MINUTES

ASSEMBLY JUDICIARY COMMITTEE
March 3, 1977

Members Present: Chairman Barengo
Assemblyman Hayes
Assemblyman Banner
Assemblyman Coulter
Assemblyman Polish
Assemblyman Price
Assemblyman Ross
Assemblyman Sena
Assemblyman Wagner

Chairman Barengo called this meeting to order at 8:35 a.m. The purpose of this meeting was discussion of the testimony heard the previous morning and to introduce additional testimony in written form which had been received concerning the medical malpractice issue.

Jerry Lopez of the Legislative Counsel Bureau attended the meeting to give the members of the committee some background on the bill as to their intent and development.

The following written testimony was offered to the committee to supplement the information received during the hearing and is submitted to the record according to date of each:

EXHIBIT A: Statement on AB 265 from Jo Powell, R.N., Trustee, Washoe Medical Center. (with attachments)
EXHIBIT B: Letter regarding SB 189 and AB 268 from Geo. E. Miller, State Welfare Administrator.
EXHIBIT C: Letter regarding SB 187 from Robert A. Byrd, CPCU, President, Nevada Medical Liability Insurance Assoc.
EXHIBIT D: Letter regarding SB 185, SB 188, SB 190 and SB 191 from Wm. E. Isaeff for Robert List, A.G.
EXHIBIT E: Letter regarding recommendations on SB 191 from Bryce Rhodes, Legal Counsel.
EXHIBIT F: Statement on SB 185, SB 187, AB 268 and AB 221 from Ellen Pope, LPN.
EXHIBIT G: Memorandum regarding AB 265 from Andrew Grose, Research Director, Legislative Counsel Bureau. (with attachments)
EXHIBIT H: Report on the Proffessional Liability Issue (status within each state) submitted by Wm. K. Stephan, M.D.
EXHIBIT I: Memorandum regarding costs of duplication of records from Mr. Galatz.

Discussion of the bill followed:
AB 266: There was discussion as to whether the language on page two broadened or restricted further the doctor's ability to treat minors. Mr. Lopez said after discussion that this was not one of the more substantive changes. The committee postponed a decision on this bill.

AB 264: The committee found no problems with this bill as it is.

AB 265: The committee found no problems with this bill as it is.

SB 190 and AB 221: This two bills are quite similar and were discussed at the same time as to their comparison. Mr. Lopez stated that they were basically the same, however, in SB 190 there is an addition which is the matter of proceedings which have to do not only with the licensing of the physician but also, his insurability and these are proceedings that the commissioner of insurance is going to be involved in. And, this bill would protect people who are testifying in those types of proceedings. Therefore, SB 190 is a more inclusive bill than AB 221. Both bills will be held for now.

AB 267: Mr. Lopez stated that this bill was initiated to make the medical screening panel work more smoothly. After discussion on this bill amendments were discussed. They were: 1. addition of nurses in the statute and to the medical-legal screening panel as needed, 2. Extension of time of notice for scheduling a medical malpractice hearing from 10 to 30 days, 3. Exclusion of any person from the medical-legal screening panel who has treated any patient whose case is being reviewed for possible malpractice, 4. Inclusion of subpena power for witnesses, 5. Adding in section 2, subsection 4, the words "or his designee" after administrator and, also in subsection 3, the same addition after administrator, 6. Extension of nurse to mean licensed nurses.

Mr. Lopez stated the LCB would make up these amendments and submit them back to the committee.

AB 269: Chairman Barengo stated that he and other members of the committee would contact Dr. Rottman regarding this bill as this deals with the formation of the Nevada Medical Liability Insurance Association which essentially does the same thing as The Nevada Essential Insurance Association mentioned in section 2 of this bill. The primary questions which came up here were regarding the assessments on the policies for protection against future settlements.

AB 270: The committee found no problems with this bill as it is.

The meeting was adjourned, as the committee members had to go into morning session, at 9:05 a.m.

Respectfully submitted,

Linda Chandler

Linda Chandler, Secretary

EXHIBIT A

February 14, 1977

Statement to the Committee on Judiciary——Assembly Bill No. 265
Rober R. Barengo, Chairman

" I speak to you today with the sanction of the Chairman of the Board of Trustees Washoe Medical Center, Reno, Nevada on A.B. 265. The internal risk management in hospitals is the issue at hand.
Section 2, lines 17-18 deal with a structural area. I recommend editorial changes or amendment after the statement, 'administrative duties', to read:
" under the direction of the hospital Board of Trustees, with written internal risk management program proceedure and evaluation of said programs by each department director, medical and nursing staff, in a manner the elected, governing board deems appropriate."
The Board of Trustees at Washoe Medical has initiated initial communication lines established and included in the minutes of the January meeting, 1977.
The press release is included with this statement regarding this initial action.

In Section 3, line 23, I speak to the issue of voter representation.
Across this country, elected officials accountability is to the constituency they serve——the voter——not to another elected official. Each one of us here, holding public trust, have the responsibility of representation to the individual constituency we serve. My own constituency is over 23,000 voters in Washoe County and I would be remiss in my duty to each and every voter if I, personnally failed to speak to this issue. Therefore, I recommend the deletion of line 23 after the word "program", or respectfully suggest that internal risk management programs be "forwarded " to the commissioner of insurance.
My rationale for this request is very basic...to represent those who vote for all elected public officials, to protect the value of that vote and to reinforce the accountability which we, as public servants, hold sacred.
As a second consideration, it is noted that not all patients carry hospitalization insurance, and though the agency must be covered, risk factors must be lowered, evaluated and recorded, the commissioner of insurance should be kept currently informed.

In Section 4 of this bill, 265, I question the constitutionality of this full written statement in regard to public disclosure.
Because Washoe Medical Center is a public institution, administered by public officials and deal with public funds, I recommend that if item 4 is not omitted, that this issue be reviewed by the Attorney General.

If this section is to remain, the bill might read as follows: "Every hospital whose plan as approved by the governing body and is filed as provided in sub-section 2 and 3 (as amended or corrected), has the priviledge as a private institution, and has a duty as a public institution, to disclose the internal risk management process as approved by the governing board, corrections of the program and the cost of the program, as public information and according to the "Bill of Rights for Patients"."

Respectfully Submitted,

Jo Powell

Jo Powell, R.N.
Trustee, Washoe Medical Center

cc: Robert R. Barengo, Chairman, Assembly Committee on Judiciary
Karen W. Hayes
James J. Banner
Steven A. Coulter
John Polish
Robert E. Price
Jan R. Ross
Nash M. Sena
Sue Wagner
Maida J. Prindle, Chairman, Washoe Medical Center Hospital Board of Trustees
Members of the Hospital Board of Trustees, Washoe Medical Center
Fred Hillerby, Nevada Hospital Association
James Joyce, Lobbist
Nevada Nurses' Association, Board of Directors, Dist #1 (Washoe County)
Ann Hibbs, Nevada Nurses' Association Lobbist
Carroll Ogren, Administrator, Washoe Medical Center.

RENO EVENING GAZETTE

Phone (702) 786-8909 Reno, Nevada, Tuesday, Feb. 1, 1977 Thirteen

County hospital

Medical staff, trustees to meet on care quality

Quarterly meetings between the Washoe Medical Center Board of Trustees and members of the institution's medical staff to discuss the quality of care at the hospital were arranged Monday night.

Hospital administrator Carroll Ogren earlier discussing progress of a federal validation team study and a joint conference committee said that among recommendations made was the establishment of regular meetings between the board members and medical staff.

He said that court rulings in the past five years have increasingly held hospital trustees responsible for the quality of medical care.

Trustee Bill Farr's motion provided that some nursing personnel be included in the meetings. Medical department heads and perhaps other medical practitioners and nurses, will be called on a selective basis. The selections of those to appear will be made by doctors on the board of trustees.

The results of the study are expected in about two months.

In other business, an exception was made to approval by the board in writing off uncollected accounts receivable. Newly elected trustee Jo Powell cast a dissenting vote, particularly in connection with out of state accounts.

She said the board must concern itself with developing some way to collect from out of state patients, most of them from California, who are becoming an ever increasing factor in the hospital's patient load.

In January, the record indicated a loss of $18,135 from out of state patients who were listed in collection agency accounts.

Mrs. Powell said the loss in December was about $20,000 and "this goes on month after month." She said one of the particular problems with Reno's location so close to California is that insurance companies incorporated in Nevada can seldom press collections in California.

Mrs. Powell, herself a registered nurse and currently president of the District II (Washoe County) Nevada Nurses Association, said the problem has gone on for too long, "and I know it was going on 10 years ago when I worked here in the emergency room."

Hospital administrator Ogren, at an earlier meeting, had commented that such writeoffs are "an incredibly small percentage of gross patient revenues," and hospital trustees generally agree that the hospital cannot arbitrarily refuse to accept patients from out of state.

When those patients fail to pay their bills, the matter is turned over to a collection agency (with some success), but if this fails, the accounts are generally and routinely suspended.

But Mrs. Powell, in asking the board to explore all necessary legal ramifications with the district attorney, Department of Commerce, or the Legislature, said that she was particularly concerned about how continued writeoffs of patients' bills might complicate various forms of future health insurance programs.

In another matter the board moved formally to give due notice of their meetings and provide a complete packet of summary financial reports to the press.

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An Editorial

HIGH COST OF HEALTH

BY HOWARD FLIEGER

Can Americans afford to go on much longer paying the skyrocketing prices of keeping or restoring their health?

The question is becoming a crucial one for every family in the country.

The Social Security Administration reported not long ago that total spending on health care and maintenance reached 139.3 billion dollars in fiscal year 1976. That is an increase of 17 billion over 1975.

In the two years since price controls ended, the bills of all Americans for health care—hospital services, medical fees such as doctor and dentist bills, insurance premiums, prescriptions, etc.—have risen by 33 billion dollars, almost a third. That far outdistances the rise in the over-all cost of living.

Is the answer a federal take-over? The Government's own Council on Wage and Price Stability has concluded that is probably the worst thing that could happen.

The Council recently completed a year-long study of medical expenses, and some of its findings are almost unbelievable.

Take hospital bills as just one example.

The average cost per patient for a stay in a hospital, as measured by the American Hospital Association, was $311 in 1965. By 1974, the figure had almost tripled to $873. Since then it has gone well above $1,000.

Even those figures fail to tell the full story. The average individual's stay in a hospital is shorter now than it was 10 years ago. So the expense per day is higher than the over-all figures indicate.

Everybody is painfully aware that the prices of food, of buying a home or renting one, of buying a car or getting one fixed are much higher than they were a few years ago. But none of these compare with the rise in medical bills. The latter have not attracted as much attention, perhaps, because part of the cost to individuals is obscured by indirection such as payroll deductions for Social Security and health insurance, checkoffs on union dues for hospitalization, and so on.

But the Wage and Price Council says the day is coming when Americans will wake up to just what it is costing them to take care of themselves and their dependents.

Reading from its report:

"When that day comes, we believe the people of this country will turn to the Federal Government and demand that it solve the problem. No matter that the Government, in its Medicare and Medicaid programs, has a poor record of controlling costs. No matter that the blizzard of rules and regulations which would accompany full federal financing and administration of the health industry would add to costs. . . . And no matter that a federal take-over would result in national expenditures of truly astronomical proportions, even compared with what we are spending today."

The answer to constantly escalating costs lies in controls, the Council concluded, but not in Government controls.

Cost restraints, to be effective, will have to be initiated by the private sector of the economy—by industry and its employes. They have already been started in a limited way in a few areas. Some private plans now encourage a second opinion before an insured patient undergoes an operation, for example. In many cases, both the cost and incidence of surgery has declined, often markedly.

The Council urges companies and employe representatives to become much more active and involved—to get themselves elected to memberships on hospital boards, to establish in-house medical facilities with salaried staffs, to encourage bulk purchasing of prescription drugs and other devices to bring costs down.

Without such private initiatives, says the report, "the Federal Government will step in, and when that happens, we are going to be faced with a permanent problem which will defy solution."

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'I'm a positive person . . .'

Meet Jo Powell, R.N., trustee

Involvement is a way of life with Jo Powell, R.N.

To an impressive list of community and professional affiliations, the diminutive Reno native recently added that of Washoe Medical Center trustee.

Running for the office wasn't a sudden idea, she says. "I sort of suspected years ago that someday I would run for the Board of Trustees."

An active participant in her organizations, she is president of Nevada Nurses' Association District 1, Washoe County, and is also a member of the NNA Board of Directors and NNA's Special Interest Group, Continuing Education for Nursing.

NEW TRUSTEE Mrs. Jo Powell, R.N.: "This hospital is a big part of my life . . ."

"My priorities are the hospital board and the Nevada Nurses' Association," she says, "but I am remaining active in the others, too. They all intermesh, and add to my usefulness in them."

