REPORT
to the
One Hundred
and
Eighth Legislature

Submitted by
THE COMMISSION TO REVISE THE LAWS RELATING TO MEDICAL AND HOSPITAL MALPRACTICE INSURANCE

January 22, 1977

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January 25, 1977

The Honorable Joseph Sewall
President of the Senate
State House
Augusta, Maine 04330

Dear Sir:

On June 3, 1975 Private and Special Laws, Chapter 73 of the One Hundred and Seventh Legislature created a Commission to Revise the Laws Relating to Medical and Hospital Malpractice Insurance. Pursuant to that Statute the members of the Commission were appointed by the Speaker of the House, the President of the Senate, the Governor and the Chief Justice of the Supreme Judicial Court. A full list of the members and the manner of their appointment is enclosed. The initial meeting of the Commission was convened by Governor James B. Longley at 9:00 a.m., on Thursday, October 2, 1975 in the State Capital Building in Augusta. Justice Charles A. Pomeroy was recognized as statutory Chairman of the Commission and the Reverend Frederick D. Hayes was elected Vice Chairman. Ms. Susan S. Saunders was elected Secretary-Treasurer. Representative Louis Jalbert was appointed Chairman of an ad hoc committee to establish rules of procedure, and Justice Pomeroy served as Chairman of an ad hoc committee to recommend selection of legal counsel. The second meeting of the Commission was held on October 31, 1975. The enclosed Rules of Procedure were adopted and Bert S. Prunty was unanimously designated Chief Counsel to the Commission pursuant to section four of the enabling Act.

The legislative charge to the Commission was to prepare statutory proposals "...to insure the availability of medical and hospital malpractice insurance to physicians and hospitals throughout the State and to develop a more equitable system of relief for malpractice claims." To these ends the statute directed the Commission to "...hold public hearings as may be necessary to gather factual data from interested persons and to acquaint persons interested with its proposals and recommendations..." The Commission construed this language as requiring two types of hearings: (1) Hearings at which the Commission would receive factual data from the relevant professions, businesses and the public; and (2) Hearings at which the Commission would present proposals for discussion and evaluation. Consequently, two hearings were scheduled and held in each of the State's recognized "health service areas", i.e. Portland, Lewiston, Augusta - Waterville, Bangor, and Presque Isle. Each hearing was preceded by 30 days legal notice as required by statute and by actual notice to all area hospitals, medical societies, bar associations and insurance representatives. Where possible, additional public notice was affected through the cooperation of the news media. Public response to the hearings was generally very good and the Commission received a vast amount of original data as well as constructive development of tentative

proposals. Due to the complexity of the subject matter the Commission held an additional and special hearing in Portland to gather information from the insurance industry. Every company writing medical liability insurance in Maine was specifically invited and each sent one or more representatives some of whom were senior executives who came from substantial distances. Representatives of the insurance marketing system, insurance consultants and the Insurance Services in New York City were also invited and attended. Upon recommendation of the State Department of Insurance the Commission retained an actuary as consultant for this hearing. A copy of the consultant's report is enclosed.

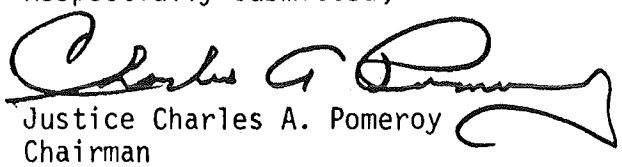
During the course of its work the Commission researched and collected a vast amount of legal and factual data from the State of Maine and from other states. Together with the information gathered through hearings and by public submissions to the Commission, this material was used by the Commission acting through subcommittees, to prepare legislative proposals in tentative draft form which were then offered for public scrutiny and comment. This process resulted in substantial modification and development; and it is the fifth draft of proposed legislation that is the final one adopted by the Commission. As is indicated in the enclosed Summary of Recommendations, the proposals of the Commission cover several areas: (1) Quality control over the delivery of health care services; (2) Information and data development; (3) Continued availability of insurance; (4) Improvement of claims resolutions; and (5) General provisions. The Commission does not submit these proposals as a cure-all for the problems addressed; but as an important first step toward maintaining and improving a generally favorable legal climate in which quality health care will continue to be available to the People of Maine and in which the providers of that care will find reasonably priced protection against the consequences of untoward medical results without depriving the victims of iatrogenic injury their just compensation. It is the judgment of the Commission that the enclosed recommendations, if implemented, will help to insure the availability of medical and hospital malpractice insurance to physicians and hospitals throughout this State, and that they will make available a more equitable system of relief for malpractice claims.

Under the law creating the Commission, funding consisted of a $24,000 appropriation of dedicated funds available to the Board of Registration in Medicine and a $1,000 appropriation of dedicated funds available to the Board of Examination and Registration in Osteopathy. Commission expenses included travel, legal fees, hearing costs, printing, consultant's fees and miscellaneous disbursements for materials, telephones and postage. A detailed accounting will be submitted shortly to the appropriate offices. The Commission is pleased to report here, however, that it was able to stay well within its budget and that it expects to return a substantial surplus to the State.

The legislation proposed by the Commission places substantial new responsibilities on the Department of Insurance. We are advised by Superintendent Hogerty that this will require authorization to utilize an additional $15,000 from available dedicated funds.

On behalf of the Commission, this report is transmitted to you for the members of the One Hundred and Eighth Legislature for their consideration and appropriate action.

Respectfully submitted,



Justice Charles A. Pomeroy
Chairman

. . . . . .

Eugene M. Beaupre, M.D.

Senator Gerard P. Conley

Roger B. Gorham

Frederick D. Hayes

Frank M. Hogerty, Jr.

Representative Louis Jalbert

Harold L. Jones

John N. Kelly*

Francis I. Kittredge, M.D.

Richard F. Nellson

John M. O'Brien

M. Carmen Pettipiece, D.O.

Susan S. Saunders

David E. Smith

* Mr. Kelly has informed the Chairman he wishes to dissent from unspecified portions of the Commission's recommendations.

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-FIVE

S. P. 494 — L. D. 1825

AN ACT to Create a Commission to Revise the Laws Relating to Medical and Hospital Malpractice Insurance.

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, a national crisis is developing with regard to the availability and cost of hospital and medical malpractice insurance; and

Whereas, the effect of this situation is already being felt in the State of Maine; and

Whereas, it is vitally necessary that the Legislature immediately take action which will provide for a thorough and comprehensive review of the medical and hospital malpractice situation in Maine; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. Commission, duties. A special commission shall be constituted and appointed to supervise the preparation, in final legislative draft form, of a proposal to insure the availability of medical and hospital malpractice insurance to physicians and hospitals throughout the State and to develop a more equitable system of relief for malpractice claims. Such proposal may, without limitation, incorporate such necessary repealers, amendments and modifications of existing laws as, in the judgment of such commission, are necessary and appropriate to accomplish such purposes. Such proposal may include such new or modified provisions as, in the judgment of the commission, will best serve the interests of the people of the State, and the commission shall give due consideration to the insurance laws of the other states; proposals before the Legislatures of other states and proposals before the Congress of the United States. Such proposal shall be submitted to the regular session of the 108th Maine Legislature or at such earlier time as the commission deems appropriate. Such commission shall employ a chief counsel, and, subject to said counsel's recommendation, such additional counsel as may be required, to perform the necessary research and drafting of such proposal, the chief counsel to meet the requirements as set forth. Such commission shall hold public hearings as may be necessary to gather factual data from interested persons and to acquaint persons interested with its proposals and recommendations, and the commission shall have full access to all of the records of the Maine Bureau of Insurance for the purpose of its investigation.

Sec. 2. Membership. The membership of the commission shall be constituted and appointed as follows: One member shall be a Member of the House of Representatives in the 107th Legislature to be appointed by the Speaker of the House; one member shall be a Member of the Senate in the 107th Legislature to be appointed by the President of the Senate; one member shall be a sitting or retired Justice of the Supreme Judicial Court of Maine and said justice shall serve as chairman of the commission upon his appointment by the Chief Justice; one member shall be a representative of the Maine Hospital Association to be appointed by the Governor upon recommendation of the Maine Hospital Association; one member shall be a representative of the Maine Medical Association to be appointed by the Governor upon recommendation of the Maine Medical Association; one member shall be a representative of the Maine Bar Association to be appointed by the Governor upon recommendation of the Maine Bar Association; one member shall be a representative of the Maine Osteopathic Association to be appointed by the Governor upon recommendation of the Maine Osteopathic Association; one member shall be a representative of an insurance company presently writing hospital and medical malpractice insurance in Maine to be appointed by the Governor; one member shall be a representative of Blue Cross and Blue Shield to be appointed by the Governor; and 4 additional members, none of whom shall, or immediate family members shall, derive a part or whole of their income from the health care or insurance field, shall be appointed by the Governor. The Commissioner of Health and Welfare and the Superintendent of Insurance shall serve as voting members of the commission. Each member shall serve until the commission shall have completed its work, or until his prior death or resignation. In the event of the death or resignation of any member, his place shall be filled, upon written notice thereof from the commission, by the then President of the Senate, Speaker of the House, Governor or Chief Justice, as the case may be, in the same manner as with respect to the original appointment.

Sec. 3. Meetings. The said commission shall be appointed promptly upon enactment hereof, and the Governor shall notify all members of the time and place of the first meeting. At that time the commission shall organize, elect a vice-chairman and secretary-treasurer, adopt rules as to the administration of the commission and its affairs, which rules shall require a minimum of 30 days' notice of any public hearing to consider one or more aspects of the laws or prospective laws to be considered by the commission and which rules shall require that all proposals shall be transmitted to each person in the State who shall have recorded his desire to receive and willingness to pay for the costs of printing and mailing same, and thereafter shall meet as often as necessary until its work is completed. In all matters as to which there is disagreement, a majority vote shall prevail, and a quorum shall consist of at least 7 members. The commission shall maintain minutes of its meetings and such financial records as may be required by the State Auditor. The members of the commission shall serve without compensation, but they may be reimbursed for their reasonable expenses involved in attending meetings, procuring supplies, securing clerical services and handling correspondence and for other related and necessary expenditures.

