of equity and equality; the current law is biased, discriminating and totally unfair and must be changed! The retroactive repeal of the 180-day notice for state medical employees needs to be made ASAP so more people are not totally defeated by this unfair and biased favoritism.

**STATEMENT**

**By**

**ROBERT E. PHILLIPS, M.D.**
**GENERAL INTERNAL MEDICINE DEPARTMENT**
**MEDICAL DIRECTOR, GOVERNMENT RELATIONS**
**MARSHFIELD CLINIC**

**BEFORE THE**
**ASSEMBLY COMMITTEE ON INSURANCE**

**18 OCTOBER 2005**

Chairperson Nischke and members of the Assembly Committee on Insurance, I am Doctor Robert Phillips, a practicing general internist and Medical Director of Government Relations for the Marshfield Clinic. I am here representing the 722 physicians and other healthcare providers in the Marshfield Clinic system. Thank you for the opportunity to testify in support of AB 766.

Marshfield Clinic's mission is to provide accessible high-quality healthcare, research, and education to all who access our system. Marshfield Clinic cares for all who seek our care regardless of their ability to pay. The repeal of caps on non-economic damages by the Wisconsin Supreme Court in the Ferdon vs. Wisconsin Patients Compensation Fund in June of this year has already begun to impact our system of care. Within days after this decision, Marshfield Clinic was notified by a plaintiff's attorney with an open claim against us that he was doubling damages in the case. Because of our self-funded primary medical malpractice insurance program for our physicians and staff, Marshfield Clinic is required by the Office of the Commissioner of Insurance to set aside reserves to cover possible claims. On September 28, 2005, Marshfield Clinic deposited an additional $900,000 into its trust fund to meet its funding requirement. This amount was determined to be necessary by the Clinic's independent actuary.

In 2004, Marshfield Clinic paid $1.8 million as assessments for its physicians and staff to the Injured Patients and Families Compensation Fund (IPFCF). The Fund provides coverage in excess of that provided by the Clinic's self-insurance plan. Although currently unknown, there is speculation that Fund assessments could as much as double over the next couple of years, which could require the Clinic to pay an additional $1.8 million to the IPFCF. The combination of the Clinic's self-insurance plan increased reserves and increased IPFCF assessments represents the amount that could be used to purchase a new $1.6 million linear accelerator for radiation oncology to treat cancer patients, a new $1 million CT scanner which would be used for diagnosing and following response to treatment of cancer patients and for diagnosis of other serious medical conditions, and a $600,000 digital mammogram machine which is used for breast cancer screening and diagnosis of early stages of breast cancer. Patient with cancer are often very ill with limited energy. Marshfield Clinic tries to bring cancer care closer to home for its patients because this facilitates more timely patient-centered healthcare.

In previous testimony, Marshfield Clinic pointed out the challenges of recruiting physicians, primary care and specialty positions, to our northern service areas. Stability of the medical malpractice insurance environment is important to physicians from out-of-state and our own resident physicians who are considering practicing within our system. Access to obstetrician/gynecologists, emergency room physicians, and specialty surgeons is very important to ensure that citizens in rural Wisconsin receive the same high-quality healthcare their urban counterparts do. As of September 30, 2005, the Clinic was recruiting 97 physicians in 43 different specialties. Marshfield Clinic finally recruited a pediatric general surgeon to its Marshfield Center after a 6-year search. On average time to recruit and fill positions in our rural centers is between 3-4 years. Recently, a vascular surgeon and nuclear medicine physician from out of state inquiring about positions in our system asked what impact the loss of caps on non-economic damages would have.

Marshfield cares for all who come to us regardless of their ability to pay, that includes the uninsured, Medicare, Medicaid, and BadgerCare patients on an unlimited basis. In two counties in north central Wisconsin in fiscal year 2004, Marshfield Clinic cared for 82% of the eligible

Medical Assistance patients and in another county 57% of eligible Medical Assistance patients. Because government sponsored healthcare programs cannot pay fully the cost of care, healthcare organizations like Marshfield Clinic will need to prioritize new service development vs. provision of healthcare services.

Because of our not-for-profit tax status, Marshfield Clinic invests net revenues in infrastructure development, new equipment, new clinical services, research, and/or student and resident education. Marshfield Clinic has invested millions of dollars since the early 1990s in an integrated computerized medical record linking all 41 of our centers, which includes physician's notes, consultations, lab, x-ray results, and electrocardiograms (EKG's). A clinical decision support service will link individual providers to the latest standards of medical treatment to ensure that patients receive the most current evidenced-based healthcare. A medication management program is providing a single medication portal with drug interaction and allergy warning software built in to ensure safe drug prescribing. A patient web portal currently allows patient access to immunization records, appointments, and lab results. These initiatives are examples of infrastructure development the Marshfield Clinic has invested in to enhance patient care. Diverting revenues to medical malpractice self-insurance reserves and IPFCF assessments will adversely affect development of new technologies.

Marshfield Clinic, a founding member of the Wisconsin Collaborative for Health Care Quality, is committed to ongoing public reporting of validated health outcomes, both quality and cost of care, so that government and private purchasers ultimately will pay differentially for quality healthcare and achieve value in services provided. Marshfield Clinic is concerned that the repeal of non-economic caps will impede healthcare organizations' willingness to report publicly quality of care institutionally and even individually. Our commitment to quality is predicated on the Institute of Medicine's six aims, healthcare that is safe, patient centered, timely, effective, efficient, and equitable.

Marshfield Clinic supports AB 766 because it will provide reasonable caps on non-economic damages in medical malpractice judgments based on age. The combination of reasonable caps on non-economic damages and the IPFCF's unlimited coverage for economic damages will ensure that limited healthcare resources can be invested in information technology for quality reporting, new clinical services and access to healthcare for all Wisconsin citizens.

Thank you again for the opportunity to testify.

I will be pleased to address any questions the committee might have.

Robert E. Phillips, M.D.

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*A System for Life*

**TO:** Assembly Committee on Insurance

**FROM:** Ralph V. Topinka, Vice President & General Counsel
Mercy Health System
Janesville, Wisconsin

**DATE:** October 18, 2005

**SUBJECT:** Testimony Regarding - AB764 (Collateral Source) AB765 (Medical Residents) AB766 (Medical Malpractice Caps)

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## INTRODUCTION

Mercy Health System is an integrated health care delivery system that provides physician, hospital, nursing and other health care services to residents in Southern Wisconsin and Northeastern Illinois. Mercy employs more than 3,300 individuals, including approximately 1,250 persons who are licensed or certified health care professionals, more than 250 physicians and more than 650 registered nurses. We provide clinic-based services in 39 community clinics located in six counties in Wisconsin and Illinois. Our clinics range from single physician practices to large multi-specialty centers with ambulatory surgery, urgent care services and various diagnostic services.