She is a member of the Nevada League for Nursing, co-chairman of the Governor's Rural Health Action Committee, member of the Governor's Consumer and Professional Health Education Committees, co-chairman of the Northern Nevada Task Force on Child Abuse and Neglect, and is co-chairman of the Education Committee.

A member of the Consumer Section, Northern Nevada Better Business Bureau, she has also served as project director and member of the Reno Bicentennial Commission, is an immediate past vice-president of the Washoe County Republican Central Committee and served as northern Nevada volunteer chairman for then-Congressman David Towell.

"I also jog a lot, play tennis, love to ski and ice skate, read a lot, and I love watching Little League ball," she smiles.

The latter interest is a result of her nine-year old son Tommy's participation, she confesses. "He's also in Y basketball and Scouts and last year won in his division in the Heart Association Cyclethon. He rode 51 miles!"

Mrs. Powell also has three daughters. Michele, 20, is a student at UNR; Alanna, 18, is "tending toward the humanities" at UNR, and Erin, 17, is a Reno High senior.

CAREER DECISION

Although her mother was a Washoe Med emergency room nurse during the early school years, Mrs. Powell feels that wasn't a primary reason in her own career choice. "I was always the nurse when the kids played Robin Hood or soldiers," she laughs. "I've wanted to be a nurse since I was five, I guess."

Her father's death was also a factor. "As my mother went through the grieving period, I felt there was more I could do to help in times like that, more I had to learn to deal with illness and sorrow."

A hospital blood bank employee during her senior year at Bishop Manogue High, she did a school paper on medical technology as a career. "It helped me see that I wanted to work directly with people," she says.

After high school she entered Holy Cross Hospital School of Nursing in Salt Lake City on an earned scholarship, completed that plus nine months of surgical nurse specialty training, then married a civil engineer and moved to Placerville, Calif.

During their stay there she spent nine months as the evening charge nurse in the community hospital before her husband's work took them to Marysville. They arrived a week before the 1956 killer flood inundated nearby Yuba City.

"We were going on vacation," she recalls. "We were the last car allowed out before they closed the highways, but weather stopped us at Echo Summit. So I sat there in the car, pregnant, with a dog and a cat, listening to the Christmas music on the radio. What a way to spend Christmas eve!" she laughs.

CONTINUING EDUCATION

As her family grew, she continued her nursing career. She was a special and private duty nurse in Marysville hospitals, a consultant to the Sutter County School District Outdoor Recreation Program and served as a general practicioner's nurse for more than six years.

When her husband's work took them to Pla-Vada, near Donner Summit, she worked part-time at Tahoe Forest Hospital until 1965, when she returned to the Reno area to enroll in the Orvis School of Nursing.

Employed at Washoe Med, where she rotated through Emergency, Cardiac Intensive Care, Intensive Care and Psychiatric nursing assignments, she continued her schooling. In 1967 son Tommy was born at Washoe Med.

Later, severe illness followed by a series of operations, complications and convalescent periods forced her to forego a fulltime nursing career. "The education continued," she says. "I was restricted to voluntary work during a long convalescence."

Now combining part-time work as a substitute school nurse in the Washoe County School District with her civic and professional affiliations, she is looking forward eagerly to her service as a hospital trustee.

"I'm a very positive person, and I'm going to try my best to meet my campaign committments as a consumer representative and as a representative of the quality of service this hospital stands for."

She adds: "After all, this hospital has been and still is a big part of my life!"

TPR
Our Temperature, Pulse and Respiration

TPR is published for all employees, medical staff, volunteers, patients and friends of Washoe Medical Center, 77 Pringle Way, Reno, NV. 89502.

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Coming: an Overhaul of Health Programs

WITH A STRONG COMMITMENT to national health insurance, Jimmy Carter is expected to make significant changes in the country's system of health care during the next four years.

Soaring medical costs and scandals in existing Government health programs pose the most immediate problems for the new Administration.

To find solutions, Carter and his top-ranking aides in the health field can be expected to examine plans that would:

- Support cost-control programs throughout the health industry.
- Reduce waste and fraud in medicare and medicaid.
- Phase in national health insurance over the next five years.
- Reorganize Federal Government health programs.
- Set new priorities in medical research that emphasize health education, community health programs and preventive medicine.

Soaring costs. Carter and his health advisers see the No. 1 health problem right now as inflation. Medical costs are ...sing faster than almost any other ...gment of the economy. In the ...cal year that ended June 30, ...nericans spent 139.3 billion dollars on health—more than five times the amount spent in 1960.

To break the cost spiral, plans are under consideration to set limits on amounts that Government health programs will pay for supplies and equipment as well as for physicians' services and hospitalization.

Medicare, medicaid. Getting high priority in the new Administration is reform of medicare and medicaid. An estimated 750 million dollars is wasted yearly in fraud and errors in the medicaid program—involving patients, doctors, pharmacists, hospitals and nursing homes.

Key to the proposed reforms is a different system of financing. Called "prospective reimbursement," it means that the Government would negotiate and set rates of physicians and hospitals in advance, and fee schedules would be established.

Under the present system, doctors and institutions set the rates and the Government automatically reimburses what the individual is charged, an arrangement that critics say invites abuse.

...bout 25 States already have es...shed similar hospital-rate re...w commissions, but their authority varies widely.

The strategy is to start with medicare and medicaid and then extend cost reforms throughout the health industry.

Since Blue Cross and Blue Shield set rates on a par with medicare and medicaid in many areas, changes in the Government programs should also have an immediate impact on private insurance companies as well.

In addition to direct cost controls, the Carter Administration will be trying to reduce the need for hospitalization by such means as increased funding for home health-care programs and outpatient surgery. A plan to reimburse hospitals for closing out unnecessary beds also is being considered.

Although Carter gave national health insurance top billing during the campaign, his Secretary of Health, Education and Welfare, Joseph A. Califano, Jr., told a Senate hearing that the Administration will introduce no legislation for it this year.

National plans now under consideration to cover catastrophic, or unusually high, medical expenses would add 10 billion dollars to the health budget. Dr. Peter Bourne, psychiatrist and one of the President's health advisers, says that Carter "wants to avoid any program that would disrupt the country's basic economy."

The new President is expected to appoint a task force to draw up a plan he can submit to Congress next year. A proposal is expected by autumn.

Key elements in Carter's proposal for national health insurance include:

- Mandatory and universal coverage.
- Built-in cost and quality controls.
- Freedom in choice of physician.
- A combination of private and Government financing.

Reorganization, growth. This year, the emphasis will be on overhauling existing health programs—expanding them where possible and consolidating overlapping services.

As part of his over-all plan to reorganize the Government, Carter is considering the idea of breaking up the Department of Health, Education and Welfare. In such a breakup, one agency for health and social services would be created. HEW Secretary Califano points out, however, that a major overhaul of the Department will not be proposed for at least a year.

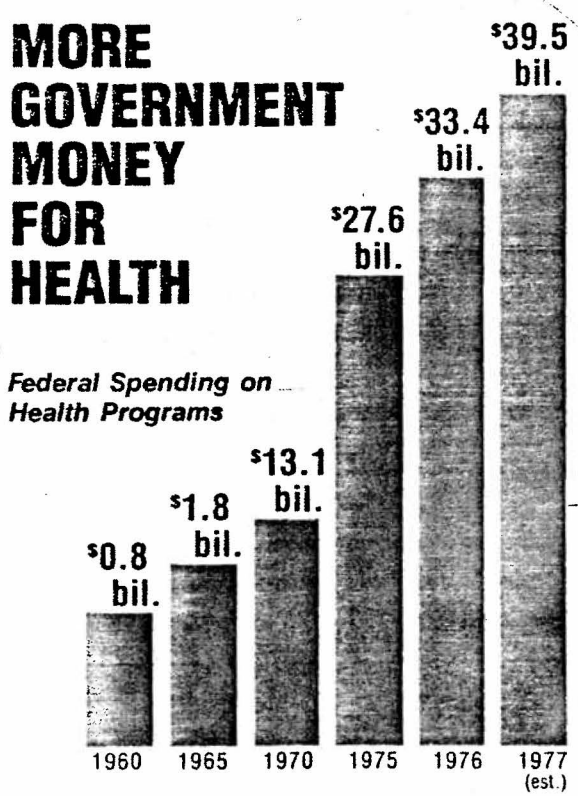
Community health. The President grew up in the rural South, where he saw his mother serve as paramedic to blacks in his home town because medical services were not available. Accordingly, programs providing community health care for the poor are expected to receive more attention in the new Administration.

Staff aides predict that funding will be increased for neighborhood health clinics and programs stressing prenatal and infant care. Rural health projects like the Beaufort-Jasper Comprehensive Health Services in South Carolina will be expanded.

Reflecting another major concern, the President appointed his wife Rosalynn as honorary chairman of a 20-member mental-health commission on February 17.

Mrs. Carter has long been interested in mental-health problems, estimated to involve some 20 million Americans.

The commission will point out weaknesses in current mental-health services and recommend new Government policies. The panel's preliminary report is due by next September and a final study by April, 1978.



IN FUTURE YEARS, outlays will top 45 billion dollars and head still higher if Carter does not succeed in holding down costs.

Note: 1977 unofficial estimate for year ending September 30; other years ended June 30.

Source: U.S. Office of Management and Budget

In the news

American Medical Association reaffirms support for comprehensive national health insurance bill

With power to spare, the American Medical Association's House of Delegates last December crushed the efforts of an impassioned minority determined to lead the AMA into abandonment of its own national health insurance (NHI) proposal and into an all-out battle against any NHI plan.

But the 181 to 57 vote by the house to continue AMA support of a comprehensive NHI proposal and to seek reintroduction of an AMA-sponsored bill in the 95th Congress was not a foregone conclusion. The vote came during the AMA's clinical convention in Philadelphia.

Almost a decade ago, the AMA's leadership—its officers, Board of Trustees, and key councils—persuaded the House of Delegates that the AMA's unbending opposition to Medicare proposals had lost the association a significant say in the final form of that legislation. The AMA should not repeat the error in the debate over what is now known as national health insurance, the leadership reasoned.

Heeding that advice, the AMA's house abandoned its half-century-old "opposition to the institution of any plan embodying the system of compulsory, contributory insurance against illness" and hammered out its own basic terms for a national health insurance proposal:

Any national plan should build on existing private insurance and should not be operated as a government service; the plan should be financed by private payments for insurance coverage for those who are able to pay and from general tax funds for persons in low-income groups; the plan should utilize pluralistic health care systems; the benefits should be comprehensive, embracing both basic and catastrophic coverage; there should be minimum federal involvement, no payroll tax, and no administration by the Social Security Administration; the program should include appropriate cost sharing; and federal subsidies should provide assistance for those in need.

There has always been a hard core of conservative opposition within the AMA to AMA sponsorship of any national health insurance legislation.

In other action:

—The AMA again made clear that it opposes the National Health Planning and Resources Development Act, P.L. 93-641. However, despite the fact that the AMA has challenged the law in the courts, the AMA's Council on Legislation is developing proposed amendments to the law, which comes up for extension this spring.

—The house, although noting that state medical societies have no legal jurisdiction over hospitals, said that "nevertheless the AMA and the state medical societies have a responsibility to encourage and to assist in the development of medical staff bylaws that assure 'due process' for physicians."

—The AMA delegates looked askance at the "growing trend toward locating physicians' offices in or near hospitals" as a phenomenon "that could facilitate an improper entry of hospitals in the practice of medicine. . . ."

T

Consumer group urges health planning takeover

A do-it-yourself guide to taking over the national health planning program at the local level was unveiled December 7 at a press conference called by the Health Research Group, a Ralph Nader consumer group based in Washington, DC.

The introduction to the consumer booklet says that health planning should not be left to the " 'experts'—doctors and hospital administrators. . . . Consumers have much to gain by being active in health planning and much to lose by letting others, especially providers, make planning decisions."

Ted Bogue, author of the booklet *Trimming the Fat Off Health Care Costs: A Consumer's Guide to Taking Over Health Planning,* told the press that the planning effort "needs to be a consumer advocacy program rather than a partnership between providers and consumers."

T

Two indexes offer better look at hospital inflation

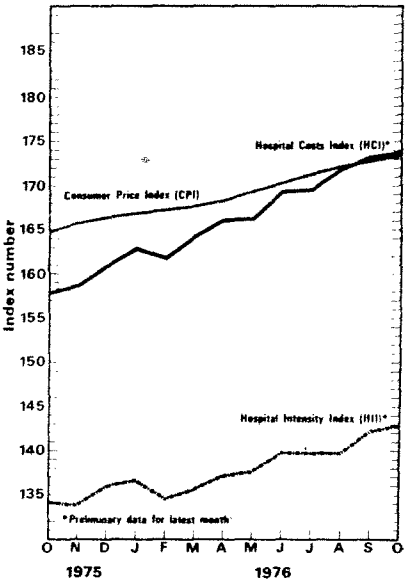
Recently released data from two new statistical indexes developed by the AHA provide a better, more accurate look at hospital inflation than previously has been available. The two new indexes, called the Hospital Costs Index (HCI) and the Hospital Intensity Index (HII), provide statistical measurements of increases in the costs of what hospitals are purchasing and increases in the services that hospitals are providing, respectively.