Sec. 4. Chief counsel. The commission shall contract a chief counsel who shall have the responsibility for legal research and drafting required in connection with the preparation of the proposed legislative proposal under the direction and supervision of the commission. No person shall be employed as chief counsel who shall not, by virtue of prior training, experience, ability and reputation, have clearly demonstrated the ability to perform the tasks to be assigned to him by the commission.

Sec. 5. Clerical assistance. The commission may employ clerical assistance when justified as needed to carry out its duties.

Sec. 6. Financing of commission by the Board of Registration in Medicine and by the Board of Osteopathic Examination and Registration. The Board of Registration in Medicine is authorized and directed to expend an amount

of money not to exceed $24,000 for the partial financing of this commission and to disburse said funds to the commission upon the receipt of an appropriate voucher signed by the chairman of the commission.

The Board of Osteopathic Examination and Registration is authorized and directed to expend an amount of money not to exceed $1,000 for the partial financing of this commission and to disburse these funds to the commission upon the receipt of an appropriate voucher signed by the chairman of the commission.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved.

IN HOUSE OF REPRESENTATIVES,.....1975

Read twice and passed to be enacted.

.....*Speaker*

IN SENATE,.....1975

Read twice and passed to be enacted.

.....*President*

Approved.....1975

.....*Governor*

COMMISSION TO REVISE LAWS RELATING TO MEDICAL AND HOSPITAL MALPRACTICE INSURANCE

MEMBERS

Honorable Charles A. Pomeroy (Chairman) 142 Federal Street Portland, Maine 04111	Appointed by Chief Justice Maine Supreme Court
Frederick D. Hayes (Vice-Chairman) 5 Church Street Belfast, Maine 04915	Public Member, Appointed by Governor
Susan S. Saunders (Secretary/Treasurer) Wolf's Neck Road Freeport, Maine 04032 Telephone: 772-0124 (office) 865-6528 (home)	Public Member, Appointed by Governor
Eugene M. Beaupre, M.D. 6 Eaton Drive Waterville, Maine 04901	Representative Maine Hospital Association; President, Mid-Maine Medical Center
Senator Gerard P. Conley 29 Taylor Street Portland, Maine 04102	Appointed by President of the Senate
Roger Gorham Campbell, Payson & Noyes 27 Pearl Street Portland, Maine 04111	Appointed by the Governor to represent an insurance company presently writing malpractice insurance.
Frank Hogerty Superintendent of Insurance Dept. of Business Regulation State House Augusta, Maine 04330	Member of Statute
Representative Louis Jalbert 39 Orestis Way Lewiston, Maine 04240	Appointed by Speaker of the House
Harold L. Jones 99 Purington Avenue Augusta, Maine 04330	Public Member, Appointed by Governor
John N. Kelly 482 Congress Street Portland, Maine 04101	Represents the Maine Bar Association

Francis I. Kittredge, M.D. 498 Essex Street Bangor, Maine 04401	Represents the Maine Medical Association
John M. O'Brien 465 College Street Lewiston, Maine 04240	Public Member, Appointed by Governor
M. Carmen Pettipiece, D.O. 335 Brighton Avenue Portland, Maine 04103	Represents Maine Osteopathic Association
R. Weston Pierce * 2 Mill Road Falmouth, Maine 04105	Appointed by Governor to represent Blue Cross and Blue Shield
Richard F. Nellson 220 Capisic Street Portland, Maine 04102	Appointed by Governor to succeed Mr. Pierce
David E. Smith Commissioner Department of Human Services State House Augusta, Maine 04330	Member of Statute

* Resigned on April 30, 1976

STATEMENT BY GOVERNOR JAMES B. LONGLEY

TO: ORGANIZATIONAL MEETING OF COMMISSION TO REVISE THE LAWS RELATING MEDICAL AND HOSPITAL MALPRACTICE INSURANCE

THURSDAY, OCTOBER 2, 1975 ...9:00 A.M.

AS GOVERNOR, I WANT TO THANK EACH MEMBER OF THIS COMMISSION FOR AGREEING TO HELP THE STATE OF MAINE IN AN AREA OF VITAL CONCERN TO ALL THE CITIZENS OF OUR STATE AND NATION. THIS COMMISSION IS CHARGED WITH THE RESPONSIBILITY OF HELPING PREPARE LEGISLATION TO INSURE THE AVAILABILITY OF MEDICAL AND HOSPITAL, INSURANCE MALPRACTICE INSURANCE TO PHYSICIANS AND HOSPITALS THROUGHOUT THE STATE AND TO DEVELOP A MORE EQUITABLE SYSTEM OF RELIEF FOR MALPRACTICE CLAIMS.

I DO NOT HAVE TO REMIND ANY OF YOU THAT THE TASK YOU ARE UNDERTAKING IS A SERIOUS ONE BECAUSE PEOPLE MUST HAVE MEDICAL CARE AND PHYSICIANS MUST BE ABLE TO ADMINISTER THAT CARE WITHOUT HAVING TO PAY UNREASONABLE PRICES FOR INSURANCE.

THE PATIENT MUST HAVE PROTECTION AGAINST THE FEW CARELESS PHYSICIANS WHO DO NOT ADMINISTER PROPER TREATMENT, BUT BY THE SAME TOKEN PHYSICIANS MUST BE PROTECTED FROM THE FEW IN OUR SOCIETY WHO MAKE A MOCKERY OUT OF MALPRACTICE CLAIMS. YOU MUST STRIKE THE PROPER BALANCE.

IN THIS ADMINISTRATION WE HAVE TAKEN GREAT CARE IN SELECTING CITIZENS TO SERVE ON BOARDS AND COMMISSIONS SUCH AS THIS ONE. DESPITE SOME CRITICISM AND SOME SUGGESTIONS THAT WE SHOULD PICK THE FIRST NAME THAT COMES ALONG, WE HAVE STUCK BY OUR POLICY TO GIVE EACH VACANCY CAREFUL CONSIDERATION.

WE HAVE TRIED TO PICK PEOPLE FOR ALL BOARDS AND COMMISSIONS WHO ARE SINCERELY INTERESTED IN SERVING THE STATE AND WHO WILL ATTEND MEETINGS.

I AM CONFIDENT THAT WE HAVE THESE TYPE PEOPLE REPRESENTED HERE AND I AM EQUALLY CONFIDENT THAT YOU PROVIDE A GREAT SERVICE TO THE PEOPLE OF MAINE.

REPORT OF RULES COMMITTEE
OF
COMMISSION TO REVISE THE LAWS RELATING TO
MEDICAL AND HOSPITAL MALPRACTICE INSURANCE

To: Honorable Charles A. Pomeroy, Chairman

Date: October 9, 1975

Rules Committee Members:

Louis Jalbert
Gerard Conley
David Smith
Frederick Hayes
Susan Saunders
John N. Kelly

The following procedural rules are recommended to the Commission by the Rules Committee:

1. Notice of public hearings of the Commission shall be issued to the news media at least 30 days prior to hearing date in accordance with the statutory requirement of Chapter 73 of the Private and Special Laws of Maine, 1975. In addition, notice of public hearings of the Commission shall be issued to the news media at least 7 days prior to hearing date.

2. Notice of meetings of the Commission shall be issued to the news media at least 7 days prior to meeting date, except that such notice requirement may be waived by the chairman or vice chairman when it is deemed necessary.

3. Statements of Witnesses. Witnesses presenting evidence at public hearings of the Commission shall submit prepared statements to the clerk of the Commission to allow sufficient time for the reproduction and distribution of such statements to members of the Commission at least 7 days prior to a public hearing.

4. Time Limit for Testimony. The chairman or member of the Commission designated to preside at a public hearing may implement a time limit on the

testimony of individual witnesses at such hearing when it is deemed necessary in his discretion.

5. Meetings of the Commission. All meetings of the Commission, other than public hearings, shall be conducted pursuant to Robert's Rules of Procedure when requested by a single member of the Commission present at such meeting.

6. Amendments to Rules. The rules of procedure of the Commission may be amended from time to time by majority vote of the Commission.

Summary of Recommendations

This summary presents in abbreviated form the major recommendations of the Commission. Unless otherwise indicated each recommendation is supported by proposed legislation set out in the enclosed Report of the Commission which begins on page xv of this submission. As is done in the proposed legislation, this summary presents recommendations arranged by categories reflecting the principal purpose of the legislation, i.e., quality control, data development, claims resolution, insurance availability and general provisions. The last category (general provisions) includes some changes in the law of torts.

A. Quality Control

1. All hospitals are required to establish internal risk management programs designed to monitor medical staff privileges, review the quality and necessity of medical care, institute a patient grievance procedure, establish a data collection system and maintain relevant educational programs. (MHSA Section 2503).*

2. Medical societies are required to establish professional quality control committees (MHSA Section 2504).

3. All licensed physicians, all hospitals and all medical societies must report malpractice, drug abuse or incompetence to the appropriate licensing board. (MHSA Sections 2505 - 2507).