Please accept our strong support for Assembly Bills 764, 765 and in particular, 766. Assembly Bill 764 modifies the collateral source rule to reflect a common sense approach to awarding damages in medical malpractice actions, that is, making sure that claimants recover only once for the same item of damages. Similarly, AB 765 is a sound approach to making sure that residents in training, and their employers, may participate in the Injured Patients and Families Fund and may have the protection of caps on non-economic damages that apply to other health care providers.

## CAPS ON NON-ECONOMIC DAMAGES

The main focus of my testimony today is Assembly Bill 766. This bill restores caps on non-economic damages in medical malpractice cases.

Unlike patients in most states, patients in Wisconsin who make successful claims for medical malpractice can be assured that they will receive financial compensation. That is because in Wisconsin, health care providers by law must obtain medical malpractice

insurance, and must participate in the Injured Patients and Families Compensation Fund (the "Fund"). The combination of providers' malpractice insurance and the Fund means that in Wisconsin, successful malpractice claimants will receive their full economic damages, less costs and attorneys fees. As we are aware, until the recent *Ferdon* decision, there was a statutory cap on recovery of non-economic damages. Even with the cap, however, plaintiffs could recover hundreds of thousands of dollars in non-economic damages in addition to unlimited economic damages.

There are a variety of reports and actuarial studies that demonstrate certain basic facts about the Wisconsin medical malpractice marketplace. These facts include:

- Wisconsin's malpractice insurance market compares favorably to other states in terms of affordability of insurance;
- States with caps on non-economic damages generally have more affordable malpractice insurance and loss ratios;
- States with low to medium caps are more likely to have favorable malpractice insurance markets.

Wisconsin's careful legislative balance--mandatory malpractice insurance and participation in the Fund, unlimited Fund protection for malpractice awards and settlements, and reasonable caps on non-economic damages--has contributed to Wisconsin's favorable malpractice insurance market. This is just one of the reasons we believe maintenance of a cap on non-economic damages in medical malpractice actions is critical.

In his concurring opinion in *Ferdon*, Supreme Court Justice Patrick Crooks emphasized that "statutory caps on noneconomic damages in medical malpractice cases, or statutory caps in general, can be constitutional." While finding the caps created by the Legislature in 1995 unconstitutional, Crooks concluded, "Wisconsin can have a constitutional cap on noneconomic damages in medical malpractice actions, but there must be a rational basis so that the legislative objectives provide legitimate justification, and the cap must not be set so low as to defeat the rights of Wisconsin citizens to jury trials and to legal remedies for wrongs inflicted for which these should be redress." We believe Assembly Bill 766 meets these standards.

The majority opinion in *Ferdon* recognized that, according to a study by the U.S. General Accounting Office, a shortage of physicians existed in rural locations in states without limitations on damage awards. Further, the majority recognized that malpractice pressures are among the factors that affect the availability of services.

There are a number of reports that outline Wisconsin's current and increasing shortage of physicians. Given Wisconsin's aging population and other changing demographics, the retention and recruitment of physicians are crucial in order to provide sufficient access to health care. In addition, there are studies that have found that the retention and

recruitment of physicians, especially in rural and urban areas, are more successful in states that have stable and affordable medical liability insurance rates.

One of Mercy Health System's primary goals is to provide health care services in communities where the services are needed. In order to do that, we work diligently to recruit and retain high quality physicians. In light of a national shortage of physicians, recruitment and retention of physicians is always a difficult task.

Wisconsin has historically enjoyed a stable medical malpractice climate. Because we provide physician services both in Wisconsin and Illinois, Mercy has a good appreciation and perspective on the advantages of a stable medical malpractice climate. We have first hand experience with physicians who have left their practices in Illinois, some of them come to Wisconsin, because of the historically unfavorable Illinois medical malpractice climate. Our favorable malpractice climate has helped our recruitment and retention efforts.

## CONCLUSION

As recognized by the Court in *Ferdon*, Wisconsin currently enjoys a stable and affordable medical liability environment. We believe that reasonable caps on non-economic damages in medical malpractice actions contribute to that environment. Based on actuarial analyses of the insurance exposure amount that would provide stable and affordable insurance rates and studies of the caps in other states, we believe a cap no greater than $550,000 will help maintain Wisconsin's current positive environment. On the other hand, based on the same and other studies, it is reasonable to conclude that a cap or limitation in an amount above $550,000 would have a negative impact on that environment. The studies and actuarial analyses indicate that a high cap or limitation would not provide the same predictability, stability, or affordability as a low or medium cap.

Coupled with assurances of recovery through mandatory malpractice insurance for health care providers and mandatory participation in the Fund, Assembly Bill 766 is a sound and rational approach to ensuring a stable malpractice environment and improving access to health care in Wisconsin by stabilizing or increasing the supply of physicians in Wisconsin and encouraging physicians and hospitals to provide health care services in rural and urban areas.

# Wisconsin Society of Podiatric Medicine, Inc.

To: Chairperson Ann Nischke and Members of the Assembly Insurance Committee

From: Kevin Kortsch, DPM
Executive Director

Date: Tuesday, October 18, 2005

Re: Support for Medical Malpractice Reform Legislation
- AB 764 and AB 766

The statewide membership of the Wisconsin Society of Podiatric Medicine urges you to **support** and **favorably advance** AB 764 and AB 766. These proposals well balance the interests of health care consumers and health care providers. Taken together, the bills afford injured consumers with appropriate redress for valid malpractice claims. At the same time, health care providers, including doctors of podiatric medicine and surgery, can practice without having to be worried about excessive claims of medical malpractice.

Today, Wisconsin law requires podiatrists to have malpractice insurance coverage. It is a condition of licensure in Wisconsin.

Doctors of podiatric medicine and surgery purchase malpractice insurance in the private sector. Typically the carrier is one that has podiatry advisors regarding claims and premiums. Valid claims for reasonable amounts are settled promptly, while others are disputed. While the number of claims against podiatrists is not increasing, the amounts sought (claim severity) have been increasing.

To conclude, AB 764 and AB 766 are reasonable support their passage and respectfully request your assistance in that regard.

Dr. Kevin Kortsch
Executive Director
dr_kortsch@juno.com
(262) 521-9108

CTCW
Civil Trial Counsel of *Wisconsin*
1123 N. Water St. Milwaukee, WI 53202 phone: 414-276-1881 fax: 414-276-7704 www.ctcw.org

TO: Members, Assembly Committee on Insurance

FROM: Jim Hough, Legislative Director

DATE; October 18, 2005

**RE: Support for AB 766**

On behalf of the Civil Trial Counsel of Wisconsin (CTCW), I commend the excellent work of the Speaker's Task Force on Medical Malpractice, chaired by Rep. Gielow.

