COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
COMMITTEE ON JUDICIARY

In re: House Bill 1105

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Stenographic report of hearing held in Room 418, Main Capitol Building, Harrisburg, Pennsylvania

Tuesday,
July 18, 1989
10:00 a.m.

HON. THOMAS R. CALTAGIRONE, CHAIRMAN
Hon. Babette Josephs, Secretary
Hon. Gerard A. Kosinski, Subcommittee Chairman on Courts
Hon. Kevin Blaum, Subcommittee Chairman on Crime and Corrections

MEMBERS OF COMMITTEE ON JUDICIARY

Hon. Michael E. Bortner
Hon. Lois Sherman Hagarty
Hon. Richard Hayden
Hon. David W. Heckler
Hon. Nicholas B. Moehlmann
Hon. Christopher K. McNally
Hon. Jeffrey E. Piccola
Hon. John F. Pressmann
Hon. Karen A. Ritter
Hon. Michael R. Veon
Hon. Chris R. Wogan

Also Present:

Hon. J. Scot Chadwick
David Krantz, Executive Director
William Andring, Majority Counsel
Katherine Manucci

Reported by:
Ann-Marie P. Sweeney, Reporter

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CHAIRMAN CALTAGIRONE: I'd like to open the House Judiciary Committee hearing dealing with testimony on House Bill 1105. I will call the first witness, who will be Honorable Scot Chadwick.

Scot, if you would introduce yourself for the record and commence with your testimony.

REPRESENTATIVE CHADWICK: Yes. Thank you, Mr. Chairman.

My name is Scot Chadwick, member of the House of Representatives, 110th District, Bradford County.

Good morning, Mr. Chairman. I'd like to thank you and the members of this committee for conducting this hearing to examine the crisis in medical malpractice insurance. As you know, I am the prime sponsor of House Bill 1105, which would amend Act 111 of 1975 to provide some much needed relief to the Commonwealth's physicians. I'm pleased to report that 110 of my colleagues, including 8 members of this committee, have joined as cosponsors of the bill. Clearly, a majority of the members of this House recognize the need to address the medical malpractice insurance crisis. I intend to make my testimony brief. There are other witnesses whose testimony is extremely important and who the committee may want to question in detail. However, I do a want to make a number of points about House Bill 1105 and about the

medical malpractice crisis in general.

House Bill 1105 can be characterized to some degree as tort reform for doctors. Many of the bill's provisions would make changes in the civil justice system to level the playing field on which plaintiffs and doctor defendants compete. What the bill does not do, contrary to the myths being circulated by opponents of this legislation, is prevent victims from suing for their injuries or being compensated for their losses. There is no cap on pain and suffering awards in this bill. I should repeat that. There is no cap on pain and suffering rewards in this bill. Victims of medical malpractice have nothing to fear from House Bill 1105. The only losers would be those who stand to profit from excessive jury awards. In my experience, many of the opponents of this legislation are not nearly as concerned with victim's rights as they are with the size of their contingent fees.

Another myth being perpetuated by opponents of this bill is that this crisis was somehow manufactured by the insurance industry. Fortunately, that misconception can be dealt with by this committee today. Testimony will be presented later by the Pennsylvania Medical Society Liability Insurance Company, commonly referred to as PMSLIC. PMSLIC is a nonprofit company owned by the doctors themselves. It doesn't earn a dime

in profits. Every penny is returned to the doctors in the form of reduced premiums. No tricks, no deceptions, no hidden profits. Just malpractice insurance as inexpensively as it can be offered. Yet, despite plowing its earnings into reduced premiums, PMSLIC must charge some doctors as much as $68,000 for liability coverage. Now admittedly, that's a worst-case scenario, but that would be the tops. I invite members of this committee to question PMSLIC members carefully. I am confident that you will reach the same conclusion I did, that the industry did not invent this crisis and that it cannot be cured solely through insurance reform.

Fourteen years ago, the General Assembly recognized that a crisis existed in medical malpractice liability insurance. We acted to ease that crisis by creating a mandatory arbitration system for medical malpractice cases. That system was subsequently struck down by the Supreme Court. In the 14 years since Act 111 was enacted, liability insurance rates have soared. The problem is far worse now than it was in 1975. We must act now before we drive physicians out of practice and out of Pennsylvania.

Last session, the House of Representatives took action by overwhelmingly passing House Bill 2520 by a vote of 184 to 9. Unfortunately, that action occurred on

November 16, 1988, just two weeks before we adjourned sine die. The bill, regrettably, died in the Senate. We must not allow that to happen this session. I urge the members of this committee to act quickly to bring House Bill 1105 before the full House. The process of give and take which fashioned House Bill 2520 must begin much earlier this session if we are to put a bill on the Governor's desk before November 30, 1990.

Mr. Chairman, I'd like to again thank you for conducting this hearing, and I'd like to thank both you and the minority chairman for cosponsoring House Bill 1105. I believe the bill is in good hands.

That concludes my testimony. I'd be happy to answer any questions members of the committee might have.

Thank you.

CHAIRMAN CALTAGIRONE: Thank you, Scot.

Members?

Mike.

BY REPRESENTATIVE BORTNER: (Of Rep. Chadwick)

Q. Scot, I'd like to ask you just about a couple specific provisions of the bill which I guess I have some questions about or have some confusion on. One of them involves informed consent, and there's a provision that Section (d) indicates that all of the things that

have previously been said in the bill about informed consent don't apply in certain situations. Two of them are pretty clear-cut, but the third one causes me some concern, which says that it would--

REPRESENTATIVE HAGARTY: Mike, can I ask you what page you're on?

REPRESENTATIVE BORTNER: I'm on page 7 of the bill, excuse me, under informed consent.

BY REPRESENTATIVE BORTNER: (Of Rep. Chadwick)

Q. That a physician is not under a duty to follow these provisions for informed consent where the information would be detrimental -- where the doctor determines the information would be detrimental for the patient's health if it were to be known by the patient. I mean, that strikes me as a fairly -- as a loophole wide enough to drive a truck through. I mean, under what kind of circumstances would you see that applying?

A. I'm not a physician, Mike. I can only speculate that there may be situations where the patient's health is fragile enough that telling them a certain fact might be a significant shock to his system, and that's the kind of thing that perhaps the physician would want to discuss with members of the family in detail before a decision was made to discuss that item with the patient himself. I might suggest that you might want to direct

that question to one of the physicians who's going to testify later and perhaps they could answer it more specifically.

I guess the final point I'd make is if there's a dispute over whether or not lack of informed consent was appropriate, it would certainly be a jury question. You would be allowed to present arguments like that to a jury as to whether or not there was informed consent.

Q. Well, I do have some other questions. Maybe I'll hold those for some of the people who are going to testify on some more substantive parts of the bill.

A. Okay.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Thank you, Scot.

REPRESENTATIVE CHADWICK: Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Don Matusow. And if you would just introduce yourself and who you represent.

Was there written testimony submitted?

MR. MATUSOW: Yes, there was. It was submitted this morning. My apologies.

Good morning. My name is Donald Matusow, and I'm here representing the Pennsylvania Trial Lawyers. I'd like to let you know that I'm not really a

Johnny-come-lately to this particular issue. I've been involved on behalf of the trial lawyers since the mid-1970's, and I was a member of the Senate Select Committee that was formed in 1984 to study this problem. I will also confess that I do suffer from the dreaded lawyer's disease of talkitis, so if at any time anyone has a question or wants to interrupt me, I would not be at all disturbed by that.

I think one of the things as the hearings go forward today you'll notice is there's not one penny of promised savings if all of the tort reform sought by PMS is enacted. If you look carefully through each of the sections of the legislation and the legislation in toto, again, there is no guarantee of a single dime in savings for physicians for their premiums or otherwise. So what you really have in front of you is a bill that seeks to take away victim's rights without any corresponding benefit to really society. It's really -- this is more an emotional issue on behalf of physicians than it is an attempt to really rectify the problem.

As I mentioned, I was a member of the Senate Select Committee where the trial lawyers participated as well as PMS and the Hospital Association and other interested parties. And during the course of those negotiations which stretched out over several years, the

trial lawyers reluctantly did agree to participate in some tort reform. It was -- there was a condition to that agreement, however, and that is that the really major problem facing the medical profession be addressed also, and that was insurance reform. And again, you'll see in the legislation in front of you there really is not one word that would address the serious problems of the insurance delivery for physicians in Pennsylvania.

The horror stories that you hear in terms of premiums for doctors, and I agree that they are out there, I would not hide from that fact, and that is a problem, all of those serious horror stories really involve high-risk physicians - neurosurgeons, anesthesiologists, other people who are involved in surgery. And this really occurred as a result of the way the insurance system has evolved in Pennsylvania. You know, I think everybody has come to recognize that the liability crisis of the early 1980's really had a lot to do with the way insurance companies did business, their overreliance on investment income keeping premiums artificially low, and I think almost everybody, and I think even the insurance companies themselves acknowledged that a big problem with rising insurance rates generally had to do with the way insurance companies do business.

This is particularly true in Pennsylvania

with regard to medical malpractice insurance. In the late 1950's, early 1960's, there were only really two class of doctors. Insurance is based on a pooling of the risk. The larger the pool of people available, each person has a smaller part of that risk. It keeps premiums down for everyone. And there were only two classes of doctors in the late '50's, early '60's - those who did no surgery and those who did surgery. At the present time, there are 13 to 15 different classes of doctors that have been created by the insurance companies. For instance, one specialty, the neurosurgeons. There are 200 of them, approximately, in Pennsylvania. They're in a separate class, risk classification. They're also in a specialty that if something goes wrong with one of their procedures, it's likely to be a horrendous result for the patient. You can see that trying to spread the risk of this kind of injury just among 200 physicians is an unreasonable way to approach it, and that's why neurosurgeons are paying an unduly high amount of premiums. Again, the basic coverage for most low-risk doctors is not out of hand in Pennsylvania. It's perfectly consistent with the experience across this country for those type of physicians.

Part of the proposal that the trial lawyers have put forth in the negotiations was to reduce the

classes back down to three classes - those who did no surgery, basically the GPs, those who did some limited amount of surgery, and those then in the high-risk professions. This would have resulted in an immediate 54 percent savings for the high-risk physicians. Immediate. No question. It would have also resulted, I must add this, in a 19-percent increase for the low-risk, who were then paying, this was 1986, I believe, most of whom were paying under $10,000 a year. So the 19-percent increase was not going to be a make-or-break situation, because again, this large pool of doctors would have made up that loss. A neurosurgeon who was paying $80,000 a year would have, with that legislation being passed that was proposed in Senate Bill 1513, would have been paying less than $40,000 per year. Again, consistent with the experience across this country. So the insurance delivery system has failed and is largely responsible.

There's another serious problem in Pennsylvania, and it's true, PMSLIC is not for profit, but they compete with companies that are for profit, and those companies have engaged in a practice known as cream-skimming. Cream-skimming involves a company with some shrewd practices, and I don't mean that unethical practices, just hard, good business practices, take a look and only insure the best risk doctors, and they can keep

the premium below what PMSLIC charges. PMSLIC, which is a captive company owned and controlled by the doctors, by their charter, they have to have insurance offered for every physician. They aren't in a position to compete, but they must try to compete and they kept their rates artificially low for a period of time also. Again though, their loss experience did not justify those low rates and again you had that explosion which is now leveled off of the increase in premiums especially for the high-risk doctors. Our proposal in SB 1513 would have eliminated the practice of cream-skimming.

Another surprising thing in Pennsylvania concerns that as of 1986, I think some of the companies are starting now, and frankly, the trial lawyers would like to take credit for that, I'm sure no one's going to give it to us, and that involves experience rating. We made a big point of this back in the negotiations that none of the insurance companies in that time did experience rating to control bad doctors. The statistics of a study, it was a Hofflander and Nye Report which cost some $100,000 supported by all the groups that participated, really couldn't understand in Pennsylvania they didn't experience rate bad doctors. They showed that 4 percent of the orthopedic surgeons in this Commonwealth were responsible over a 10-year period for 25 percent of

the Cat Fund pay-out for that specialty. Unbelievable. Those doctors still paid the same rate as the other doctors, and the good doctors had to pay for the problems of the bad doctors. So that also was part of that combination approach that the trial lawyers advocated during the course of the negotiations.

I must take issue with Representative Chadwick when he said that this House Bill 1105 will not seriously impact on victim's rights. It will indeed, and I'll just take one or two sections that are illustrative of the unfairness, the basic unfairness of some of the provisions in this bill.

The first is Section 204, which is on page 8 of the bill. It deals with a collateral source. Currently, under current law, if a victim gets benefits from another source, a collateral source, an insurance company, it's true that that cannot be mentioned in court and he can recover again those benefits in court. Most times, however, the entity that paid him those benefits, whether it's Blue Cross or public assistance or worker's comp, had the right to get that money back. It wasn't that the victim was recovering twice. It was that he was allowed to show those losses, recover those losses, but he paid them back to the workmen's compensation carrier, to Blue Cross and Blue Shield or to whoever. And sometimes

there was a duplication of recovery and there would be a legitimate argument as to whether or not that would be proper. That was a rarity though and not the rule.

What this bill seeks to do, however, is not allow the victim to claim those benefits in court but allows the insurance company to get the money back from him out of his recovery. They have the right of subrogation. So worker's compensation might have paid the victim $50,000 in medical bills and $50,000 in lost wages and has a lien against his recovery up to $100,000. He won't be able to prove those bills in court and collect them, but he'll have to pay them back. This means he will be in a worse position. The victim will not even be allowed to recover his out-of-pocket losses where there's a subrogation right.

And if they wanted to really properly do away with a collateral source, you have to do away with the right of subrogation. But is that fair? Should the citizens of this Commonwealth, by paying public assistance, lose the right to get the benefits back from the doctor's insurance company? That's what would occur. In other words, if you said, okay, we get rid of the collateral source rule, you can't show any losses in court that you've already recovered. That's fine. But to be fair, and this bill is not, we'll take away the

subrogation rights of the workmen's compensation carrier, Blue Cross and Blue Shield, and the State of Pennsylvania for public assistance. That means that it's the doctor's insurance company that takes advantage of that. And the citizens of Pennsylvania who pay that public assistance are not able to get it back.

So I realize that the collateral source rule is a complicated issue, but as drafted in this bill will put the plaintiff in a worse position and not allow him to recover his economic losses.

One of the proudest possessions I have in my work for the trial lawyers over the last decade is a pen signed by Governor Thornburgh in May of 1984. It commemorated the passage of the Minor's Tolling Statute. There's a statute of limitations that all suits must be brought within two years of the date of the occurrence. Pennsylvania, up till 1984, was the only State in this country that did not protect minors against the statute of limitations. So that if a two-year-old was badly injured *as a result of neglect conduct, if the parents didn't* bring suit within two years, that claim was forever barred. This was the only State in the country that had such a harsh law. If the child was in custodial care, a foster child, and no one brought suit on behalf of that child, his rights were forever barred and at the age of 4

years old when he never even knew he had a claim. This legislature, almost unanimously, passed a bill to protect the minor and allow him until the age of 18 to bring suit, and this was consistent with the practice in most States in this country. And I had a little bit to do with it and that's where the pen came from. I know it's sort of not stylish to be proud of pens these days, I understand, but I am proud of that pen.

And this bill that is in front of you, House Bill 1105, I'd take the pen off the wall because they would do away with the Minor's Tolling Statute that was just passed in 1984 and they'd make it that if you were 8 years old, all right, we'll give you four years. It's meaningless if you're less than 8 but your parent knew you only have four years anyway. I mean, the provision in there of eight years, the statute starts to run on a child at age 8. Well, what's the difference between age 4? It's going to reduce and eliminate the right of minors before they even knew they had such protection.

There's additional bad government in this bill. Right now, all carriers are covered by a $200,000 insurance policy. And above that, they have quasi-State-run catastrophe loss fund for another million dollars in coverage. The way the system works presently, if the case is over $200,000, the primary carrier tenders

the case to the Cat Fund to consider how it should be then further settled or tried. Under this bill, the primary carrier would be given full authority over not only its $200,000 but over the $1 million of quasi-State money. And there's a conflict of interest in doing that. So you'd have a private carrier with ultimate and full control as this bill is written with the proceeds of the State catastrophe loss funds. And I really believe that that's not something that should be permitted.

I haven't even mentioned the worst part of this bill, and the reason I haven't mentioned it, I tried to explain it to my wife last night and she looked at me blankly, and I've even dealt with this issue with her before. It's a very, very complicated issue called reduction to present value. It's sort of like -- I hate to mention the Lottery because everybody's going to say that's what lawsuits are, they're a lottery, but pardon the analogy to a lottery. When they say the prize is $42 million, it doesn't cost the State anywhere near $42 million. That's a total pay-out over 26 years. It probably costs the State for that $42 million over 26 years probably about $18 million to fund. So that's what the State's Lottery of $42 million is probably about $18 million that they have to put aside to guarantee that stream of payments. It's a proper economic concept, and

this bill wants to reduce future losses to present value, and that's proper.

But there's another side of the equation that the bill does not look at at all, and that's inflation and productivity for a worker's increases that he would have received over the years. If you just reduce the present value without considering the other half of the equation, that is inflation and productivity. Again, in 20 years when you gave the worker $10,000 a year, reduced it to present value, he will not be at the poverty level. It's a provision that if not changed and is one-sided, and it's inconsistent with the law of almost -- certainly of any State that I'm familiar. It's an attempt to slash again, and it's not sound economically. You could get any economist to ask whether this bill is sound economics and unanimously, including anyone from the medical society, anyone would have to agree that that is not sound economics. And unfortunately, it's not only not sound economics, it's to the direct detriment of a claimant and he will not be able to recover in full for his losses.

That completes my unprepared testimony.