4. Licensing boards are required to maintain permanent confidential records of professional incompetence. (MHSA Sections 2509 - 2510)

* MAINE HEALTH SECURITY ACT

5. Immunity of those reporting, generating or dealing with evidence of malpractice is expanded. (MHSA Section 2511)

B. Data Development

6. Insurance companies are required to make periodic statistical reports of malpractice claims to the Superintendent of Insurance. (MHSA Sections 2601 and 2603)

7. Insurance companies are required to make reports of any disposition of claim. (MHSA Sections 2502 and 2503)

8. The Superintendent of Insurance must maintain claims and disposition data for legislative purposes, and must transmit relevant matter to the appropriate licensing board. (MHSA Sections 2604 - 2605)

9. Insurance companies and the Department of Insurance are given immunity for compliance. (MHSA Section 2606)

C. Claims Resolution

10. A complete system of voluntary binding arbitration is established. This system is designed to save time and money, and to provide the public with a more easily available avenue of relief. (MHSA Sections 2701 - 2714)

11. A complete system of voluntary non-binding pre-litigation screening is established. This system is designed to weed out bad cases and expedite meritorious ones. (MHSA Sections 2801 - 2809)

D. Insurance Availability

12. The Commission recommends continuation of the existing Joint Underwriting Association and endorses the legislation proposed on behalf of that organization including the abolition of exclusivity for physicians' participation.

E. General Provisions

13. Stated dollar amounts (the ad damnum clause) are forbidden in malpractice complaints. (MHSA Section 2902)

14. The statute of limitations for actions against hospitals and hospital employees is set at two years for consistency with the law for physicians. (MHSA Section 2902)

15. Medical malpractice actions require a 90-day notice prior to filing. (MHSA Section 2903)

16. The immunity of physicians rendering voluntary gratuitous service is extended to include such service provided through non-profit organizations or state agencies. (MHSA Section 2904)

17. The standards for information required to be given patients and the effect of patient's consent to treatment are codified. (MHSA Section 2905)

18. The Commission recommends amendment of the Maine Rules of Civil Procedure to require court approval of contracts for contingnet legal fees in medical malpractice cases.

I. The Problem

A. Introduction

The so-called "malpractice insurance crisis" began to surface as a national phenomenon in the early 1970's when professional organizations in the medical community began to articulate the concern of their membership over the rising cost of insurance against liability for medical malpractice. The manner and content of that expressed concern attracted the attention of others, and shortly national and local professional journals, trade magazines and other media reflected an intensifying debate involving the medical and legal professions, hospital administrators, the insurance industry and consumer advocates. By 1975 all agreed there was a cost problem exacerbated by the threatened or actual unavailability of insurance coverage at any price. Agreement on the presence of a problem, however, was not accompanied by agreement as to that problem's genesis or its resolution. The search for solutions had been transferred to virtually every law-making body in America, including the Congress of the United States and the Legislature of Maine. The latter body responded initially with the enactment of two major pieces of legislation. The first was Title 24 M.R.S.A., Chapter 20 which created a standby joint underwriting association (JUA) for activation upon determination that the private insurance market was in fact unwilling or unable to provide essential insurance coverage. After several public hearings, such a determination for hospital coverage was formally made by Superintendent of Insurance Frank M. Hogerty, Jr. in the fall of 1976 and the Association was formally activated on September 1 of that year. The second Maine statute was Chapter 73 of the Private and Special Laws of 1975 which created the Commission to Revise the Laws Relating to Medical and Hospital Malpractice Insurance. The Commission's charge was to prepare proposals in final legislative draft form "...to insure the availability of medical and hospital malpractice insurance to physicians and hospitals throughout the State and to develop a more equitable system of relief for malpractice claims."

B. Scope.

The legislative statement of fact which accompanied the creation of the commission submitting this report said in part:

> "There is a substantial problem in the State concerning the ability of physicians and hospitals to secure and maintain malpractice liability insurance. Excessive awards being paid under insurance contracts in areas outside the State of Maine are having an effect on the cost and availability of malpractice coverage in Maine."

The work of the Commission confirms the existence of "a substantial problem" in this State. It also confirms the increasing incidence of very large awards in malpractice cases in other parts of the country as well as the proposition that such awards have an effect upon the cost of malpractice

insurance in Maine. The nature and magnitude of that effect, as well as its amenability to unilateral adjustment remain debatable.

Premium determination (ratemaking) for the hospitals and physicians of any state is a complex process involving the use of both local and national data in an attempt to produce an adequate but fair reserve for the payment of successful claim in the local market. The actual premium charged for a given amount of coverage is a function of two component rates. The so-called "basic limit rate" is the rate calculated for insurance in the amount of $25,000 per incident with an aggregate policy limit of $75,000. Insurance companies determine the basic limit rate separately for each state. For Maine physicians it is the experienced losses in Maine that form the base for this rate calculation. This base, however, is adjusted upward through adjustments based upon national data intended to infuse such factors as liability trends, administrative expenses and inflation. To the extent that this process increases the cost to Maine physicians it is said to be justified as a predictor of things to come rather than a subsidy for policy holders elsewhere. This would seem to be true if the process is faithfully followed and constantly evaluated in the light of developing local experience. The process for "increased limits" ratemaking is different. This is coverage in excess of the $25,000/$75,000 basic limit. It is catastrophic insurance and for statistical reasons a national experience base is used. There simply isn't enough local experience (fortunately none is reported in Maine) to serve as a valid base for loss prediction. For this excess coverage, it can be argued, and will be disputed, that Maine is subsidizing practicioners in the high-award areas. If Maine can stabilize its claims/awards picture at near present levels the argument would seem to be valid.

The malpractice emergency in Maine is not cataclysmic but it is clearly present and it must be addressed. The Commission was informed of the premature retirement of two badly needed physicians in Aroostook County for reason of insurance costs. A skilled surgeon in a rural area performed occasional emergency procedures for the implantation of temporary pacemakers. This activity put him in a higher risk classification with an incremental cost that exceeded his total charges for the procedure. Several hospitals have had serious insurance-related difficulty staffing emergency rooms. Voluntary civil work by military and naval physicians has been curtailed. Several young doctors have reported difficulty obtaining insurance coverage; but no such case has been developed to the point of an attempt to trigger activation of the JUA for physicians.

Medical malpractice insurance in Maine has climbed steeply in recent years. Some physicians in high risk classifications report increases of 400% in three years. Most have at least doubled. A survey among the more favorably rated Doctors of Osteopathy showed an average five year increase of 165% and an average increase of 312% over ten years. The largest single increases were 625% in five years and 525% in one year. Despite these depressing figures, the situation of Maine's doctors and hospitals remains a

relatively favorable one. The Insurance Services Office reports Maine's hospital rate to be the sixth lowest in the country, and the rate for physicians to be the twelfth lowest in the country. The latest data available to the Commission shows the annual dollar cost for physicians to be between 585 and 4374 depending upon risk classification. The Commission cautions that these figures have probably seen subsequent upward revision.

C. Causes.

Although the medical malpractice insurance problem is a pervasive one in the United States and has been studied with an unusual intensity, there is no data available from which to deduce objectively a single or overriding cause of the crisis. Published reports by interested participants have occasionally charged others with full responsibility followed by simple solutions achieved through constraints of the conduct of the group charged. The Maine Commission did, indeed, receive assertions that the problem has no greater dimension than the predatory lawyer, the incompetent physician or the avaricious insurance company. The preponderance of opinion, however, was more informed and recognized that the issue is most complex and involves the interaction of general social attitudes and developments within the professions of medicine, law and insurance.

(1) The medical profession.

Without a measure of malpractice by physicians and others in the health care delivery system there would be no malpractice insurance crisis. No member of the medical community denies that doctors err or that their mistakes are uniquely costly. But can it be assumed that the rapid increase in patient claims and the growth in the size of compensatory awards are functions of increasing incompetence and deteriorating judgment within the profession? No such evidence was available to the Commission. To the contrary, health technology and the quality of medical education have advanced markedly in recent decades; and it is common knowledge that the statistical index of ability among those admitted to the medical profession is at an all time high. Further assurance is found in the greater modern emphasis on peer review and the increasing role of licensure boards as instruments of control and correction. The Commission does not find that the rising cost of malpractice in Maine is attibutable to a rising rate of malpractice in Maine.

There are, however, developments within the medical profession that have fueled the problem. The following are repeatedly offered by experts as major contributors:

1. Medical care is increasingly complex and often embraces high-yield but equally high-risk procedures which were unimagined in the past.

2. Medical witnesses willing to testify for the patient-plaintiff are much more available than was the case a few years ago.

3. Specialization and shortage have contributed to a deterioration of the traditional doctor-patient relationship.

Although none of these factors may have progressed in Maine to the point reached in California or New York, the Commission recognizes them as operative in this State.

(2) The Legal profession.

Throughout the voluminous malpractice literature including that which came directly to the Commission, are occasional charges casting the lawyer as villain in the form of a predator in search of a fee-generating client-patient-plaintiff. Such individuals may exist elsewhere but the Commission could identify none in this State. To the contrary, Maine's attorneys consistently viewed this type of case as among the least desireable to prosecute. The closeness of the Maine community and the relatively open interdependence of professionals were cited as factors by both lawyers and doctors in this regard. Those members of the bar who have served as plaintiffs' counsel are among the most respected in the community.

The matter of the contingent fee contract remains troublesome to many concerned physicians. They view it at best as inflationary and at worst as a breeder of litigation. The question of the inflationary pressure of legal fees in monetary awards is problematical. Fee contracts cannot and would not be made explicit to a jury and we cannot measure any effect they might have. At the current level of awards in Maine they would not be a significant factor in premium determination. Certainly, however, it is reasonable to assume a sizeable fee would be a factor in an attorney's decision to proceed with a meritorious case with a high damage potential. Conversely, the bad case will not be pursued as it will generate no fee. The contingent fee system does function to screen out bad cases. Unfortunately, it also screens out meritorious cases with low damage potential, leaving the wronged but modestly injured patient without recourse.

(3) The insurance industry.