Three recent Wisconsin Supreme Court cases and the fact that Wisconsin law is out of sync with most of the country on expert opinion evidence and the standard for determining strict/product liability, have seen our national ranking for "litigation atmosphere" plummet, creating a true liability crisis in our state. We need a comprehensive response to this crisis to restore a favorable legal environment that impacts on business and personal expansion and location decisions.

Assembly Bill 766 responds to the *Ferdon* decision issued by the Court in July of this year and which struck down the caps on noneceonomic damages in medical malpractice cases which were adopted by the Wisconsin Legislature in 1995. As one who was involved in the 1995 legislation, I can assure you that the Wisconsin Legislature adopted the caps in direct response to legitimate concerns regarding the cost of medical malpractice insurance, availability of medical services, defensive medicine and overall health care costs.

In my personal opinion, the Supreme Court, in the majority opinion in *Ferdon*, demonstrated a blatant desire to legislate and/or a fundamental lack of understanding of how the legislative process operates in establishing public policy.

Assembly Bill 766 is reasonable and rational and we respectfully urge your support.

[CTCW is a statewide organization of trial lawyers engaged primarily in the defense of civil litigation. Past President Mary Wolverton served as a member of the Speaker's Medical Malpractice Task Force.]


# Wisconsin Economic Development Association Inc.

TO: Members, Assembly Committee on Insurance

FROM: Jim Hough, Legislative Director &
Peter Thillman, President

DATE; October 18, 2005

**RE: Support for AB 766**

On behalf of the Wisconsin Economic Development Association (WEDA), we commend the excellent work of the Speaker's Task Force on Medical Malpractice, chaired by Rep. Gielow.

Three recent Wisconsin Supreme Court cases and the fact that Wisconsin law is out of sync with most of the country on expert opinion evidence and the standard for determining strict/product liability, have seen our national ranking for "litigation atmosphere" plummet, creating a true liability crisis in our state. We need a comprehensive response to this crisis to restore a favorable legal environment that impacts on business and personal expansion and location decisions.

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In our opinion, the Supreme Court, in the majority opinion in *Ferdon*, demonstrated a blatant desire to legislate and/or a fundamental lack of understanding of how the legislative process operates in establishing public policy.

Assembly Bill 766 is reasonable and rational and we respectfully urge your support.

[WEDA is a statewide organization of over 400 economic development professionals who advocate policies beneficial to Wisconsin's economy and that encourage retention expansion and location of businesses within and into our state.]

PEOPLE • JOBS • PROFITS
4600 American Parkway, Ste. 208 Madison, WI 53718 608-255-5666

*Wisconsin Coalition for Civil Justice*

TO: Members, Assembly Committee on Insurance

FROM: Jim Hough, Legislative Director &
Bill Smith, President

DATE; October 18, 2005

**RE: Support for AB 766**

On behalf of the Wisconsin Coalition for Civil Justice (WCCJ), we commend the excellent work of the Speaker's Task Force on Medical Malpractice, chaired by Rep. Gielow.

Three recent Wisconsin Supreme Court cases and the fact that Wisconsin law is out of sync with most of the country on expert opinion evidence and the standard for determining strict/product liability, have seen our national ranking for "litigation atmosphere" plummet, creating a true liability crisis in our state. We need a comprehensive response to this crisis to restore a favorable legal environment that impacts on business and personal expansion and location decisions.

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In our opinion, the Supreme Court, in the majority opinion in *Ferdon*, demonstrated a blatant desire to legislate and/or a fundamental lack of understanding of how the legislative process operates in establishing public policy.

Assembly Bill 766 is reasonable and rational and we respectfully urge your support.

[WCCJ is a statewide coalition of organizations dedicated to fairness and equity in our civil justice system. A list of members is attached.]

*Wisconsin Coalition for Civil Justice*

## WCCJ Members

**October 18, 2005**

American Council of Engineering
American Insurance Association
Associated Builders & Contractors of Wisconsin
Associated General Contractors of Wisconsin
Building Industry Council
Civil Trial Counsel of Wisconsin
Community Bankers of Wisconsin
National Federation of Independent Business
Petroleum Marketers of Association of Wisconsin
Professional Insurance Agents of Wisconsin
Tavern League of Wisconsin
Wisconsin Asbestos Alliance
Wisconsin Association of Consulting Engineers
Wisconsin Association of Health Underwriters
Wisconsin Auto & Truck Dealers Association
Wisconsin Builders Association
Wisconsin Economic Development Association
Wisconsin Federation of Cooperatives
Wisconsin Grocers Association
Wisconsin Health Care Association
Wisconsin Health & Hospital Association
Wisconsin Institute of CPA's
Wisconsin Insurance Alliance
Wisconsin Manufacturers & Commerce
Wisconsin Medical Society
Wisconsin Merchants Federation
Wisconsin Mortgage Bankers Association
Wisconsin Motor Carriers Association
Wisconsin Paper Council
Wisconsin Petroleum Council
Wisconsin Realtors Association
Wisconsin Restaurant Association
Wisconsin Society of Architects
Wisconsin Society of Land Surveyors
Wisconsin Transportation Builders Association
Wisconsin Utilities Association
Wisconsin Utility Investors

**Catherine Mode Eastham, Esq.**
*Vice President & General Counsel*

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Froedtert & Community Health

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ceastham@fmlh.edu

October 17, 2005

Representative Ann Nischke
Chair, Assembly Committee on Insurance
Wisconsin State Assembly

Ms. Nischke:

I am writing in support of 2005 Assembly Bill 765, which makes changes to the statutes covering the Injured Patients and Families Compensation Fund. The proposed changes directly affect the many residents who participate in training programs at Froedtert Hospital and who are employed by the Medical College of Wisconsin Affiliated Hospitals ("MCWAH"), of which Froedtert is a member. Assembly Bill 765 fills a gap in the Patient Compensation Fund statutory structure and the licensure structure for certain residents. The legislation will codify current practice used by the Fund and continue to support the excellent training we have for medical professionals in Wisconsin.

Background

As Chapter 655 is currently written, there is an ambiguity as to whether the Injured Patients and Families Compensation Fund ("Fund") covers medical residents before they have been licensed by the Medical Examining Board. This ambiguity was an issue in the recent Wisconsin Supreme Court ruling in *Phelps v. Physicians Insurance Co,* 2005 WI 85. The Fund currently covers certain identified health care providers, primarily licensed professionals such as physicians and registered nurses. It also provides coverage for employees of hospitals and other health care providers. In *Phelps,* the Court concluded that these residents who are not yet licensed physicians are not health care providers covered by the Fund. The Court did not determine whether these residents could be considered employees of a hospital, however, which would have given them Fund coverage.

Residents involved in the programs of The Medical College of Wisconsin and MCWAH are not a traditional employee of any hospital. These residents are employed by MCWAH, which has employment contracts with the residents and provides the payroll, benefits, and liability insurance for the residents.