BY REPRESENTATIVE McNALLY: (Of Mr. Matusow)

Q. Mr. Matusow, with regard to the collateral source rule, you said that it's the rule rather than the

exception for an insurer to have some right of subrogation. What could possibly be an exception to that rule? Why would a claimant be allowed to receive insurance benefits from Blue Cross and then get it from the physician's insurance company?

A. Representative McNally, from Blue Cross there is no exception, so that's why I say most cases which the claimant is either covered by Blue Cross, Medical Assistance, or worker's compensation. There are no exceptions. There are a few insurance carriers who, for one reason or another, which I have no way of understanding, did not write the provision for subrogation into their contract. They just don't have that right. And that's the only exception is when carriers neglected to put that right into their contract, and that does happen sometimes.

Q. Can you tell me how often that happens or how many insurance companies that you know of don't do that?

A. I would estimate, really roughly, somewhere between 10 and 20 percent of the time, when you combine medical losses and disability policies. But again, it might be a little bit lesser and I doubt if it's more. I think I've erred on the side of being conservative.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Mike.

REPRESENTATIVE BORTNER: Just to follow up on that.

BY REPRESENTATIVE BORTNER: (Of Mr. Matusow)

Q. Is there subrogation for Social Security?

A. There is. This bill, the only thing it does recognize is if it's a Federal recovery that's being protected and there's an absolute right of subrogation, then it makes it -- then the rule does not apply. So this statute does recognize in very limited instances where there's a Federal statute that would override any Pennsylvania law on the right of subrogation that the collateral source rule would be preserved.

Q. I want to get back to your comments about reduction in present value. You've explained, I think the fact that it's improper to reduce or deal with one side of the equation without dealing with the other side of the equation. My recollection is, and I can't remember the name of the case, but that when this issue came before the Supreme Court, that's essentially what they said, that there's two sides to this equation and that rather than getting involved with that, rather than getting involved with enlarging awards to deal with inflation over the lifetime of a loss or to recognize salary increases and so forth and then reduce it back to present worth, we're not

going to do that. It's a wash, and that's why we have the situation that we have.

Refresh my memory, if you will, or maybe some of the other members. Is that the way that case was decided?

A. That is exactly the way, Representative Bortner. It's Kascowski vs. Boullabaisse, and what the Supreme Court said was that if you look at it in economic terms, that generally the reduction to present value whether, say, it's 7 percent, I'm going to make up a number. That's not necessarily the exact number. If that would be the percentage to use, that between inflation and productivity of a worker, that's approximately 7 percent also. It's not exact, but it's very close. And to get the precise numbers, it would have taken each side to call in an economist, and that would take a day of court and then the trial judge would have to charge the jury on this concept, which frankly most lawyers do not understand, so certainly the jury is not going to understand. So as a practical solution, they made this offset.

I will say one thing, that if this section, the reduction of present value, passed as it is presently constituted, it would be worse than any cap I've seen in terms of what it would do to recoveries where there's damages for a number of years in the future. The bill

uses a reduction to present value based on 5-year Treasury notes. That's somewhere around 8 or 9 percent. Money doubles at 7 percent every 10 years. You could see if -- and at 8 or 9 percent, which this bill, and again, uneconomically sound index that they're using, it's not the real world. A case on behalf of a child which might be for death of a child which, say, is worth under present law approximately $400,000 would be worth be about $60,000, maybe $30,000. I haven't done the numbers at the rate of 9. That's what a lawyer would be forced to settle. A clear liability where a doctor, absolutely no question about it, was guilty of neglect conduct for a child, say age 5 or 6 or 7, the value of that case would come down to about -- I'm going to venture to say, and I'll bet I'm right in this, somewhere between $25,000 and $60,000 because of just this reduction of present value without considering the other side of the coin. So when the proponents of this bill say it's not going to have much effect, it's worse than the cap, that reduction of present value, *in my opinion*. *I'm not sure* all trial lawyers agree, but that would be my position.

Q. I move on to another issue that you didn't testify to but which I also had a question about. The bill deals with delay damages. There's a section that deals with delay damages. I believe the Supreme Court

Rules Committee has, within the last year or two, changed the law with--

A. I serve on that committee. I'm a member of that committee for the Supreme Court.

Q. Does that make this section of the bill moot or unnecessary?

A. No. The Supreme Court Rules Committee did provide for delay damages, at the Supreme Court's direction, in order to have an incentive to settling cases and to help the system. This bill would seek to overrule the Supreme Court's procedural rule, Rule 238 it's known as. I leave it to you as to whether or not there would be a conflict between the Supreme Court power in that area and the legislative power, but it's in direct conflict.

Q. Well, the rules that presently exist say that if you make an offer to settle a case that's within 125 percent of final award, there are no damages, is that correct?

A. That is correct.

Q. So the purpose of the rule is to bring people to the table to settle cases. Is that the motivation behind the Rules Committee's thinking on that?

A. That was the motivation and there was considerable thought that over the years that Rule 238 had been in existence that it had been ineffective because it

would start to become a problem for insurance companies to delay as they had done previously because they were going to have to pay for that period of time that they refused to engage in settlement discussions.

Q. One other section I'd like to focus on, and that's the expert witness part of the bill which causes me some concern. Do you do medical malpractice work yourself?

A. Yes. I'd say about -- and I should have said that to begin with. Our firm, it's a 17-man law firm in Philadelphia, Litvin, Blumberg, Matusow & Young, and I would say that probably 50 percent of our business is medical malpractice work. And the reason for that is most of our cases come from other lawyers, are referred to us. Medical malpractice cases are probably the most difficult for the plaintiff's lawyer to handle, except maybe some complicated products cases, of all the cases around. Lawyers do not want to deal with medical malpractice cases.

Currently, I was in Montgomery County and in front of Judge Brody on a case and she said that they had kept a record that out of the last 45 medical malpractice cases, 43 were won by the doctors, 2 were won by the claimants. I've heard the argument that we need a level field. Well, if the field gets any more level -- they're

very difficult cases to win in front of a jury because jurors still put, properly so I believe, in some respects, doctors on a little bit of a pedestal, and I don't think jurors want to believe that the next time they go into a doctor's office, that physician is going to be the instrument of their harm. So they're very difficult cases, and that's why it comes, most of medical malpractice work is handled by specialists.

Q. Well, the bill, as I understand it, would require that a board certified specialist in the same field be able to testify as an expert in a medical malpractice case. Do you ordinarily seek experts that are board certified?

A. Yes, but not necessarily in the same field, because medicine overlaps a number of disciplines. So if you have a dermatologist involved who failed to recognize a cancerous lesion on your arm, you might need an oncologist as well as a dermatologist or one of the other, or a pathologist. If an orthopedic surgeon severs a nerve in your back while he's performing surgery, you could just as easily use the services of either a neurosurgeon who does the same type of work or a neurologist. This bill would not permit that. It doesn't recognize that medicine is not neatly classified and pigeonholed in just the particular areas of specialty.

Q. What's your experience in being able to secure expert witnesses in medical malpractice cases?

A. Well, I think that's really why a firm like ours is so heavily weighted to medical malpractice. It takes someone constantly at that task to achieve a result for the claimant. That's the hardest part of putting together a medical malpractice case is getting a qualified expert. While you've heard horror stories about verdicts, premiums -- and there are horror stories, there's no doubt about that -- there are horror stories with the conspiracy of silence, where doctors will not testify and pressure is brought to bear on them by the heads of their departments. They're threatened if they do testify. It is very difficult to get doctors to testify, one, for an emotional reason, not wanting to get involved, certainly understandably. The ones who are more responsible again are then subject to tremendous pressure by their peers. The ones who do testify, there are some who do not meet this standard and maybe look at it as a business, I'm sure there are such doctors, no doubt, but the legitimate doctors who testify really have to be praised. They have to be recognized to realize the courage it takes to do that. This bill would make it much, much more difficult to secure medical testimony.

Q. One last area. A big part of the bill

deals with trial procedures and would give these cases priority over all other cases, every other type of case. How long does it take to bring a medical malpractice case, get it to trial? A typical kind of case that you would be handling.

A. That would vary particularly from county to county. Representative Hagarty and I are in the worst counties probably in Pennsylvania, Montgomery and Philadelphia County. I hate to tell you, Representative, that Montgomery I think is outstripping Philadelphia in this area slowly, but in those two counties, it's four to five years, and it's not because it's a medical malpractice case, it's any case of serious injury. If you were in Lancaster, it might take you a year and a half or two. Delaware County, a year and a half or two. It depends on the county.

Q. Thank you.

REPRESENTATIVE BORTNER: Thank you Mr. Chairman.

CHAIRMAN CALTAGIRONE: Dave.

REPRESENTATIVE HECKLER: Thank you, Mr. Chairman.

I'm happy to have the opportunity for a dialogue here. That so rarely happens on this issue.

BY REPRESENTATIVE HECKLER: (Of Mr. Matusow)

Q. Let's start with collateral source. I note that the bill does make it contain a flat prohibition as to the recovery of certain sums. However, it also provides for the admissibility of the subrogation arrangements. If that -- and provides that the benefits would be admissible and the subrogation arrangement would be admissible.

A. Correct.

Q. Now, I think the general tort bill, of which I'm a prime sponsor, does not contain that blanket prohibition of recovery but simply says we're going to tell everybody everything. We're going to tell the jury about the public benefit, whatever it may be, and if there's a subrogation right, we're going to tell them about that. What's your response to that?

A. That's certainly a fairer approach, Representative Heckler. The present bill is really deceptive because it says we will admit evidence if there is a right of subrogation, but the jury can't do anything about it. All they're going to know is that you are being hurt. I was going to use a stronger word. They will know that, but they won't be able, under the court's instructions, to do anything about it. But the approach that you've suggested certainly would be fair. There would be arguments that I would make against that, but I

certainly would have to recognize a legitimate disagreement with that approach, but not with the approach in this bill.

Q. I'd be, at the risk of trespassing on the committee's time, I'd be interested in hearing what your arguments would be against that approach.

A. Well, basically the collateral source rule recognizes that if you basically, either as a benefit of your company, which really is part of your compensation, or you've paid for the benefit itself, your own Blue Cross/Blue Shield, that you ought to be entitled to take advantage of that. And the tortfeasor shouldn't get the benefit of what you've paid for by not allowing you to recover that. So that's the reason for the collateral source rule.

Q. Okay.

A. I recognize it's subject to some controversy.

Q. Okay. So that there's a philosophical objection at least and you would, I think, agree that both this bill and the general tort bill provide that if the benefit was more than 50 percent paid for by the individual, that, again, the collateral source rule would not be abrogated?

A. That is correct.

Q. Okay. I'm a little confused by your comments about the reduction of present worth issue. My understanding would be that in making your arguments or shaping the presentation to the jury, let's say we're in a trial context, on what damages should be awarded that let's say in the case of a child who's injured and there's some demonstrable impact on their future earning ability, that you're going to be presenting testimony on their loss of earnings over their projected career and that that would include projections for productivity, projections for what inflation will do to their salary over the period of time. No?

A. We would be entitled to do that under present law, we would not be entitled to do that under this bill because it does not recognize the inflation or productivity factors that are permitted.

Q. Could you show me where the bill says that, because I am--

A. It says it really by admission, and it's clear to all of the -- it's section--

Q. I think it's page 17, and just at the bottom and then onto 18 is reduction of present worth.

A. Yeah.

Q. But I don't see that in that section. That's why I'm wondering what I'm missing.

A. Again, because the current law -- it seeks to change current law which allows it by just going on the reduction, it's clearly -- and it's overruling present law, it does not provide for inflation or productivity. If that language was inserted, I'd have no problem with this section. In other words, if you're saying we could do it, I'm saying the way this language was drafted carefully, because it overrules existing law which allows inflation and does not provide for it, the courts are going to interpret this as only reducing the present value. And again, so there's no problem, I'd ask the proponents of this bill, would you mind if we made it clear that inflation and productivity would be also considered? And I will guarantee you, Representative Heckler, if they're candid they'll say no, because then this section doesn't do anything for them. This section can only be meaningful to the proponents of it if it eliminates productivity and inflation. If those two things which you believe are in there, if you would just say fine, ask one of the groups to put that language in there, the trial lawyers would not object to this section.

Q. Well, I'll be very interested in pursuing that and again, maybe I am discovering that I don't understand present law, but under Bouillabaisse, my understanding would be that in going to trial in a case I

would be able to present first of all the fact, you know, whatever the injuries were and that that inhibited my client's ability to do whatever, practice whatever profession he had, or whatever, and then establish what he was making. Let's say we're talking about somebody who was into their earning years. Establish what they had been making before, what their earning capacity was now and project what their capacity was for earning not only in terms of what they made in 1982 but what, through an actuary or an economist, what they would be able to have expected to be able to make through the rest of their earning life, correct?

A. Absolutely right. That's present law.

Q. And then we come up with a number. That actuary plays a lot of games and we come up with, say $400,000. Now, right now under Bouillabaisse, the defense is not able to say, well, fine, reduce that to present worth. Take that $400,000 number which was derived by recognizing inflation and productivity increases--

A. I'm sorry, I misunderstood. It's not. It's not a product of inflation. You're not allowed to show inflation under current law, and the trade-off is this balancing act of reduction of present value. You're not allowed to show any inflation. The jury is instructed under current law that they must not consider inflation as

part of their award. That's clear.

Q. Okay.

A. What you can do is show what the average of that -- if a man is only 18, you can show what the average earnings of a plumber are and break it down by each year to age 65, but that's not inflation. You'd be permitted to do that. And the jury is instructed and must not consider one dollar for inflation.

Q. Right, but they will, at least if you've presented competent testimony, be able to be told that that person's salary would have been anticipated to be X whatever it is, which would factor in inflation.

A. No. It must not factor in inflation. The economist who testifies is instructed that he cannot consider inflation. It's just as of today without inflation, what are carpenters, the average earning capacity of carpenters? And that's the number. That's as of this date. And that will not include one dollar of inflation. So this bill seeks to just again have one side of the equation and not the other. And again, I submit that that's poor economics. And if it was unintended, if the drafters of this didn't intend that harsh, harsh result that I foresee, it would be very easy to correct the -- I'm sure they'd be happy to throw in two sentences and the trial lawyers would have no problem with this

section. I shouldn't say that. I don't speak that firmly for the trial lawyers. I'm sure my brethren would probably have no objection.

Q. Um-hum. On the issue of witness qualifications, you've observed that you might very well have an orthopod whose alleged to have committed malpractice and relevant testimony coming from a neurosurgeon or neurologist or whatever. Do you have any response to the proposition that within the expert's specialty he or she should have qualifications equal to the qualifications of the alleged tortfeasor?

A. I'm not sure of the value of that other than just to make it more difficult to get an expert because the jury listens to the qualifications, and that's subject to considerable explanation whether he's board certified or not, and it's for them to weigh the judgment and opinions of the various experts. Again, make no mistake, Representative Heckler, this is really just designed to make it more difficult for the claimant to get into court. It's difficult enough to get experts. The doctors will complain that there are paid professionals out there. Well, if all the doctors would testify, we wouldn't have a problem. You know, if they were all willing to say, if PMS would withdraw its subtle and not-so-subtle intimidation and allowed physicians across

this Commonwealth to testify, you could put that -- I'd again have no problem with that provision. This is strictly designed to say, hey -- it's not to make the doctor feel better. Suppose -- and they also want them in practice. Some of the people are in the medical, you know, in the universities. Again, it's purely designed to limit access to the courts. And the situation that I can tell you as a practitioner for 18 years in this field is not an easy one.

Q. Well, since you and your firm do a substantial amount of litigation, with what frequency would you say you go into court using somebody who is simply admitted to the practice of medicine in Pennsylvania without more in a pining about somebody who's practicing in a specialized field, such as neurosurgery or orthopedic surgery?

A. Rarely.

Q. Do you use experts who are not--

A. California we go to a lot though, and I'll tell you what, we have to pay to transport those witnesses from California because we can't get anyone locally. Or if you get someone, some of the deans of the profession, especially in a small specialty where they go to Omaha, Nebraska for their annual convention and that doctor is going to look up any doctor in his specialty who is going

to testify against him. He's going to say hello. He's probably going to say a lot more than hello.

But the problem is not so much the board's specialty part, in my view. It really is the same discipline. That's where the unfairness is particular. I don't think the board certification is a necessary requirement. There are many experts who are very qualified who, for one reason or another, don't have that certification, so I don't think it's necessary, but that's not nearly as bad as trying to limit to the same specialty.

Q. Let me -- one of the standard cries of the trial bar is that there's no problem here, it's some kind of insurance cycle problem or it's worse yet, it's manufactured. I think that's tough for me to swallow, looking at the experience of PMSLIC, which doesn't generate a profit, as I understand it.

A. Correct. It's my understanding.

Q. It's a captive insurance company that's simply providing insurance to a limited field. What -- were they influenced in some way by the insurance cycle, the whole interest issue that we've heard so much about?

A. Yeah. Again, in the statistics where their biggest increases were during this cycle, they, like most other insurance companies, did have that overreliance in

the investment income. Their problem, though, is more cream-skimming. And there are several companies who do a very nice job. I wish I had thought to go into that business some period of time ago. I'd be delighted to get in that part of the industry right now. It's very, very profitable. PMSLIC might not be by definition, it's a nonprofit corporation, but the cream-skimmers who PMSLIC competes with put them in a disadvantageous position, PMSLIC, and they kept their rates artificially low not so much by the interest cycle, that was part of it, but by the cream-skimmers. When their experience, because they had more of the bad doctors, when they got hit with their claims experience differently from the other, from the cream-skimmer, they had to raise the rates dramatically. And guess what? The cream-skimmer now could raise their rates even if they didn't have to just below PMSLIC, so they could out-compete them. But all of this was a tremendous profit because their claims experience didn't warrant that kind of increase. So when PMSLIC went up, they said, oh, this is a nice time, and they increased their rates also at the same dramatic rate as PMSLIC did. So PMSLIC's problem is more of the cream-skimming. And our proposal in SB 1513 would have eliminated that.