It is not unusual to read or hear that a root cause of the malpractice crisis is the uncontrolled greed of the liability insurers. The facts do not support the accusation. Most of the data supplied to the Commission and to agencies of government throughout the country show either actual or clearly predictable underwriting losses of major dimensions. To some degree this is attributable to a lack of underwriting skill and experience in a line of coverage which is not a specialty for the carriers involved. As a consequence some companies became bankrupt. Others cut their losses and dropped the line. Some, including those in Maine, continued to write existing coverage but were reluctant to expand by accepting new risks. Many of those who stayed in changed coverage to the less risk-laden "claims made" type of policy; and premiums were sharply increased in acute if tardy awareness of accellerating claims. This added to the malpractice crisis; it did not create it.

(4) The Legal system.

Some observors believe that the American legal system of compensation for injury or damage wrongfully inflicted is malfunctioning in the area of medical liability. The problem is seen as a reparations system generating awards for patients who undergo unsuccessful treatment or experience unfortunate results at the hands of fully competent and highly attentive physicians employing the most advanced state of the art. In short, the idea is that tort law has abandoned the concept of fault in a disasterous attempt to substitute insurance company money for the joy of good health. It must be conceded that some verdicts in some courts in some states support this view; but not in Maine. Traditional tort law is being applied by the Maine courts with no evidence of distortion or irresponsibility. Indeed, the law which the Commission finds here is more favorable to defendants than that being adopted by legislation seen as corrective in some other States.

(5) Social attitudes.

A fundamental step toward understanding, if not resolving, the malpractice crisis lies in recognizing a change in public attitudes. The deterioration of the doctor-patient relationship has already been noted. Surveys in both urban and rural areas show a far greater willingness of patients to sue physicians than was the case even ten years ago. Of course the change is not confined to health care. A generation has been raised on civil rights litigation, the products liability explosion and actions against government. We are a contentious and litigious society. More deeply, perhaps, is a growing acceptance of risk transferrence. Misfortune and adversity are to be borne by others; and the expectation of dollars is the almost Pavlovian response to every loss -- dollars from government, dollars from a corporation, dollars from a neighbor. The relentless quest for a non-existent level of universal security can ultimately quench the fires of individual productivity. The medical malpractice crisis in part may be a manifestation of this broad societal phenomenon.

D. Recommendations

Because the Commission was unable to isolate any one factor as the precipitating cause of the malpractice crisis it cannot recommend corrective legislation in only one area. The recommendations which the Commission does make are pervasive but they are not dramatic. If they succeed they will succeed in their collective capacity and the Commission strongly recommends that its proposal be considered as an entity. The essense of the report is that Maine still enjoys a relatively favorable climate for the delivery of quality health services at bearable cost; but a storm is coming. If we are to preserve an environment that is attractive to medical professionals, not unduely inflationary, and fair to those with legitimate grievance we must act now. The proposals that follow are specifically designed, in the context of what we now have, to reassure the medical community, to assure the public of controlled quality of health care delivery, to avoid the erosion of legal rights, and to demonstrate to the insurance industry that Maine remains a viable market for their essential services.

(1) Quality control

The recommendations in this area are submitted in final draft form in proposed sections 2501 and 2512. Their principal thrust is the codification of a risk management system for hospitals, a peer review system for doctors and a reporting system for boards of licensure. The risk management obligations imposed by section 2503 are already the practice in Maine's better hospitals and they should be universalized. The section requires every hospital to assure that staff privileges in the hospital do not exceed the physician's training or competence. The section also requires every hospital to institute formal programs to identify and prevent medical injury, to educate personnel on increasing patient safety, and to collect and maintain data on internal performance.

The doctors of Maine are justly proud of their self discipline in terms of organized quality control. Their efforts will be stengthened, and the public reassured by the enactment of sections 2503 through 2507 which make a minimal level of peer review a legal duty for hospital medical staffs and for medical societies. These sections also substantially broaden the existing law on reporting incompetence or negligence to the appropriate licensing authority. To protect physicians and others under a legal duty to report, section 2511 provides for total immunity from civil or criminal liability for compliance. The section also grants a qualified immunity (without malice) for others who report pursuant to the statute. Sections 2508 through 2510 deal with the licensing authority's use of reported information. The board is required to observe full due process of law and to act in a manner that is completely fair to the reported physician. All reported information must be kept confidential except for (1) use in a disciplinary hearing; (2) transmittal to other governmental licensing or disciplinary authorities or to a hospital considering the physicians staff privileges; (3) compliance with a court order; or (4) disclosure in a statistical fashion for research purposes. Section 2510.3 precludes the use of information collected under the statute in, or in connection with a malpractice suit for damages.

(2) Data development.

The Commission is concerned by its knowledge that the problem under consideration is a very complex one and that the Commission is unable to finally resolve it. Time is needed to evaluate what is done now and more data must be assembled to track the problem intelligently. Sections 2601 through 2606 call for a new system of reporting medical malpractice insurers. The burden is a modest one and is not objected to by the insurance community. Section 2601 requires a detailed report of claims made under professional liability policies. Section 2602 requires a report of any disposition of such a claim. Both types of reports are to be made to the Superintendent of Insurance in form prescribed by him (2603) and the Superintendent is to maintain the information for several purposes including future legislation (2604). These reports cannot be obtained or used in

civil or criminal litigation other than action by a licensing board. The Superintendent must provide such boards with copies or summaries of reports filed (2505). Insurance companies and the Superintendent are granted immunity for compliance (2606).

(3) Claims resolution.

All litigation is expensive and time consuming. None of it is pleasant. The Commission believes that if a cheaper, quicker, more accessable and at least as accurate a method for dispute resolution can be found, it should be tried. Arbitration is such a system. Arbitration is a substitute or alternative for litigation. Arbitration takes a matter out of the courts and puts it before a panel of persons having some degree of expertise in the subject matter of the dispute. The panel (usually 3 but fewer by agreement) hears the matter and decides it. There is no jury. Because the Constitution of Maine guarantees the right to a jury trial, the Legislature cannot force disputants to arbitrate. Arbitration can be authorized only if both parties agree, but agreement may be reached in advance and will thereafter be enforceable. Maine law currently permits arbitration agreements and that law could be used in the malpractice area. It might, however, be harsh and subject patients to hardship as it is designed for the business community rather than doctor and patient or hospital and patient. The proposed statute is very specifically tailored to the health care area. It is found in section 2701 through 2714.

Section 2702 authorizes arbitration agreements in two different situations and controls the manner of their execution as well as some of their contents. The first type of agreement authorized is between a hospital and patient. Any hospital may decide to offer its patients, at the time of admission or thereafter, an agreement to arbitrate any dispute that may arise. The patient may, if he wishes, accept the offer and become bound to the agreement. To protect patients from decisions made under pressure or in panic, the statute forbids agreements during emergency treatment. Further protection of patients is set out in 2702.1B which permits a patient to revoke a hospital arbitration agreement within 30 days of discharge. Patients cannot be required to sign arbitration agreements as a condition of admission. The statute does permit Blue Cross or a similar organization to provide for arbitration by advance agreement with its members. Such agreements would not be revocable.

Subsection 2 of 2702 authorizes agreements between doctor and patient. The option is with the doctor and, absent emergency, he may refuse to accept patients who do not agree to arbitrate. Agreements under this subsection are not required to be revocable, but they expire in one year.

Section 2704 sets out the manner of instituting an arbitration proceeding. It may be done by either party to the agreement by service of a demand, essentially as would be done in an ordinary legal action.

The statute provides for a panel of three arbitrators, one of whom shall be an attorney, one a doctor and one neither doctor nor lawyer. Rules for the selection of arbitrators are to be promulgated by the Superintendent of Insurance. These rules must contain certain safeguards to insure fairness and impartiality. The parties may agree upon a different number or manner of selection of arbitrators and such an agreement may be made in advance in connection with Blue Cross, Blue Shield or similar membership. (2705)

Sections 2706 and 2707 are procedural. The rules are essentially the same as for a civil action in the Superior Court. The cost of arbitration will be allocated to the parties as determined by the arbitrators (2708). Arbitrators reach a decision by majority vote and must render a written opinion. Awards may be in the form of money damages or some other form of relief such as additional hospitalization or surgery (2709) but a claimant need not take anything but money if that is his wish (2711). Arbitration is binding and the parties may not try their case again in court; but they may appeal questions of law (2712).

The statute does not permit insurance companies to refuse coverage because a doctor or hospital wishes to use arbitration (2714).

Sections 2801 through 2809 provide for a different form of claims resolution. As in arbitration, this sytem is voluntary and requires the agreement of both parties; but unlike arbitration, the resolution here is only a preliminary one on the probability of liability and it is not binding on either party. The agreement to use this system would normally not be made in advance of dispute but would come into being when litigation is contemplated. The purpose is to provide panels of experts to fully and confidentially screen cases before trial. If the panel judges the case to lack merit the claimant is discouraged from proceeding. If the case is judged to have merit, expert medical assistance for the claimant will be secured. This proposed screening-panel system is adapted from two currently in use in Maine by agreement between local bar associations and local medical societies.

(4) Insurance availability.

Although the Commission realizes that the current Joint Underwriting Association in this State is not a permanent answer to any malpractice problem, it strongly recommends the continuation of the Association. A bill to that end has been introduced and the Commission urges its enactment. It is the view of the Commission that the JUA authority should be continued for two years and that the exclusivity (all or none) provision that is in the present law relative to physician's coverage be removed.