The Fund recently issued an administrative determination that these residents can be considered employees of an affiliate of a hospital providing health care services to the patients of that affiliated hospital. The determination has never been tested in court, however, and we feel a statutory clarification would be better protection for these physicians-in-training.

There is also a gap in the statute as to the granting of temporary educational permits for first year residents. The statutes provide that the permit can be obtained only after completion of 12 months of training in an accredited medical education program. During that 12-month period, it is not clear what status that resident has.

Also, it is after 12 months of training when a resident may apply and take the examinations to obtain a license to practice medicine. Residents who follow this approach may never hold a temporary educational permit.

Proposed Change

The change to Chapter 655 contained in Assembly Bill 765 adds another entity that can be covered by the Fund: a "graduate medical education program." MCWAH would qualify as such a program and as such could *statutorily* obtain coverage under the Fund for its employees. Even if a court were to over turn the administrative decision of the Fund to cover the MCWAH residents, the statute would provide coverage.

In addition, the Bill changes the rules to require that a temporary educational permit be obtained before a medical school graduate can participate in a residency program.

We support 2005 Assembly Bill 765 because it codifies current practice with respect to Fund coverage and will protect Wisconsin as a good location for residency programs. These benefits will help the state continue to attract quality residents to train here and eventually provide care to Wisconsin residents.

Thank you for your consideration.

Sincerely,

Catherine Mode Eastham
Vice President and General Counsel

WISCONSIN
CITIZEN ACTION

*The State's Largest Public Interest Organization*

**Wisconsin Citizen Action Testimony before the**

**Assembly Committee on Insurance**

**In Opposition to AB766**

My name is Darcy Haber and I am the Health Care Campaign Director for Wisconsin Citizen Action. Thank you for the opportunity to testify today in opposition to AB766. Wisconsin Citizen Action believes that putting a cap on the pain and suffering of patients injured by malpractice is simply cruel and immoral – there is perhaps no more appropriate use for the term," adding insult to injury."

Moreover, we have not seen any credible evidence to justify such cruelty in the name of holding down health care costs. I believe the Wisconsin Academy of Trial Lawyers will be testifying further on why this is so, and I don't want to waste your time saying the same thing. I will leave the details of that issue to them. I would like to talk just briefly about the bigger picture. While I understand we are not here to talk about the larger health care crisis in Wisconsin, leaders of this legislation have claimed that somehow adding this insult to injured patients will somehow ease our health crisis.

This is simply untrue. Malpractice costs represent less than .04% of health care costs in Wisconsin. The sponsors of this legislation are simply misguided if they are attempting to ameliorate our health care crisis with this legislation. In the latest ratings by Expansion Management Magazine (2/14/05), the magazine the business executives read when deciding where to locate their business, Wisconsin was rated the best (lowest) in terms of medical malpractice rates and the second worst (highest) in terms of health insurance premiums. But unfortunately we aren't here today to talk about health insurance premiums.

→PTO

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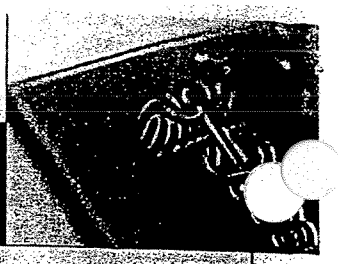
We *are* here today to talk about the unfortunate patients – the real people and families who will testify here today. Can we really look them in the eye and say that we are sorry this terrible thing happened to your family but we do need to make the whole situation even worse for you because we think it might help hold down premiums on malpractice, which represent .04% of Wisconsin health care costs? I know I couldn't do that.

For the reasons mentioned above, the legislation before you will not survive constitutional scrutiny and will be struck down as firmly as the other cap.

The malpractice task force was hoping to find a magic number that would make the caps constitutional but discovered there was no such number.

Because in Wisconsin justice belongs to the people, not insurance companies.

Thank you for your attention today.



# EXPANSION MANAGEMENT'S
# 2005 HEALTH CARE COST QUOTIENT™

**All rankings are from 1 (best) to 50 (worst).**

| 2005 HQ Rank | STATE | Health Care Facilities Ranking | Health Care Providers Ranking | Health Insurance Costs Ranking | Health Care Provider Visit Costs Ranking | Malpractice Costs Ranking |
|---|---|---|---|---|---|---|
| 1 | Kansas | 36 | 19 | 3 | 14 | 13 |
| 2 | Tennessee | 10 | 26 | 9 | 6 | 32 |
| 3 | Louisiana | 22 | 33 | 36 | 2 | 3 |
| 4 | North Dakota | 30 | 11 | 17 | 8 | 24 |
| 5 | South Dakota | 21 | 16 | 17 | 17 | 18 |
| 6 | Missouri | 7 | 25 | 6 | 8 | 41 |
| 7 | Ohio | 2 | 15 | 16 | 4 | 43 |
| 8 | Iowa | 16 | 13 | 12 | 19 | 28 |
| 9 | California | 16 | 28 | 4 | 44 | 4 |
| 10 | Alabama | 14 | 40 | 13 | 7 | 29 |
| 11 | Pennsylvania | 1 | 8 | 42 | 1 | 31 |
| 12 | Nebraska | 31 | 9 | 38 | 11 | 10 |
| 12 | Virginia | 24 | 22 | 13 | 27 | 16 |
| 14 | Michigan | 8 | 27 | 26 | 19 | 17 |
| 15 | South Carolina | 44 | 43 | 2 | 32 | 7 |
| 16 | Rhode Island | 40 | 5 | 17 | 31 | 15 |
| 17 | Utah | 44 | 36 | 11 | 13 | 22 |
| 18 | Arkansas | 28 | 43 | 17 | 3 | 36 |
| 18 | Indiana | 18 | 35 | 34 | 29 | 2 |
| 18 | Kentucky | 14 | 31 | 24 | 5 | 40 |
| 21 | Hawaii | 42 | 12 | 1 | 47 | 19 |
| 21 | Minnesota | 6 | 4 | 41 | 40 | 8 |
| 23 | Vermont | 43 | 2 | 17 | 43 | 14 |
| 24 | Montana | 24 | 30 | 5 | 36 | 30 |
| 24 | Wisconsin | 12 | 10 | 49 | 37 | 1 |
| 26 | Arizona | 27 | 45 | 9 | 22 | 34 |
| 27 | New Mexico | 50 | 45 | 15 | 34 | 5 |
| 28 | Massachusetts | 13 | 1 | 44 | 41 | 11 |
| 29 | Mississippi | 34 | 48 | 8 | 10 | 47 |
| 30 | Oklahoma | 38 | 49 | 40 | 15 | 9 |
| 31 | Colorado | 23 | 34 | 36 | 38 | 6 |
| 32 | Maryland | 26 | 18 | 34 | 41 | 12 |
| 32 | Texas | 9 | 47 | 31 | 12 | 38 |
| 34 | New Hampshire | 46 | 7 | 39 | 23 | 21 |
| 35 | Oregon | 36 | 24 | 6 | 49 | 26 |
| 36 | Idaho | 48 | 41 | 17 | 30 | 20 |
| 37 | North Carolina | 19 | 23 | 25 | 32 | 35 |
| 38 | Georgia | 11 | 42 | 26 | 16 | 45 |
| 39 | Delaware | 47 | 29 | 30 | 25 | 23 |
| 39 | New York | 3 | 13 | 42 | 27 | 39 |
| 41 | Maine | 32 | 6 | 50 | 23 | 25 |
| 42 | Illinois | 3 | 19 | 47 | 18 | 44 |
| 43 | Florida | 3 | 37 | 32 | 21 | 48 |
| 44 | Washington | 29 | 19 | 26 | 48 | 37 |
| 45 | Alaska | 49 | 39 | 17 | 50 | 26 |
| 46 | Connecticut | 33 | 3 | 45 | 45 | 33 |
| 47 | New Jersey | 20 | 17 | 48 | 39 | 42 |
| 48 | West Virginia | 35 | 32 | 45 | 25 | 50 |
| 49 | Wyoming | 40 | 37 | 32 | 35 | 49 |
| 50 | Nevada | 38 | 50 | 26 | 46 | 46 |