The data also support the AHA's contention that the hospital service charge component of the Consumer Price Index (CPI), an index prepared by the U.S. Department of Labor, does not accurately reflect inflation in the hospital industry.

From October 1975 to October 1976, the HCI, which is a measure of the cost to hospitals of purchased goods and services used in the provision of hospital care, rose 10.1 percent. During the same period, the overall CPI rose 5.3 percent, and the hospital service charge component of the

CPI rose 11.6 percent. Thus, while consumers were experiencing a 5.3 percent rise in prices, the price of goods and services required by hospitals went up 10.1 percent.

Moreover, during that same time the HII—the second of the AHA's new indexes—increased 6.6 percent. The HII measures



increases in the intensity of hospital services and in recent years has shown the results of increased use of services in the provision of hospital care. The HII data show that part of the reason that patients' prices are rising is that hospitals are providing more and better services.

The AHA indexes are compiled each month from data provided by nearly 600 hospitals on 37 service elements included in a typical patient day.

VOL. 13, NO. 7, FEBRUARY 18, 1977

Hospital Week T.M.

RECENT WASHINGTON REPORTS MAKE IT CLEAR THAT THE CARTER ADMINISTRATION IS CONSIDERING VARIOUS PROPOSALS designed to reduce the rate of increase in payments for hospital care. While no specifics are available, one proposal apparently is similar to the Phase IV Plan of the Economic Stabilization Program and would attempt to limit increases in payments for operating costs per admission in each hospital to 9 or 10 percent.

Alex McMahon, AHA president, responding to the reports, said, "Hospitals will oppose any arbitrary cap on payments that fails to take into account wage and price increases beyond their control and that fails to take into account the individual circumstances in each hospital. If a hospital is to continue to take care of its sick and injured patients, it must receive sufficient revenue to pay adequate wages; the price of necessary supplies and services, like energy and malpractice premiums, which are rising faster than total hospital costs; and the capital and operating expenses of necessary improvements in services."

McMahon is scheduled to meet with HEW Secretary Califano Feb. 18 to express AHA's concern in greater detail.

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ABOUT $440,000 WILL BE REFUNDED TO 49 IOWA HOSPITALS by the St. Paul Fire and Marine Insurance Company as a result of improper billing techniques used between November 1975 and June 1976, according to the Iowa Insurance Commissioner. St. Paul provides malpractice insurance for 96 hospitals in the state. The company admits the error, saying that it resulted from "an honest difference of opinion" on the interpretation of the rating procedure used.

According to the insurance commissioner, the matter arose when it was reported to the insurance department that St. Paul appeared to be cutting its rates in anticipation of competition from the Iowa Hospital Mutual Insurance Corporation, which was recently formed by the Iowa Hospital Association. The commissioner's investigation found that the rate reductions began to appear when St. Paul discontinued use of an unapproved procedure for determining rates. Donald Dunn, president of the Iowa Hospital Association, said that the Iowa Hospital Mutual Insurance Corporation would continue in a partially capitalized standby capacity "to allow activation in the event that malpractice insurance costs should rise unduly in the future."

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THE RECENTLY PUBLISHED CERTIFICATE OF NEED REGULATIONS contain several provisions "so inadequate that we recommend immediate correction," Alex McMahon said in a Feb. 17 letter to HEW Secretary Joseph Califano. McMahon pointed out that the regulations do not cover ambulatory health care facilities, home health agencies, or certain other types of health care organizations. "The planning process should apply to all health facilities," McMahon stated.

Another section of the regulations provides that if a state agency does not make its decision within a certain time, the proposal shall be rejected. This is "just the opposite" of what is found in other planning regulations "and is contrary to a number of existing state certificate of need laws and procedures," McMahon said.

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A THREE-MEMBER PANEL OF THE NATIONAL LABOR RELATIONS BOARD HAS RULED THAT PHARMACISTS at four California hospitals are not entitled to a separate bargaining unit. Instead, the NLRB ordered a representation election that would include the pharmacists with other professional employees. The AHA had argued in an amicus curiae brief before the board that petitions from hospital pharmacists for separate bargaining unit representation should be dismissed at the regional level because the board previously has ruled that staff pharmacists do not have a sufficient community of interest to war-

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BY THE AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE, CHICAGO, ILL. 60611
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rant separate units. The matter, the AHA said, "is not open for question." (See Apr. 23, 1976, Hospital Week.) The NLRB panel, in deciding the case, cited the precedent mentioned by the AHA in its brief.

The staff pharmacists have virtually no interaction with other employees, the NLRB said. However, they do have "a commonality of professionalism, involving similar professional educational requirements, internships, standards, ethics, and responsibilities" with other professionals, the panel added. The hospitals involved in the case are members of the Association of Hospitals of Santa Clara County. The pharmacists are members of the California Society of Hospital Pharmacists, which is an affiliate of the American Society of Hospital Pharmacists.

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THE FUTURE HOLDS "A PERIOD OF UNPRECEDENTED COMMUNICATION AND COOPERATION BETWEEN HOSPITALS AND PHYSICIANS," Alex McMahon, AHA president, said Feb. 11 at a conference of the Multnomah County Medical Society in Gleneden Beach, OR. At the conference, whose theme was "Standing Alone Together--Physicians and Hospitals in a Changing Era," McMahon outlined a number of factors that have prompted greater cooperation between hospitals and physicians, including "shared adversity" in the form of external and internal pressures exerted on the health care industry. Other unifying factors, McMahon said, can be found in recognition of common goals, such as joint efforts to reduce the malpractice problem and cost containment activities. "Sharing of clinical facilities, for example, is impossible without the full cooperation of the institutions and those who actually use the facilities for treatment," McMahon said. "In-hospital cost containment programs will never reach their full potential without the involvement of physicians," he added.

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"COMPETITION IN THE HEALTH CARE SECTOR" will be the subject of a conference conducted by the Federal Trade Commission on June 1-2 in Washington, DC. The conference is part of the FTC's ongoing study of the health care industry and will be open to the public, the commission said. One of the sessions will include analyses of the types of competition found among hospitals and between Blue Cross plans and commercial insurers, the FTC said. The final session of the conference will deal with the role of competition in achieving high-quality care most efficiently. Competition in the private sector will be evaluated "as an alternative to government regulation in containing the rapidly rising costs of health care," the FTC said.

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THE ILLINOIS PODIATRY SOCIETY WAS CHARGED WITH RESTRICTING FEE COMPETITION in a suit filed Feb. 14 by the U.S. Justice Department. Filed in Chicago in a U.S. District Court, the complaint states that the society's use of relative value studies or guides to determine fees is in violation of federal antitrust laws. Such fee guides, the suit states, result in price fixing and deprive consumers of competitively determined fees. Another Justice Department suit is pending against the American Society of Anesthesiologists for its use of relative value scales.

The Federal Trade Commission, also, has been active in attempting to restrict the use of relative value scales. Prior FTC action has resulted in agreements from the American College of Obstetricians and Gynecologists and the American Academy of Orthopaedic Surgeons to halt use of the scales. A similar agreement with the American College of Radiology is pending.

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THE AMERICAN MEDICAL ASSOCIATION WILL GIVE $15,000 TO QUENTIN YOUNG, M.D., toward legal expenses incurred in his court battle with the Cook County Health and Hospitals Governing Commission. Young, director of medicine at Chicago's Cook County Hospital, was active in the 1975 strike by the hospital's interns and residents. The commission's two attempts to fire Young were ruled improper by a U.S. District Court in Chicago, and the case is being appealed by the commission.

The AMA authorized the financial assistance in July 1976, but waited for approval from the Chicago Medical Society and the Illinois State Medical Society. The AMA supports Young's contention that, as a physician in an administrative position at a hospital where he has clinical duties, he cannot be dismissed without due process. After Young was initially fired by the hospital commission, a federal district court ordered that he be given a fair hearing. The hearing panel recommended his retention, but the commission fired Young again anyway. Young continued his court action, and the district court barred his dismissal.

ROOM RATE COMPARISON - HOSPITALS OF COMPARABLE SIZE
SAN FRANCISCO-SACRAMENTO AREAS

HOSPITAL:	# BEDS	PRIVATE ROOM	SEMI-PRIVATE	WARD	NOTES:
Pacific Medical Center San Francisco	336	$173.00	$158.00	$ none	Raised 31 January 1977 by $10
Mt. Zion Hospital San Francisco	419	166 - 179*	162.00	none	Raised 13 December 1976 *Luxury - $196
St. Mary's Hospital San Francisco	406	165.00	none	none	Raised 3[illegible] January 1977 by $8
San Francisco General San Francisco	579	160.00	none	none	Raised 1 July 1976
Children's Hospital San Francisco	362	160.00	150.00	148.00	Raised October 1976 - another due in March, probably $10 acros
St. Francis Memorial San Francisco	335	155.00	155.00	140.00	Raised 1 December 1976
Sacramento Medical Ctr, Sacramento	499	130.00	125.00	125.00	Raise probably in July-no info. how much.
St. Marys Hospital Reno	293	129.00	120.00	114.00	
Washoe Medical Center Reno	566	123.00	113.00	108.00	1 September 1976
Mercy Hospital Sacramento	364	120.00	120.00	118.00	Raised 31 December 1976
Sutter Community Sacramento	658	118.00	113.00	111.00	15% up in Lab costs effec. 1/22/77. Room rate increase planned.

Depressing Diagnosis

Medical Advances and the Growth of Insurance Dim Hopes of Curbing Rising Health-Care Costs

By JERRY E. BISHOP
Staff Reporter of THE WALL STREET JOURNAL

HILTON HEAD ISLAND, S.C.—Economists probing the mysteries of the spiraling rise in medical costs are coming to a dismal conclusion: Americans' insistence on getting the best possible medical care is dashing any hopes of putting the lid on doctor and hospital bills any time soon.

Such, at least, is the implication of some new economic analyses of why medical costs are rising two to three times faster than other goods and services in the economy. The studies show that such potentially "controllable" factors as rising wages and inflating prices are far less important than had been thought in determining medical costs. More significant, some economists suggest, may be the remarkable—and costly—technological advances in medicine in recent years. Americans' demand for such "Cadillac medicine," they say, may be pushing medical bills out of control.

This year, higher medical bills are going to take another big bite out of the national pocketbook. For most consumers, the blow will be softened by the use of health insurance and such government programs as Medicare. But for the corporate and government treasuries that will be paying higher insurance premiums, the impact is likely to be severe.

Up to $250 a Day

The cost of keeping a patient in the hospital for a day is likely to jump 15% or more this year, predicts medical economist Paul J. Feldstein of the University of Michigan. This would push the average cost of a hospital stay to nearly $190 a day across the nation, and to close to $250 a day in some high-cost areas on the East and West Coasts.

Doctors' fees are expected to climb 13.5% this year on top of a 13% increase in 1976, adds Judith R. Lave, associate professor of urban and public affairs at Carnegie-Mellon University in Pittsburgh. This means, for example, that the $25 to $30 paid for an initial visit to a doctor's office in big cities will become commonplace in other areas of the country as well.

"During the past year, the cost-of-living measure of health-care services rose by over 10%, over twice the rate of everything else," says John van Steenwyk, vice president of Martin E. Segal Co., a New York-based consultant on employe benefit programs. "As this continues, it simply means ...t more and more of our resources go into ...h care."

...neral Motors, he notes, says that the ...f health care now adds more to the ... of a car than does the cost of steel. ...iant auto maker says its Blue Shield-...Cross program has now surpassed the ...ndustry as its largest "supplier." ...ealth-insurance outlays in the last six ...s have climbed to $120 a month per ...ct covering a worker and his family, ...crease of $19 over late last summer. By this year, the outlay will hit $144 per ...er contract each month.

...he reason for the relentless upward ...mb in health-care costs is a major economic enigma, judging from the observa...s of medical economists gathered here ...ently at the invitation of the Blue Cross ...ociation. Some of the more widely offered explanations, many of the economists argue, fall short of explaining what's really going on.

The Labor-Cost Myth

For example, the spotlight in recent years has focused on the big increases in wages of hospital workers, from dishwashers to nurses and interns. Because labor costs in many hospitals make up as much as 60% or 70% of total costs, it seemed only logical that wage boosts well beyond the national averages would account for much of the increase in hospital costs.