(5) General provisions.

a. The ad damnum clause. When a malpractice action is filed against a physician it is not unusual for the plaintiff to state his monetary demand

in very high figures. The large figure demanded may bear no relationship to the damages that are ultimately provable, yet the asserted damage is often deemed newsworthy and given wide circulation. The Commission believes such circulation may substantially and unfairly injure the reputation of the defendant physician. This can be prevented without injury to anyone by a statute forbidding the inclusion of any dollar amount in a malpractice action (2901). The Commission recommends its enactment.

b. Statute of limitations. The statute of limitations for malpractice actions against physicians is two years in Maine. A much longer period (6 Years) is prescribed for such actions against hospitals and hospital employees (nurses). The Commission believes this is incongruous in that the charitable organization in which the physician performs his service and the people who work under his direction should be accorded the same time protection given the doctor. Therefore it is recommended that the statute of limitations for hospitals and hospital employees be reduced to two years (2902).

c. Notice of claim. The Commission believes that any reasonable measure that helps weed out doubtful claims and encourage the settlement of meritorious ones is beneficial to the parties and the public. In malpractice cases this may be the result if there is a mandatory waiting period prior to suit in which negotiations may take place. It is therefore recommended that a potential plaintiff be required to give at least 90 days notice, in writing, of his intention to file a malpractice action (2903).

d. Immunity for volunteer activities. Many physicians in Maine who are employees of hospitals have malpractice insurance coverage only when they are working in or for the hospital. In order to encourage such physicians to volunteer their time for service to the State and to non-profit organizations, the Commission recommends the enactment of a statute similar to the Good Samaritan Act granting immunity in connection with such service from civil liability in the absence of willful, wanton, reckless or grossly negligent conduct (2904).

e. Informed consent. The decisional law of Maine has not fully developed the tests and standards for a physician's duty to inform a patient concerning the nature and possible consequences of proposed treatment or procedures. In the current malpractice climate the confusion and disagreement on this matter in other states has left Maine hospitals and physicians in doubt as to what is required. For this reason the Commission believes statutory clarification is desireable. It recommends a duty to inform based upon the standards of medical practice in the community, and an objective test (reasonable person) of the patient's consent to treatment (2905).

f. Contingent fee contracts. As mentioned earlier, the Commission does not find the contingent fee contract to be a significant negative factor in the malpractice insurance crisis in Maine. The Commission does believe the medical profession and the public are entitled to have such contracts controlled and is recommending to the Supreme Judicial Court a rule change that will require court approval of every contingent fee contract in medical malpractice cases.

MAINE HEALTH SECURITY ACT

TABLE OF CONTENTS

AN ACT relating to medical and hospital practices to insure the availability of medical and hospital malpractice insurance and to develop a more equitable system of relief for malpractice claims.

Be it enacted by the people of the State of Maine, as follows:

24 MRSA c.21 is enacted to read:

CHAPTER 21

MAINE HEALTH SECURITY ACT

Section 2501. Short Title

This act shall be know as the Maine Health Security Act.

Subchapter I. Professional Competence Reports

Section 2502. Definitions

As used in this chapter, unless the context requires otherwise, the following words shall have the following meanings:

1. Health care provider. "Health care provider" means any hospital, clinic, nursing home or other facility in which skilled nursing care or medical services are prescribed by or performed under the general direction of persons licensed to practice medicine or surgery in this State and which is licensed or otherwise authorized by the laws of this State.

2. Professional competence committee. "Professional competence committee" means a committee of members of a professional society or other organization of physicians formed pursuant to state and federal law and authorized to

evaluate medical and health care service, or a committee of licensed professionals authorized or privileged to practice in any health care facility provided such medical society or other organization or the medical staff or such health care facility operates pursuant to written bylaws that have been approved by the governing body of such society, organization or facility.

3. Physician, "Physician" means any natural person authorized by law to practice medicine, or osteopathic medicine within this State.

4. Professional Society. "Professional Society" means a state professional organization of physicians, surgeons or osteopathic physicians.

4. Board. "Board" means the Board of Registration in Medicine or the Board of Osteopathic Examination and Registration.

Section 2503. Hospital duties

The governing body of every licensed hospital shall assure that:

1. Its medical staff is organized pursuant to written bylaws that have been approved by such governing body;

2. Provider privileges extended or subsequently renewed to any physician are in accordance with those recommended by the medical staff as being consistent with that physician's training, experience and professional competence;

3. It has a program for the identification and prevention of medical injury which shall include at least the following:

A. One or more professional competence committees with responsibility effectively to review the professional services rendered in the facility for the purpose of insuring quality of medical care of patients therein. Such responsibility shall include a review of the quality and necessity of medical care provided and the preventability of medical complications and deaths.

B. A grievance or complaint mechanism designed to process and resolve as promptly and effectively as possible grievances by patients or their representatives related to incidents, billing, inadequacies in treatment, and other factors known to influence malpractice claims and suits.

C. A system for the continuous collection of data with respect to the providers experience with negative health care outcomes and incidents injurious to patients (whether or not they give rise to claims), patient grievances, claims, suits, professional liability premiums, settlements, awards, allocated and administrative costs of claims handling, costs of patient injury prevention and safety engineering activities, and other relevant statistics and information;

D. Education programs for the provider's staff personnel engaged in patient care activities dealing with patient safety, medical injury prevention, the legal aspects of patient care, problems of communication and rapport with patients, and other relevant factors known to influence malpractice claims and suits.

4. Where the nature, size or location of the health care provider makes it advisable, the provider may, upon recommendation of its medical staff, utilize the services of an external professional competence committee or one formed jointly by two or more providers.

Section 2504. Professional societies

Every state professional society shall establish a professional competence committee of its members pursuant to written bylaws approved by the society's governing board. Such committee shall receive, investigate and determine the accuracy of any report made to the society of any member physician's acts amounting to gross or repeated medical malpractice, habitual drunkenness, addiction to the use of drugs or professional incompetence.

Section 2505. Committee reports

Any professional competence committee within this State, and any physician licensed to practice or otherwise lawfully practicing within this State shall, and any other person may, report the relevant facts to the appropriate Board relating to the acts of any physician in this State if, in the opinion of said committee, physician, or other person, such committee or individual has reasonable knowledge of acts of such physician amounting to gross or repeated medical malpractice, habitual drunkenness, addiction to the use of drugs or professional incompetence.

Section 2506. Provider reports

A health care provider shall within 60 days report in writing to the appropriate Board the name of any member of the medical staff or any other physician practicing in the facility whose privileges have been revoked, limited or terminated, or who has been otherwise formally disciplined by the provider or the provider's medical staff, together with pertinent information relating to such action, if such revocation, limitation, termination or discipline is the result of negligence, habitual drunkenness, addiction to the use of drugs, gross incompetence or repeated acts of incompetence.

Section 2507. Society reports

Any professional society within this State which takes formal disciplinary action against a member relating to professional ethics, medical incompetence, moral turpitude, or drug or alcohol abuse, shall within 60 days of such action report in writing to the appropriate Board the name of such member, together with pertinent information relating to such action.

Section 2508. Effect of filing

The filing of a report with the Board pursuant to this Act, investigation by the Board, or any disposition by the Board shall not, in and of itself, preclude any action by a hospital or other health care facility or professional society comprised primarily of physicians to suspend, restrict, or revoke the privileges or membership of such physician.

Section 2509. Board records

1. Each Board shall create and maintain a permanent record of the names of all physicians licensed by it or otherwise lawfully practicing in this State and subject to the Board's jurisdiction along with an individual historical record for each such physician relating to reports, or other information furnished the Board under this Act or otherwise pursuant to law. Such record may include, in accordance with rules established by the Board, additional items relating to a physician's record of medical practice as will facilitate proper periodic review of such physician's professional competency.

2. Upon determination by the Board that any report submitted to it is without merit, such report shall be removed from the physician's individual historical record and destroyed.

3. The Board shall provide forms for filing reports pursuant to this Act. Reports submitted in other forms, however, shall be accepted by the Board.

4. A physician shall be provided written notice of the substance of any information received pursuant to this Act and placed in his individual historical record.

5. A physician or his authorized representative shall have the right, upon request, to examine such phusician's individual historical record which the Board maintains pursuant to this Act, and to place into such record a statement of reasonable length of the physician's view of the correctness or relevance of any information existing in such record. Such statement shall at all times accompany that part of the record in contention. This subsection shall not apply to material submitted to the Board in confidence prior to licensure by the Board.

6. A physician shall have the right to seek through court action pursuant to the Maine Rules of Civil Procedure the amendment or destruction of any part of historical record in the possession of the Board.

7. Except as to information relating to biographical background, education, professional training and practice, prior disciplinary action by any entity, or that which the Board may be otherwise required by law to maintain, the Board shall destroy information in a physicians historical record unless the Board has intitiated a proceeding for a hearing upon such information within 2 years of its placement into the historical record.

Section 2510. Confidentiality of information

1. Any reports, information, or records received and maintained by the Board pursuant to this Act, including any such material received or developed by the Board during an investigation or hearing shall be confidential; provided, that the Board may disclose any such confidential information only:

A. in a disciplinary hearing before the Board or in any subsequent trial or appeal of a Board action or order relating to such disciplinary hearing;

B. to governmental licensing or disciplinary authorities of any jurisdiction or to any health care providers located within or outside this state which

are concerned with granting, limiting or denying a physician's hospital privileges, provided, that the Board shall include along with any such transfer an indication as to whether or not such information has been substantiated by the Board:

C. as required by subsection 5 of section 2509 of this chapter;

D. pursuant to an order of a court of competent jurisdiction; or

E. to qualified personnel for bona fide research or educational purposes, if personally identifiable information relating to any patient or physician is first deleted.

2. Orders of the Board relating to disciplinary action against a physician shall not be confidential

3. In no event shall confidential information received, maintained, or developed by the Board, or disclosed by the Board to others, pursuant to this Act, or information, data, incident reports or recommendations gathered or made by or on behalf of a health care provider pursuant to this Act, be available for discovery, court subpoena, or introduced into evidence in any medical malpractice suit or other action for damages arising out of the provision or failure to provide health care services.