Sunday

# LEADER-TELEGRAM

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EMBATTLED SURGEON

# Questionable operation

## *Concerns raised over doctor's numerous malpractice suits*



**By Traci Gerharz Klein, Eric Lindquist and Dan Holtz**
Leader-Telegram staff

Since coming to Eau Claire 5 ½ years ago, Dr. Thomas V. Rankin has been the target of more than twice as many malpractice claims as any other neurosurgeon in Wisconsin, according to a Leader-Telegram investigation.


Narotzky


Immerman


Steans

Rankin, 57, who performs spine and brain surgery at Sacred Heart Hospital, has been sued 11 times in the past three years. An Eau Claire County jury found him negligent in one case, and three cases were settled out of court. The remaining seven cases are pending.

"I don't think you will find one other person in the whole world, who is a neurosurgeon, who has this pattern," said Menomonie attorney Michael Wagner, who has represented clients with claims against Rankin. "I think it's unusual for any physician, regardless of his specialty."

Rankin denied all charges but would not comment directly on the lawsuits. He conceded that 11 suits in three years are a lot but blamed another neurosurgeon's allegations — not his own actions — for prompting the string of claims in Eau Claire.

Rankin has had 12 claims against him registered with the state agency that handles malpractice cases since he began practicing at Sacred Heart in October 1993. No other Wisconsin neurosurgeon had more than five malpractice claims in the same period, according to the state Medical Mediation Panels, a division of the Supreme Court of Wisconsin.

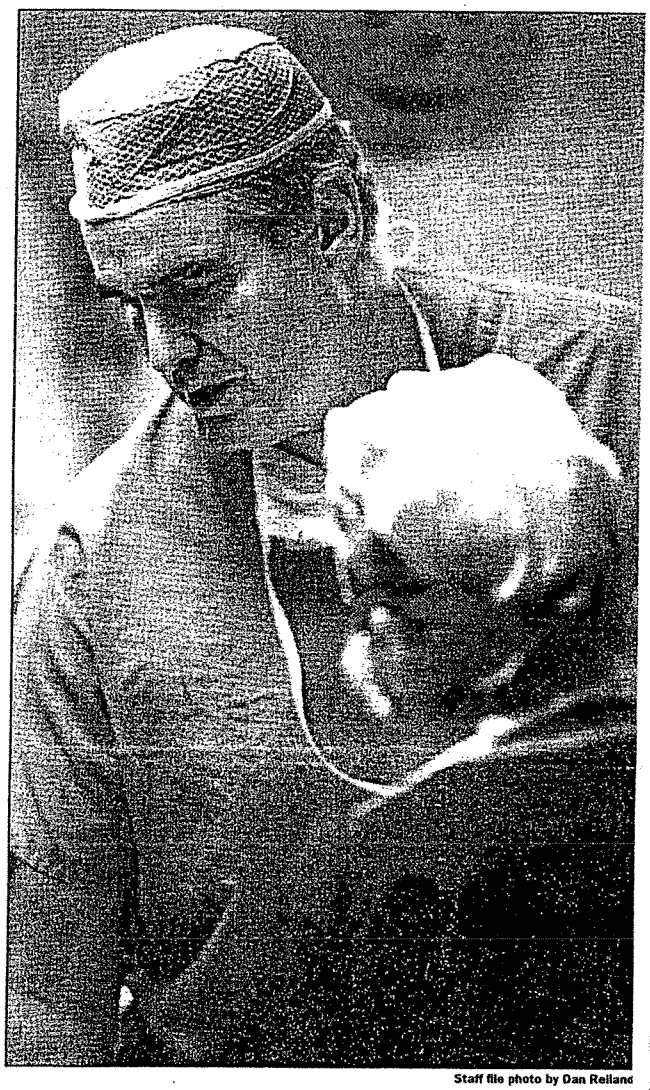
During that time 61 percent of the state's 84 licensed neurosurgeons had no claims, and 93 percent had two or fewer claims, the Medical Mediation Panels reported. The agency tracks malpractice claims, which include lawsuits and requests for mediation.

Before coming to Eau Claire, Rankin was the target of several lawsuits in Florida, where he filed Chapter 7 bankruptcy to erase his debts in October 1992 after his malpractice insurer went out of business.

He filed a petition to reorganize his debts under Chapter 11 of the U.S. Bankruptcy Code in September 1996 in Eau Claire after accumulating $1.2 million of debt to the Internal Revenue Service and $90,000 of debt to the Wisconsin Department of Revenue for unpaid income taxes for 1994 and 1995, according to U.S. Bankruptcy Court documents. The filing showed Rankin also owed $436,000 to Sacred Heart Hospital for an unpaid loan. He estimated his gross monthly income for the next 11 years at $70,000.

While a record of malpractice lawsuits alone doesn't give consumers enough information to judge a doctor, it should raise a red flag any time a doctor has been sued that many more times than his peers, said Michael Donio, director of projects for the People's Medical Society, a national health care consumer advocacy organization based in Allentown, Pa.

See **RANKIN**, Page 6A

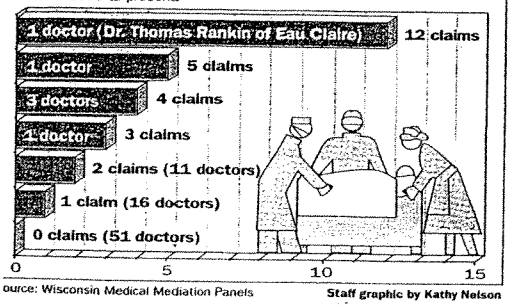


Staff file photo by Dan Reiland

Dr. Thomas V. Rankin, a neurosurgeon at Sacred Heart Hospital, has faced more malpractice lawsuits in Eau Claire County than any other place in his career, he said. Rankin, shown in this 1993 photo, was recruited to revive the hospital's neurosurgery program following the exodus of Midelfort Clinic neurosurgeons after the clinic and Luther Hospital merged with Mayo Clinic in 1992.