While pay raises might have been a major cost-boosting factor in such spots as New York City, it appears that wage increases don't account for most of the national increase in hospital costs. The President's Council on Wage and Price Stability recently issued a staff study that declared flatly: "Although hospital wage rates have risen more rapidly than wages in other parts of the economy, these relatively greater wage increases are responsible for only a small part of the overall increase in the cost of hospital care."

One widespread theory, now being discounted, held that the above-average increases in hospital costs were mainly the result of hospitals catching up with other service industries, particularly in wages. If this were true, there was hope that the rise in hospital costs might eventually slacken as hospital wages fell into line with other industries.

But according to the wage-price council's study, if hospital workers' pay raises had been limited to what other non-farm workers received in the last 20 years, hospital costs still would have climbed at a rate of 8.8% a year, only one percentage point less than they actually did rise. As long as 1972, the council calculates, hospital workers "could no longer be considered underpaid" in comparison with similar workers in other fields. Instead, the study found that the labor portion of the daily hospital bill actually has been dropping, to 53% from 62% two decades ago.

"The 'catch-up' hypothesis isn't true any longer, if it ever was operable," says Michigan's Prof. Feldstein.

Services Soar

Rather, the economists say, the biggest spurt in medical costs is occurring in nonlabor areas. And here, they explain, only one fact is clear: Every time the hypothetical average American walks into a doctor's office or enters a hospital, he or she is receiving—and paying for—far more medical services than ever before. (Whether the patient is emerging any healthier, however, is a question the economists prefer to dodge.)

Carnegie-Mellon's Prof. Lave, for example, notes that visits to doctors have leveled off in recent years to an average of about five per year for each American. Nevertheless, payments to doctors have gone up spectacularly, and far faster than doctors' fees have risen. "Surely, more physician's services are being rendered per contract," she concludes.

In casting about for some explanation for what's causing this costly increase in the use of medical services, economists are focusing on two phenomena—neither of which would be easy to bring under control. One is the rapid advance in medical technology, and the other is the pervasive use of health insurance to pick up the tab.

That new medical advances can be ex-

for the aged has voluntarily submitted to such state-run programs in some areas.)

There is also a spreading effort to change the way Blue Cross, Medicaid and Medicare determine their payments to hospitals. Until recently, most reimbursements were calculated by figuring the past year's costs of caring for an average Blue Cross or Medicaid patient. This system permitted hospitals to "pass along" any and all cost increases, critics charged.

Now, however, many hospitals and third parties are switching over to "prospective reimbursement" formulas. Under this system, the inflationary impact on hospital costs is projected in the coming year, and reimbursement rates are set accordingly. Any hospital whose costs exceed the projected increases simply loses out.

In Washington, health planners in the Carter administration are proposing that government regulation of hospital rates and use of prospective reimbursement formulas be invoked on a national scale. Such a move, affecting almost every hospital in the country, would require legislation by Congress, however.

While it's too early to gauge the impact of these costs controls, they appear to be a mixed blessing. Some hospitals are taking a financial drubbing. The voluntary, nonprofit hospitals in New York City, for example, are reporting collective operating deficits of over $90 million a year. Much of this is blamed on outpatient clinics that are swamped with near-poor who aren't covered by any insurance. But one medical expert figures that about a fourth of the deficit can be chalked up to the new stringent state-determined reimbursement formulas.

The giant auto maker says its Blue Shield-Blue Cross program has now surpassed the steel industry as its largest "supplier." GM's health-insurance outlays in the last six months have climbed to $120 a month per contract covering a worker and his family, an increase of $19 over late last summer. By late this year, the outlay will hit $144 per worker contract each month.

The reason for the relentless upward climb in health-care costs is a major economic enigma, judging from the observations of medical economists gathered here recently at the invitation of the Blue Cross Association. Some of the more widely of-

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In casting about for some explanation for what's causing this costly increase in the use of medical services, economists are focusing on two phenomena—neither of which would be easy to bring under control. One is the rapid advance in medical technology, and the other is the pervasive use of health insurance to pick up the tab.

That new medical advances can be expensive is unquestioned. For instance, in the last decade, intensive-care units, where costs can run several hundred dollars a day, have come into wide use. In the last five years, hundreds of thousands of Americans with heart disease have undergone the new coronary-bypass surgery, running up hospital bills of $10,000 to $25,000 each.

Costly Diagnoses

"Diagnostic procedures are an important contributor to these (overall) costs," says Dr. H. David Banta, a public-health expert on the staff of the Congressional Office of Technology Assessment. He notes that a study done at the University of Rochester Medical Center found that laboratory charges constituted over 25% of the average hospital bill, and that the number of chemistry laboratory tests given in the hospital in 1970 was 95% greater than in 1965.

Citing reports in medical journals, Dr. Banta says that laboratory tests done for a patient with a perforated appendix now total 31, or six times as many as in 1951. "Women receiving routine maternity care had an increase from 4.8 tests in 1951 to 13.5 per case in 1971," he says. Also, the average heart-attack victim now gets nine electrocardiograms instead of five or six.

Once a new medical technique is developed, there is a strong pressure to use it, often with little regard to its additional cost. Michigan's Mr. Feldstein, for example, proposes what he calls the "prestige-hospital hypothesis" of rising hospital costs. Most hospitals are nonprofit institutions, and when local citizens sit down at the board table as trustees, their tendency is to try to make their hospital the best. Encouraged by local doctors, the trustees will strive to add new wings and such quality features as new computerized X-ray machines and units for open-heart surgery, burn treatment and intensive care.

The spread of health insurance and government-paid medical programs fuels this tendency, economists say. "With insurance now paying approximately 90% of all hospital costs, there is a strong incentive for patients and their physicians to seek 'the best possible care' almost without concern about its costs," the wage-price council study says.

Added to the demand for the best possible care are such cost pressures as rising malpractice insurance rates and a decline in philanthropic contributions. With fewer donations, hospitals increasingly have to borrow capital funds and take on new interest costs.

A Vicious Cycle

The resulting higher hospital costs trigger a vicious economic cycle. High-cost hospital care induces patients to buy more complete insurance, the wage-price council notes. In turn, the growth of insurance encourages hospitals to provide more extensive and expensive health-care facilities.

In an attempt to control costs, at least nine states currently have laws putting hospital rates under some type of public regulation. Generally, the laws require advance state approval of changes in hospital rates paid by so-called third parties, notably the Medicaid program for the poor and Blue Cross. (The huge federal Medicare program

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Carter Proposes U.S. Lid on What Hospitals Can Charge

Washington

A strict federal limit on how much hospitals can charge patients for care was proposed by President Carter ysesterday as a first step in cutting the country's runaway medical costs by billions of dollars a year.

In what could become the nation's first permanent health cost control, the administration said it will ask Congress for authority to set a hospital charge ceiling that could save those who pay for health care more than $2 billion in fiscal year starting October 1.

Health, Education and Welfare Secretary Joseph A. Califano Jr. denied that the step would be a wage-price control for hospitals — President Carter has said he would not impose wage-price controls — but rather a way of negotiating with hospitals to give them a "reasonable price increase."

The health industry was under temporary price control in President Nixon's "economic stabilization" period of August, 1971, to April, 1974.

Califano said a nine per cent increase in hospital charges to the government, health insurers and individuals in fiscal 1978 would be "ample." He added that such a limit would save the government and the public $2 billion.

Hospital charges rose 15 per cent last year to make the average daily cost $154 per patient, he said. The $154 is a nationwide average — the current figure is more than $200 in the Washington area and equally high in other big metropolitan centers.

Califano called the nine per cent figure only an example of the possible ceiling to be negotiated with hospitals. He called it "an ample increase," in his opinion, and said it could save the federal government alone $829 million in fiscal 1978 Medicare and Medicaid payments.

Medicare-Medicaid payments make up 40 per cent of the country's total hospital bill, however. So savings to health insurers and cash-paying patients could total another $1.24 billion.

If the Carter measure is not enacted, Medicare-Medicaid spending for the elderly and the poor will rise an expected $53 billion in fiscal year 1978 to $66 billion in 1982, Califano warned.

He said the measure is needed to allow time to design a permanent system to contain other health costs and to make comprehensive national health insurance possible.

The negotiations on actual hospital charges might be conducted by federal officials with state hospital associations. Califano said he will name a national advisory board to help him set hospital cost limits.

He said details of a bill must still be worked out with health leaders in Congress, the American Hospital Association, American Medical Association and Blue Cross.

Alexander McMahon, hospital association director, said any program that controls one part of the economy without controlling others is "inequitable and unworkable," and hospitals will battle any limit that fails to consider each hospital's circumstances.

Washington Post

Carter and Ford Budgets Compared

DEPARTMENT	COST	CHANGE
Legislative Branch	$11 Billion	NC
The Judiciary	$400 Million	NC
Executive Office of the President	$100 Million	MC
Funds Appropriated to the President	$5.3 Billion	+$1.3 Billion
Dept. of Agriculture	$14.6 Billion	+$2.2 Billion
Dept. of Commerce	$4.2 Billion	+$2.3 Billion
Dept. of Defense Military	$118.9 Billion	—$2.8 Billion
Dept. of Defense Civil	$2.6 Billion	MC
Dept. of Health, Education and Welfare	$162.2 Billion	+$1.1 Billion
Dept. of Housing and Urban Development	$39.2 Billion	+$9.5 Billion
Dept. of Interior	$3.6 Billion	—$100 Mill
Dept. of Justice	$2.3 Billion	MC
Dept. of Labor	$26.6 Billion	+$6 Billion
Dept. of State	$1.4 Billion	MC
Dept. of Transportation	$13.3 Billion	+$300 Mill
Dept. of Treasury	$55.7 Billion	+$4.7 Billion
Energy Research and Development Administration	$7.8 Billion	—$100 Mill
Enviromental Protection Agency	$5.3 Billion	MC
General Services Administration	$300 Million	MC
National Aeronautics and Space Administration	$4 Billion	MC
Veterans Administration	$19 Billion	+$900 Mill
Other Independent Agencies	$32.9 Billion	+$1.8 Billion
Total	$507.3 Billion	+$26.8 Bill

NC — No Change MC — Minor Change

This budget breakdown shows the expenditures proposed by Carter (left column) and their amounts of change from the budget proposed by Ford (right column)

DISTURBING FACTS ABOUT OUR HOSPITALS

There is recent and authoritative evidence that while our hospitals are considered the best in the world and are satisfactory to most patients, they could be better.

By Paula Dranov

Most of us will spend some time in a hospital sooner or later.

What kind of care can we expect? Is there anything to recent reports that there are big differences in the quality of care from hospital to hospital?

Disturbing questions. Especially since there are no easy answers. Right now, there is no authoritative way to determine in advance the kind of treatment we'll get in the hospital.

And yes, the quality of care does vary from one hospital to another, according to the results of a major study sponsored by the prestigious National Academy of Sciences (NAS) and recently made public. Fortunately, the follow-up to that study which is now underway may someday yield the kind of information we all would like to have. It may help establish criteria by which we can judge how well one hospital stacks up against another. Eventually, it could result in upgrading the quality of hospital care in this country.

However, the results to date are somewhat alarming: they show a big enough difference in the quality of care from hospital to hospital to constitute an important public-health problem.

That conclusion wasn't reached lightly. It came only after the Stanford University Center for Health Care Research, working under an NAS grant, pored through the records of 314,000 patients who underwent surgery at 1,224 hospitals in 1972. Then, the researchers zeroed in on 8,593 patients who were operated on in 17 hospitals from May 1973 to February 1974.

The purpose of all that research was to measure the quality of hospital care based on the outcome of 15 different kinds of operations. The researchers compiled data on each patient's age, sex, general health and several other factors, including whether or not the operation was an emergency. After the operations they followed each case to determine 1) how many patients died following surgery, 2) how many suffered complications within a week of their operations and 3) how many had complications or died within 40 days of surgery. The complications and deaths were then compared with what the researchers had determined the results of surgery should have been on the basis of the individual patient and his or her condition.

Paula Dranov is a free-lance writer who writes on medical and consumer issues.

For the second phase of the study, the Stanford researchers interviewed every one of the 8,593 patients and doctors, nurses and anesthetists. After all the results were in and the statistical adjustments made, the researchers concluded that a patient's chances of dying or suffering severe complications of surgery were two and a half times as great at one hospital as at another.

Why such a big difference?

At present, that's the $64,000 question. The Stanford researchers are continuing their work in an attempt to pinpoint the reasons. Indications are, however, that the hospitals which showed up best:

—Had a higher percentage of nurses on their staffs.

—Spent more money per patient.

—Were more careful than others in awarding staff privileges to doctors.