4. Any person found guilty of the unlawful disclosure of such confidential information possessed by the Board shall be guilty of a class E crime.

5. The physician-patient privilege shall, as a matter of law, be deemed to have been waived by the patient and shall not prevail in any investigation or proceeding by the Board acting within the scope of its authority, provided, that the disclosure of any information pursuant to his provision shall not be deemed a waiver of such privilege in any other proceeding.

6. Except in matters requiring dismissal because they are frivolous and clearly unfounded on their face, or which fall outside the Board's jurisdiction, a disciplinary order or other disposition of a report before the Board shall not be made until the physician has been provided an opportunity for a hearing before the Board; provided, that the Board may temporarily suspend a physician's license simultaneously with the institution of proceedings for a hearing before the Board, if the Board determines that evidence in its possession indicates that a physician's continuation in practice would constitute an immediate danger to the public; provided further that in the event of such temporary suspension or restriction, without a hearing, a hearing must be held within 15 days of such action or on such later date as the physician requests.

Section 2511. Immunity

Any person acting without malice, and any physician, health care provider, professional society, or member of a professional competence committee or of the Board, in making any report or other information available to the Board pursuant to law, or in assisting in the origination, investigation or preparation of such information, or in assisting the Board in carrying out any of its duties or functions provided by law, shall be immune from civil or criminal liability, except as provided in subsection 4 of section 2510, for any such actions.

Section 2512. Appeal

Any person against whom disciplinary action is taken by the Board pursuant to this Act, shall have the right of judicial appeal as provided in Rule 80 B of the Maine Rules of Civil Procedure; provided, that no such person shall

be allowed to practice medicine in violation of any disciplinary order or action of the Board while any such appeal is pending.

Subchapter II. Liability Claims Reports

Section 2601. Report of claim

Every insurer providing professional liability insurance in this state to a person licensed by the Board of Registration in Medicine or the Board of Osteopathic Examination and Registration, or to any health care provider shall make a periodic report of claims made under such insurance. For purposes of this section a claim is made whenever the insurer receives information from an insured, a patient of an insured or an attorney that an insured's liability for malpractice is asserted. Such report shall include:

1. The date and place of the occurrence for which each claim was made;
2. The name of the insured or insureds and the classification of risk;
3. The incident or occurrence for which each claim was made;
4. The amount claimed;
5. Whether or not each reported claim is subject to an arbitration agreement;
6. Whether or not suit has been filed or arbitration demanded at the time of report on each reported claim;
7. Such other information as may be required pursuant to section 2603.

Section 2602. Report of disposition

1. If any claim subject to section 2601 results in:
   A. A final judgment or award to the claimant in any amount;
   B. A settlement involving payment in any amount of money or services;

C. A final disposition not involving any payment of money or services; the insurer shall make a report of disposition as provided in subsection 2. For purposes of this section a judgment or award is final when it cannot be appealed, and a disposition is final when it results from judgment, dismissal, withdrawal or abandonment.

2. The report of disposition required pursuant to subsection 1 shall include:

A. The name, address and specialty coverage of the insured;

B. The insured's policy number

C. The date and place of the occurrence which created the claim.

D. The date of suit, if filed or arbitration if demanded.

E. The date and amount of judgment, award or settlement, if any;

F. The allocated claim expense, if any;

G. The date and reason for final disposition, if no judgment, award or settlement.

H. A summary of the occurrence which created the claim

I. Such other information as may be required pursuant to section 2603.

Section 2603. Place and form of reports

Claims reports and reports of disposition required by this subchapter shall be made to the State Superintendent of Insurance who shall prescribe the form and content of such reports. The Superintendent shall determine the frequency of claims reports, provided the period covered by such reports shall not be less than one month nor more than one year. Reports of disposition shall be made within 60 days of the judgment, award, settlement or other disposition of claim within section 2602.

Section 2604. Records of Superintendent

For the purpose of evaluation of policy provisions, rate structures and the arbitration process and for recommendations of further legislation the Superintendent of Insurance shall retain the information and maintain the files in the form and for a period as he shall determine necessary. The Superintendent shall maintain the data and information filed in accordance with this section as strictly confidential records and shall release the same only for bona fide research, educational or legislative purposes, or as required by section 2605. The Superintendent shall determine the validity of any request for the information. Reports made to the Superintendent and records thereof kept by the Superintendent shall not be subject to discovery and shall not be admissable in any trial, civil or criminal, other than proceedings brought before or by the Board.

Section 2605. Report to Board

The Superintendent shall, within 30 days of their receipt, submit to the appropriate Board a copy or summary of reports received pursuant to section 2601. or section 2602.

Section 2606. Immunity

There shall be no liability on the part of and a cause of action of any nature shall not arise against an insurer reporting hereunder or its agents or employees, or the Superintendent or his representatives, for any action taken by them pursuant to this subchapter.

Subchapter III. Medical Malpractice Arbitration

Section 2701. Application

1. The provisions of this subchapter shall be applicable to the arbitration of a dispute, controversy, or issue arising out of or resulting from injury

to, or the death of, a person caused by the alleged error, omission, or negligence in the performance of professional services by a health care provider, physician, or the agent or employee of a provider or physician, or based on a claimed performance of such services without consent, in breach of warranty, or in violation of contract.

2. An agreement to arbitrate executed pursuant to this chapter shall be presumed valid, but a court of competent jurisdiction may stay arbitration, modify, correct or refuse to confirm an award as provided by law or court rule.

3. In an arbitration agreement or proceeding under this chapter, the provisions of this chapter shall govern if a conflict arises between such provisions and those of Title 14 MRSA c. 706.

Section 2702. Agreements permitted

1. A person admitted to a health care provider may execute an offered agreement to arbitrate any dispute, controversy, or issue arising out of health care or treatment provided by the provider or its employees.

A. No person receiving emergency treatment or care shall be offered the option of an arbitration agreement until such emergency treatment or care is completed.

B. Every arbitration agreement offered pursuant to this subsection shall contain the following provision in 12 - point boldface type immediately above the space for signature of the parties:

NOTICE TO PATIENT

YOU CANNOT BE REQUIRED TO SIGN THIS AGREEMENT IN ORDER TO BE ADMITTED TO (name of provider) OR TO RECEIVE TREATMENT THEREIN. THIS AGREEMENT PROVIDES THAT ANY CLAIM YOU MAY ASSERT RELATIVE TO YOUR CARE HERE WILL BE SUBMITTED TO A PANEL OF ARBITRATORS RATHER THAN A COURT FOR DETERMINATION BY A JURY OR A JUDGE.

UNLESS YOU ARE PARTY TO AN EXISTING ARBITRATION AGREEMENT IN CONNECTION WITH MEMBERSHIP IN A NONPROFIT HOSPITAL OR MEDICAL SERVICE ORGANIZATION THIS AGREEMENT MAY BE CANCELLED BY YOU WITHIN 30 DAYS OF YOUR DISCHARGE BY OR DEPARTURE FROM (name of provider). TO EFFECT SUCH CANCELLATION YOU MUST NOTIFY (name and address of provider) IN WRITING BY CERTIFIED MAIL.

An agreement executed pursuant to this subsection may be revoked by the person receiving health care or treatment within 30 days of discharge by or departure from the health care provider, or by such person's legal representative within 30 days of such person's death occurring within the period of revocability. No agreement may be revoked after commencement of arbitration proceedings. Revocation shall be effected by delivery of written notice to the health care provider or by depositing such notice properly addressed as certified mail. An arbitration agreement may not be revoked by the health care provider. This paragraph shall not preclude the inclusion of irrevocable provisions for arbitration pursuant to this chapter in contracts of Nonprofit Hospital or Medical Service Organizations with their members or hospitals.

D. The form of the agreement promulgated shall be accompanied by an information brochure which clearly details the agreement and revocation provision. The brochure shall be furnished the person receiving health care at the time of execution. The person receiving health care shall be furnished with either an

original or duplicate of the agreement.

E. Each admission to a health care provider shall be treated as separate and distinct for the purposes of an agreement to arbitrate but a person receiving outpatient care may execute an agreement with the provider which provides for continuation of the agreement for a specific or continuing program of health care or treatment under the provisions of subsection 2.

2. A person who receives health care or treatment from a physician other than as an employee of a health care provider may execute an offered agreement to arbitrate any dispute, controversy or issue arising out of such care or treatment.

A. Every arbitration agreement offered pursuant to this subsection shall contain the following provision in 12-point boldface type immediately above the space for signature of the parties:

NOTICE TO PATIENT

THIS AGREEMENT PROVIDES THAT ANY CLAIM YOU MAY ASSERT RELATIVE TO TREATMENT BY (name of provider) WILL BE SUBMITTED TO A PANEL OF ARBITRATORS RATHER THAN A COURT FOR DETERMINATION BY A JURY OR A JUDGE AS WOULD BE YOUR CONSTITUTIONAL RIGHT IN THE ABSENCE OF THIS AGREEMENT.

B. An arbitration agreement under this subsection shall expire one year after its execution but may be renewed by execution of a new agreement. An expired agreement shall apply to claims relative to care or treatment provided while the agreement was in force.

C. The form of agreement and brochure shall be furnished to the person receiving health care or treatment as provided in paragraph D. of subsection 1.

Section 2703. Parties

1. If a claim is asserted in connection with health care or treatment delivered in a health care provider covered by an agreement executed pursuant to subsection 1 of section 2702 and the attending physician is not covered by such agreement or an agreement executed pursuant to subsection 2 of section 2702, all issues of the provider's liability shall be determined by arbitration and all issues of the physician's liability shall be determined by judicial process except as provided in subsection 3.