### Malpractice Claims Against Wisconsin Neurosurgeons

Of the 84 licensed neurosurgeons in Wisconsin, here is a breakdown of how often they have been the target of malpractice claims from October 1993 to present:




Source: Wisconsin Medical Mediation Panels

Staff graphic by Kathy Nelson

# Woman blames Rankin for mother's ailments

**By Traci Gerharz Klein**
Leader-Telegram staff

Judi Wolter's 78-year-old mother can't button her blouse, zip her coat, pull a sweatshirt over her head or lift a pan to cook a meal.

Wolter blames neurosurgeon Thomas V. Rankin for her mother's limited arm and hand use and nerve damage. Wolter, of Eau Claire, believes he performed unnecessary surgery on her mother.

Another neurosurgeon who treated Wolter's mother following her surgeries by Rankin plans to testify to that effect in June 2000, the date her mother's lawsuit against Rankin is scheduled to go to trial, Wolter said.

Wolter's mother is one of seven people with malpractice suits pending in Eau Claire County against Rankin. Four other former patients have received settlements or jury awards for their claims against Rankin since he began practicing at Sacred Heart in October 1993.

Rankin declined to comment on individual cases.

In January 1998 Wolter noticed her mother — whom she did not want to name for this story — started to become unsteady on her feet, get dizzy spells and fall.

Rankin said the cushioning between discs in Wolter's mother's neck was deteriorating, and he recommended surgery, Wolter said. "He said if it

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# Doctor questions Rankin's work

RANKIN
from Page 1

"People definitely should take his history into consideration if they are referred to that neurosurgeon," Donio said, recommending patients do as much research as they can before submitting to a procedure by a doctor with a questionable record.

The 11 lawsuits filed against Rankin in Eau Claire County all deal with complications resulting from surgery. While the cases vary, many of the lawsuits contend Rankin performed unnecessary surgical procedures without considering less intrusive treatments.

"What I see evolving is a pattern of Dr. Rankin convincing people they need surgery they don't really need, and then I see complications that require a second surgery," Wagner said. "If you have a problem and it's him recommending surgery, I think you owe it to yourself and your family to get a second opinion."

In one lawsuit against Rankin, the plaintiff — Robert Determan of Red Wing, Minn. — contended Rankin punctured his lung because the screws used in the spinal surgery were too long.

In another suit, Brian Pierce of Chetek claimed Rankin aggravated his back problems and caused permanent nerve damage during spinal fusion surgery. Medical reports indicated Pierce, 36, suffered from chronic leg pain, numbness and weakness and was unable to stand for more than 30 minutes at a time.

Both Determan and Pierce required corrective surgeries by other doctors, the suits contend.

In Pierce's case an Eau Claire County jury in January found Rankin negligent and awarded Pierce $463,000, including $250,000 for past and future pain, suffering, disability and disfigurement. Determan's case against Rankin ended with a $65,000 out-of-court settlement.

Marlene Cartrette of Chippewa Falls sued Rankin because of complications — including a loss of strength and permanent nerve damage — resulting from an October 1996 surgery. The case was settled in March for an undisclosed sum, which Cartrette's attorney, Phil Steans of Menomonie, characterized as a "multiple six-figure amount."

In Florida, where Rankin practiced from 1987 to 1993, he had five malpractice claims against him. Three of the cases resulted in settlements, and two remain pending.

One of the suits claimed a 31-year-old Boca Raton woman woke up from a 1988 surgery with permanent brain damage. One claim against Rankin resulted in a $1 million payment by his malpractice insurer.

Another Florida suit on behalf of a paraplegic man in his 20s seeks millions of dollars for medical expenses, pain, suffering and the loss of earning capacity and enjoyment of life. The suit, scheduled for trial this fall, alleges Rankin failed to identify a spinal injury that, if treated immediately, might have prevented the man's paraplegia. The man's chances of collecting much appear bleak because Rankin shielded his assets when he filed for bankruptcy, said Lawrence Friedman, the Boca Raton attorney representing the plaintiff, who was injured in a motorcycle accident.

Upon learning Rankin has had 12 more malpractice claims since coming to Wisconsin, Friedman exclaimed, "Obviously, he should not be allowed to practice anymore. The medical review board has got to do something with repeaters like this. They're endangering the lives of patients.

"If he had that many cases down here, his license would have been pulled a long time ago."

Rankin also said he reached a settlement in one malpractice claim in Pennsylvania, where he worked for eight years before moving his practice to South Palm Beach County in Florida.

When Rankin applied for a license to practice medicine in Wisconsin, he submitted a large file filled with claims and lawsuits, according to the state Division of Health Professions and Services Licensing in Madison.

As a result Rankin was asked to take an oral exam, which required him to explain the lawsuits. He passed the oral and practical exams, and was granted his license.

In a recent interview, Rankin downplayed his litigation history by pointing out he has been sued 17 times in his 31-year neurosurgery career. He said he has performed more than 25,000 operations.

"It hasn't been that my skills have deteriorated," he said.

Rankin contended another Eau Claire doctor has tried to damage his reputation.

"Another physician in the community has indicated to this particular group of patients the care fell below the standards, and one might wonder what his motivation might be," Rankin said. "His actions speak for themselves, and we will leave it to the discretion of others to determine his motives."

Staff file photo by Dan Reiland

Dr. Thomas V. Rankin wore special surgical glasses to perform a procedure in 1993.

Dr. Robert Narotzky, a neurosurgeon at Midelfort Clinic and Luther Hospital who left Eau Claire earlier this year to begin a practice in Wyoming, acknowledged he is the doctor to whom Rankin is referring.

"I got involved because I saw patients who were needlessly hurt," Narotzky said in a telephone interview from Wyoming. "A lot of physicians will turn their backs, but I felt I needed to stand up and get involved to the point of testifying about what I was seeing."

Narotzky said he performed "redo surgeries" on some of Rankin's patients and then ended up testifying against Rankin in some cases.

Narotzky saw several of Rankin's patients after Rankin operated on them and said he believes there were serious problems with Rankin's surgeries on these patients. Rankin performed unnecessary operations, and patients were harmed by the surgeries, Narotzky said.

"Complications were happening at a much greater rate and frequency than they needed to be," Narotzky said.

"They are coming out of surgery with new neurologic deficits," he said. "That should be a rare occurrence. You are not going to get a perfect outcome every time, but the risk of making somebody worse should be very low."

Wagner, the Menomonie lawyer, portrayed Narotzky as a brave person who has shown the willingness to do the right thing, even when it means taking the unusual step of questioning a fellow neurosurgeon.