Q. Do you have some statistical data beyond your written testimony to support that argument?

A. Yes. There was the Hofflander and Nye study, which was about '84, '85. We are trying to update at least certain aspects of it to provide that additional information.

You know, there was a study done in Minnesota. It was probably the largest study of all, the Hatch Report. It was on the Koppel show, and we have a transcript of that show. Which again, the claims experience and payout experience in Minnesota had leveled off where premiums were going out of the roof, and again they noted in Minnesota it was purely an insurance problem. Here, it's a little bit more complicated than that, I think. I don't think that study is directly relevant, but it has some relevance. There is a tremendous component of the insurance delivery system that's certainly responsible for the, again, the horror stories of the orthopedic surgeon, the anesthesiologists, God bless them, and the neurosurgeons, et cetera, who I have a lot of sympathy for in this regard. Passage of this bill will not help them one bit, will not save them one premium dollar. So if we're going to help out the neurosurgeon and the anesthesiologist, this bill isn't going to do it.

Q. Well, let's get to that argument that again is a standard argument. You want to broaden the pool,

whether it's automobile insurance--

A. Yes.

Q. Get all the rest of the State in with the craziness that's going on in Philly so we can pluck them too, or let's take the high-risk specialties that, as you point out, are going to have, if there is a problem, whether it's caused by negligence or simply circumstances beyond anybody's control, the results are going to be horrendous, let's get them in with the family GP whose likelihood or opportunity to commit malpractice is going to be substantially less. I mean, we talked about principle a little while ago with collateral source. What is the rationale for making a family practitioner, and presumably a prudent one who's never had a claim, help absorb the cost, whether legitimate or not legitimate? You know, whether that's proceeding from sloppy practice or whether it's proceeding from the high-risk nature of the practice, why have them tapped to help the neurosurgeon or the orthopod?

A. Primarily because mostly the neurosurgeon and/or orthopod's cases come from the family physician who may or may not have been involved or held out too long. I mean, medicine, these specialties aren't just there in a vacuum. They're part of a combined medical delivery system that entails clearly the general practitioner as

well as all the other subspecialties. Again, this is the way insurance had gone in the medical profession until the '60's when they then went to 3 classes and then 5 classes and then 9 classes; now 13 to 15 classes. Maybe it's 12 to 15. The exact numbers have changed year to year.

So I will say, Representative Heckler, that's been the traditional mode and methodology of insurance, and again, to put neurosurgeons in their own class, no wonder. I mean, I don't care what else you would do for them, you would have to eliminate every lawsuit in the world to give them any relief. And that's what we fear, by the way, about this bill. As bad as it is, when it doesn't save a dime in premiums, the Medical Society will be back here. Maybe it's two years, maybe it's three years. Hopefully someone more articulate on behalf of the trial lawyers will be sitting here espousing the arguments, and the Medical Society says, well, you just didn't go far enough in this bill. You really have to limit the lawsuits even more if we're going to make a recovery. So nothing that's in this bill will address the main problem that exists. I mean, that is clear.

Q. And what is that main problem, again?

A. The doctors who are paying $40,000, $80,000, $100,000 in premiums. If they weren't paying -- you know, if there was that leveling, if they were paying

what their brethren were in States around the country, there's not a crisis as such. Frequency of claims is down. PMSLIC argues -- and I don't know why. Somebody says that's an insurance cycle. I can't understand why frequency goes downs. But frequency of claims has gone down, and PMSLIC argues that severity has gone up. Well, that's a lot to do with rising costs of medical expenses themselves.

Q. Well, by the way, you mentioned some statistics that Judge Brody of Montgomery County shared with you.

A. Yes.

Q. Would you say that that low frequency of recovery or favorable verdict would be equally applicable in Philadelphia?

A. No, but not far different. I would say probably 90 percent in Philadelphia are won by the doctors. You know, people really do have a misconception of what goes on in a courtroom. You read about the horror stories, the psychic, the lawn mower, and you wonder, oh my God, is this system really -- well, first of all, none of those people will collect the money. They will with runaway jurors, and that will occur, but if you go day by day into the courtrooms of Philadelphia, Pittsburgh, Lancaster, I don't care where, you will find juries who

are the most conscientious, as they are in other States, they're not more conscientious, and the results would not be displeasing to any of you. The day-to-day results, you take out the horror stories from the newspaper and you wouldn't be disappointed. You'd say that system works. And again, I think it works too hard for the doctors. In Philadelphia, they win, I would say, 90 percent of the lawsuits.

Q. Now, when you say -- wait a minute, I think Representative Hagarty has just pointed out to me what should have been obvious to begin with. When we say 90 percent of the lawsuits, you're not talking about plaintiff's actions filed, you're talking about plaintiff's actions which go to trial?

A. That's correct. Absolutely. Just the trial results.

Q. So that an awful lot of those cases are going to be settled prior to trial? An overwhelming number of them?

A. Yeah, but if it's a serious case and you're an insurance company and you know those statistics, you're not going to pay, when you've got the hammer of the good results in court, you're sitting in a pretty good negotiating position, in the driver seat. So, you know, the fear of the courtroom is what produces settlements.

And I can tell you who has more fear of the courtroom, which side, the plaintiffs or the defense, by the results that are achieved in court. Same is true in product liability. I think the numbers aren't quite as high, but I think 80 percent of those are won by the defendants.

It's a system -- if the people in this room are jurors, and they're not much different in Philadelphia than they are anywhere else, and on a day-by-day basis there's no better system than the jury system that could ever be created. Everybody mouths that we don't want another system, but then they don't want to trust the jurors. Oh, well, they're runaways. They're not. They really are not.

Q. Well, unless you have some statistical data, while we appreciate you -- or I appreciate, at any rate -- your reaffirmation in that, I certainly recall from the criminal context scratching my head on a variety of occasions, both win and lose.

Thank you.

REPRESENTATIVE HECKLER: I have no further questions.

CHAIRMAN CALTAGIRONE: Thank you very much.

MR. MATUSOW: Thank you, Representatives. Thank you for so much time. I appreciate it.

CHAIRMAN CALTAGIRONE: Gerald Andriole.

DR. ANDRIOLE: Good morning, Mr. Chairman and ladies and gentlemen. I'm Dr. Andriole, President of the Pennsylvania Medical Society, the largest physician organization in the State with more than 20,000 members. I would also speak as a specialist in neurology with more than 34 years of experience.

As I have crisscrossed this State since last October talking with doctors, I heard over and over again how pernicious the medical liability crisis is. Not only is it driving up costs, but it's invading the basic doctor/patient relationship and undermining the bond of trust so important to the healing process. The unresolved liability crisis has been consuming increasing amounts of economic resources which would better be invested in the delivery of the health care. Instead, this money is fueling a hungry legal system which is out of control and out balance.

We believe that House Bill 1105 is urgently needed to restore some degree of balance and reason to a tort system which, through judicial generosity, has grown rather obese. Even as I speak about medical liability, you also have on your agenda the issue of automobile insurance reform which concerns tort law. While medical liability fails to gather as much public and press attention as auto insurance and product liability, all

together they underline the serious review of this important subject. There was a time when the medical community was alone who was calling for tort reform. We were dismissed as a special interest and self-serving. Today, particularly with the auto mess, there are many voices calling for tort reform.

Since Pennsylvania voters do not have easy access to a referendum-style government as California does, the Medical Society has used public opinion polling to determine voter's sentiment on the issue of medical liability. In 1983, and again in 1987, we hired professional pollsters from out of State to scientifically survey Pennsylvania voters. Each time a majority of respondents supported medical liability reform. In any discussion of tort reform, I appreciate the fact that the trial bar has some very basic concerns. At this time, I'd like to try to review the main provisions of House Bill 1105 in light of those concerns.

Frivolous lawsuits. Sanctions against attorneys who bring frivolous lawsuits are not new. They exist in both State and Federal law. The principle is very clear. Litigation is costly and time consuming. The people's courts are a resource too precious to be wasted by foolish lawsuits. Nationally, 67 percent of all malpractice suits ultimately are found to be without merit

or frivolous in the legal sense. Nevertheless, these cases cost money to defend. The Society's own insurance company, PMSLIC, reports that for the period 1978 to 1988, 63 percent of all closed claims were concluded without payment. Nevertheless, the grand total for defending these cases was $20.4 million. In area, it is the Federal courts which have spoken most vigorously through the enforcement of Rule 11. All House Bill 1105 does is require that attorneys, when practicing in State courts, perform to the same standard as they would in Federal court. This hardly seems unfair or revolutionary but rather brings consistency to the rule on frivolous lawsuits in Pennsylvania. It is also consistent with the new State rules for attorneys.

Collateral sources. Under present law, it is not possible for the defense attorney to inform the jury of all sources of compensation available to the plaintiff. The result is that frequently in the award the plaintiff is compensated a second time for expenses already paid under some form of insurance. Under House Bill 1105, defense attorneys could inform the jury of compensation received by the plaintiff. The existence of subrogation rights also would be admissible. This collateral source reform would have two significant effects, both of which are more of a policy decision than

a legal decision. The first is whether in today's economy, given the rising cost of medical care, the legislature wishes to compensate a plaintiff twice for expenses occurred or whether once is enough. The second question is how much to compensate plaintiff's attorneys. Since the percentage taken by the attorney is based on the gross award, any decrease in the award affects that attorney's fee. The tort system should not be synonymous with a new lottery. As both the nation and Pennsylvania move toward a system of health insurance for all citizens, we must eliminate the windfall which can occur under the present collateral source rule.

Joint and several liability. On the issue of joint and several liability, it's important to know that in House Bill 1105, all of the plaintiff's economic losses are covered, but it does say that in certain limited circumstances the defendant's responsibility for noneconomic damages, that is like for pain and suffering, will be limited to his or her liability. This provision only applies if the defendant's responsibility is 10 percent or less or is less than that of the plaintiff.

Punitive damages. Currently, punitive damages are available to the court as a deterrent in punishment for, quote, "outrageous conduct." But these awards are unlimited. Because they are unlimited, they

are being used by attorneys as a bludgeon to threaten defendants and insurance companies. This kind of extortion can be effective since punitive damages cannot, by law, be covered by insurance or the medical cat fund. House Bill 1105 says that punitive damages can only be awarded with clear and convincing evidence that the defendant acted with an evil motive or disregard, a high degree of risk.

Secondly, punitive damages would be limited to not more than 200 percent of the compensatory damages. Have punitive damages been eliminated? No. Has the opportunity to demand punitive damages without sufficient ground been limited? We say yes.

Informed consent. In the matter of informed consent, House Bill 1105 will place in statute form the standard which the courts now hold. Physicians, under House Bill 1105, will continue to be required to obtain informed consent to major invasive procedures, except in emergency or where the court deems inappropriate. Otherwise, the patient must be given a description of the procedure along with the risks and alternatives. A written signed consent presumes informed consent.

Statute of limitations. Under current law, an action can be brought within two years of discovery regardless of when treatment occurred. This means the

tail which must be insured is indeterminable. This present House Bill 1105 would require that action be filed within two years of discovery or no later than four years from the date of treatment. Of course, the four-year limit does not apply to foreign objects left in the body. For minors under the age of 8, the action could or should be brought within four years after the parent or guardian knew or should have known of the injury, within four years after the minor's 8th birthday. Of all the provisions in 1105, this could be interpreted as possibly limiting access, but even this provision offers a reasonable window for both adults and minors to access to the court. The amendment's main purpose and benefit, however, is to reduce the very long tail for medical liability which complicates reserving for possible claims. A shorter tail would allow more accurate reserving and reduce guesswork in setting rates.

Reduction of awards to present worth. Under present law, it's possible, in the case of large lump sums, for the plaintiff to receive a windfall because all future damages are received before they are earned. House Bill 1105 says that we simply can no longer afford to overcompensate plaintiffs. It says that lump sums should be discounted to allow for their future earnings based on the average return of the five-year U.S. Treasury notes.

Although we want to be sure the court provides sufficient funds to meet the awards, we do not believe society can afford to give bonuses.

Expert witnesses. This bill declared that in today's legal environment, of which there seems to be no shortage of medical experts, an individual testifying as an expert witness must possess a similar medical license or certification as the defendant. This expert is also to be in the same medical specialty. But even these requirements may be waived if no expert fitting the definition can be obtained. Given the increasing complexity of modern medicine, this provision merely says that the expert testifying against the defendant doctor should be at least as expert as that defendant. But the language also assures that no plaintiff will be barred from the courtroom through lack of a newly defined qualified witness.

I have summarized 1105 in part to address the concerns of the trial bar. With the exception of redefining the statute of limitations, and there only marginally, we do not feel that 1105 affects access to the courts. While members of the trial bar will contend that critical legal principles are at stake, we see it differently. We see 1105 as a set of adjustments to current legal procedures which level the playing field and

restore balance and fairness to the legal system. Since I'm sure this matter will be brought up, I wish to address head-on. Clearly, if we look back over the events in the liability insurance industry, we can observe a cyclical flow. Four years ago, we were on the upswing with rapidly accelerating rates. Currently, we appear to be at the bottom of a cycle. Does this mean that the liability crisis is over or that it has solved itself? We say no, and here in Pennsylvania there are several factors to keep in mind.

First, there are few States with more complete liability insurance statistics than Pennsylvania. This is because the Medical Society, with PMSLIC, determined from the beginning to maintain a sophisticated data system which would be open to the parent company, the Pennsylvania Medical Society. Currently, PMSLIC data shows that although the frequency of claims is dropping, as it is elsewhere, the severity or the total cost of settling a claim is going up significantly. In 1987, PMSLIC severity rose 22.1 percent. One year later, in 1988, the cost went to 28.2 percent. Is there a crisis? Yes, we think there is a crisis. At the same time, the amount of defensive medicine is becoming an increasing factor. This defensive medicine affects patients in a number of ways.

In an American Medical Association national poll released in June, 75 percent of the physicians polled said they ordered more tests than they otherwise would have. These additional lab tests, diagnostic procedures, and referral patterns have cost an estimated $35 million a year in Pennsylvania. These are the same defensive measures which will also affect Medicare costs. Nationally, the AMA has estimated that defensive medicine may be costing the nation $10 billion a year. In a previous survey, the AMA found that 37 percent of all physicians had been sued at least once. In Pennsylvania, the American College of Obstetricians and Gynecologists found that 8 out of 10 had been sued at least once. In the Society's insurance company, PMSLIC, 42 percent of its doctors had been sued at least once. In Pennsylvania, the Academy of Family Physicians primary care deliverers have found that 80 percent of the State's family practitioners no longer or will no longer deliver babies.

Since 1975, physicians in the Commonwealth, through the Pennsylvania Medical Society, have taken leadership in strengthening discipline against incompetent doctors. It was this State Medical Society which insisted that Act 111 of 1975 include language which gave the Medical Board permission to keep the money it raises from licensing, authority to set its own fees, and authority to

hire investigators, prosecuting attorneys, and hearing officers. By 1977, that board had collected millions of dollars but had failed to spend it to find and discipline incompetent doctors. As a result, the State Medical Society sued the Medical Board and the Governor on January 11, 1978, to get them to release some of the $2 million in reserves and to begin policing the profession.

Two years later, PMS sued the Medical Board again to get it to spend some of its money, and as recently as 1985, Pennsylvania Medical Society supported Act 6, which allows the Medical Board to immediately temporarily suspend a physician who poses an immediate and clear threat; Act 7, which provides for automatic suspension for conviction of a drug-related felony; and Act 48 requires hospitals and other health care facilities to report to the Medical Board physicians who have been fired or had privileges revoked for misconduct or malpractice; a revised medical practice act which gave the board subpoena authority and mandated hospitals and other physicians to report evidence of a physician with an active addictive disease who is not under treatment. These are the kinds of things the Medical Society is doing.

At the time the Medical Society was lobbying for approval of these bills, it was acting on its own to

safeguard the public. We hired a full-time physician in 1986 to direct the impaired physician program. Since then, the program has added a full-time assistant and a part-time clinical coordinator. Currently, the program has enrolled and continues to monitor some 400 physicians. The State Medical Board's recognizing the effectiveness of the Pennsylvania Medical Society program now refers impairment cases to it and uses it as the impairment program mandated in the Medical Practice Act. Soon, in addition to the mandatory reporting law for drug and alcohol impairment and its relationship to malpractice, Pennsylvania hospitals and insurance companies will begin compliance with the Federal Health Care Quality Improvement Act, which requires payments for medical liability to be reported to a national data base. This information will then be available to hospitals across the country on physicians who would seek staff privileges.

Special interest versus public interest. Is House Bill 1105 special interest legislation or is it, in fact, public interest? Opponents will say that it is a special interest legislation and should be rejected out of hand for that reason. But as members of the Pennsylvania Civil Justice Coalition, State Medical Society tells you that House Bill 1105 is just one manifestation of a broad problem. The need for tort reform can be seen in auto

insurance, product liability, and in medicine. I've described a crisis which has been growing steadily worse for 14 years, and I've described the need for reform which has been blocked by opponents, including representatives of the plaintiff's bar, for these 14 years.

The crisis is in fact real. It is here and continues unabated. Unless you enact the fair and reasonable reforms embodied in 1105, the cost of liability claims in Pennsylvania will probably shoot up more than 20 percent again next year. So then I would urge you then to take that fair, balanced, needed action found in this bill which already has the sponsorship of 112 members of this body on both sides of the aisle.

Thank you very much.

CHAIRMAN CALTAGIRONE: Thanks, doctor.

Lois.

REPRESENTATIVE HAGARTY: Thank you, Mr. Chairman.