The study found that old assumptions about what makes one hospital better than another no longer apply. For example, it had long been believed that the best hospitals are the ones with the most board-certified doctors—those physicians who have passed rigorous tests in one of the 21 recognized medical specialties. It also was thought that teaching hospitals—the ones that train doctors—are better than non-teaching institutions. Neither of those two factors seemed to make any difference in the quality of care in the hospitals studied.

The finding that care seemed to be better at hospitals with more registered nurses on their staffs may lend support to nurses' efforts to gain a greater say at the top-management level at hospitals. As things now stand, the nurses have been excluded from most medical policy-making. They don't have representation on the Joint Commission on Accreditation of Hospitals or the National Professional Standards Review Council, organizations that monitor the quality of hospital care.

Nurses, once content to remain in the background, have been speaking up recently. And what they've got to say about the kind of care available in our hospitals has been making waves inside and outside of the medical profession.

In response to a recent poll conducted by *Nursing 77*, the nation's largest nursing journal, 42 percent of the 10,000 nurses who responded said they knew of deaths due to doctors' mistakes, and 15 percent said they knew of more than one such case. One nurse told of a surgeon in her hospital who made mistakes that had cost the lives of eight patients in eight years.

Frederic Lewis

The nurses weren't quite as hard on themselves as they were on the doctors, but what they had to say is cause for concern. Eighteen percent said they knew of deaths caused by errors made by nurses, and four percent admitted to making fatal mistakes themselves.

One nurse described this experience: "On the 11 to eight shift in the intensive care unit, an aide, a licensed practical nurse and I had six critically ill patients, all on ventilators in three separate rooms. I spent 15 minutes with one who was hemorrhaging, and when I returned to the other room, one of the patients had accidentally disconnected himself from the ventilator, arrested and died. That was three years ago, and I still can't get it out of my mind."

Some of the nurses took advantage of the questionnaire to unload their gripes. The biggest ones were the amount of paper work they have to do, what they saw as doctors' indifference to their opinions about patients and the level of psychological support doctors give their patients. A full 77 percent rated doctors' performance in this last area as "fair" or "poor."

And what do the nurses think about the quality of hospital care in general? An average of the "grades" the nurses were asked to assign their own institutions came out to a "low B." Furthermore, 38 percent said they wouldn't want to be a patient in their own hospitals.

Although the public usually doesn't hear this kind of thing from the medical profession, laymen have long been aware that going to the hospital is not without some risk. We're asked to consent in writing to surgery, to anesthesia, to other medical procedures, some routine, some not. The risk of anesthesia is one we don't think of too often, but

it's been well documented: anesthesia causes or contributes to the death of one in 3,000 surgical patients, and one in 10,000 dies as a result of an anesthesia accident. Those don't sound like bad odds. But they represent risks that doctors as well as patients would rather not take.

What causes anesthesia deaths? Some recent studies suggest that they may be traceable to errors made in administering the anesthesia. A report in a recent issue of the *New England Journal of Medicine* describes the deaths of two young women undergoing abortions who were given overdoses of the local anesthetic *lidocaine*. A third girl died from an allergic reaction to the anesthetic *mepivacaine*.

A group of malpractice suits in California generated another study of deaths due to anesthesia errors. The patients involved "were healthy and required relatively routine elective surgical procedures," the *Journal of the American Medical Association* reported. Nine of the patients died because of "gross mismanagement" of their cases—overdoses of the anesthetic, disconnecting the patient from the breathing tube and insertion of the breathing tube into only one lung. All told, of the 41 cases studied, 30 patients died, and eight suffered severe brain damage.

Why does this kind of thing happen? A study conducted by Massachusetts General Hospital concluded that 69 percent of the anesthesia mishaps or near mishaps investigated there recently were due to human error. More than half of those could be traced to the "adverse general mental or physical condition of the responsible individual." Another 27 percent of the problems studied were due to equipment failure.

While all of this may seem to be a shocking picture, the American Hospital Association helps put things in perspective by pointing out that American hospitals are still the best in the world. They also cite a Roper poll that shows that 76 percent of the public is satisfied with the quality of hospital care.

In addition, there also are things we can do to protect ourselves in the hospital and to make sure we get the kind of care we should have. Obviously, we've got to leave the medical decisions to the doctors, although there's nothing to prevent us from asking for a second, or even a third, opinion. And the increase in malpractice suits against physicians is testimony to the fact that more and more people are holding doctors accountable for their mistakes.

However, what many patients don't realize until something goes wrong is that doctors are ethically and legally required to obtain their patients' "informed consent" in connection with the treatment they recommend. The key word there is "informed"— the doctor has an obligation to make sure that the patient fully understands the risks involved. So if you should have to enter a hospital, keep these facts in mind to help you get the best care available.

Hospital seeks $40 million budget

The Washoe Medical Center Board of Trustees will consider a $40.1 million budget for fiscal 1977-78 at its regular meeting 7:30 p.m. Monday at the hospital.

The budget represents a $6.1 million increase over the current year — or 18 per cent.

The budget is based on anticipated revenues for the 531-bed facility, and expected costs for the coming year. It includes $1.4 million (3.5 per cent) of income from Washoe County for services provided to welfare patients.

Room rate increases, effective April 1, include maternity rooms, which were raised last in 1975. A private room will from $90 to $100 a day, a semi-private from $68 to $80 and a ward from $63 to $93. Delivery room rates will go from $105 to $120.

Daily medical and surgical room costs will increase from $113 to $123 for a private room, $103 to $113 for a semi-private and $98 to $108 for a ward.

Pediatric unit rates will drop from $103 to $100 if the proposed budget is approved.

Infant intensive care — for the most intensive level — will remain at $265 a day. But costs for the less intensive levels will go from $200 to $240 per day and $135 to $200 per day.

Private cardiac care rooms will go from $150 to $200, semi-private from $130 to $175.

Hospital Administrator Carroll Ogren said the hospital is projecting an 8.1 per cent increase in the number of patient days in the hospital with the new budget based on a 70 per cent average occupancy rate.

The budget provides for a 5 per cent cost of living increase for employes and regular pay increases of about 3 per cent. Total salaries include $20.2 million — or about half the proposed budget.

Capital improvements for the upcoming year include $200,000 for construction of an obstetrics operating room, $150,000 for an automatic chemical analyzer, $95,000 for a computer for dictation and transcription, $101,077 for surgery and recovery room monitors and equipment and $97,268 for nursing services equipment.

1977 STAFF WRITER: CHARLES J. ROLO

Wall Street:

THE COLD WAVE WILL SHRINK SOME FIRST-QUARTER PROFITS, BUT ANALYSTS ARE MORE CONCERNED ABOUT ITS WINTRY IMPACT ON INFLATION.

Wall Streeters say transportation problems and temporary layoffs will hurt earnings in a number of industries--among them transportation, hotels, restaurant chains, construction and retailing. Other businesses particularly affected, according to Charles F. O'Hay, director of investment strategy for ABD Securities: heavy gas users such as textiles, fibers, glass and fiberglass, stone, clay, cement, chemicals, fertilizers, metals and machinery. Except in rare instances, however, brokerage houses aren't issuing "sell" recommendations even though the freeze will shrink such companies' earnings. Robert H. Stovall, director of investment strategy at Reynolds Securities, compares the cold spell to a severe strike and invokes the adage, "Never sell on strike news." (The reason is that the market shrugs off earnings dips caused by transitory setbacks.)

Like many others, Kevin J. Bradley, research director of Bache Halsey Stuart, worries that the surge in food and fuel costs and other effects of the cold wave could add as much as one percentage point to inflation in 1977. But, says Michael T. Murray, a vice president of Robert W. Baird & Co., "Investors shouldn't confuse the price increases that are a consequence of the cold weather with the mammoth forces that ignite inflation--they just aren't present today." So far, the weather hasn't changed the generally bullish long-term forecast for stocks.

MORE MUTUAL FUNDS ARE SELLING OPTIONS.

The five mutual funds managed by Franklin Research, Inc. of San Mateo, Calif. have joined the small group of funds that are selling call options on their securities. The group includes two of the Boston-based Colonial funds and Tri-Continental Corp., a closed-end fund whose shares are traded on the New York Stock Exchange. Henry L. Jamieson, chairman of Franklin Research, says the 1976 tax law has made mutual fund option writing more advantageous. He adds that the added income from option premiums will make funds more attractive to income-conscious investors and cushion losses when stock prices sag. There is, of course, a trade-off: the risk of losses on options if the securities on which options are sold rise sharply in price.

THE MEDICAL SERVICES INDUSTRY GETS A TOP RATING FOR POSSIBLE 1977 MARKET PERFORMANCE.

The Value Line Investment Survey sees "very attractive investment opportunities" among seven companies that own and operate private hospitals. Profits rose about 33% in 1976, Value Line estimates; it expects a further 27% rise in 1977 and "considerable earnings progress over the next several years." A vigorous expansion program has given the hospital chains ample capacity, so growing demand should improve occupancy rates and raise profits. Value Line's favorites: American Medical International (recently traded on the New York Stock Exchange at $14), American Medicorp. (NYSE, $10)

EXHIBIT B

state of nevada

DEPARTMENT OF HUMAN RESOURCES
WELFARE DIVISION
251 JEANELL DR., STATE CAPITOL COMPLEX, CARSON CITY, NV. 89701

February 16, 1977

The Honorable Robert Barengo
Chairman, Assembly Judiciary Committee
Nevada State Assembly
Legislative Building
Carson City, Nevada 89701

Dear Mr. Barengo:

I am taking this opportunity to inform you of some real concerns I have regarding SB 189 and AB 268.

A.B. 268, Section 5 (lines 22-33)

The Welfare Division, on average, has legal custody of in excess of 500 foster children. This agency's custody is pursuant to Juvenile Court orders for wide ranging reasons of neglect of the child by its parents or other custodians. While my staff usually does a good job, it is impossible for them to always be aware of every child's rights against every health care provider.

I feel that for me, as Welfare Administrator, to be held personally liable for an inevitable oversight by my staff is asking too much of a welfare administrator. The 1975 Legislature already wiped out NRS 11.280 (Statute of Limitations tolled during minority) for the benefit of health care providers. It is unconscionable to shift the cost of their malpractice to an administrator who under NRS 41.038 (1)(b) may be insured against this risk at State expense but by fiat of the State Insurance Placement Committee has to go bare or pay the State's insurance premiums out of his own salary (see attached news bulletin).

I respectfully ask that I and the Welfare Division be expressly exempted from the personal liability provisions of Section 5 of AB 268.

S.B. 189 (Lines 14, 15 and 21)

This bill appears to give a provider of medical care guilty of malpractice the benefit of public welfare programs. It is in direct conflict with existing firmly established public welfare policies to give the guilty provider a windfall at the expense of the Federal and State public treasuries.

Title XIX (Sec. 1902(a)(25)) of the Social Security Act, 45 C.F.R. §250.31, and NRS 428.325 all make the legal liability of every third party for causing a welfare recipient to incur medical costs at the potential expense of the public treasuries a prior (not collateral) resource to welfare medical benefits. Furthermore, these laws require such liable third party to reimburse the public treasuries to the extent those treasuries actually paid those medical costs.

If you have any questions regarding my comments, I would be happy to arrange a meeting with you and our Deputy Attorney General Bob Holland.

Sincerely,

George E. Miller
State Welfare Administrator

bl

EXHIBIT C

nmlia

nevada medical liability insurance association

February 17, 1977

The Honorable Robert R. Barengo
State Assembly
State Legislative Building
401 South Carson Street
Carson City, Nevada 89710

Dear Mr. Barengo:

Thank you for the courtesy extended to me on February 15, 1977 while testifying before the Joint Committee on Judiciary regarding SB 187.

It appears appropriate at this time to briefly reduce that testimony in writing.

The Nevada Medical Liability Insurance Association and its Board of Directors stand in strong support of this bill.

In addition to the basic support given to SB 187, we have recommended two amendments thereto:

1. Under Sec 2, Subsection 1
   Item (c) should be added to include anticipated future income.

2. Under Sec 3, Subsection 1
   The last sentence should be deleted. Adding insurers as a party to the action creates an untenable position for insurers. Being put in this posture could cause insurers, if for no other reason, to refrain from writing malpractice insurance in Nevada. It also creates questions of equity and constitutionality.

We intend to have a representative at each of the meetings of this joint committee. We will stand ready to offer any testimony or answer any questions relating to the professional liability insurance question as you may desire.