Narotzky, who got involved in Cartrette's care after the operation by Rankin, testified on behalf of Cartrette in the case, and two other expert witnesses corroborated his opinion, Steans said.

"I've been doing medical malpractice for over 20 years, and I've never seen such a cluster of cases against one doctor in this region," Steans said.

Considering malpractice cases are difficult for plaintiffs to win, the record of cases against Rankin that led to payments suggests these are more than just idle complaints by unhappy patients, he said. "It would appear that there are problems with Dr. Rankin's practice," Steans said.

Still, state regulators haven't taken any disciplinary action against Rankin or placed any restrictions on his Wisconsin medical license.

A state Department of Regulation and Licensing screening panel reviews all cases in which a settlement is paid. The agency took no action after concluding its review of three Rankin cases — one of which prompted an investigation — earlier this year, said Michael Berndt, records custodian and attorney supervisor for the department's Division of Enforcement.

Berndt said he is prohibited from commenting on cases under review. While the agency doesn't automatically investigate physicians with unusually large numbers of malpractice claims, Berndt noted that screening panel members have the records of previous cases in front of them when new cases are reviewed.

Rankin's malpractice insurer has made payments in all four of the surgeon's closed cases in Wisconsin. By contrast, the Physicians Insurance Association of America reported that in 1997 only 28.7 percent of the closed claims against U.S. neurosurgeons resulted in payments to plaintiffs.

Of the 69 paid neurosurgery claims reported in 1997 to the PIAA — a trade association of more than 60 professional liability companies that insure about 60 percent of the nation's private practice physicians — the median payment was $225,000.

Rankin said he is a reviewer and examiner for a national neurosurgical peer review organization, which means one of his roles is to help investigate neurosurgeons who may have a large number of lawsuits in a limited amount of time.

"You have to look at each of the cases, but more than that you have to look at the total body of the person's work" to judge the surgeon's skills, he said.

People who hear about his 11 lawsuits in Wisconsin will not know about the rest of his career and will judge him incorrectly, Rankin said.

"I want to put it in context of my whole career," he said. "I understand very well technically and intellectually what (neurosurgeons) are supposed to be about, and this is why I am able to answer somewhat categorically why the charges brought against me are rather frivolous and self-serving."

For most of his career at Sacred Heart, Rankin has been the only neurosurgeon. For 15 months, from about January 1997 to March 1998, neurosurgeon Dr. Thomas Oravetz worked with Rankin.

As a result Rankin — whose practice consists of about 70 percent elective spine surgeries and about 30 percent brain operations — is available 24 hours a day, seven days a week to do surgery if necessary. He is searching for another neurosurgeon to join his practice.

"It's been a significant challenge," he said of being the hospital's sole neurosurgeon. "It's not a casual undertaking. It's a very demanding situation."

But neurosurgery gives his life great meaning, he said, because it's intellectually, spiritually, physically and technically challenging.

Rankin said he operates significantly more often than most U.S. neurosurgeons, who perform an average of 260 procedures a year, according to the American Association of Neurological Surgeons.

"If you are operating on 300 or 400 people a year, you are afforded the opportunity to do some significant good," Rankin said.

The numbers of surgeries he does varies from year to year, but he did the most operating during the Vietnam War when he was based at Brooke Army Medical Center at Fort Sam Houston in San Antonio, Texas, he said.

Huge numbers of soldiers were sent home to the United States for operations, said Rankin, a lieutenant colonel in the U.S. Army who began as a staff neurosurgeon and finished as chief neurosurgeon at the military hospital.

Lance Gambrell, now 15, the son of Leonard Gambrell and Lori Miller of Eau Claire, became one of Rankin's success stories in July 1997 when Rankin operated to remove a rare tumor growing in the 13-year-old's brain.

"This was life-threatening for Lance," Leonard Gambrell said. "Rankin said Lance could lose vision, he could lose speech. He went over this a half-dozen times with us.

"He had a very blunt demeanor and was professionally cold in that, but I'm not sure I'd be any different in that way."

Rankin told them he was as confident as he could be but that even with confidence, the operation might not go as hoped, Leonard Gambrell said.

Lance Gambrell is doing well today, but his type of tumor tends to return 30 percent of the time, his father said.

If it does return, "I wouldn't hesitate to have him do (the surgery) again," Leonard Gambrell said of Rankin.

Rankin also operated on Chrissy Schlageter, 12, of Eau Claire in December to remove an egg-size brain tumor.

Rankin told her parents, Mark and Jane, the operation was risky. "He was so honest with us I had to get up and leave the room," Mark Schlageter said. "I didn't want to hear that my daughter might die."

Chrissy Schlageter was like a newborn baby after the surgery and a subsequent coma. She needed to learn to walk and talk again, but she is making significant progress, her father said.

"If something would have happened to Chrissy, I would not have blamed Dr. Rankin," Mark Schlageter said. "He went into it to do his best."

Dr. Steven Immerman, a general surgeon in Eau Claire, operates with Rankin about twice a month and has recommended him to relatives who've needed surgery.

If Rankin needs to reach the spine from the front or side, Immerman is a surgeon called in to open the chest or abdomen. After Rankin does his surgery, Immerman returns to close the chest or abdomen.

What impresses Immerman is that Rankin accurately estimates how long it will take him to do his work, so Immerman knows when to return. "That implies that he knows what he's doing and how long it will take as opposed to him getting into problems," Immerman said.

"If I didn't think he was doing a good job and we weren't getting good results, I would be reticent to work with him," he said.

But lawyers who are handling cases against Rankin paint a far different picture.

In addition to the 11 lawsuits, Rankin has been involved in three mediation cases that have yet to result in litigation. All three cases were mediated last year, and none were settled through the mediation process.

Malpractice cases are heard by a state medical mediation panel consisting of an attorney, medical professional and member of the general public before a lawsuit can be filed. The purpose of mediation is to try and settle cases without litigation, said Steans, the Menomonie attorney who has represented plaintiffs in suits against Rankin.

Both parties can waive the mediation process, Steans said.

Wagner, the other Menomonie attorney, is investigating five more cases, and Steans is looking into three more cases that could result in new lawsuits against Rankin.

"It's nuts. (Potential clients) call almost every week," Wagner said. "I've never seen anything like it."

Wagner said he hears a common question from his clients and prospective clients in Rankin-related cases: " 'How come Sacred Heart lets him do surgery over there?' "

In a statement, Sacred Heart's director of communications, David Duax, said Rankin leases space at the hospital but is not an employee.

The hospital monitors the performance of doctors who work there through a process called physician peer review. "Peer review involves ongoing review and analysis of a wide variety of patient care rendered in the hospital," Duax said. "This includes incidents of unusual or serious nature."

However, the review process is confidential under state law, and the hospital is not able to release information about specific doctors, he said.