BY REPRESENTATIVE HAGARTY: (Of Dr. Andriole)

Q. I'm curious, on the informed consent procedure, what do you see as the problem in the present informed consent law that you're seeking to correct?

A. I think the informed consent as manifested in this bill, seen on page 7, you're referring to.

Q. Well, my question is, what is the problem

currently with informed consent in Pennsylvania? I'm not aware, I guess, or it hasn't been explained to me that there is now a problem.

A. I think the problem can be interpreted as one of interpretation.

Q. By whom?

A. Usually by plaintiff's attorneys, or by people who wish to interpret what they see as the lack of informed consent or that which is lacking in the communication between the doctor and the patient.

Q. But I guess my question is, can you tell me what it is in the present law that creates a problem?

A. Well, that plus--

Q. I mean, I don't understand it. I guess my only experience as a patient is you're now given a written form and you sign it?

A. Yes.

Q. So I don't understand what the problem is with informed consent that you're seeking to correct?

A. We're wishing and hoping to correct the implication on the part of anyone who would not see what you just said you saw in informed consent. So that's maybe the address of that problem.

Q. Are you saying that currently a written, signed consent form does not presume informed consent?

A. No, I'm not saying that at all.

Q. Okay. Well, I'll ask you one more time, or someone else wants--

MR. JONES: I'm Ken Jones. I'm the General Counsel for the Medical Society.

I think essentially what you have there in the informed consent provision is a codification of present law, which I think is what you've been suggesting. What it does, however, is it clarifies what the law presently is and it gives physicians clear direction, and I'm not sure they have that right now.

REPRESENTATIVE HAGARTY: So your position is, though, we are not changing the informed consent law?

MR. JONES: No, we are not.

REPRESENTATIVE HAGARTY: I mean, I'm concerned about that because I think one of the most important things that we provide for a patient is information with regard to their making a decision.

DR. ANDRIOLE: Yeah, I would agree to that.

REPRESENTATIVE HAGARTY: And you don't believe that we're changing that then?

MR. JONES: No, I believe -- I hesitated because I'm not sure that in law there is a recognized presumption that a signed informed consent form means that an informed consent is given. But as a general rule, I

think basically what that section does is codify what the law is now.

REPRESENTATIVE HAGARTY: Don't most doctors -- it seems to me the practice is to explain, in addition to what is in writing, what a procedure is. Do doctors object to explaining to a patient what is going to happen to them?

DR. ANDRIOLE: No, not at all.

MR. JONES: No, and that has been the law since 1948 in Pennsylvania, and probably before. So this does not propose a change in present law, I believe.

BY REPRESENTATIVE HAGARTY: (Of Dr. Andriole)

Q. Okay, because my next question is, under the statute of limitations, what types of cases are now brought that concern you that fall outside of, for example, your new suggested guidelines, four years after treatment and two years after knowledge? Are there cases now that are being brought that we're going to be barring? And I'm curious what type of problems people might be discovering. It surprises me to see that there would be problems four years after treatment. What types of cases are now being brought?

A. I don't know that you could say what type of cases but rather we want to put a limit on that so that whomever it is that might try to discover those cases at

least would have a time limit within the statute of limitations to say that that's when action should be taken.

Q. I guess again my--

A. It can't be open-ended is what we're really saying. And I can't give you a specific kind of case.

Q. As a legislator, when I vote on changing the law, I do so because I believe a problem exists that we should correct. And I have not heard what the problem is with regard to the statute of limitations currently, other than you're philosophically saying it shouldn't be open-ended. On the other hand, I guess my concern is that I don't know what kinds of injuries might result to someone, but if five years after an operation I discover a problem that was caused by a doctor's negligence five years ago, I don't know why I shouldn't be able to sue, and I'm wondering if you have any thoughts on what problems are causing you to want to limit the statute of limitations or what types of--

A. Well, that's a presumption on your part that there was that negligence.

Q. Well, I'm asking the question.

A. Yes, I know you are, but I'm just saying that you can only answer it philosophically, and I guess we could give up a compendium of the kinds of cases that--

Q. You're not aware, though, yourself of any problem then with cases?

A. Only in the sense that I must stick to the philosophic kind of situation in saying that these can be discovered by friends or allies of those kinds of people who would bring that kind of action.

Q. I guess, again, I mean, I'm also one of the people who I believe that the goal, the goal that the doctors have expressed to me of this House Bill is to reduce insurance rates.

A. Yes.

Q. So that if I'm not aware of a problem or that lawsuits have been brought outside of a proposed statute of limitations, I don't see how there's any relationship to reducing lawsuits if there's no problem.

MR. JONES: Ken Jones, again.

If I could comment, I know there are cases brought outside the four-year limitation. I believe most of those are handled by the Cat Fund, and we should be able to get you figures, if that's what you're--

REPRESENTATIVE HAGARTY: I would appreciate that, because I'm curious as to what kind of cases they are and who we might be limiting from recovering.

BY REPRESENTATIVE HAGARTY: (Of Dr. Andriole)

Q. I guess -- and my one last question is,

under the expert witnesses, I was concerned, probably because of an operation within my family recently, about the fact that we are going to limit an expert in one discipline from testifying against an expert in another discipline. Do you believe that we should be limiting within disciplines this testimony, as this bill does, as I now understand?

A. I think there should be true peer review. That is, the person who is involved in exactly this kind of health care delivery should give that kind of testimony in support of or to the disillusionment of that support in a court of law, whenever that's possible.

Q. Little me pose the example, and I don't understand much about medicine, but I'll do my best on it. A member of my family had a back surgery that was done by a neurosurgeon. Had an orthopedic surgeon operated, let's say an orthopedic surgeon had done this operation, had done what I understand would have been a different, more complicated operation, and let's say there was negligence in that procedure, one of the things that it would seem to me that would have been important to know was for the neurosurgeon to have been able to, let's say in that instance, that a simpler operation could have been done that would not have caused, let's say, some hypothetical problem. Now, why shouldn't, when you have a medical

condition that can be corrected by either a neurosurgeon or orthopedic surgeon, why shouldn't a neurosurgeon be able to testify on that issue? I would not want to limit that.

A. Well, now, I don't think we're saying we want to limit it either, but we also want the view of whatever procedure that was, I suppose, complicated rather than the simpler procedure to be explained as to why he reached the judgment as to why he should do, quote, that "complicated" procedure.

Q. But then the doctor's expert witness would be able to explain that.

A. Yes.

Q. It seems to me that you would want to have the plaintiff's attorney have the opportunity to call an expert from what is a relevant field, and that concerns me.

A. Well, I suppose that has justification, but we are saying that there should be that peer review process.

Q. Let me ask you, and also on the issue of expert witnesses, what is the problem that you now see occurring? I take it you believe there are unqualified experts?

A. Yes.

Q. And you find that the jury, even though they have an opportunity to hear the qualifications of both experts, is unable to compare those credentials and form a conclusion?

A. One of the things that occurs, for instance, in a hospital setting that is very important is the granting of clinical privileges, et cetera, according to some stipulated kinds of information we get. We don't see that you should have to bring in somebody from California because, quote, there is "subtle and unsubtle pressure" from the Medical Society. And by the way, I've never known that that has occurred on the process of allowing or not allowing expert witnesses to testify.

Q. You don't agree that doctors tend, and I certainly emotionally understand that also, not to want to testify against each other?

A. No, what I heard in the testimony was that the Pennsylvania Medical Society was party, subtly and unsubtly, to the mechanism which suggests that pressure is brought to bear upon doctors. As a society, we don't do that.

Q. Oh, I don't know that. I'm just commenting on what I just hear run-of-the-mill. I mean, I think the mentality, and I think it's terribly regrettable, but the mentality of doctors towards lawyers is tremendously

hostile, I'm sad to say.

A. How do you think this has happened vice versa? Is the same thing occurring?

Q. No, I don't.

A. No?

Q. But that's off the subject of this hearing. I'm just commenting that I think it is certainly a concern to me and it is regrettable, but I don't understand, again, the problem with expert witnesses that causes you to want to restrict expert witnesses to be either board certified or the opposition to cross-discipline experts?

A. We're saying that doctors understand who it is are best qualified to do whatever procedures, et cetera, and so that when this person is put in a liability situation as a defendant, that he should have testifying against him one of his peers who have those same kinds of privileges and experiences so that, quote, "the level field" will be created and then let the jury system decide who it is that is telling the best story.

Q. Okay, thank you.

A. With the presentation of those facts.

Q. Thank you.

(Whereupon, Representative Blaum assumed the Chair.)

ACTING CHAIRMAN BLAUM: Any other questions?

Representative Bortner.

REPRESENTATIVE BORTNER: Yeah.

BY REPRESENTATIVE BORTNER: (Of Dr. Andriole)

Q. I want to follow up on that expert witness situation and make sure I understand your view of this. Are you agreeing or disagreeing with the fact that it is frequently very difficult to get doctors to testify against another physician in a medical malpractice case?

A. I'm agreeing to the fact that I guess they find difficulty in getting witnesses to testify because that's clear knowledge.

Q. Well, let's be specific. I mean, have you ever testified against a physician in a -- I mean, have you ever been called as a witness to testify against a physician?

A. No. No, sir.

Q. Would you testify against one in your community?

A. Sure, if the case presented itself to such a degree that there was egregious and outrageous behavior, et cetera, where as a member of the medical profession, sure, I'd go up there.

Q. You would have no hesitation to testify against another doctor at your hospital or in your community?

A. Absolutely not. We do this in peer review at a very limited degree within the hospital setting itself where we do these things that we have alluded to in my testimony saying that if there's someone that we see who is convicted of a felony for whatever reason, we bring that to the attention of the CEO and put in process the disciplinary procedures. And that, in its sense, is testimony to that fact.

Q. Well, what I fail to see in this bill is, in part of your testimony you state that where you can't meet this requirement of getting a board certified physician to testify against a board certified physician, I think you say that nobody would be barred for lack of a witness, lack of a qualified witness. I don't see the out in bill that provides for that.

A. I really don't understand the thrust of the question, other than you're finding complaint with the bill that it doesn't really address the fact of the expert witness.

Q. Yeah.

A. "The court determines that the person is duly licensed or certified in the same health care specialty and is engaged in the practice or teaching of the same health care specialty."

Q. Well, I suppose that there's a difference

between being board certified and being duly licensed or certified in the same health care specialty.

A. As a degree of difference, yes.

Q. But as a non-doctor, that's a very insignificant difference to me. I mean, you're still saying that you've got to be in the same discipline, you've still got to be either licensed in that discipline or certified in that discipline before you even get to the question. The second part of that determination is whether or not you've been able to find a board certified physician in the first place, is that correct?

A. Yes.

Q. I'm acknowledging that I see that as a serious problem with that part of the bill at any rate.

I'd like to follow up on what Representative Hagarty was asking about informed consent, and I guess also put to you one of the concerns I had with when the sponsor of the bill was here. This provides an exception to the informed consent rule which essentially, as I see it, allows a doctor to decide whether or not it's in the patient's best interest to be informed. Do you see that as a problem?

A. No. Not at all. I think you've struck the question that comes really to the heart of medicine, that is the doctor/patient relationship. And if that doctor in

his caring for that patient understands the patient, which obviously and hopefully he does, then he knows that eliminating that kind of information to that patient, and all patients are different, as you would agree, that that would be best for the situation, emotionally or otherwise, or the fact that the patient, as a statistical kind of comment. Why should the patient be appraised that this procedure would be successful only 1 time out of 30? Why make that, even though that's a fact of medical literature, to that patient which in fact may not allow him to emotionally be cooperative or emotionally endure the kind of treatment that's going to be given? So I see this as very helpful. We're not saying that we want to hide anything, but rather that in the doctor/patient relationship you know what is best in that discipline of medicine for your particular patient.

Q. I understand what you're saying and I guess it's all -- every individual is different. I think personally I'd like to know going into it, you know, what the odds were. There may be some people out there who prefer not to. I am curious though, in that kind of a case, would you typically consult with family members on the same--

A. Yes. Certainly. You would pick the big brother of the family or whatever it is and lay out the

facts and statistical kind of format to say this and that, but I'm not going to tell your brother Joe that because I don't think it would be helpful in this kind of a situation. That's the essence of medicine, really.

REPRESENTATIVE BORTNER: Okay. That's all I have at this time, Mr. Chairman.

(Whereupon, Chairman Caltagirone resumed the Chair.)

CHAIRMAN CALTAGIRONE: Representative Pressmann.

BY REPRESENTATIVE PRESSMANN: (Of Dr. Andriole)

Q. Following up on Mr. Bortner's questions, if you are doing a new procedure, one that has not been done very often and maybe one that you have not done before or maybe you have only done it once before, do you inform the patient of that under the same circumstances you mentioned about giving him the odds?

A. Sure. Why not?

Q. I mean, you do that?

A. Yeah. I don't see that that happens very often, but yes, given that kind of scenario that you present, sure.

Q. Okay, does that happen all the time?

A. I can't say that it happens all the time. You asked me if I would do it. I certainly would.

Q. Okay. In being board certified--

A. Yes.

Q. --this is an ongoing thing, to be board certified? You must do continuing education or something?

A. (Indicating in the affirmative.)

Q. Now, if you're some kind of surgeon, a person who does procedures that, you know, means an invasion of the body, must you do certain types of operations in order to remain board certified? I mean, if you're -- I don't know, I'm fishing for something.

A. Well, what you're saying is what the board certification process is, and that's the attempt on the part of the peer to say that that kind of specialty which is being practiced out in the hustings or out in field is being done in the manner they see as being correct, responsible, and so forth.

Q. Um-hum.

A. Now, once that particular doctor gets out there and is board certified, we'll say, within a hospital setting, it now becomes the duty of that hospital as well as that specialist to maintain that kind of quality so that the person responsible for the maintenance of discipline within the hospital, whether it be the administrator or the medical staff itself, will say, hey, you're not supposed to be doing that particular kind of

procedure, unless he can show clear and convincing evidence to the credential committee or the executive committee that he in fact has become adept and rather proficient at doing that particular kind of new procedure, as you determined.

Q. I guess my question is leading is this: Could there be a circumstance where a doctor, in order to keep his board certification, will recommend a certain type of operation to achieve the same end that doing it another way could be done, in order to keep his certification?

A. I really don't think so, but that falls within the individual judgment of the doctor, again subject to all the provisos that I have attempted to point out. But no, he doesn't have to do four "X" procedures during the course of a year to maintain his board certification, if that's in answer to your question.

Q. If a new procedure is done, a first-time doctor does a procedure, he makes a mistake, something goes wrong, and he didn't inform the patient that he was performing this surgery for the first time, would you think that patient has a tort?

A. Yeah, I would think that if he has told them that he is not proficient and this is a new procedure and this is the first time he's doing it and then you get,

quote, "failure" out of it, I think the circumstances would lend itself quite well to something occurring.

Q. Do you agree then that that would be -- all right, okay. Your answers have prompted some of us up here to think that you have a future in politics the way you've handled some of your questions.

A. That's good.

REPRESENTATIVE HAGARTY: In case the malpractice feasance survive.

REPRESENTATIVE MOEHLMANN: Except that politicians usually do eventually answer the questions.

BY REPRESENTATIVE PRESSMANN: (Of Dr. Andriole)

Q. Would you agree that there is intimidation by doctors to other doctors not to testify?

A. Well, I'd have to answer that politically once more then if you say that because intimidation has to be defined very specifically, but if you're saying that someone at a higher level will call up and say, "And make sure you don't testify in the case of Mr. X," I don't think that does occur. If you're suggesting that there are subtle influences, I guess there are subtle influences over which organized medicine has little or no control and doesn't wish to have that kind of control.

Q. Following up on that, your concern about expert witnesses.

A. By the way, that occurs like in the House of Representatives.

Q. Yeah, I know.

A. I'm talking about the national level.

Q. We usually get called in front of a grand jury though, and that usually works itself out.

I lost my train of thought. You're concerned about expert witnesses.

A. Yes.

Q. And you have said about the fact that the idea that someone in not a like specialty is testifying, the thing that concerns me about that is there would then seem to be that something is wrong with our system in that you're winning 90 percent of your jury trials or whatever with these non-expert witnesses, so, I mean, you're doing real good in the court system with, you know, neurologists testifying against gynecologists, or whatever, you know, whatever it is, and I guess what I'm leading to is that the expert witness doesn't seem to be a problem, though, I mean, because the jurors are making a decision on whether or not the expert in the case is -- has credibility or not obviously by the decisions that juries are making. Juries are deciding in your favor in overwhelming numbers. Why do you see there's a problem?

A. Well, it's not a money problem, but we see

the need for this tort reform as being a moral issue, and in that sense, we want to have that fairness where we recognize all the imponderables about law, the delivery of medicine, et cetera, to make it equitable for everybody so that when there's the perception or the perceived indiscretion on the part of a physician, that we want that to be corrected by someone who is that person's peer. And, yes, evidently if they're winning 90 percent of the cases, that must mean the doctors are doing basically then a good job.

Q. And maybe the court system is also.

I want to follow up on one thing. You mentioned in your testimony that you are a member of the Civil Justice Coalition?

A. The Medical Society is, yes, sir.

Q. Right. Okay. And they have three objectives - auto insurance, product liability, and medical malpractice reform. Would they be three broad objectives?

A. No, it's the manifestation of the broad problem relative to tort reform can be seen in these auto insurance, product liability, and the medical malpractice.

REPRESENTATIVE HAYDEN: Jack, I never heard from them on auto insurance.

BY REPRESENTATIVE PRESSMANN: (Of Dr. Andriole)

Q. The issue of product liability, which is not the subject of today, but questioning you as your organization is a member of the Civil Justice Coalition, one of the main concerns in that issue is the issue of the tobacco industry and their efforts to seek protection under laws of Pennsylvania under product liability laws. Do you see any consistency in the Medical Society being involved in a coalition with the tobacco industry in these efforts?