2. If a claim is asserted in connection with health care or treatment delivered in a health care provider not covered by an agreement executed pursuant to subsection 1 of section 2702 and the attending physician is covered by an agreement executed pursuant to subsection 2 of section 2702, all issues of the physician's liability shall be determined by arbitration and all issues of the provider's liability shall be determined by judicial process except as provided in subsection 3.

3. If arbitration is instituted, a person who is not a party to the arbitration agreement may join in the arbitration with the consent of all parties and shall have all the rights and obligations of the original parties.

4. A minor child shall be bound by a written agreement to arbitrate disputes, controversies, or issues upon the execution of an agreement on his behalf by a parent or legal guardian. The minor child may not subsequently disaffirm the agreement.

5. In cases involving a common question of law or fact, if separate arbitration agreements exist between a plaintiff and a number of defendants or between defendants, the disputes, controversies, and issues shall be consolidated into a single arbitration proceeding.

Section 2704. Commencement of proceedings and reparation offers

1. Arbitration proceedings under this Act shall be commenced by serving a notice of demand for arbitration, together with a statement of the claim and cause of action, on all parties to the arbitration agreement from whom damages are sought. The statement of the claim and cause of action shall be substantially in the form of a complaint under the Maine Rules of Civil Procedure. Service of the notice and statement shall be by any method authorized for service of complaints under such rules or by certified mail. For purposes of any statute of limitations, notice of a demand for arbitration to any party from whom damages are sought, whether by certified mail or any other valid process, shall be deemed to have tolled such statute as to all parties served with notice.

2. In a case where a potential claim is identified by a physician or a health care provider or where reparations, in its judgment, are not appropriate, the provider may, at its option, file a demand for arbitration which demand shall identify the potential claim and deny liability.

3. Prior to the institution of a proceeding or claim by a patient, any offer of reparations and all communications incidental thereto made in writing to a patient by a health care provider or a physician are privileged and may not be used by any party to establish the liability or measure of damages attributable to the offeror.

4. Such an offer shall provide that a patient has 30 days to accept or reject the offer, or such lesser period of time as may be necessitated by the condition of health of the patient.

5. After any rejection or the lapse of the applicable time, any party may demand arbitration, where an arbitration agreement is in effect.

6. Any such offer to a patient shall include a statement that the patient may consult legal counsel before rejecting or accepting the offer.

Section 2705. Arbitrators

1. An arbitration under this chapter shall be heard by a panel of 3 arbitrators. One shall be an attorney who shall be the chairperson and shall have jurisdiction over prehearing procedures, one shall be a physician, preferably but not necessarily from the respondent's medical specialty, and the third shall be a person who is neither doctor, lawyer, or representative of a provider or insurance company. Where a case involves a provider only, a provider administrator may be substituted for a physician.

2. Arbitrator candidates shall be selected pursuant to rules promulgated by the Superintendent of Insurance. Such rules shall provide for:

A. reasonable participation of all parties through selection or deletion of names from a pool of candidates generated by the Superintendent;

B. a method of appointment or selection in the event a panel cannot be formed by agreement;

C. procedures for screening for bias or partiality;

D. protection against unauthorized communication between parties and candidates.

3. Notwithstanding the foregoing, the parties may agree upon arbitrators or any method of selecting arbitrators or the number of arbitrators, provided such agreement is made after the commencement of arbitration proceedings.or appears in or is pursuant to an agreement with a Nonprofit Hospital or Medical Service Organization.

Section 2706. Depositions; discovery; length of proceeding

1. After the appointment of the panel of arbitrators, the parties to the arbitration may take depositions and obtain discovery regarding the subject matter of the arbitration, and, to that end, use and exercise the same rights, remedies, and procedures, and be subject to the same duties, liabilities, and obligations in the arbitration with respect to the subject matter thereof, as if the subject matter of the arbitration were pending in a civil action before the Superior Court of this State.

2. The panel shall conclude the entire proceeding as expeditiously as possible.

3. Discovery shall commence not later than 20 days after all parties have received a copy of the demand for arbitration and shall be completed within 6 months.

4. A party may be granted an extension of time to complete discovery upon a showing that the extension is not the result of neglect and that the extension is necessary in order to avoid substantial prejudice to the rights of the party.

Section 2707. Conduct of proceedings

1. Counsel; standard of care; damages.

A. The parties may be represented by counsel, be heard, present evidence material to the controversy, and cross examine any witness. A party may appear without counsel and shall be advised of such right and the right to retain counsel in a manner calculated to inform the person of the nature and complexity of a proceeding.

B. The prevailing standard of duty, practice, or care applicable in a civil action shall be the standard applied in the arbitration.

C. Damages or remedial care shall be without limitation as to nature or amount unless otherwise provided by law.

2. Expert witness: A party is entitled to disclosure of the name of any expert witness who will be called at the arbitration and may depose the witness.

3. Hearing

A. A hearing shall be informal and the rules of evidence shall be as provided for an administrative proceeding in this State except that the panel shall adhere to civil rules of evidence where the failure to do so will result in substantial prejudice to the rights of a party.

B. Testimony shall be taken under oath and a record of the proceedings shall be made by a tape recording. Any party, at that party's expense may have transcriptions or copies of the recording made or may provide for a written transcript of the proceedings. The cost of any transcription ordered by the panel for its own use shall be deemed part of the cost of the proceedings.

C. Expert testimony shall not be required but where expert testimony is used it shall be admitted under the same circumstances as in a civil trial and be subject to cross-examination.

D. The party with the burden of establishing a standard of care and breach thereof shall establish such standards whether by the introduction of expert testimony, or by other competent proof of the standard and the breach thereof, which may include the use of works as provided in paragraph E.

E. Authoritative, published works on the general and specific subjects in issue may be admitted and argued from, upon prior notice to all other parties.

F. The panel shall accord such weight and probative worth to expert evidence as it deems appropriate. The panel may call a neutral expert on its own motion, which expert witness shall be subject to cross-examination by the parties. The cost of the expert will be deemed a cost of the proceeding.

4. Subpoenas

1. The panel or its chairperson in the arbitration proceeding shall, upon application by a party to the proceeding, and may upon its own determination, issue a subpoena requiring a person to appear and be examined with reference to a matter within the scope of the proceeding, and to produce books, records, or papers pertinent to the proceeding. In case of disobedience to the subpoena, the chairperson or a majority of the arbitration panel in the arbitration proceeding may petition the Superior Court in the county in which the hearing is being held to require the attendance and testimony of the witness and the production of books, papers, and documents. The Court, in case of contumacy or refusal to obey a subpoena, may issue an order requiring the person to appear and to produce books, records, and papers and give evidence touching the matter in question. Failure to obey the order of the court may be punished by the court as contempt.

5. Discovery

A. For the purpose of enforcing the duty to make discovery, to produce evidence or information, including books and records, and to produce persons to testify at a deposition or at a hearing, and to impose terms, conditions, consequences, liabilities, sanction, and penalties upon a party for violation of a duty, a party shall be deemed to include every affiliate of the party as defined in this section. For that purpose the personnel of an affiliate shall be deemed to be the officers, directors, managing agents, agents, and employees of that party to the same degree as each of them, respectively, bears that status to the affiliate; and the files, books, and records of an affiliate shall be deemed to be in the possession and control of, and capable of production by, the party.

B. As used in this section, "affiliate" of the party to the arbitration means and includes a party or person for whose immediate benefit the action or proceeding is prosecuted or defended or an officer, director, superintendent, member agent, employee, or managing agent of that party or person.

Section 2708. Fees and costs

1. Except for the parties to the arbitration and their agents, officers, and employees, all witnesses appearing pursuant to subpoena are entitled to receive fees and mileage in the same amount and under the same circumstances as prescribed by law for witnesses in civil actions. The fee and mileage of a witness subpoenaed upon the application of a party to the arbitration shall be paid by that party. The fee and mileage of a witness subpoenaed solely upon the determination of the arbitrator or the majority of a panel of arbitrators

shall be paid in the manner provided for the payment of the arbitrator's expenses.

2. The cost of each arbitrator's fee and expenses, together with any administrative fee, may be assessed against any party in the award or may be assessed among parties in such proportions as may be determined in the arbitration award.

Section 2709. Awards

1. A majority of the panel of arbitrators may grant any relief deemed equitable and just, including money damages, provision for hospitalization, medical, or rehabilitative procedures, support, or any combination thereof.

2. The panel may order submission of written briefs within 30 days after the close of hearings. In written briefs each party may summarize the evidence in testimony and may propose a comprehensive award of remedial or compensatory elements.

3. The panel shall render its award and opinion within 30 days after the close of the hearing or the receipt of briefs, if ordered.

4. The award in the arbitration proceedings shall be in writing and shall be signed by the chairperson or by the majority of a panel of arbitrators. The award shall include a determination of all the questions submitted to arbitration by each party, the resolution of which is necessary to determine the dispute, controversy, or issue.

Section 2710. Opinions

1. In addition to the award the panel shall render a written opinion which states its reasoning for the finding of liability or nonliability, and the reasoning for the amount and kind of award if any. A panel member who disagrees with the majority may write a dissenting opinion.

2. The panel shall determine the degree to which each respondent party was at fault for the total damages accruing to any other party to the arbitration.

3. The panel shall prepare a schedule of contributions according to the relative fault of each party which schedule shall be binding as between those parties, but such determination shall not affect a claimant's right to recover jointly and severally from all parties where such rights otherwise exists in the law.

Section 2711. Noncash awards

1. In the case of an award, any element of which includes remedial services, annuities, or other noncash award element, the panel shall determine the current cash value of each element of the award and shall also determine a total current cash value of the entire award.

2. An award of remedial surgery or care shall not require that the patient undergo such treatment or care by the health care provider whose conduct resulted in the award.