In an interview, Duax said patients are the hospital's first priority. "As a Catholic hospital we want to provide the best possible care both from a medical and spiritual perspective," he said. "Secondly, quality improvement in all we do is a very high priority."

Rankin said his litigation history in his short time in Eau Claire and the negative perception of him by a few people leave an inaccurate impression. Many patients have been pleased with his surgical care, he said.

In addition, Rankin rejected the insinuation by some people that he is a "money grabber." It's not true, Rankin said, claiming that more than half of his work in Eau Claire is uncompensated and that he feels a moral obligation to care for people regardless of their ability to pay.

He wouldn't have been able to operate on large numbers of people in his career and "be a person with impaired judgment and moderate skills," he said. "That simply doesn't work."

*Klein can be reached at 833-9206. Lindquist can be reached at 833-9209. Holtz can be reached at 833-9207. They also can be reached at (800) 236-7077.*

> **"If you have a problem and it's (Dr. Rankin) recommending surgery, I think you owe it to yourself and your family to get a second opinion.**
>
> — Michael Wagner, Menomonie attorney who has represented clients with claims against Rankin

## Rankin Cases

Following is a summary of the 11 malpractice lawsuits filed against neurosurgeon Thomas V. Rankin in Eau Claire County since 1996:

**March 1996** — Robert Determan of Red Wing, Minn., sued Rankin and Sacred Heart Hospital, claiming Rankin's negligence while performing surgery led to the man suffering permanent lung damage.

The suit was settled in May 1998 for $65,000.

According to Determan's suit, he was admitted to Sacred Heart on Aug. 2, 1994, with injuries, including a fractured vertebrae, suffered in a motorcycle accident.

Three days later Rankin performed spinal fusion surgery on Determan, inserting screws to stabilize the fractured vertebrae.

The suit claimed Rankin inserted screws that were too long, puncturing Determan's lung, which required corrective surgery three weeks later at the University of Iowa Hospital.

**September 1997** — Kristin Bonn of Durand sued Rankin, claiming he deviated from standard care by performing an anterior discectomy and fusion surgery.

Bonn claimed the June 13, 1994, surgery was unnecessary.

Bonn accused Rankin of failing to conduct appropriate diagnostic testing and ignoring findings on two MRI scans that were essentially normal.

Rankin used bone plugs from a bone bank during surgery instead of using bone from Bonn's body.

Rankin failed to take an appropriate health history of Bonn, which would have disclosed she was a heavy smoker and a poor candidate as a recipient from a bone bank, the suit claimed.

Rankin failed to inform Bonn of alternative treatments to surgery, including diagnostic testing, steroid injections and physical therapy.

The suit was settled last December for an undisclosed sum.

Bonn was seeking $500,000 in the lawsuit and offered to settle for $400,000 in September 1997.

**October 1997** — Brian Pierce of Chetek sued Rankin for negligent care and for inadequately informing him of his medical condition before, during and after his Feb. 16, 1996, surgery.

Pierce's suit claimed his back problems were aggravated by Rankin's negligence, which included causing permanent nerve damage.

Rankin performed a spinal fusion on Pierce at Sacred Heart that failed. Pierce eventually had a second successful surgery at Luther Hospital, said Chuck Bye of River Falls, Pierce's attorney.

A jury in January found Rankin negligent in the care and treatment of Pierce and awarded him $463,000.

**April 1998** — Kimberli J. Hansen of Blair sued Rankin for performing unnecessary surgery on March 22, 1995, without conducting normal and accepted diagnostic procedures.

Hansen injured her neck at work and was referred to Rankin.

The suit claims Rankin's negligence during surgery resulted in nerve impingement and permanent loss of nerve function, including numbness and weakness.

The surgery resulted in significant disfigurement at the site of the original bone graft harvest, the suit claims.

Hansen's suit against Rankin is scheduled for trial Aug. 10.

**April 1998** — Marlene Cartrette of Chippewa Falls sued Rankin because of complications resulting from an Oct. 18, 1996, surgery.

Cartrette was referred to Rankin because of severe pain and numbness in her left arm and hand.

After she emerged from surgical anesthesia, Cartrette lost use of both arms and required prolonged hospitalization, the suit claimed.

Complications from the surgery included possible osteomyelitis and six weeks of antibiotic therapy.

The suit claimed Rankin failed to use the degree of care, skill, and judgment normally exercised by a neurosurgeon under like or similar circumstances.

The case was settled in March for an undisclosed sum.

**November 1998** — Donald Allard Jr. of Holcombe sued Rankin for negligently performing an anterior cervical fusion on Allard on Aug. 26, 1994.

Allard's suit accuses Rankin of performing an unnecessary surgery and misdiagnosing Allard's neck problem.

Rankin failed to take an appropriate health history which would have disclosed that Allard was a heavy smoker. That made Allard a poor candidate as a recipient from a bone bank for the surgical procedure.

Rankin failed to give Allard sufficient information concerning his medical condition and the risks and benefits of treatment options, the suit claims.

Allard sought $400,000 in the lawsuit and made a settlement offer for that amount in January.

A trial date has not been set.

**December 1998** — Mary Haun of Eau Claire sued Rankin for negligently recommending and performing two surgeries on her in January 1998.

Rankin failed to inform Haun of alternative treatment methods to surgery. Rankin failed to give Haun enough information about her medical condition before she opted for the surgeries, the suit claims.

Haun named Sacred Heart as a defendant for allowing Rankin to perform the surgeries.

The case is pending, and no trial date has been set.

**January 1999** — Elke Nelson of Fall Creek sued Rankin because of negligence stemming from her Nov. 14, 1997, surgery.

The suit claims Rankin was negligent in his care of Nelson before, during and after surgery.

Nelson claims Rankin inadequately informed her about her treatment.

The case is pending, and no trial date has been set.

**January 1999** — Darrin P. Johnson of Eau Claire sued Rankin as a result of three surgeries performed by Rankin in 1996 and 1997.

Rankin was negligent by failing to disclose alternative procedures and the risks and disadvantages of the three surgeries, the suit claims.

That negligence didn't allow Johnson to make an informed choice about his care, the suit claims.

Sacred Heart is named in the lawsuit as a defendant for allowing Rankin to perform the surgeries.

Johnson has suffered severe temporary and permanent injuries as a result of the negligence, the suit claims.

The case is pending, and no trial date has been set.

**April 1999** — Richard Lahner of Augusta sued Rankin for negligent care and treatment he received through April 16, 1996.

The suit provides no details about the type of care Lahner received from Rankin.

The case is pending, and no trial date has been set.

**May 1999** — Anthony Dahlby of Colfax sued Rankin and Sacred Heart for negligence before, during and after Dahlby's surgery on July 1, 1996.

Dahlby claims Rankin failed to adequately inform him about the procedure and didn't obtain Dahlby's proper informed consent.

The case is pending, and no trial date has been set.

— Dan Holtz