A. You're calling into play a moral judgment.

Q. And you mentioned this is a moral issue.

A. Yes, this is a moral problem, but you're asking for a moral decision relative to a judgment on the part of the Medical Society, whether or not they can interfere in the true business interests, which apparently Pennsylvania allows to occur, whether it be R. J. Reynolds or whoever it is that's making that product. It's up to the legislature to impose on them whatever they're going to do for their business practices, and so forth and so on. So no, I don't think the Medical Society as such as a member of that Justice Coalition can pass business judgment on the part of the tobacco industry by that alone.

Q. So that you're not uncomfortable in being an ally to the tobacco industry in this cause?

A. I don't see it as a matter of being comfortable or uncomfortable. It's a matter of just good judgment.

Q. Expediency?

A. No, expediency is a bad word because I think you render under Caesar what is Caesar, and so forth and so on.

Q. Okay. One last question, on punitive judgments. And maybe I should wait until the person from PMSLIC comes up. Do you have any idea what percentage of your claims are made up in product liability dollars versus compensatory dollars?

A. No, sir.

Q. Okay, I'll wait a minute for the person from PMSLIC.

Thank you.

BY REPRESENTATIVE McNALLY: (Of Dr. Andriole)

Q. Thank you, doctor. And I guess since I am a lawyer and you had asked earlier whether lawyers have a similar disaffection for physicians and I can tell you that I certainly like my doctors, and I think they like me.

A. See, there are relative terms.

Q. But, you know, I had one question about one of your statements concerning non-meritorious cases, but I

suppose for the record I wanted to go back to an area that Mr. Bortner questioned you about, and specifically, or maybe it was Lois Hagarty, about informed consent and, you know, if I can paraphrase, you had made a comment to the effect that there are times when you would not provide some statistical information to a patient as to the success rate of a particular procedure, and in my own personal experience with physicians, and usually not personal physicians, you know, that seems to be a fairly common attitude and one that is somewhat disconcerting to me, I might add.

And just to give you one example, when my son was a few months olds we took him for a DPT vaccine and I recall on the very first occasion the pediatrician, and it may have been the first or second visit we made to the pediatrician, told us about the pertussis part of the vaccine and how, you know, 1 in 10,000 children has a negative reaction and there are very serious consequences from the administration of the pertussis vaccine in some instances, and as an attorney, from the plaintiff's bar, incidentally, I was aware of the fact that the pertussis vaccine is somewhat risky, at least comparatively speaking, to other vaccines.

A. Right.

Q. And, you know, I was rather reluctant to

have my son receive the vaccine. He did receive it and it appears there's no adverse consequences, but one thing the pediatrician said that sort of echoed what you earlier said today is that he told me and my wife that the odds of your son getting any adverse reaction to this vaccine are minimal. In fact, I really don't feel I should even have to tell you this, but it's a defensive mechanism. And the bottom line was that he felt that he knew better for my son than I did, that he didn't need to tell me what was good for my son or what the risks were because he could make that judgment on his own. And as I said, I just relate that story to you.

A. Yeah.

Q. Because I find that attitude somewhat disconcerting as a patient and as a father. It's one I hope that, you know, members of the medical society might re-examine. I think that informed consent in giving patients a wide range of information is extremely important and it's something that shouldn't be taken lightly, in my opinion.

A. No. If I can comment on that, I don't think they do take it lightly, and that was very good anecdotal evidence you gave, but the fact does remains that it still has to remain with the judgment of the physician knowing who his patient is as to how he will

deal with given amounts of information. Look at it like from the public health standpoint where maybe they're mandating this vaccine to be given to 2 million people within a given area and after the examination of all the facts both by government and the manufacturers, the medical community, and so forth and so on, they determine that it's best to do that for that reason in the given area. You then think that they should have to sit down with that attitude that you said with each of those 2 million people and do that, since it's been mandated by the government, legislation would be overriding all other considerations?

Q. Well, absolutely, and I'll tell you why, at least in this particular case, because there is another vaccine for pertussis that is less risky and, you know, we as patients and as consumers in the health field don't really have the bargaining power. We can't force, you know, unless we go through this informed consent and make people aware of the risk factors, you know we cannot force the pharmaceutical companies to--

A. I'm not disclaiming that you should eliminate risks or any of that thing. I'm just trying to say that you're basically coming to what is the doctor/patient relationship, to the heart of why medicine is an art just as well as it is a science, and there has

to be some leeway within that prerogative of that physician's judgment, you know, with whom he is dealing, et cetera, and then to make the best kind of judgment that he can. We hope that he does make the best kind of judgment that he can, given all those kinds of facts.

Q. Well, you know, that was really a sort of side of what I wanted to talk about.

On page 2 of your testimony, under frivolous lawsuits, you state that the society's own insurance company reports that for the period 1978-88, 63 percent of all closed claims were concluded without payment, and nevertheless, the grand total for defending these cases was $20.4 million.

A. Yes, sir.

Q. And the question I had is that apparently you take that statistic from page 15 in the report that you handed out and a pie graph is provided there and it indicates that 63 percent of the cases were non-meritorious, apparently another 37 percent were meritorious, and frankly, I think that that particular paragraph in your testimony is somewhat misleading. Just because a case results and is concluded without payment, number one, doesn't mean it ever actually was a lawsuit; and secondly, it doesn't mean that it shouldn't have been brought. There are reasonable claims of negligence that

if brought to court, as the previous witness indicated, 43 out of 45 cases in Montgomery County resulted in a verdict for the defendant. That doesn't mean that those 43 cases should not have been initiated, and that, I think, is what this seems to suggest.

A. No, I don't think so. I think it was pointing out here what the grand total for defending these cases. Now, alleging what the cases are does become tautological, I suppose, is the best thing. How do you refer to these cases? Obviously, somebody, someone thought that they had merit when they brought the action, and we're not saying that they didn't bring the action or should not have brought the action, but rather to statistically categorize how we see them once they ended up as to what it cost once these things were found to be without merit in the legal sense, and therefore we would call them frivolous and therefore say they cost $20.4 million. That was our only point.

Q. That's, I think, where you're either mistaken or misleading, because just because a case is non-meritorious in the sense that it results in a verdict for the defendant doesn't make it frivolous. And in fact, it seems to me that if we're going to have any benefit accrue to physicians in this State, we are going to have to reduce, basically work on those 63 percent of all

claims that result in no verdict. I mean, I hope you're not arguing that the meritorious claims should be eliminated from the civil justice system. What you're suggesting is that some of those non-meritorious cases shouldn't ever be initiated. And because, as I said, a non-meritorious case can include a case which was a reasonable claim and simply resulted in a loss for the plaintiff, it can include, for example, I know in the Minnesota Medical Malpractice Insurance Study that was done a claim included when a patient wrote to the physician that I think that you're responsible for my injury and the physician put his insurance carrier or her insurance carrier on notice that a claim may be pending. I mean, those were also considered claims. You know, I don't see how we, you know, can really make a reasonable and informed decision about how to resolve the insurance liability crisis for physicians if we get these blanket statements that there's 63 percent of all the closed claims aren't meritorious when in fact that can include claims that are perfectly reasonable and belong in the system and it can include claims that never went beyond a letter to the physician.

A. Yeah, well, perhaps you're correct--

Q. We need more information.

A. --in the sense that then what we really

have to do is determine when cases are meritorious and when they are, in fact, frivolous, if that's the kind of information that you want to extrapolate and say then how much it costs to defend the frivolous as determined by whatever methodology you want to put in place and how much it costs to defend, even the reasonable ones that come to naught, and that's reasonable.

Q. You know, we already have that mechanism. Every case can be decided at what are called preliminary objections. A judge can determine at a very early stage in the proceedings whether a case is frivolous or not, and, you know, from my experience in Allegheny County, physicians are very ably represented. If a case really is frivolous, it's going to be dismissed at a very early point. You know, and there's no way you can keep people from filing frivolous lawsuits, but you know, there is a mechanism, it seems to me, that eliminates those claims at a very early point in the process.

A. I think you're correct. Fine.

REPRESENTATIVE WOGAN: Thank you, Mr. Chairman.

Dr. Andriole, Section 304(a) seems to impose a time limitation or deadline on the introduction of expert witness reports, or I should say the distribution to the opposing party. And Mr. Jones, maybe you can help

along with this. What is it in current practice that resulted in this inclusion in House Bill 1105?

MR. JONES: There was a general perception that the slowness of the tort process, the time that was referred to earlier from the time that the claim was filed until there was an ultimate resolution, in effect not only hurt the patient because they didn't get paid but also hurt defendants because it increased costs. So basically that whole section is an attempt to speed up the process with the idea that there would be advantages to both patients bringing lawsuits and to defendant physicians if we could do that.

REPRESENTATIVE WOGAN: And there weren't any other concerns then other than purposes of speeding up cases?

MR. JONES: No, I don't believe so.

REPRESENTATIVE WOGAN: All right. Thank you.

REPRESENTATIVE VEON: Thank you, Mr. Chairman.

BY REPRESENTATIVE VEON: (Of Dr. Andriole)

Q. Thank you, Doctor.

Doctor, I, too, wanted to echo the comments of Mr. Pressmann regarding the unholy alliance between the tobacco industry and the medical profession in this broad

coalition, and although it's not extremely relevant to this bill, you had brought it up at the end of your testimony in discussing the coalition and the need for some broad changes in the tort issue, and my hope is that one result of this hearing is that the news media would take and closer look at that coalition that's being, at least to a large degree, financed by the tobacco industry and how maybe you care to comment again, and I wasn't exactly clear of your comments on Mr. Pressmann's question about how the Medical Society justifies that coalition.

A. See, you use "justification" and "unholy" and those kinds of very subjective kind of terms. I'm saying that the overriding concern of the Medical Society in alliance with these partners within this Civil Justice Coalition has as its goal the tort reform system. What those particular people do is really not the overwhelming concern of all the parties of the Civil Justice Coalition to examine meticulously what it is they do for a living or lack of living in their particular pursuit of business interests.

Q. I appreciate that. I guess obviously what I'm getting to is that as I understand their concern, and they would like to see us also restrict the ability to sue for damages for their product, and so their concerns are similar in that attempting to restrict the ability to sue,

and that this coalition, in a broad sense, is asking for those kinds of restrictions. So in that sense I think there is some alliance, and I'm very concerned. I'm not sure that many of the rank and file doctors are aware of that coalition and that alliance, and at least in my district I have been trying to educate them to see what their concerns are relative to that connection. And I appreciate your comments and I have one other question.

You also brought up auto insurance and throughout your comments there are some concerns about the cost of medical malpractice insurance, and I appreciate that and I hope that that's at least one of the major goals is to attempt to reduce the costs. Along those lines, would you be willing to support a mandatory roll-back in fees for the insurance and also a freeze concept similar to what we've been attempting to do with auto insurance where we've been trying to address the cost side but that clearly unless we also require some mandatory reductions, the thought at least in the legislature and the House in the bill that passed, you wouldn't see those reductions, and I don't see anywhere in this bill that we would be requiring mandatory reductions in premiums, and would you care to comment? Perhaps you'd be willing to support that and some freeze concept?

A. Relative to the auto insurance?

Q. No, sir, relative to the cost of medical malpractice insurance.

A. Well, we think the byproduct of what would occur if this bill is passed is that, in fact, medical liability insurance costs would go down.

Q. Would you be willing to support a mandatory roll-back in costs?

A. In conjunction with all the other things that should be done relative to the tort system, yes.

Q. You would be willing to support a mandatory roll-back if this -- if this bill were to get through as is and it would be able to be voted on in this committee and supported, would you be willing, as a further provision to this bill getting out of committee, supporting a mandatory roll-back in fees of some percent that we would have to come up with in addition to a freeze in rates?

Because my obvious point that I'm trying to get to is that the theory is, and throughout the comments of the medical profession, is we want the rates to come down, but the theory is that the rates will come down if you do the following things, and I'm not convinced that that's the case. And that's why I would like to know when and how we could get the medical profession in agreement to support mandatory roll-backs so that in fact if I were

to vote for this bill, the doctor in my district sees some result in his insurance costs. Because that's one of the goals of the Society, as I understand it.

A. Yes, but I really can't, you know, you've got to have palpable evidence that other things are occurring with the stipulation that in fact, yes, we would support a freeze or a roll-back mandating a roll-back of the costs.

Q. Thank you.

A. And if I could be parenthetical, for instance with the auto insurance thing, I think what was unfair there was the setting of an artificial kind of situation where you said there would be 110 percent of the Medicare payment, which is the 75 percentile, et cetera, et cetera, et cetera. I don't think the legislature properly addressed it because we're for the cost cutting, and yes, we would be for that as long as everybody else within the same equation is treated the same way. And I don't think that really addressed those kinds of concerns.

Q. I appreciate that, and I know what I'd like you to do, if you could, is go back and take a look at this and perhaps come up with an official position on a mandatory roll-back of costs for medical malpractice insurance and for some concept of a freeze. I'd appreciate it if you could take a look at that and go back

and consult and perhaps come up to the committee at a future date with an official position on that.

Again, you're asking us to do these various things to reduce costs. Theoretically, these things would reduce costs. I think we need to put some teeth into this concept and require that costs go down if we are to have this concept pass.

A. Yes, I see that and I think that would merit a study and answer to your kind of proposal.

REPRESENTATIVE VEON: Thank you, Doctor.

Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Thank you very much.

We'll take a 5-minute break.

(Whereupon, a brief recess was taken at 12:28 p.m. The hearing was resumed at 12:45 p.m.)

CHAIRMAN CALTAGIRONE: We'll get started again.

Next witness, Joe Merlino.

MR. MERLINO: Good afternoon. My name is Joe Merlino, and for the past five years I've been the President of the Society for Patient Awareness, which is a nonprofit organization that seeks to inform and support health care consumers and to advocate their views on policy issues. Over the years, we have received hundreds of letters and phone calls from people who have been

distressed in one way or another from medical care. Today, on their behalf, I wish to present a view of House Bill 1105 that represents neither the lawyer's side nor the doctor's side but the side legislators are presumably on, which is the side of protecting the health and safety of Pennsylvania citizens.

We agree with the first finding of the General Assembly that there are serious problems with the current system for resolving the claims of medical negligence, but most of the problems subsequently enumerated are problems the medical industry faces, not the victim of medical negligence. Let's examine these findings and see if they bear witness to the facts. In the bill, quote, "The cost of resolving those medical negligence claims is rapidly increasing and is becoming an increasingly large and important component of the cost of health care and of the expenses incurred by health care providers." While it is true the costs of resolving medical malpractice claims is increasing, it is equally true that the cost of medical care has also been rapidly increasing. In 1960, for example the national health care expenditures were approximately $27 billion, or 5.3 percent of GNP. By 1982, health care costs had risen to $321 billion, or 10.5 percent of GNP, almost a doubling of the pie. The most recent figures available for '87 put

health care expenditures at over $500 billion. If Pennsylvania represents 5 percent of the population in the country, that puts Pennsylvania's expenditures somewhere around $25 billion in Pennsylvania. By the year 2000, the U.S. Division of National Costs Estimates puts health care expenditures at $1.5 trillion. Overall, medical costs have been rising between 9 and 15 percent a year since 1970.

According to the Hofflander and Nye study on medical malpractice insurance in Pennsylvania, the average annual growth rate from '76 to '83 of incurred losses for the medical Cat Fund was 12.7 percent and concluded that medical malpractice insurance premiums have been, quote, "entirely compatible with perfectly normal growth of the medical care index in incurred losses." In short, although the costs of resolving medical malpractice claims has risen, it appears to be in line with the overall rise in health care costs that are averaging between 9 and 15 percent a year.

Secondly, how much do medical malpractice premiums contribute to the overall cost of health care? According to the Insurance Information Institute in 1983, about $1.6 billion were written in medical malpractice premiums, or about four dollars out of every thousand. In overall, health care costs went for medical malpractice

coverage or less than a half a percent.

Gentlemen, this percentage is simply not the important component of the cost of health care that some would like us to believe. What is an important component of the overall health care costs is the spectrum of what I call negative care. Negative care are your unnecessary surgeries, your misprescribed and overmedicated patients, doctor induced and hospital induced injuries and infections. Studies of iotragenic injuries and nomoscomial injuries reveal often staggering rates and additional costs. I have, for example, a study, just as one example, the New England Journal of Medicine which studied 16 patients who had avoidable adverse outcomes from colonic surgery. Their finding, which was written by doctors, concluded that these misadventures resulted in 10 times the mortality and 7 times the average cost, and 4 times the length of hospitalizations. Medical malpractice represents only the litigated instances of negligent medical injury. The total spectrum of negative care costs, however, dwarfs that of medical practice premiums. If we were serious about reducing health care costs, we first need a comprehensive plan to reduce the disproportioned expenses associated with negative care practices.

Number three, according to the data supplied

from the Journal of Medical Economics, the 1986 median net income for physicians, after all expenses, was $112,000. By contrast, the median net income for households in 1986 was less than $25,000. Medical malpractice insurance comprises only about 3.5 percent, that should be a percent there, of gross physician income on average, according to Medical Economics. In short, while medical malpractice premiums may appear high to the average household for certain specialties, insurance costs must be seen relative to the gross income of that specialty. The median net income for neurosurgeons, for example, whose malpractice premiums are often used by the Medical Society in advertising, is over $200,000. Median. If one is concerned about the financial hardship of neurosurgeons, don't forget the patient whose costs for a negligent brain operation may be his life.

The true cost of medical malpractice which are borne much more heavily by patient's physical and emotional injuries than physician's wallets brings us to the *second finding of the General Assembly*. Quote, "The current system further increases costs by inducing health care providers to engage in defensive health care practices, such as the conduct of tests and procedures primarily to produce protection against legal actions."