Sincerely,

Robert A. Byrd, CPCU
President

RAB:cl

1755 e. plumb lane, suite 269/p. o. box 7456 reno, nv. 89510/telephone (702) 329-2246

EXHIBIT D

STATE OF NEVADA
OFFICE OF THE ATTORNEY GENERAL
CAPITOL COMPLEX
SUPREME COURT BUILDING
CARSON CITY 89710

ROBERT LIST
ATTORNEY GENERAL

February 24, 1977

The Honorable Melvin Close, Jr.
Nevada State Senator
Legislative Building
Carson City, Nevada 89710

Re: S.B. 185, 188, 190 and 191

Dear Senator Close:

As a followup to my recent testimony before the joint senate and assembly committees on judiciary regarding the above captioned bills, I should like to once again urge the committee to take swift action on these measures, most of which are designed to assist the Board of Medical Examiners and the Attorney General to more effectively play their respective roles in the quest for providing quality medical care to Nevada citizens.

I particularly believe the amendment which I submitted to the committee for S.B. 185 will insure proper regard for the privacy of the patient and I most respectfully urge that said amendment be included as a part of S.B. 185.

As you will recall, at the end of the last hearing on these bills, Senator Hilbrecht announced that S.B. 188 was not a part of the interim committee's recommendations. This was a correction to his earlier testimony that morning. I would like to take the opportunity once again to urge that S.B. 188 not be approved since it only works to the detriment of the public in its efforts to secure qualified expert witnesses in medical malpractice matters before the Board of Medical Examiners. Obviously there are differences between the type of medical practice in a rural Nevada community as opposed to our larger metropolitan areas. But I believe that these matters are matters of defense by any doctor who may be subject to a board hearing and it is fully within the knowledge and ability of the Board of Medical Examiners to take such a defense into proper consideration. S.B. 188 would actually only tie the Board members' hands.

You will recall that during my testimony I suggested that Section 1 of S.B. 190 be amended to cover all the areas which could lead to charges under Chapter 630 including gross malpractice, malpractice, professional incompetency and unprofessional conduct, rather than the simple term "malpractice" as it now appears in said section. As for Section 2 of S.B. 190, we would certainly encourage the amendment on line 20 of the bill of the figure "$2,000" to read "$5,000" or even higher, if the committee deems that appropriate. I also question the need for referring to the Board of Medical Examiners each malpractice claim as opposed to each settlement, award or judgment. A claim which has not yet resulted in any settlement, award or judgment, would probably only produce excessive paper work for the Board of Medical Examiners or serve as duplication of prior written allegations which have been made against the same doctor from another source.

Concerning S.B. 191, I personally would endorse the comments of Bryce Rhodes, Esq., the private attorney for the Nevada State Board of Medical Examiners. Most certainly I agree with his statement that NRS 630.315 should not be repealed but instead should be retained in the present law and indeed strengthened. If this section of the present law is retained, then Section 7 of S.B. 191 should be deleted, as being superfluous. In addition Section 7 allows the physical or mental examination at the wrong time in the proceedings. As Mr. Rhodes pointed out in cases of extreme danger to public health and safety the Board should have the authority to require such an examination at the earliest possible time, along with authority to summarily suspend a physician from the practice of medicine for 90 or 120 days. In addition, where written allegations are filed against a physician, the requirement of a physical or mental examination may indicate additional charges which should be brought.

In conclusion, I would like to urge the joint committees to amend S.B. 185 and Section 1 of S.B. 190 to make both these statutes effective on passage and approval. These two bills are critical to completing two investigations now pending in the Attorney General's Office which are being hindered by the lack of accessibility to patient records.

Thank you for this opportunity to expand upon my comments to the joint committees. If this office may be of any further assistance to you in the consideration of these matters, please advise.

Sincerely,

ROBERT LIST
Attorney General

By WILLIAM E. ISAEFF
William E. Isaeff
Deputy Attorney General

WEI:rab

cc: All members of the
Senate and Assembly
Judiciary Committees

Bryce Rhodes, Esq.

EXHIBIT E

MIKE O'CALLAGHAN, Governor

Nevada State Board of Medical Examiners

AIRPORT CENTER BUILDING
1281 Terminal Way, Suite 211 • (702) 329-2559
Mailing Address: Post Office Box 7238 • Reno, Nevada 89510

LESLIE A. MOREN, M.D., President
KIRK V. CAMMACK, M.D. Vice President
KENNETH F. MACLEAN, M.D., Secretary-Treasurer
RICHARD D. GRUNDY, M.D.
THEODORE JACOBS, M.D.

MRS. EVELYN HILSABECK, Executive Secretary

February 28, 1977

The Honorable Melvin Close, Jr.
Nevada State Senator
Legislative Building
Carson City, Nevada 89710

Dear Senator Close:

RE: SB 191

This Board recommends:

1. That NRS 630.315 not be repealed (as provided by Sec 8 of SB 191).

2. That Sec. 7 of SB 191 not be inacted.

3. That NRS 630.315 be amended by adding thereto a new sub-section as follows:

> 5. In the event the Board shall determine, following said mental or physical examination, that the physician lacks the ability to safely practice medicine, the Board may suspend the physician's license to practice medicine until there has been a hearing on the allegation, provided that said suspension pending a hearing on the allegation shall not be for a period of more than 90 days.

The Board further recommends that SB 191 be amended by the addition of a new section, amending NRS 630.340 by adding thereto the following new sub-section:

> 3. Until the Order of Revocation or Suspension is modified or reversed, as provided in this section, the Court shall not stay the same by temporary restraining order or preliminary injunction.

It is submitted that the above requested new sub-section is indicated to protect the public health, safety and welfare pending judicial review. Otherwise, a physician whose license to practice medicine has been revoked or suspended after a full hearing and who has been found to lack the ability to safely practice medicine due to indulgence in the use of alcohol or drugs or who willfully disregards established medical practices or fails to exercise

proper care, diligence and skill in the treatment of patients, may be permitted to practice medicine during the period of judicial review to the detriment of the public health, safety and welfare.

RE: SB 190

The Board concurs in the suggestions of William E. Isaeff, Esq., Deputy Attorney General, made at the hearing on February 14, 1977 and as set forth in his letter to you of February 24, 1977; that Sec. 1 of SB 190 be amended to cover gross malpractice, malpractice, professional incompetency and unprofessional conduct, rather than the simple term "malpractice", as it now appears in said section.

The Board also concurs in Mr. Isaeff's suggestion that the figure "$2,000.00" in Sec. 2 of SB 190 be amended to read "$5,000.00" or even higher if the Committee deems that appropriate.

Further, Sec. 3(2) provides that the Commissioner shall report each claim to the Board of Medical Examiners. This would appear premature if every claim made under a policy of insurance had to be reported to the Board prior to any settlement, award or judgment. It would appear premature to have every claim forwarded with all of the excessive paper work involved and a more workable approach would be to have only those claims forwarded upon which a settlement or award was made or a judgment rendered.

RE: SB 188

The Board concurs in the suggestion of William E. Isaeff, Deputy Attorney General, as detailed in his letter to you of February 24, 1977, that SB 188 not be approved because it would work to the detriment of the public and would cause a serious handicap to the Office of the Attorney General and to the Board of Medical Examiners in proceeding with hearings involving allegations of gross malpractice, malpractice, professional incompetency and unprofessional conduct.

RE: SB 185 and Sec. 1 of SB 190

The Board concurs in Mr. Isaeff's suggestion that both of these statutes be effective on passage and approval.

The Board will appreciate consideration by the Joint Committees of the above recommendations.

Sincerely,

Bryce Rhodes

Bryce Rhodes
Legal Counsel

BR/mm

EXHIBIT F

NEVADA LICENSED PRACTICAL NURSES ASSOCIATION
member of
NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.

March 2, 1977

Re: S.B. 185
S. B. 187
A. B. 268
A. B. 221

Committees on Judiciary

Mr Chairman &
Kembers of the Committees

I am Ellen Pope. Licensed Practical Nurse. I live at 1298 Lovelock Highway, Fallon, Nv. I am Chairman of the Legislative Committee of the Nevada LPN Association.

I have contacted members of my Association concerning bills in the Malpractice package. We are concerned about the omission of the LPN in the defination of "Provider of Health Care" and feel that the LPN should be included. At this time S. B. 185; S. B. 187 and A. B. 268 include "registered nurse"

The LPN today does provide many services of health care: He or she can be found in the emergency rooms across the state. We administer drugs-- we are in operating rooms- recovery rooms. In the newborn nursery- with the labor patient. We are change nurses in the extended care facilities. Public health Nurses, School Nurses and many more areas of acute care. We are licensed under the same act as the registered nurse. Chapter 632 of Nevada Revised Statutes.

In the bill A B 221 the language does not include even register nurse. It just says nurses and their or some persons who do call themselves nurses who are not graduates of accrediated schools and are not licsened in the state of Nevada. We feel that this must be changed to protect the patient.

The use of the term "licensed nurse" would include both levels of nursing but would protect the patient in as much as a nurse must be licensed and the bounderies of his or her actions are clearly defined in the rules and regulations of the Nevada Statutes.

Ellen Pope LPN

Ellen Pope LPN
Registration # 77-380

NEVADA LICENSED PRACTICAL NURSES ASSOCIATION
member of
NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.

March 2, 1977

PROPOSED AMENDMENTS

S. B. 185 Page 1 Section 3 line 7 add:
Licensed Practical Nurse or change
"Registered nurse" to Licensed Nurse

S. B. 187 Page 1 Section 2 subsection 2 line 10 add:
Licensed Practical Nurse or change
"Registered Nurse" to Licensed Nurse

A. B. 268 Page 2 Section 6 line 36 add:
Licensed Practical Nurse or change
"Registered Nurse" to Licensed Nurse

A. B. 221 Page 1 Section 2 subsection 2 line 10
change "Nurse" to Licensed Nurse

STATE OF NEVADA

LEGISLATIVE COUNSEL BUREAU

LEGISLATIVE BUILDING
CAPITOL COMPLEX
CARSON CITY, NEVADA 89710

ARTHUR J. PALMER, *Director*
(702) 885-5627

EXHIBIT G

LEGISLATIVE COMMISSION (702) 885-5627
JAMES I. GIBSON, *Senator, Chairman*
Arthur J. Palmer, *Director, Secretary*

INTERIM FINANCE COMMITTEE (702) 885-5640
DONALD R. MELLO, *Assemblyman, Chairman*
Ronald W. Sparks, *Senate Fiscal Analyst*
John F. Dolan, *Assembly Fiscal Analyst*

FRANK W. DAYKIN, *Legislative Counsel* (702) 885-5627
EARL T. OLIVER, *Legislative Auditor* (702) 885-5620
ANDREW P. GROSE, *Research Director* (702) 885-5637

March 3, 1977

M E M O R A N D U M

TO: Assembly Committee on Judiciary

FROM: Andrew P. Grose, Research Director

SUBJECT: A.B. 265

At the March 2, 1977 Joint Hearing, Fred Hillerby of the Nevada Hospital Association voiced what could be characterized as lukewarm opposition to mandated risk management.

The subcommittee was not unaware of the standards and procedures, designed to minimize accidents and poor practices, in use in Nevada hospitals. It felt these efforts were commendable and to be encouraged. The subcommittee also felt that the concept of risk management or loss reduction as it is known to the insurance industry goes beyond what now goes on. Dr. Rottman concurs in this feeling and, as I suggested to you, he would be happy to explain what risk management entails.

To give you an idea of some of the things on which the subcommittee based the A.B. 265 recommendation, we have attached four items.

1. ABA Interim Report, Sept. 1976, recommendation area 3. In particular, see the second and third items of the second page.

2. Report to the 1976 Florida legislature of the Medical Liability Insurance Commission. Based upon experience in hospitals with 300 or more beds, the commission recommended extending mandated risk management to all hospitals.

3. HEW Report of the Secretary's Commission on Medical Malpractice, 1973. See especially the recommendation in the upper right of page 63. This report is 4 years old but little has been done voluntarily to develop hospital risk management.

4. The Florida law. Note the greater detail and broader mandate compared to A.B. 265 which was designed to allow flexibility.

APG/jd
Encl.

interim report of the commission on medical professional liability

The Commission's recommendations set out in Appendix C of this interim report with respect to tort law and procedure, and this report insofar as it relates to such recommendations, have not been acted upon in any way by the House of Delegates of the American Bar Association and therefore, while they do reflect the views of the Commission, do not represent the policy of the Association unless and until approved by the House of Delegates. The other recommendations of the Commission contained in this interim report have been approved by the House of Delegates and do represent the policy of the Association.

AMERICAN BAR ASSOCIATION

3. *Prevention*

One certainty is that reduction in the frequency and severity of medical incidents[3] which might lead to claims is of great importance, not only to patients, whose welfare comes first, but also to providers and insurers. Since more than 80 percent of all malpractice claims are based on incidents which take place in hospitals,[4] it is obvious that priority should be given to fixing and maintaining higher standards of care in hospitals.