3. A claimant need not accept the benefits of an award for remedial surgery or other noncash award element and such refusal shall not affect the claimant's right to receive any other part of the award, nor the current cash value of the portion refused.

Section 2712. Review

An appeal from the arbitration award shall be under the procedure and for the grounds permitted under the general arbitration law and applicable court rules.

Section 2713. Administration and costs

1. The adminstration of this subchapter shall be by the Superintendent of Insurance who may promulgate such rules as are necessary for its implementation.

2. The Superintendent shall create an arbitration administration fund which shall be funded anually as necessary to defray the actual costs of administration.

Section 2714. Insurance

No professional liability or medical malpractice insurer doing any business in this State shall refuse to offer or continue insurance to any health care provider or any physician for the reason that such insured or applicant has entered, offered to enter, intends to enter or offer to enter agreements authorized by this subchapter; and no such insurer shall limit policy coverage to the absence of such agreements.

Subchapter IV. Professional Malpractice Advisory Panels

Section 2801. Purpose

The purpose of Professional Malpractice Advisory Panels shall be:

1. To Prevent, where possible, the filing of court actions against physicians for professional malpractice in situations where the facts do not allow at least a reasonable inference of malpractice.

2. To make possible the fair and equitable disposition of such claims against physicians as are, or reasonably may be, well founded.

Section 2802. Formation

1. There shall be created a panel of eighteen persons of whom six shall be licensed attorneys, six shall be physicians licensed by the Board of Osteopathic Examination and Registration and six shall be physicians licensed by the Board of Registration in Medicine. Such persons shall be known as the Professional Malpractice Advisory Panel. The Chairman of the panel shall be an attorney-member elected by the vote of a majority of the panel members.

2. Selection of the panel shall be as follows: six attorneys designated by the Maine State Bar Association; six physicians designated by the Maine Osteopathic Association; and six physicians designated by the Maine Medical Association. Each association shall notify the Superintendent of Insurance of the names and mailing address of each panel member so selected. Panelists shall serve for a term of four years the first of which shall begin 30 days from the effective date of this Act.

3. If any panel member is unable or unwilling to serve in any matter or is challenged by any person who is a party to a proceeding before a panel the sponsoring association shall select a replacement and so notify the Superintendent.

Section 2803. Submission of Cases

1. Any attorney may submit a case of asserted medical malpractice for the consideration of the Panel by a request in writing signed by both the party and his attorney and delivering the original and six copies thereof to the Chairman of the Panel. This written request shall contain the following:

A. A brief statement of the facts of the case, showing the persons involved, the dates and the circumstances, so far as they are known, of the alleged act or acts of malpractice.

B. A statement authorizing the Panel, by its Chairman, to obtain all medical and hospital records and information pertaining to the incident complained of, which statement shall be accompanied by true copies of any and all medical and hospital records then in the possession of said party or his attorney, and which, for only the purpose of the Panel's consideration of the matter, waives privilege as to the contents of such records. Such statement shall not be construed as waiving such privilege for any other purpose or any other contest, in or out of court.

C. A statement that the deliberations and the discussions of the Panel and of any member of the Panel in the deliberation of the case will be confidential and privileged, and that no Panel member will be asked in any action to testify concerning the deliberations, discussions and internal proceedings of the Panel.

D. A statement that the party, or attorney, understands and subscribes to the purpose of screening medical malpractice cases and has advised his client thereof and that the client agrees to the submission of the facts pursuant to the plan.

E. A request that the Panel consider the merits of the claim and render its report.

2. Upon receipt of the request the Chairman shall immediately forward a copy to the physician involved who, if he agrees to the submission, shall forthwith forward to the Chairman a statement as provided in paragraph B, C, D and E of subsection 1 of this section. Neither the party making the original request pursuant to subsection 1 nor his attorney shall be bound by any waiver

or agreement made thereunder until the Chairman shall have received from the physician a like written waiver or agreement.

3. Upon receipt of the statement provided in subsection 2 of this section the Chairman shall immediately designate and convene a hearing committee of panel members to consider the case. Such committee shall consist of two attorneys, one of whom shall be designated Chairman, and two physicians licensed by the Board that licensed the physician involved. The call of meeting may be oral or written and the place and time shall be as determined by the Panel Chairman. The Committee Chairman shall attempt to have available at said meeting all medical and hospital records and information pertaining to the case.

Section 2804. Hearing

1. The hearing on a request for review shall require the presence of both attorney-members and the two physician-members who were called. At the time of hearing, the attorney submitting the request shall present the case before the Committee. The physician involved shall be entitled to be present at said hearing and likewise make such counter-presentation as he deems necessary and appropriate. Wide latitude shall be afforded the parties by the Committee in the conduct of the hearing, including but not limited to the right of an examination and cross-examination by attorneys. No official record of the proceedings before the Committee at said hearing shall be kept. Neither the parties nor the Committee shall inquire into or become involved in any way with the question of monetary damages.

After presentation by the parties as herein provided, the Committee may request from either party additional facts, records or other information to be submitted in writing or at a continued hearing, which continued hearing

shall be held as soon as possible. Such continued hearings shall be attended by the same members of the Committee who have sat on all prior hearings in the case.

3. The Committee shall determine all matters of procedure governing hearings.

Section 2805. Determination by Panel Committee

At the conclusion of the presentation, the Committee shall take the case under advisement, and shall within 15 days thereafter, by majority vote taken by secret ballot, determine the following questions:

1. Whether there is a reasonable probability that the acts complained of constitute professional negligence, and if so,

2. Whether there is a reasonable, medical probability that the party was injured thereby.

Section 2806. Notification of Determination

Written answers to these questions, signed by the Chairman of the Hearing Committee, acting on behalf of the entire Committee, shall forthwith be submitted to the parties involved and their attorneys. A copy of the original request and of the report of determination shall be retained in the permanent files of the Panel, which files shall remain in the possession of and under the direct supervision and control of the Chairman. Thereupon, all exhibits, reports, records and other data submitted to the Panel shall be returned to the persons submitting same. Other writings pertaining to the case shall be destroyed by the Panel chairman forthwith.

Section 2807. Confidentiality

All proceedings before the Panel, including its final determinations, shall be treated in every respect as confidential by the Panel and the parties to the case. No report or other writings of the Panel shall be used in any other proceedings.

Section 2808. Effect of Determination by Panel

In fulfillment of the Statement of Purposes contained herein, a determination by the Panel of any case hereunder shall be implemented as follows:

1. If the determination of both questions contained in Section 2805 hereof is in the affirmative, the appropriate society of physicians will utilize its best efforts to obtain for and make available to the party a competent physician skilled and recognized as such in the field or fields involved, who will consult with and testify on behalf of the party for a reasonable fee.

2. If the determination of either of said questions contained in section 2805 hereof is in the negative, the attorney for the party shall thereafter refrain from filing any court action based thereon unless personally satisfied that strong and overriding reasons compel such action to be taken in the interest of his client, and that it is not done to harass or gain advantage in the negotiation for settlement.

It is not intended that the submission of any case to the Panel shall be considered as a waiver by the attorney or his client of the right to decide for themselves whether an action should be commenced. However, any attorney who brings a case before the Panel shall weigh its conclusions in the greatest professional good faith.

Section 2809. Statute of Limitations

The statute of limitations shall be tolled for a period of 10 days from the date upon which the Chairman of the Panel receives a request for submission pursuant to subsection 1 of Section 2803. In the event the submission is agreed to and a hearing held, the statute shall be further tolled until the day following the day upon which the parties receive notification pursuant to section 2806.

Subchapter V. General Provisions

Section 2901. Ad Damnum Clause

No dollar amount or figure shall be included in the demand in any malpractice complaint, but the prayer shall be for such damages as are reasonable in the premises.

Section 2902. Statute of Limitations for Hospitals and Employees

An action for damages for injury or death against any hospital or its employee, whether based upon tort or breach of contract, or otherwise, arising out of patient care shall be commenced within two years after the cause of action accrues.

Section 2903. Notice of Claim before Suit

No action for death or injuries to the person arising from any medical, surgical or dental treatment, omission or operation shall be commenced until at least 90 days after written notice of claim setting forth under oath the nature and circumstances of the injuries and damages alleged is served personally or by registered or certified mail upon the person or person accused of wrong-doing. Any applicable statute of limitations shall be tolled for a period of 90 days from service of notice.

Section 2904. Immunity from civil liability for volunteer activities.

Notwithstanding any inconsistent provision of any public or private and special law, no licensed physician who voluntarily, without the expectation or receipt of monetary or other compensation, provides professional services within the scope of his licensure to a non-profit organization or to an agency of the state or to member or recipients of services of that organization or state agency shall be liable for damages or injuries alleged to have been sustained by such person nor for damages for the death of such person when such injuries or death are alleged to have occurred by reason of an act or omission in the rendering of such professional services, unless it is established that such injuries or such death were caused willfully, wantonly, recklessly or by gross negligence of the licensed physician.

Section 2905. Informed Consent to Health Care Treatment

a. No recovery shall be allowed against any physician or any health care provider upon the grounds that the health care treatment was rendered without the informed consent of the patient or the patient's spouse, parent, guardian, nearest relative or other person authorized to give consent for the patient where:

1. The action of the physician in obtaining the consent of the patient or other person authorized to give consent for the patient was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities and

2.A reasonable person, from the information provided by the physician under the circumstances, would have a general understanding of the procedures

or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other physicians engaged in the same field of practice in the same or similar communities or

3. A reasonable person, under all surrounding circumstances, would have undergone such treatment or procedure had he been advised by the physician in accordance with paragraphs 1 and 2 or this subsection.

b. A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person, shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such consent was obtained through fraud, deception or misrepresentation of material fact.

c. A valid consent is one which is given by a person who, under all the surrounding circumstances, is mentally and physically competent to give consent.