First, the issue of defensive medicine has

been dealt with at length in a hearing before the U.S. Senate Committee on Labor and Human Resources in July of 1984, and here it is. The term "defensive medicine" can be given either a positive or a negative meaning, depending on whose definition you want to use. If you're a patient, it can mean that 57 percent of physicians keep more detailed patient records than they would normally do, that 44 percent refer the case to another doctor, that 27 will provide additional treatment, according to an AMA study of 1,200 doctors. Indeed, according to James Davis, Speaker of the House of Delegates of the American Medical Association, quote, "The fear of being sued is only one small part of defensive medicine. If one looks at the studies that have been done on what really constitutes a definition of defensive medicine, there are many very positive aspects to it. It has been shown that physicians in this climate of, quote, `defensive medicine' spend more time with their patients than they did previously, they tend to maintain better records, they are more apt not to enter fields of care in which they may not be as competent as they should be, and they're more apt to refer patients to other more competent physicians," closed quote.

If a physician reacts to the possibility of being held legally accountable for negligent medical practice by imposing more tests on a patient than is

medically warranted, then that physician is guilty of malpractice by his very reaction. By what rationale should patients be subject to the risks of unnecessary testing because of a physician's misplaced fears? According to an analysis of 2,476 medical malpractice claims conducted by the largest malpractice insurance carrier, the St. Paul Fire and Marine Insurance Company, only 17 percent of its claims were diagnostic issues. By contrast, patient falls, which is a very low-tech item, accounted for almost one quarter of all claims.

The current system does indeed induce physicians to do more testing than is necessary, but as Dr. Davis remarked, it is a small part. A far greater force of inducement is the revenue generated from testing. If health care costs want to be reduced, one way is to educate patients and their families about unnecessary testing, not by eroding their ability to bring suit for negligent care. In my opinion, the real cost of medical malpractice to the Medical Society and the individual physician is not so much money, it is the threat of loss of prestige and the uncomfortable notion that mere mortals may hold an aspiring deity to account for his less than perfect actions. House Bill 1105 misses the mark when it tries to justify reducing the ability of patients and their families to redress medical grievances by claiming

health care costs will thereby be reduced. If anything, physicians freed from legal accountability will tend to increase costs since there will be no incentive to increase medical practices. Of course, it is not politically practical for the medical societies to fully immunize their members from legal accountability, but they can do the next best thing, by placing roadblocks along the already difficult legal path to discourage would-be litigants and their attorneys. Unfortunately, House Bill 1105 is filled with these roadblocks. Not one word is spent addressing the problem of medical malpractice itself in particular, nor the vast amount of medical injury and negative practices that never see the light of litigation.

Does the current system inefficiently resolve negligent claims in that an excessive period of time elapses between the filing of a claim in court and its resolution? You bet it does, and the plaintiff's attorneys are no white knight on this score. But before we go inserting the proposed pretrial and trial procedures contained in Article 3 of this House Bill, we should know with statistical certainty the exact causes for delay. To date, I am unaware of any study conducted that analyze the nuts and bolts legal course of medical practice actions or their outcome. We have no information right now on the total universe of malpractice suits in Pennsylvania, aside

from Cat Funds.

Do plaintiff's attorneys take too many cases? Yes, I think they do. Do defendant's attorneys file frivolous motions or delay discovery? Yes, I think they do. But my fear is that without such knowledge and a statistical format, establishing these pretrial procedures will, in practice, inure to the detriment of patients and their families pursuing claims.

For example, board certification is afforded an extraordinary status in House Bill 1105 requiring that a board certified expert testify on another such member. The credibility of a witness should be a matter for the jury to decide on a case-by-case basis. By this provision, the legislature is elevating a private entity which sets its own rules and criterion for certification to a quasi-judicial status. Under this rule, physicians would have the great incentive to seek protections of board certified membership, confident that no one from outside their small circle would be permitted to testify as to any alleged negligence.

The same kind of anti-patient rules are evident in Article 2 of House Bill 1105, medical negligence claims. For example, the term "major invasive procedure" under Section 202, informed consent, is left to a, quote, "expert" to decide whether the procedure was

invasive. Presumably, if the action were against a board certified physician, only another expert from his specialty could make such a determination. Moreover, there are many procedures and treatment that are not a major invasive procedure but nonetheless can have serious, if not lethal, consequences, such as drug therapy.

On the issue of collateral source, the problem with this section has been well said already. It would shift the burden of who pays for negligent conduct from the tortfeasor to innocent public and private sectors. If little damages can be collected from the tortfeasor or his insurer, there is little incentive for an attorney to take a negligence case on contingency. Where is the means of justice for the victim? Again, on the issue of punitive damages, it should be left for the jury to decide on a case-by-case basis whether in light of all the facts the practitioner's conduct was so outrageous as to warrant the imposition of punitive damages. Should it be public policy, for example, to encourage chemically or alcohol-impaired physicians and other allied health personnel to seek treatment, lest they be subject to punitive damages? In my opinion, such a policy would do more to improve medical care, reduce mistakes, and save money than to force victims to prove a tortfeasor had an evil motive.

Finally, is there anything of genuine merit in terms of reducing the incidence of negligence thereby saving lives as well as health care dollars in House Bill 1105? I think there is. Qualified, yes. Article VI mandates reporting by malpractice insurers of settled claims to the appropriate State board. Study after study has shown that a few tortfeasors are responsible for a vastly disproportionate amount of the incurred losses to insurance companies for medical malpractice. Pennsylvania ranks toward the bottom of disciplining errant physicians. I think the figures are about a half a doctor per thousand. Yet effective policing, and that includes all kinds of disciplinary actions, not just revocations, yet effective policing of medical behavior by aggressively constituted State boards would do more to reduce medical injury and insurance premiums for good doctors than so-called tort reform. Referral by insurers to the appropriate State board, however, should occur not after a claim has been settled but when the claim has been filed. What good is it if the State board gets a case 3, 5, 8 years after the incident originally happened where the doctor can continue to go out and practice bad medicine? It should be done in the very beginning.

In conclusion, I don't think that this bill, House Bill 1105, serves the health and safety interests of

the citizens of Pennsylvania.

Thank you.

REPRESENTATIVE HECKLER: Thank you, Mr. Chairman.

BY REPRESENTATIVE HECKLER: (Of Mr. Merlino)

Q. Mr. Merlino, I have to apologize. I was out of the room when you introduced yourself, so I may be asking you to repeat yourself. Tell me a little bit about the Society for Patient Awareness.

A. We were incorporated in July of '83. We operate in two States, Delaware and Pennsylvania, mostly the eastern part of Pennsylvania. We are entirely funded through voluntary contributions and from memberships and board members. And we are a tax-exempt nonprofit organization.

Q. Okay. Nonprofit. What sort of fundraising do you do?

A. It's through our members that we have fundraisers. In other words, through membership is where we get our funds.

Q. Okay. Do you have people go door to door, for instance, to solicit?

A. No. Mostly how Patient Awareness got started, we originally got some publicity in the Philadelphia media market. We got inundated with phone

calls and letters from people, got stacks of them, and we found that we couldn't respond to the demand, so we have been slowly evolving to the point where we're forming support groups in various counties so that people can come to, let's say, libraries is how we do it and they can discuss their medical issues that they have. The volume was just so large that this is what we had to do.

Q. And the volume of people who are discontent with the medical care they're getting or have questions about -- I'm not quite clear on what it is you offer the public.

A. Basically through support groups people can come together and commiserate and share their stories. We found that -- I mean, I used to sit on the phone for hours just listening to people, and I listened to the same stories over and over again. So these people come together and talk among themselves.

Q. And these are primarily people with stories about just illness in general or specifically having been improperly treated by the medical system?

A. The latter.

Q. And you're the president of that organization. Is this what you do for a living?

A. No, this is a volunteer activity of mine.

Q. Okay. And are you folks registered with

the Charitable Organizations Commission?

A. Yes, we are.

Q. Now, the other question, I have a couple of substantive questions, but one that sort of springs to mind here, I see that your prepared testimony makes reference to the fact that "On the issue of collateral source, the problem with this section has been well said already." Did you coordinate your testimony with someone in preparing for today's testimony?

A. No, I didn't. I mean by that that since I first began testifying, which goes back to 1984, was that tort reform has been periodically introduced in the House legislature and I've testified before on this issue and there's been other people throughout the years testifying on collateral source. It is a well-tread topic.

Q. Okay. Now, specifically, you made the statement that nothing about this legislation does anything about medical malpractice. You're aware, I assume, of the requirements that were contained in the 200 section of the bill which require the reporting or, I'm sorry, I'm probably in the wrong place on this, but at any rate, the provisions of the bill which require the reporting of any medical -- I'm sorry, it's Section 600, mandatory reporting, which would require any malpractice insurer to report to the licensing boards the payment of

any claim. Do you think that's a helpful feature?

A. Yes, I do. It's similar in concept to SB 1315, which has been previously mentioned, which is a bill that we supported precisely because it gives the public and the legislature, for the first time, real data about the frequency of malpractice claims. Now, we've got that on Cat Fund claims, but we don't have data on claims underneath that threshold. This would give us that. The only problem is that we can't follow the course and do any statistical analyses of how a malpractice claim is litigated. We're kind of shooting in the dark about how many cases are settled, what percentages, what is causing delays. For example, if we had a way to monitor from the get go, when a claim is filed, and what is it that is preventing this claim from being resolved, if we had that information, which I don't think we do, then we could go in and target those areas within the legal process that is impeding this resolution. So I support that, except I think it ought to be really expanded and made into more of a data gathering operation, less of a -- I'm not interested so much in going after doctors, I'm interested in gathering information that can provide the legislature with a plan to introduce risk management programs.

Q. The other issue you mention is the possibility that defense counsel may delay the procedure

by frivolous activities of one sort or another. You are aware, I assume, that the provisions concerning frivolous suits in this bill are equally applicable to any kind of pleading or motion filed by the defense? Is that your understanding?

A. Yes, I am aware of that.

Q. So that that, I assume, you and your organization would view as a favorable feature?

A. The issue of delay in discovery, if one reads that on face value, it seems very reasonable. My only point is that I'm afraid that those restrictions are in place in an environment where we really don't have any good study of the legal process, and I'm afraid that we put a restriction in there and that the unintended effect is to make it more difficult for plaintiffs to prosecute their case. That's my only criticism.

REPRESENTATIVE HECKLER: Thank you, Mr. Chairman.

BY REPRESENTATIVE McNALLY: (Of Mr. Merlino)

Q. Yes, Mr. Merlino. One part of your testimony that I hope you would elaborate upon was on page 5, at the very bottom, specifically you said that, "Not one word in House Bill 1105 is spent addressing the problem of medical malpractice itself in particular, nor the vast amount of medical injury and negative practices

that never see the light of litigation." And in my experience, you know, probably most of the complaints that I hear and have heard from people about alleged medical negligence, actually I turn them away and would turn them away simply because it's frankly not economical to litigate the vast majority of allegations of medical negligence, even though in fact, you know, the medical negligence may be not only a reasonable claim but may very well be substantiated. I was wondering if you might be able to give some account of and maybe elaborate on this particular point of medical malpractice or negligence that occurs but is so minor, for example, or for whatever reason, the injury may be minor and as a result it's not litigated and that negligence may continue?

A. I'd be happy to. Unfortunately, because we don't have real good data on malpractice claims underneath the threshold of the Cat Fund, nor do we have any comprehensive data reporting system in Pennsylvania, we're forced to rely on sporadic studies done at the Federal level and throughout various States. In studies of iotragenic injuries conducted by the Federal government, there was a landmark study, 1973, I believe, by the Secretary of Health and Human Services, where they attempted to quantify just what you're asking for and basically they came up with the fact that out of the total

universe of potentially litigable claims, only about 1 in 10 or 1 in 20 actually pursue it. Now, it's sort of like an onion skin where you've got medical malpractice at the very core but it's a small amount and surrounding that would be potentially litigable claims, and then surrounding that are really not litigable claims but nonetheless medical injury of some sort, whether or not it's due to negligence or in a legal sense or not. So they tried to quantify this sort of onion, so to speak. And that's the figures they came up with, is that out of ones that were potentially litigable, about 1 in 20 to 1 in 10 actually go through with it, but that a far greater amount of medical injuries occurred. For example, in the New England Journal of Medicine, they did a study of two hospital floors in a Boston hospital. They found that 36 percent of the patients on those floors received some sort of iotragenic injury that was not surgically related. 36 percent

Q. What is "iotragenic"?

A. It's doctor-induced. So if you have a medicine, for example, I'll give you an illustration from my own personal experience. My father-in-law, who has cirrhosis of the liver, went to a doctor. He was given two medications on two different occasions. They were diruetics. One was a name brand and the other was a

generic drug. He mistook them for two different drugs. He wound up almost dying from dehydration. Now, that's not necessarily the doctor's fault, it is not necessarily the patient's fault, but it is an example of a lack of communication between patient and doctor that results in a medical injury, and in studies done there's about 1.2 billion visits to doctors throughout the United States every year, 1.2 billion. The average amount of time spent with a patient is 5 minutes.

So what we're seeing here is a lack of education on the part of patients to feel confident enough to question their physician, to feel confident enough to say, Doctor, spend some time with me and answer my questions. And so what we advocate is not just disciplining doctors but educating the patients as to how to negotiate the health care system, and I think if you look at the PA budget statewide you'll find extremely small, if any, amount given to patient education programs in the State, and I think that we can make real progress on health care cost containment quality assurance if we educate patients on how to communicate with their doctors, and we are not doing it right now.

BY REPRESENTATIVE BORTNER: (Of Mr. Merlino)

Q. Can I ask just a quick question? I want you to clarify one thing, if you would, from your

testimony, please. On page 3, under comment number 3, you're talking about income there and percentages of income that medical malpractice insurance involves. Is that to be 3 1/2 percent?

A. Yes. That's a typo.

Q. Okay. Thank you.

CHAIRMAN CALTAGIRONE: Thank you very much for your testimony.

MR. MERLINO: Thank you.

CHAIRMAN CALTAGIRONE: We appreciate it.

Betty Cottle.

DR. COTTLE: I guess it's good afternoon by now, and I have to commend you on your endurance. I want to thank you also for allowing me to testify.

I am Betty L. Cottle, Chairman of the Board of the Pennsylvania Medical Society Liability Insurance Company, known mostly as PMSLIC. I am presently Acting Chief of anesthesia at Mercy Hospital in Altoona, and I've been in practice approximately 30 years. I have been involved with the Pennsylvania Medical Society for almost 20 years. I'm a delegate to the AMA and have been on the PMSLIC board since 1982.

I believe I bring a unique perspective through my blend of experience as a physician practicing in a once very high-risk specialty, a member and

participant in organized medicine, and a member of the board of the Medical Society's insurance company. One thing is very clear to me: It is wrong to blame the high cost for malpractice insurance in Pennsylvania on the insurance industry. It is not only wrong, but dangerous, for to place the blame improperly is to avoid solving the problem, a problem which affects every citizen in this Commonwealth and which must be solved.

PMSLIC began writing coverage for Pennsylvania physicians in 1978. The Pennsylvania Medical Society formed the company as a response to the abandonment of the medical malpractice market by commercial carriers. PMSLIC was capitalized by physicians to serve physicians. We now insure 7,200 physicians, more than any other carrier in Pennsylvania.

PMSLIC is different from other carriers because all major operational and policy decisions are made by the physicians who comprise our board and our Claims, Underwriting, and Risk Management Committees.

PMSLIC has always been run on a not-for-profit basis. We pay no agents' commissions, brokers' fees, or dividends. All investment income is used to directly reduce premium needs.

Net operating costs for the policy year 1988, excluding State and Federal taxes, amounted to only

5.1 percent of total income, which by any yardstick indicates a highly cost-effective insurance mechanism. Despite this, over the past 11 years we were forced to implement aggregate premium increases amounting to 169.9 percent statewide. During this same period, the costs to physicians of excess coverage under the State mandated catastrophic loss fund had risen to a maximum of 87 percent of primary coverage cost.

Much criticism has been leveled at the insurance industry by insurance industry critics concerning reserving practices, and it is important to understand this aspect before we proceed.

Statutory accounting and financial reporting requirements with respect to ratemaking and reserving practices are rooted in the fully funded liability concept. Simply put, from the day a company collects its first premium and issues its first policy it is expected to escrow or reserve a certain portion of that premium to cover its predicted losses. Such reserves must be sufficient to cover not only the costs associated with those claims already reported but also those which will not be reported to the company until later years.

The fully funded liability concept ensures that if a company would cease writing business at any given time, it would have sufficient reserve set aside

which, when augmented by future investment earnings thereon, will cover all claims, including those which will be reported years after the company has ceased operations.

There has been much skepticism about what insurance companies do with their premium dollars. The total value of all payouts made by PMSLIC Claims Department in 1988 was $34.3 million. 68 percent of this was in the form of payment to claimants. The remaining 32 percent was for claims handling expenses, mostly defense attorney's fees.

A more revealing way to look at this is to see who got what. Utilizing the 33-percent contingency fee, the attorneys, both theirs and ours, got the biggest chunk. That is, they got 48 percent. The injured party, the patient, the plaintiff, got 45 percent. Other litigation and investigation costs were 6 percent, and the expert witnesses got less than 1 percent.

Ladies and gentlemen, something is wrong with a legal system that utilizes 55 percent of the funds available in order to decide how to pay 45 percent. It is clear that it's the attorneys who benefit the most, which may explain why many vigorously resist reform of the current system.