The Commission is aware of the quality assurance programs of the Joint Commission on Accreditation of Hospitals (JCAH) and of the developing Professional Standards Review Organizations under 1972 amendments to the Social Security Act. Promising programs in several individual hospitals and a few hospital associations have also been called to the Commission's attention as exemplifying enlightened and progressive approaches to the problem. The American Hospital Association (AHA) has also made materials and staff time available to the Commission to describe various programs it has undertaken or is aware of.

Nonetheless, an enormous further effort will be required if the number of compensable incidents is to be reduced significantly. That effort will require additional development of quality assurance methodologies, identification of promising work in individual hospitals and consideration of the role of insurance funding and mechanisms in prevention. It will also require cooperative efforts by medical, legal and hospital administration elements. The Commission has neither the inclination nor the capacity to tell hospitals how they should be run, but it does urge that a major, national-level cooperative effort —perhaps under the leadership of the AHA—be mounted to provide expertise and technical assistance in prevention matters to hospital administrators and others.

During the next year, the Commission intends to inform itself in greater detail on prevention-related matters. With the

3. As used in this Report, a "medical incident" is a mistake by a health care provider which injures a patient. The incident may or may not have involved negligent care.

4. The AIA study indicates that 81.4% of all claims (whether against a physician or the hospital) relate to incidents occurring in a hospital. The comparable statistic in the NAIC study is 80%.

help of staff and consultants, it will explore the following questions:

What insurance mechanisms will reinforce appropriate prevention activities by individual hospitals? Several persons have recommended that a hospital be made exclusively responsible for all negligent acts of omissions which occur in the hospital or are hospital-related. Proponents argue that focusing liability on the hospital for the negligence of physicians with staff privileges, as well as employees, will encourage more effective prevention activities. The proposal (generally referred to as "channeling"), together with suggestions as to the more flexible use of substantial deductibles and surcharges and new ways to utilize experience and retrospective rating plans, may be the subject of a major staff effort during the next year. This effort will depend in part on the findings of consultants from the Insurance Department of the Wharton School who are attempting of ascertain the extent to which premium increases in fact operate as incentives for improved prevention programs in the light of the high percentage of a hospital's operating costs which are reimbursed by third party payers.

Which hospitals and/or hospital associations have the most effective prevention programs and why? The Commission, in conjunction with the AHA, insurance companies and others, hopes to identify hospitals with superior prevention programs and analyze them—perhaps with the aid of expert consultants—and help publicize such efforts. With this knowledge as a basis, the Commission will hold discussions with the JCAH, AHA and other appropriate organizations to see if they might be willing to ferret out, on a much more extensive basis, successful prevention programs and to publicize these efforts broadly.

What reporting of incidents or injuries should take place within the hospital, and to organizations and agencies outside the hospital? What statutory support and protections are indicated? There is a need for each state to review the case law and statutory context within which the reporting of medical incidents or injuries takes place. While there has been less focus on prevention than on tort law changes in recent legislative sessions, more attention is now being given to prevention, including the statutory context,[5] and the Commission intends to work with appropriate organizations to develop recommendations in this area.

4. *Medical Discipline*

Although there is no necessary relationship between conduct which renders a physician liable for medical discipline and that which makes a physician liable to a patient for medical malpractice, improved medical disciplinary procedures and improved programs to retain, rehabilitate or eliminate from practice physicians who are grossly incompetent or unprofessional should help prevent malpractice. Through its Prevention Committee, the Commission has studied many of the problems inherent in developing effective disciplinary structures and programs and has reviewed comprehensive efforts by several states (notably Michigan) to address the problem legislatively. This research indicates that there are a myriad of issues and deficiencies, ranging from the lack of a comprehensive definition of misconduct in the enabling legislation of the state licensure board, to an overlapping and uncoordinated series of agencies, hospitals and medical societies, which all have some disciplinary authority. Moreover, proceedings of a medical disciplinary board are frequently challenged, often successfully, by the accused physician.

The Commission has reached agreement that the proceedings of a medical disciplinary board should be confidential, and that participants should be absolutely immune from civil liability for participating in the work of such a board (see Resolutions, *supra,* pages 3–4; Report, *infra,* Appendix D, pages 46–47). [Note: The Commission's recommendations in this regard were approved by the House of Delegates on August 10, 1976.]

Since committees of the American Medical Association and the National Conference of Commissioners on Uniform

5. Arizona and Oregon have enacted legislation requiring health care providers to report to the state board of medical examiners any information appearing to show that a doctor is or may be medically incompetent. This includes the reporting of incidents which have not yet become the subject of malpractice claims.

Florida has enacted legislation requiring every hospital to establish an internal risk management program, one component of which is an incident reporting system.

Jan 1976

REPORT

OF THE

FLORIDA

MEDICAL LIABILITY INSURANCE COMMISSION

TO THE

GOVERNOR

AND THE

FLORIDA LEGISLATURE

COMMISSION RECOMMENDATIONS

The following items have been recommended by the Study Commission for consideration by the Governor and Legislature:

1. Extend the Life of the Medical Liability Insurance Study Commission.

   Our first recommendation is that the life of the Commission be extended until January 1, 1977, and that the Legislature be requested to appropriate funds for the use of this Commission beyond the fiscal year 1975-76.

2. Internal Risk Management in All Hospitals.

   Every survey available to the Commission demonstrated that as many as 80% of all malpractice claims originate in hospitals. The Commission recommends that Section 395.18, Florida Statutes, requiring an internal risk management program for hospitals having in excess of 300 beds be amended to include all hospitals of all sizes, ambulatory surgical centers as defined in Section 381.493(3)(j), Chapter 75-167, Laws of Florida, Health

Maintenance Organizations and other areas of in-house patient care, such as nursing homes and convalescent centers. For these purposes, we recommend that risk management be defined as:

> "The identification, analysis and evaluation of risks and the selection of the most advantageous method of treating it."

3. Modification of Patient's Compensation Fund. A modification of the Patient's Compensation Fund, to provide for cost of corrective and rehabilitative procedures, and other out-of-pocket costs necessary in connection with a patient's care in-hospital medically related incidents. The outline of this proposed coverage follows:

(a) It be funded by an admission fee charged to each person admitted to a hospital. Attachment A to this report indicates that a reasonable admission fee would be adequate to fund the coverage contemplated herein.

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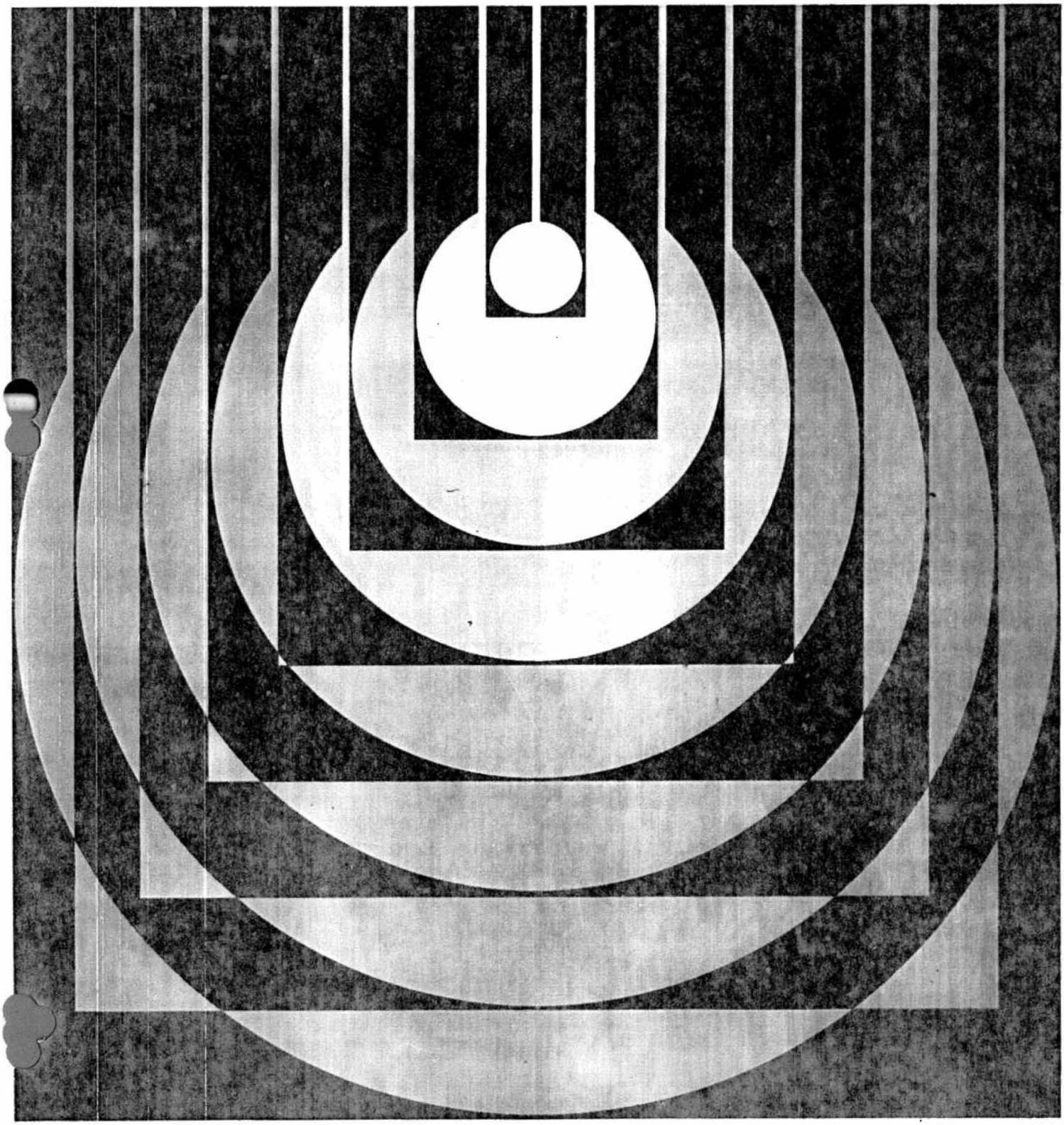
1973

medical malpractice

REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE



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1. investigation and analysis of the frequency and causes of the general categories and specific types of adverse incidents causing injuries to patients;
2. development of appropriate measures to minimize the risk of injuries and adverse incidents to patients through the cooperative efforts of all persons.

Safety programs are not without precedent. Industrial safety programs have been with us for a long time. The safety programs which were developed by the aviation industry, the space program, and the Atomic Energy Commission all involved many people with various skills who were functioning in environments where more was unknown than known and where the risks to life and limb were great. Many of the methods developed by these safety programs for identifying persons, situations, procedures, and equipment which are likely to give rise to injury could be utilized in developing the type of patient-safety and injury-prevention programs we believe are so necessary.

Institutional Quality Control Systems

Hospitals presently have many quality control systems, such as incident reporting systems, tissue, medical audit, and infection committees. The standards for accreditation developed by the Joint Commission on Accreditation of Hospitals contain many references to safety, but these references tend to be limited to physical requirements, such as grounding of electrical equipment in areas where anesthesia is administered or lead shielding in radiological service areas.

Sophisticated medical-injury-prevention and patient-safety programs require unified direction. A viable injury-prevention program cannot be the "other benefits" of quality control systems that already exist. And the systems in effect must not be allowed to stagnate.

The Commission RECOMMENDS that institutional quality control mechanisms of all types be constantly evaluated and, where proven desirable, modified so that the information they generate can be fed into a nationwide information system and into continuing education programs.

Loss Prevention

The insurance industry is in a unique position to support the injury-prevention activities of health-care providers through its loss-prevention efforts. To the insurance industry, loss prevention means taking action to bring about a reduction in the number of injuries that may lead to malpractice claims, thus holding down the total cost of claims and, therefore, of premiums.

Leading carriers carry on extensive hospital loss-prevention programs, and periodically conduct safety inspections of the institutions they insure. They provide speakers and loss-prevention material to hospitals on request. One company has produced 41 motion pictures on patient safety. Most companies do not engage in significant loss-prevention programs aimed at the individual practitioner. The following programs illustrate what can be done in this area:

- One carrier, which concentrates on coverage for the physician who cannot purchase insurance through normal channels recently distributed to individual subscribers a compilation of 381 claims that were closed between March 1958 and November 1972. The claims were broken down into types of occurrences, and specific recommendations for avoiding such incidents were given.
- An insurer who writes group plans for state medical societies distributes pamphlets and brochures, based on needs as reflected by incident reports. These publications advise doctors on ways of preventing individual injuries and types of incidents that can result in malpractice claims.

Several years ago, California health-care provider organizations and the insurance industry cooperated in sponsoring a series of meetings throughout the state on prevention of patient injuries and improvement of care. These meetings, known as The California Invitational, concentrated on ways of preventing patient suicides, on ways to reduce anesthesia injuries, on ways of handling surgical

cardiac arrest and emergency cardiac arrest, on ways to combat hospital infections, on ways to reduce maternal and neonatal injuries and infections, and on ways to reduce injuries from injections.