The call for insurance reform has been met for medical malpractice insurance in Pennsylvania by the

Health Care Services Malpractice Act of 1975, Act 111. When critics target the insurance industry as the problem, the common solutions they propose include making insurance mandatory, but we already have that under Act 111; a joint underwriting association to provide coverage for all who cannot secure it in the private market, but we have that; a catastrophic loss fund to spread the exposure over a larger population, yes, and we have that also; restrictions on the use of a claims made policy assuring continued coverage will be available, and I'm very happy to say that we also have that; restrictions on mid-term cancellation of insurance policies by the companies, and we have that. We have had all these insurance reforms in place since January 13, 1976, but the problem has not gone away.

On the other hand, reforms of the tort system which were mandated by Act 111 have been struck down by the courts, thereby destroying the good faith balance of insurance and legal reform achieved by this legislature in 1975, leaving a skewed and imbalanced mechanism in place. It is time to see through the rhetoric and bring balance to our personal injury compensation system.

The second common "straw man" is that physician discipline is wanting, and this has already been

addressed by the Pennsylvania Medical Society testimony. However, this relates to the misconception that just a handful of bad doctors generate most of the claims activity. The hope is that by making this statement the community at large and the legislature will think that we need to only beef up discipline to eliminate that handful of bad docs and the problem will go away.

We looked at the PMSLIC claims experience for our longer termed insureds, those who had been with us for at least four years. For those 3,800 doctors, half of whom have never been claimed against, only 642 have claims for which an indemnity payment has been made. If we add in contributions made by the Cat Fund, 64 percent of the total indemnity dollars have been paid for doctors with only one claim.

In fact, for the 14,000-plus doctors we have insured for various periods of time over the last 11 1/2 years, half of whom are no longer with us, only 17 have had more than four paid PMSLIC claims, and they account for only 5.4 percent of total losses.

When the usual arguments fail, inevitably someone will say, but the insurance industry only pays out a very small amount of what it has set aside in reserves. Frankly, my response to that is quite simple. I think that the critic who argues that insurance companies should

not set aside that money in reserves should be the one who makes up the shortfall when a company goes belly up, leaving a huge unfunded liability.

The majority of dollars collected during 1988 will be used to pay claimant's demand for indemnification. Our actuary estimates that the $46 million in premiums earned will generate $41 million in indemnity payments, and $24 million of loss adjustment expenses. Those expenses we incur to handle the claims. And while it might seem that we are already in the hole, these values have been reduced to present worth because we know that the funds they represent will be invested as long as 12 or more years and will grow sufficiently to cover the shortfall.

As stated before, PMSLIC is run on a not-for-profit basis, and some years we make a little and some years we lose, hoping to break even over the long run. Last year we made a profit of about $5 million, including substantial capital gains, and we have, just this week, filed for a modest rate reduction to return this profit to our policyholders.

Even so, PMSLIC's average premiums statewide, including the projected 1990 Cat Fund surcharge level, will be over $9,600. And orthopedic surgeons and neurosurgeons in the Philadelphia area will pay total

premiums of about $68,000. The Cat Fund recently projected a 1990 surcharge of 79.2 percent, an increase of 33.1 percent over the 1989 surcharge of 59.5.

What have we done as a company to ease the crisis of medical malpractice insurance costs? We have done several things.

One is that we insist upon defending all cases where the medical care was appropriate. We have a success rate of over 82 percent in the cases we tried statewide. We refused to be cowed by those who tell us that it makes more economic sense to settle. We believe that we have effected some tort reform by taking this strong stance. This is a right that physicians have, it is a right that defendants have. They should have as much right to a day in court as the plaintiff. It is clear that our courts do not believe this, as only defendants are penalized by way of significant monetary damages under the Supreme Court's Rule 238 for exercising that right. Nevertheless, we will continue to insist upon that right in every instance.

We believe that the nationwide decrease in frequency in medical professional liability claims is due, in large part, to the fact that well over half of the physicians practicing in this nation are now insured by companies like PMSLIC, owned and operated by and for

physicians, which companies are committed to taking a strong defense posture when appropriate.

We do not stop there, though. We have the most extensive physician risk management loss prevention program available in Pennsylvania, available to all the members of the Pennsylvania Medical Society, whether they are insured with PMSLIC or not. This includes our bimonthly risk management newsletter, a three-part medical/legal correspondence course, a home study program which contains a variety of pertinent medical/legal issues and topics, and a self-assessment of practice, which enables a physician to identify potential pitfalls which could lead to future malpractice litigation.

We also conduct an office audit program for physicians whereby staff visits the physician's office and offers the physician practical advice on how to improve the operation of the office practice. As you can see, the principle thrust of our risk management program is loss prevention education, which in the end benefits both the patient and the physician.

It is clear that the insurance mechanism in Pennsylvania has been significantly reformed and cannot be singled out as the cause of the problem. It is patently inaccurate to blame the problem on a few bad apples or the alleged failure of the physician disciplinary process. We

look now to the legislature to recognize that the legal system is out of balance and that it is time to correct that situation.

The courts have created numerous new theories of recovery. It is not the status quo that is being preserved by the plaintiff trial lawyers, rather we have seen a swing within our court system to inordinately favor the plaintiff in civil actions, and it is time now for the pendulum to swing back to more reasoned ground.

The provisions of House Bill 1105 are a move towards rationality, a return to the search for justice, and the effort to compensate an injured person for injuries actually sustained, the keystone of our judicial process.

The obvious question becomes, what will PMSLIC do in terms of rate adjustment if these reforms are passed? There is no question that any savings generated by these reforms will be built into our rates. The problem with saying more than that is threefold. First, if HB 1105 is not enacted in its present form, and if it is weakened, obviously the savings will be lessened. It takes strong legislation, such as exists in California, to generate any significant savings.

Second, insurance rates are prospective, which means that we must wait to see the effects of the

tort reform before reflecting the results into our rates. If we were to arbitrarily assume that this piece of legislation would generate savings of 10 percent and reduce our rates immediately, only to learn later that the 10-percent reduction in cost did not occur, then our rate structure would be inadequate, which could ultimately lead to insolvency.

Most important, perhaps, is that there is no guarantee whatsoever that these reforms will not immediately be challenged in the courts and set aside, just as the tort reforms in Act 111 were. However, PMSLIC will make this commitment to you. We will push for these reforms and we will use every dollar saved to reduce our costs to the policyholder in the form of reduced rates. Moreover, if enacted in its present form, the savings passed along will be meaningful. I look to you to create an environment in which fairness will prevail and that this result can be achieved.

I'd like to thank you for the opportunity to give you this testimony. I would like to add a comment that isn't in the testimony. I believe this is one of the first times that an insurance company has testified before this committee regarding the subject of tort reform. I think it is a wonderful thing. I think nothing does anything so good as the light of knowledge and facts, and

we need to have more facts, less whimsical and vague statistics and incidents. We need facts, and I hope that this opens a dialogue between you and our company, at least, because we are very eager to share with you whatever data we can.

I would also like, at this point, to put on another hat for a brief moment. I am also a board member of the Pennsylvania Medical Society, and as somebody who has worked very hard at the AMA and in PMS to see to it that by the year 2000 there is a society without smoke and who supports the Surgeon General's efforts to the fullest, I would like to correct the idea that there is an unholy alliance between this profession and the tobacco industry. It is perfectly true that we have things in common with the Civil Justice Coalition, but as far as I know and to the best of my knowledge, no dollars have been received from the tobacco industry to that coalition, and I would like the record so to reflect.

Thank you very much.

CHAIRMAN CALTAGIRONE: Questions?

REPRESENTATIVE HAYDEN: Mr. Chairman?

BY REPRESENTATIVE HAYDEN: (Of Dr. Cottle)

Q. Thank you, Doctor.

And frankly, having been through this discussion and debate before, I was anxiously awaiting

your testimony because like you, I think that anecdotal evidence is of little value when you try to consider major changes in legislation, so I welcome your testimony and I have some questions in terms of trying to extract what I think are more valuable pieces of information in this debate.

You mentioned that PMSLIC has 7,200 doctors who are underwritten through PMSLIC's coverage. What percentage of the market share of doctors in Pennsylvania does that represent? Do you know?

A. I'd have to turn to someone.

Q. Sure.

MR. SMARR: My name is Lawrence E. Smarr and I'm a vice president with PMSLIC, and I am responsible for the statistical research activities of the company.

We don't really have a hard number of the number of doctors actively practicing in Pennsylvania, so it's a little difficult to make an accurate estimate, but we think that we have between 35 and 40 percent of the market for physicians who require malpractice insurance.

REPRESENTATIVE HAYDEN: I'm also interested in trying to figure out in terms of what your standard business practices and procedures are in terms of how you decide or whom you decide to write or underwrite. Mr. Matusow raised an interesting question about the notion of

skimming, and if in fact your company represents between 35 to 40 percent of the market, it seems to me that there are certainly other private companies out there who the assumption is they are being more selective as to which doctors they will take and which doctors they will underwrite.

My question is, is there anything either through your company's by-laws or through your operating procedures, is there any basis upon which you will look at a physician's prior claims experience, litigation experience, or say, for instance, Cat Fund exposure to make a blanket determination that you will not accept that risk or you will accept that risk?

DR. COTTLE: Well, first of all, we generally insure all members of the Pennsylvania Medical Society who apply for insurance, but we do -- our Underwriting Committee composed of doctors does look at the past history of the doctor's performance and what his experience has been, and we do determine his insurability as far as how much his premium will be and so forth.

I think Miss Lawhorne will be able to address it in more detail.

REPRESENTATIVE HAYDEN: If I can, and you raise a good point, Doctor, does then membership in the Society guarantee you then at least availability of

insurance? Certainly it wouldn't guarantee what your costs might be or what your risk rating might be, but does it guarantee you that PMSLIC will underwrite?

MS. LAWHORNE: It guarantees that PMSLIC will initially underwrite you, and then a review is undertaken, and there are two things that can happen.

REPRESENTATIVE HAYDEN: How long will that initial decision take?

MS. LAWHORNE: It will be immediate. There's an immediate review. Unlike Mr. Matusow, we've had surcharges, which are of experience rating, since the company was started. It was something that doctors insisted upon as a method to adjust rates if a doctor had bad experience. So the physician could immediately be subjected to a consent to rate program, which means that in order to be written by us, he has to sign a form which is filed with the Insurance Department consenting to a higher rate. We now have, for the last few years, a multi-tiered rating plan where there may be automatic increments which are filed rates based on claims experience. So we have premiums that reflect experience, first of all, which most other companies don't. So that's an important way that we've addressed the problem of the alleged adverse selection.

The other thing that we do is we do

non-renew doctors, and they have a right of appeal to the Medical Society, which brings a non-insurance perspective to it, but we clearly non-renew physicians when their experience is to the point where we don't want to have them on our books because we think that there's a serious problem. They go any number of places, not just the JUA, which is always available with the mandatory insurance mechanism. We do have competitors. They're not all creaming. We have lost a significant percentage of our previously surcharged doctors to other carriers.

REPRESENTATIVE HAYDEN: Well, that's the next question I have is have you done any cost comparison in terms of a study where you take, for instance, one doctor that fits into a standardized rating category and then compare with what, say, St. Paul's might be charging or PMSLIC might be charging? I think that would be helpful in determining whether there's any basis for the argument about skimming.

MS. LAWHORNE: There are rate comparisons.

MR. SMARR: In looking at the major carriers in Pennsylvania, there are three carriers who write large portions of the market, and then a fourth, St. Paul. And our rates are pretty much consistent with two of the other carriers, and we're all in the same ballpark. Our rates are set individually based upon our own portfolios. St.

Paul is higher than we are, a lot of the carriers are a little bit lower than we are, but we're all in the same general area, and then there's a fourth carrier whose rates are inexplicably lower, as far as we're concerned, and that market is there, and we've lost doctors to that.

REPRESENTATIVE HAYDEN: Who is that fourth carrier?

MR. SMARR: The company is called PIC, in Philadelphia.

REPRESENTATIVE HAYDEN: It raises the question, at least in my mind, at least for a moment, that if you've got what is operating as a nonprofit company and your statement about, I think, you know, a $5 million profit based on probably the millions of dollars of premiums you take in, I don't think anybody would possibly contribute that as being an exorbitant profit over an operating year. It raises the question that, in my mind, is PMSLIC, like if I'm a doctor shopping for this kind of insurance, is PMSLIC like the carrier of last resort for me?

DR. COTTLE: No.

REPRESENTATIVE HAYDEN: Or is it a place where I logically would find that competitively pricing mechanism?

And the second question I have is based upon

your knowledge of the information of the operation of other insurance companies, and through my discussions in the auto insurance debate I found that there is a tremendous amount of sharing of information among insurance companies except when we need the real information that we need. Is it your experience that there is greater variation and there are greater numbers of variables in terms of how PMSLIC assesses their rates based upon a risk? For instance, you talked about risk rating, because I think that goes to the heart of a number of the arguments that have been raised that doctors are being lumped unfairly into different categories that they don't belong in.

DR. COTTLE: Well, let me get straight the two questions, because they kind of run together, and I've almost forgotten what your first question was.

REPRESENTATIVE HAYDEN: I have also.

DR. COTTLE: Is PMSLIC the company of last resort? No, I wouldn't say that. Otherwise, we wouldn't be insuring the number of physicians that we insure. And we have been steadily growing. Even since I've come to the company I think the portfolio has almost doubled. Not because I came to the company, but it's in that period of time, and I came to the company in 1982. So we have been growing steadily, so we are not the company of last

resort. In addition to that, I feel that we offer physicians a means of getting -- of a feeling of getting justice because everything that is reviewed by their peers, all the claims are reviewed by physicians and underwriting is handled strictly by a physician committee, so no, we are not the company of last resort.

Now, let's hear your second question, if you can remember it. It was very long.

REPRESENTATIVE HAYDEN: Yeah, I often, despite my experience, often ask compound questions.

Let me change the second question. The other question I have -- no, let me reask it. You talk about there's a three-tiered system currently in PMSLIC. Within those three tiers, are there variations within each of those tiers in which cost is based more closely to experience rating? Did I make myself a little clearer that time?

I think your actuary is raising your hand.

MS. LAWHORNE: No, I'm general counsel.

DR. COTTLE: No, she's general counsel.

REPRESENTATIVE HAYDEN: Well, she handles the actuary questions pretty well.

MS. LAWHORNE: Maybe I can make this relatively -- what we did was we looked at our experience and we saw that some doctors were having more bad

experience than we thought was reasonable, recognizing that a neurosurgeon -- and by the way, neurosurgeons and orthopods are lumped together, and that is also done by if other carrier that writes most of the high-risk doctors. So that's a little misleading.

REPRESENTATIVE HAYDEN: It's not uncommon?

MS. LAWHORNE: No. They already pay more to practice that specialty in Philadelphia, so we are expecting that they will have more claims. So what we did was asked our actuary to study that and develop a standard deviation by specialty and territory so that a neurosurgeon in Philadelphia's experience is compared to a neurosurgeon and orthopod's experience in Philadelphia, and if that experience then deviates from that norm, he or she may experience an increase. So there are cells for every specialty, for every territory in our rating process.

Now, we have 12 specialty classifications.

MR. SMARR: We currently have 11.

MS. HAWTHORNE: So we have tried to create as fair a method for the doctor which also reflects the risk to the company. Because one concern we had heard was the good doctors who said we don't want to pay for the bad doctors, so we think we have found the most viable way to spread the costs fairly.

REPRESENTATIVE HAYDEN: One of the societal arguments that's made for changes in the way medical malpractice law is treated is that some have made the claim that there is a drop-off in availability of services, and that drop-off sometimes occurs by specialty, and you mentioned the higher risk specialties, the higher cost specialties, as well as in some cases a drop-off by region, which may or may not be reflective of costs of malpractice insurance. I'm curious to know whether, since you are an insurance company, whether you have ever done any kind of study about those kinds of issues as they might occur within the State of Pennsylvania, being able to identify whether in fact there are people -- I mean, some people say that -- by the way, I don't think the Ob/Gyn analysis is very beneficial when you say that family doctors no longer deliver babies. Family doctors no longer do house calls either.

DR. COTTLE: I think though that's different. Could I interrupt you with that?

REPRESENTATIVE HAYDEN: Sure.

DR. COTTLE: Because I'm from the center part of the State and a great deal of rural community is there, and believe it or not, no matter what people may think about the excess number of doctors, it hasn't spread that far to rural communities. They are still suffering

the scarcity of qualified specialists. And the family doctor plays an important role in some of those communities. I realize it isn't the millions of people in Philadelphia or Pittsburgh, but there are citizens out there who need care, and family doctors out there are just saying they're not going to deliver babies, and I think that's an important point to remember before you equate it with house calls, which are another matter.

REPRESENTATIVE HAYDEN: No, I agree, and that's the point I'm trying to make is has there been any empirical data developed to either make that point or refute that point?

DR. COTTLE: I don't think so. Do you know of any?

MR. SMARR: Not to my knowledge, no.

MS. LAWHORNE: Not that we've tracked.

REPRESENTATIVE HAYDEN: A collateral issue in this, the issue about what impact this might have or might not have on costs to individual doctors I think deals with what I consider to be the credibility of data which is available, and I compliment you for giving us a very straightforward analysis of your own company's experience. But I think one thing you have to realize is that particularly when it comes to private companies, it's awfully difficult for us to evaluate some of their claims

when they refuse to let us look at what some of their data is upon which they base these claims. And our majority leader, Bob O'Donnell, has had a bill, and now this is the second consecutive session, on data disclosure which would deal -- it was offered in the concept of auto debate but last session was offered in the greater context which has languished now in two sessions in a row on the Senate side. I think it would serve both PMSLIC's cause as a nonprofit company who has to compete with some of these companies as well as us as policymakers to support any kind of proposal which would permit us to make cold, hard evaluations of this kind of actuarial data because right now we have to do it based upon either in many cases it's a gut reaction and we see a lot of conflicting data.