Physicians and nurses, hospital administrators and insurance company representatives participated in these meetings, and the general consensus was that The California Invitational was successful, not only in its stated aim of reducing patient injuries, but also in improving communication between the various health-care disciplines who participated.

The Commission believes that carriers should initiate loss-prevention programs not only for institutions but also for individual physicians. We do not suggest that insurers should limit themselves to the above examples; experimentation should be encouraged.

The Commission FINDS that where genuine cooperation and support of insurance company loss-prevention programs can be achieved, a meaningful reduction in patient injuries can also be achieved.

The Commission FINDS that loss-prevention activities generally are limited to group plans. For the most part activities aimed toward the individual practitioner have been minimal. There is a need for intensified loss-prevention efforts on the part of the medical malpractice insurance industry working with health-care providers and the consumer community.

The Commission RECOMMENDS that the medical malpractice insurance industry develop sophisticated loss-prevention programs based on both injury and claims-prevention techniques. This development will require the active participation of the provider and consumer communities.

At the present time, some carriers do not allocate a specific portion of the malpractice insurance premium dollar to loss-prevention programs. The Commission believes that part of that premium dollar should be set aside specifically for institutional programs. Health-care providers should be kept informed of that amount and should be encouraged to cooperate with the carriers in developing and carrying out these programs.

The Commission RECOMMENDS that a portion of the premium dollar for institutional medical malpractice insurance be specifically identified and allocated towards loss prevention. Health-care providers should implement and monitor the loss-prevention programs developed in cooperation with their insurance carriers.

In addition, we believe that carriers should be encouraged regularly to analyze claims against institutions and to make this data available to their subscribers. The Commission understands that this would be an additional expense to the industry, but we believe that over the long run the industry, the providers and the general public would all benefit. It is our belief as a Commission that the insurance industry has an obligation to help educate the providers—including ancillary personnel, such as electricians, orderlies, custodial staff—in patient-safety and injury-prevention programs. Summaries of incidents would alert hospital personnel to the types of things that are happening so that they can take measures to prevent them from occurring in the future.

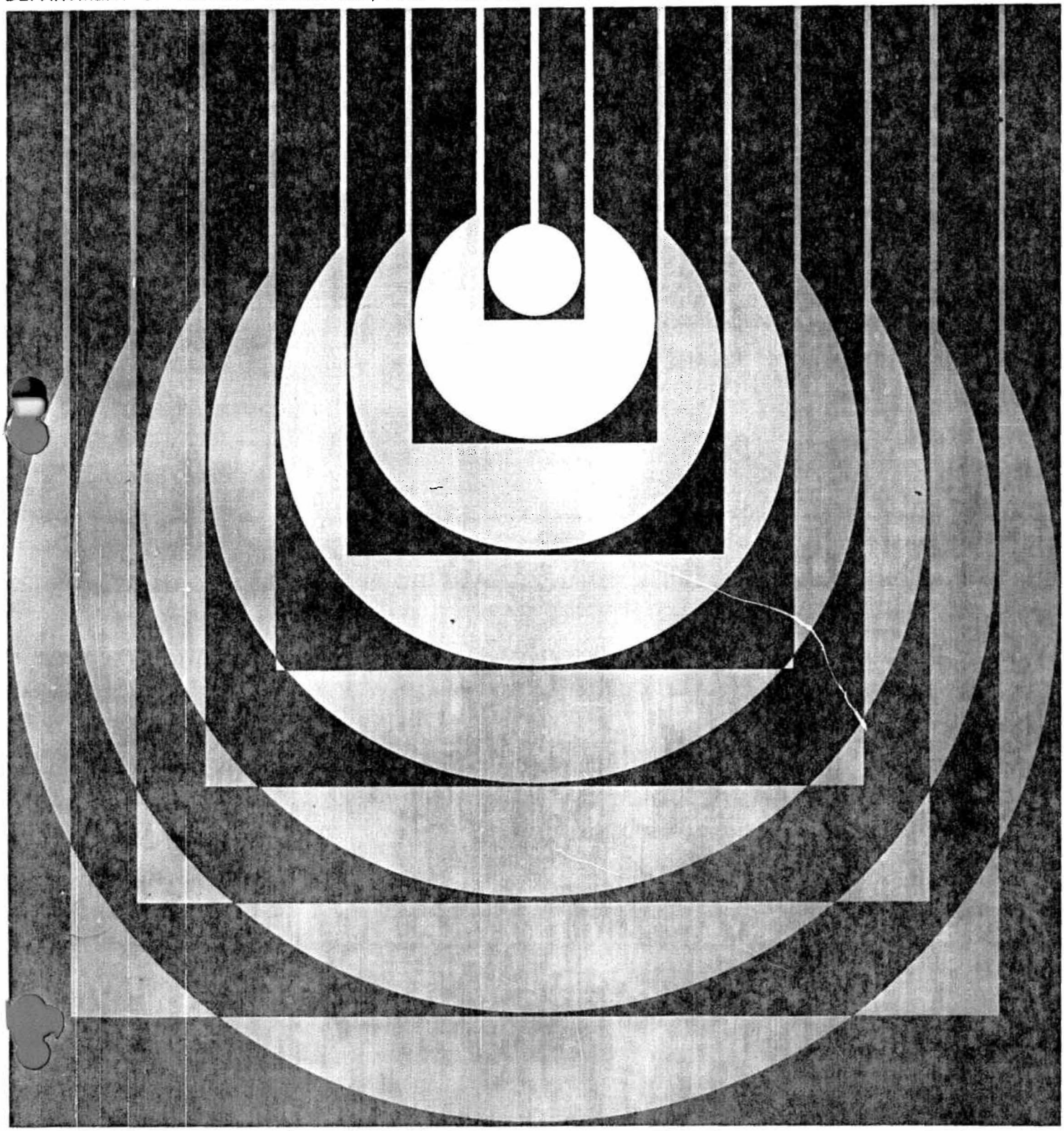
The Commission RECOMMENDS that medical malpractice carriers provide analyses of incidents to institutional health-care providers in order to aid the institution's injury prevention programs.

A Nationwide Data Gathering and Information System

Commission studies indicate that there are particular patterns, situations and locations which give rise to claims. Assuming that medical injuries occur in a similar pattern, continuous monitoring and analysis of the locations within hospitals, the procedures, times of occurrence, etc., in which incidents which give rise to claims occur could provide much of the information needed to develop and operate sophisticated injury-prevention programs.

The individual claims experience of a single

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE WASHINGTON, D.C. DHEW PUBLICATION NO. (OS) 73–88



contribution upon a judgment or settlement therein.

PART II

MEDICAL MALPRACTICE AND RELATED MATTERS

768.40 Medical review committee, immunity from liability. *(Transferred)*
768.41 Internal risk management program.
768.42 Medical incident committee; reports, screening, criteria, etc. *(New)*
768.43 Actions by medical incident committee; findings of negligence; assessment of compensation, etc. *(New)*
768.44 Medical liability mediation panels; membership; hearings.
768.45 Medical negligence; standards of recovery, etc. *(New)*
768.46 Florida Medical Consent Law. *(Transferred)*
768.47 Civil medical malpractice actions; procedures; admissibility of evidence. *(Transferred)*
768.48 Itemized verdict. *(New)*
768.49 Remittitur and additur. *(New)*
768.50 Collateral sources of indemnity. *(New)*
768.51 Alternative methods of payment of damage awards. *(New)*
768.52 Medical malpractice insurance; purchase.
768.53 Insurance risk apportionment plan as to health care providers.
768.54 Limitation of liability and patient's compensation fund.
768.55 Report by insurers of medical malpractice claims and actions required. *(Transferred)*

768.40 Medical review committee, immunity from liability.-[Transferred from s. 768.131 by Reviser. See s. 768.131, F. S. 1975, for text.]

[1]768.41 Internal risk management program.—

(1) Every hospital licensed pursuant to ch. 395, ambulatory surgical center as defined in paragraph (d), health maintenance organization certificated under part II of chapter 641, or other facility providing in-house patient care, including, but not limited to, nursing homes licensed under chapter 400 and other similar facilities, shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components:

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

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

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

(d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the health care facility to report injuries and adverse incidents to the hospital risk manager; and

(e) The development and implementation of a program designed to provide compensation to certain persons who are determined to have sustained a compensable injury, pursuant to the provisions of s. 768.42; the programs required by this subsection shall be commenced in hospitals upon the effective date of this act, but shall not be required in other health care facilities until one year after the effective date of this act.

As used in this section, "ambulatory surgical center" means a facility the primary purpose of which is to provide elective surgical care, and in which the patient is admitted to and discharged from said facility within the same working day, and which is not part of the hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, or an office maintained by a physician or dentist for the practice of medicine, shall not be construed to be an ambulatory surgical center.

(2) The risk management program shall be the responsibility of the governing board of the health care facility. When practical, two or more health care facilities may combine their risk management activities. Regardless of the method selected to carry out the program, one or more individuals shall be designated "risk manager" for the purposes of this part.

(3) In addition to the programs mandated by this act, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated. Such additional approaches may include extending risk management programs to health care providers' offices and the assuming of provider liability by a health care facility for acts or omissions occurring within the facility.

History.—s. 3, ch. 75-9; s. 3, ch. 76-168; s. 2, ch. 76-260.
[1]Note.—Repealed by s. 3, ch. 76-168, effective July 1, 1982.
Note.—Former s. 395.18.

[1]768.42 Medical incident committee; reports screening, criteria, etc.—

(1) In order to implement the requirements of s. 768.41(1)(f), each health care facility shall obtain insurance coverage, shall adequately self-insure, or shall show financial responsibility by any other means, set forth by rule or otherwise approved by the Department of Insurance, which is in keeping with the intent of this section, for purposes of compensating certain patient injuries as provided herein.

(2)(a) The Department of Insurance shall promulgate rules and regulations to implement the requirements of this act and carry out its purposes, including rules providing for an annual audit of the procedures at every hospital licensed under chapter 395. The audit shall cover both the financial aspects of the compensation system, as provided in this act, and the management of the medical incident reporting and risk management system.

(b) The Department of Health and Rehabilitative Services shall contract with a public or private ent

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EXHIBIT H

Submitted by: Dr. William Stephan
To: Joint Hearing on Medical Malpractice
Source: AMA's States Report on The Proffessional Liability Issue dated 10/76.

LAWS IN FORCE 1975-1976

Periodic Payments	Statute of Limitations	Collateral Sources	Limits on Awards
Alabama	Alabama	Arizona	Calif. (pain & suf)
Alaska	Arizona	Florida	Idaho*
California	California	Idaho	(Illinois)**
Delaware	Colorado	Illinois	Indiana
Florida	Delaware	Iowa	Louisiana
Illinois	Florida	Kansas	New Mexico
Kansas	Georgia	Nebraska	Ohio (pain & suf)
New Mexico	Hawaii	New Jersey	Oregon
New York ***	Idaho	New York	South Dakota
Washington	Indiana	Ohio	Virginia
Wisconsin	Iowa	Pennsylvania	Wisconsin
	Kansas	Rhode Island	
	Louisiana	Washington	
	Massachusetts		
	Michigan		
	Mississippi		
	Missouri		
	Nebraska		
	New Jersey		
	New Mexico		
	New York		
	North Dakota		
	Ohio		
	Oklahoma		
	Oregon		
	Pennsylvania		
	Rhode Island		
	Tennessee		
	Texas		
	Utah		
	Washington		
	Wyoming		

* Survived the Supreme Court
** Killed by the Supreme Court
*** Itemized awards

WILLIAM K. STEPHAN, M.D.
DIPLOMATE, AMERICAN BOARD OF ANESTHESIOLOGY
FELLOW, AMERICAN COLLEGE OF CHEST PHYSICIANS

TELEPHONE
735-3200

3196 MARYLAND PARKWAY
SUITE 406
LAS VEGAS, NEVADA

Dear Mr. Galatz:

EXHIBIT I

This office will provide medical information when the appropriate medical authorization, signed by the patient, is sent to us. We will send copies of medical records to your office at the fixed rate of ten ($10.00) dollars per page.

However, if additional time is required by the physician to summarize, or further elaborate on the medical information available in the patient's medical record, the charge of physician's time will be a minimum of two hundred fifty ($250.00) dollars.

Please advise if the copies of this patient's pertinent medical record will suffice for your purposes.

Full payment for the above information must be received in advance. If medical records are copied only, your office will be notified of the number of pages, total charges, and when they will be ready.

Yours truly,

4/6/76 Reproduction of Chart on:

MARGARET S. [redacted] $35.00

4 pages
2 of them billcopies
2 of their copies of office rec