We've heard reference to a Minnesota study which was referred to us by the Trial Lawyer's Association which seems to debunk the myth, at least as it relates to the State of Minnesota. And unless we have contradictory evidence which is as hard and objective as that kind of evidence, it's awful difficult for us just to accept that across the board these things are occurring. They may be occurring with PMSLIC and I think it's instructive of the problem PMSLIC is experiencing, but I would encourage you to work at least on the Senate side because we never had a problem with that bill on the House side of trying to get

a greater openness, particularly with respect to these complex issues.

The last question I'd like to leave you with is that I guess it's more along the lines of an observation. I found an article that caught my eye in the Washington Post which is dated Thursday, November 24, 1988. The headline is the "Malpractice Insurer Announces A Discount," and I'll just try to paraphrase it. It says that after 10 years of rising insurance rates, Maryland doctors will get a 10-percent discount next year on premiums offered by the State's major writer of malpractice insurance." And the company is called Medical Mutual, and they represent or they underwrite 85 percent of those that practice within the State. And they claim that, they said the reason they gave the 10-percent discount is recent changes in the law enacted by the legislature. Governor Schaefer was real happy about that and had a press conference in his office.

But I think it might be of some value to those of us on the committee to examine, and I'm in the process of examining what changes actually occurred in the Maryland law. It might be of some value to examine the changes that occurred in New York, and I know there have been some changes that occurred in New York within the past three or four years, as well as the changes that have

occurred in Maryland, these are two neighboring States, and to see whether those kinds of cost savings have actually withstood the test of time, you know, have the companies come back and gone after 10 or 15 percent more? Has it helped in terms of keeping more people within the specialty of Ob/Gyn? I mean, if you're an Ob/Gyn you'd expect that obstetrics would be part of your practice, but right now it's not the case, as you know that, Doctor.

I mean, this is the kind of empirical evidence which I think serves greater value than saying, yes, there are negligent doctors, and we all know that there are negligent doctors, but that, you know, somehow doctors across the board are incurring grave injustice when they go into the court system. I don't happen to be a proponent of either point of view. I think the truth probably lies somewhere in between. But it might be of some value, at least to me, and maybe some other members of the committee, if you could examine those kinds of changes and the impact it might have, particularly in your role as an insurer.

Thank you.

CHAIRMAN CALTAGIRONE: Mike.

REPRESENTATIVE VEON: Thank you, Mr. Chairman.

BY REPRESENTATIVE VEON: (Of Dr. Cottle)

Q. Thank you, Doctor.

Doctor, I would respectfully disagree about the tobacco industry being a part and a contributor to the Civil Justice Coalition. In the future, I'd be glad to, in the next few days, provide some evidence to that effect, and perhaps in many -- obviously some of the medical profession is not aware of that. Be that as it may, the tobacco industry has every right to be a member of that coalition, I'm not arguing that. I just want to make sure that people are aware of that, that when you join that coalition and you're advocating similar goals, I think that the medical profession, those doctors in my district need to be aware of that as we deal with this issue.

A. Politics makes strange bed fellows.

Q. And I appreciate that, but I think it needs to be, as you said, under the light of day and with a full knowledge, will be helpful as we a address this issue, and I'll offer that in the future. And as I said before, I wouldn't have brought it up except that the previous person made comments and in his testimony that this was important in the full context of this issue, and you cared to comment on that.

But let me get to another point that I made and another question I asked, and that is, I don't know if

you're familiar, but about two years ago the General Accounting Office, the investigative arm of the U.S. Congress, issued a number of reports basically looking at, I think it was six States, that had passed some sort of medical malpractice reform legislation, and the net effect of the report or the bottom line of the report said that there was no net decrease in costs of medical malpractice insurance to doctors in any of those six States. That was approximately 1987, thereabouts, and I think the study was done over a two-year period, so we're looking at maybe '85 to '87. Are you at all familiar with that report?

A. No, I am not.

Q. General counsel?

MS. LAWHORNE: I'm familiar with it, but I'm not prepared -- I mean, I can't say I've studied it or can rebut it. I can say that if they studied California, which is the prime State that had real tort reform, real significant legislation with teeth, they could not possibly have concluded that there were not savings generated by that, and I could get statistics to it. I think what happens is like what happens in New York and what could happen here, we'll pass something called reduction to present worth, and this is just as an example, but when you really look at the language, what you're talking about is reducing to present worth future

earning capacity only, and then what happens is what happened with, for example, the four-year tail which is in Act 111. In Act 111, it says that if a claim is brought more than four years after the treatment was provided, the Cat Fund takes full responsibility for it. The Insurance Commissioner then in 1975 mandated that all companies would reflect a decrease. Now, I wasn't here in '75. I can't remember the percentage reflecting this four-year cut-off in tail because our expenses were to end at that point.

The fact of the matter is that even with that provision remaining in the law, with dialogue that we've had with the Cat Fund, how do you apply this, how do you proceed, we continue to have money being spent on claims way after the four years. So in fact, a savings should not have ever been generated. And then you have what happened to Act 111 where all of the tort reforms were fairly promptly discarded so that savings, if you want savings, then we need something that would generate savings, and that's a hard pill, and then we need to keep them. We have to have them in effect.

REPRESENTATIVE VEON: I appreciate that. My obvious point is that what I'd like to do is forward that report to you and to the Society and ask for some response, because my concern is that we go through this

process, we pass a bill, there's no reduction in cost to doctors, as this report states, and there may have been -- I understand they were looking at doing a more recent update of that report, and perhaps that would reflect different figures, but I think that's important since that was, I think, a very thorough study, from everything I've read and I've looked through it. And again, the bottom line was, and right on the headlines, right on the front of the report, no net reduction in cost to doctors. And so I'd like some further comment on it. I'd like to forward those and get that, if I could.

MS. LAWHORNE: Good.

REPRESENTATIVE VEON: Which gets to my question, I guess, about how do you feel about mandatory rate roll-backs and freezes for X number of-- I guess we'd have to discuss the percentage and the length of the freeze, but in principle or in concept?

DR. COTTLE: Are you talking about fees?

MS. LAWHORNE: For rates.

DR. COTTLE: For rates?

REPRESENTATIVE VEON: Yes, Ma'am.

DR. COTTLE: I think I should leave that to Mr. Smarr.

MR. SMARR: If the projected reductions would stick, and it takes time for us to tell if the

reductions are going to really have an effect, the average claim is reported to us two years after it happens. It takes six or seven years to pay out the dollars that we will collect this year in premiums, and as long as 15 years until all the 1989 premiums, if you will, are paid out. It doesn't mean we have to wait 15 years to estimate the ultimate value of a year, but it's not like auto insurance or a short tail line where after the end of the year you know how many accidents have happened and you can affix a value to your projected losses.

So I think that we would be amenable to listening to discussion about that, but it would all depend upon with what certainty we could predict that the reductions would in fact happen.

MS. LAWHORNE: The reforms.

REPRESENTATIVE VEON: Right, and I appreciate that, as long as you appreciate, at least this one legislator's position, that you're asking me to accept a theory that all of these things we want to do in House Bill 1105 will result in lower costs for medical malpractice insurance for doctors that live in my county and district, and I have a hard time accepting that theory unless we're willing to put some teeth into it saying there will be this reduction in costs, appreciating what your points are about actuarial soundness of trying to do

that.

MR. SMARR: Yes, sir, we understand your position entirely.

REPRESENTATIVE VEON: Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Chief counsel has some questions.

MR. ANDRING: I just have a couple of quick questions.

Could you tell us how many cases you make payments on pursuant to settlements versus how many you take to trial?

MR. SMARR: Yes. Approximately 8 percent of our paid claims go all the way through verdict.

MR. ANDRING: Okay, so 92 percent of the claims you're paying as a result of a settlement?

MR. SMARR: Yes.

MR. ANDRING: And would those 92 percent fall into the category -- I think from the testimony that says you don't make a payment unless the treatment has been inappropriate, so can we follow from your testimony that in 92 percent of the cases where you make a payment pursuant to a settlement you yourself have determined that the treatment was inappropriate?

MR. SMARR: No, I don't think we can say

that because we often make a payment or settlement on a claim where we feel that the treatment has been appropriate but for other reasons the claim is one to be settled. Although by and large--

DR. COTTLE: By and large, no.

MS. LAWHORNE: That's it.

DR. COTTLE: There are exceptions, but I think they're limited. But by and large, we would do it only if it was inappropriate treatment.

MS. LAWHORNE: Of our pay claims, we're going to pay willingly only if we see a problem. And the doctor has consented.

MR. ANDRING: Okay, just a general comment. Conceptually, if by your admission 92 percent of the payments you make are in appropriate cases or where the treatment has been inappropriate and you take the other 8 percent to trial and win 82 percent of those cases, it seems to me that you're making payments in very few inappropriate cases, by your own judgment, so that if you're looking for real savings in this system, you can't look to what you would consider inappropriate payments. What you have to look at is the number of cases coming into the system where you're paying out almost all your money on cases that by your own admission are proper cases for payment.

MS. LAWHORNE: If I could respond to a couple of points about what we see happening.

Okay, now, you have two categories. You have all the claims that come to us, of which over 63 percent are closed with no payment.

MR. ANDRING: Okay.

MS. LAWHORNE: That's a big expense.

MR. ANDRING: How big?

MS. LAWHORNE: It's approximately--

MR. SMARR: Well, a claim that doesn't go to trial, that doesn't get past the first day of trial, costs us in the neighborhood of $4,000 to $5,000 on average. Of claims that go through trial, whether we win them or lose them, the average is between $17,000, $18,000, something like that. They can go into the hundreds of thousands of dollars and they can also have low values, but on average. So for 63 percent of them though we're not paying anything but we're still incurring these expenses.

MR. ANDRING: Well, as a total dollar figure, how much do you pay in a year for those 63 percent?

MR. SMARR: I would have to calculate that for you.

MS. LAWHORNE: I would be glad to do that. But there are other problems, and I think they're sort of

what's addressed by 1105. We may pay on them, but the question becomes, well, what do you pay on them? How much do you pay on them?

MR. ANDRING: Well, that gets me to my second question. You haven't specifically addressed the provisions of 1105, and rather than go through the whole thing, could you just tell us in your opinion the three most important provisions of 1105 to resolve this crisis?

MS. LAWHORNE: Probably in terms -- if you're looking just on a money basis.

MR. ANDRING: I'm looking to your organization and what you feel is important to resolve the crisis and restore the equilibrium for the justice system.

MS. LAWHORNE: Can we speak sort of as individuals, even though we're up here on behalf of PMSLIC?

I happen to think, although I know it meets with great concern and that there are legitimate questions, as an attorney, I think that the pretrial provisions which would guarantee a prompt resolution of a claim, that an expert witness will be available and that we will move forward, speeding up that process helps everybody. I think that attorneys on both sides would have to change the way they do business because I think now when an attorney in Philadelphia, one of our attorneys

in Philadelphia gets a case, he says to himself, hey, I've got five years, and I think that's a reasonable business -- I'm not being critical. I think it would require some real changes on how people practice, but I think it would be overall beneficial.

We believe that the collateral source rule, and I would like to give an aside to that, will generate savings. I was surprised to hear, and I can't rebut it from personal experience, from Mr. Matusow that subrogation is frequently enforced. We have never been approached for subrogation, and I would think that most other insurance companies would rather come before the dollars were paid out rather than trying to go directly against the plaintiff to get the money once it was paid. So I would urge you, if it's not impertinent to suggest this, that you verify whether Blue Cross and other health insurers and other entities actually do exercise that subrogation right, because I think that I was quite surprised to hear Mr. Matusow say that. And unfortunately, his testimony is not written here, but I think that's something to verify. I think that you can have this collateral source provision go in effect, the plaintiff will not be paying twice. I don't think that you're going to see Blue Cross, who has exercised its subrogation right left and right, then going against them

while we have also reduced the verdict that way.

And I understand the arguments on the other side. I think that there was a good faith effort to address all those, and we say if the patient has paid for this, it shouldn't be deducted. If there's an automatic subrogation, it shouldn't be deducted. But if the patient has already received full compensation for an injury, if our justice system is based on compensating injuries, let's not do it twice.

My husband was very seriously ill for two years and if he had been lucky enough to have had that be the result of negligence rather than cancer, I could have, after his death, received an amazing amount of duplicate money which was all covered by insurance. An amazing amount. And I just don't think it would have been a right thing for me to receive it. So collateral source, I'm not sure that everyone would agree with me about the pretrial. That's why I said can I say that personally.

I think the statute of repose would be very significant primarily because I think it gives us an ability to set our expectations more reasonably. And I would like to take a moment, if I may, to think about--

MR. SMARR: Present worth.

REPRESENTATIVE HAYDEN: That's three.

MS. LAWHORNE: Well, I want to do four.

We might say, for example, what I guess what I want to cover for is if our actuary gave you a study, those may not be the ones where there are the manifest, the objective savings. They might come out at a slightly different three. I happen to very strongly believe in our system, but I just think that it needs to be brought back to where it should be, which is why I believe in some of the pretrial stuff more than -- our actuary might have a hard time measuring that.

MR. ANDRING: Okay, I have just have one other question then. Could you tell us how much your organization spends in a year in legal expenses?

MS. LAWHORNE: Do you mean just our defense attorney fees and expert witness or--

MR. ANDRING: If you could break it down as to those fees as opposed to general administrative fees.

MS. LAWHORNE: We definitely could send it to you in a day's time because we have that. I don't know if we're going to have it right there with us, but that would be no problem. We track it.

REPRESENTATIVE McNALLY: About 43 percent.

DR. COTTLE: That's about right. The percentage is in the testimony.

MS. LAWHORNE: But it depends how you break it out. So there were two things we've been asked to do.

One is what is legal expenses, and what was the other question you asked?

MR. SMARR: Amount paid on claims closed.

MS. LAWHORNE: Okay.

MR. ANDRING: Thank you.

REPRESENTATIVE PRESSMANN: I had a question that came up when the other doctor was here before about punitive damages and what percent of your dollars paid out are punitive damages. Because one thing--

DR. COTTLE: We can't pay punitive damages.

MS. LAWHORNE: Under State law, an insurance company can't pay them except in very, very limited circumstances.

REPRESENTATIVE PRESSMANN: Okay.

REPRESENTATIVE BORTNER: Yeah, but you have some figures on how frequently they're awarded, or don't you have that available either?

REPRESENTATIVE PRESSMANN: The reason I'm asking that question is I've talked to a number of trial attorneys back in my home, guys who do this kind of stuff all the time, and one of the leading trial lawyers, he's a plaintiff's attorney, has been trying law for about 40 years, has never seen a punitive damages in his lifetime.

MS. LAWHORNE: Against physicians.

REPRESENTATIVE PRESSMANN: Against anybody.

He says to him it's one of the biggest red herrings in -- I'm not talking about, you know, we know these things happen, but in Lehigh County court, no jury has ever, in his, and he tries many cases every year, punitive damages are very rare. Also, the other thing is that punitive damages are one of the first things I notice that the appellate courts strike out when they adjust the awards, and a lot of times punitive damages, to me, has become a little bit, I don't want to say sacred, but has been a way of adjusting for a civil wrong that the licensing boards and whatever are unwilling to take on, and that's why I'm very reluctant to see punitive damages being disturbed.

DR. COTTLE: I would like to respond to that, if I may. I don't know anyone who had punitive damages carried out either, but the threat of punitive damages to the defendant is horrendous. It is not covered under your insurance, and if you were sued and, you know, your suit is taken care of and your defense is taken care of by your insurance, but when it comes to punitive damages, everything you own, have worked for or have is at stake, and it is a threat to the physician to settle, to get out of it, to make it go away and not to stand up and fight it because you can't be guaranteed that it won't come to pass. It is a tool to frighten, to intimidate and not allow justice to take place for the defendant

physician.

REPRESENTATIVE PRESSMANN: But I guess you wouldn't accept then that it's also a deterrent?

DR. COTTLE: To what?

REPRESENTATIVE PRESSMANN: To malpractice.

DR. COTTLE: I don't think that's a deterrent to malpractice. I don't think that when I practice medicine--

REPRESENTATIVE PRESSMANN: Now, wait a minute, you can't have it both ways. You're always telling me--

DR. COTTLE: No, no, no, no.

REPRESENTATIVE PRESSMANN: Now, wait, and I'll find it in your testimony, I saw it in your testimony here today that one of the things you're always thinking about is whether or not you're going to be sued and that you're doing all kinds of procedures whether or not you're going to be sued, so you can't have it both ways.

DR. COTTLE: I didn't say that, did I?

MS. LAWHORNE: Wait a minute, though. I think that most physicians may think about being sued, and who knows, maybe they do think about punitive damages. I shouldn't tell you what is subjectively in someone's mind, but I think that some of you up there might be plaintiff trial lawyers, which means you receive the same little

newsletter that I get called -- I forget what it's called. Plaintiff Trial Lawyer's Strategy?

REPRESENTATIVE PRESSMANN: I'm neither a doctor nor a lawyer.

MS. LAWHORNE: Well, okay, but actually the plaintiff trial lawyers give out strategies and they have these little newsletters, and one of them says, here is a great way to make doctors -- I mean, I could find it for you. It is within the plaintiff trial bar, it is a recognized method to induce a physician to argue with his or her carrier that even though there may not be clear negligence, that there's something about the case that's very scary. Like maybe the medical treatment was okay but maybe the doctor was impaired, so on the medical issue we say, we want to the defend you, Doctor, but he's very concerned about the fact that he was an impaired physician at that time. So it has a real effect on making the doctors want to settle.

REPRESENTATIVE PRESSMANN: And I also have a copy of a journal of one of your professional associations talking about disciplining doctors for testifying against other doctors. Not PMS, but one of the other.

MS. LAWHORNE: No, it wouldn't be PMS.

DR. COTTLE: I don't think so.

REPRESENTATIVE PRESSMANN: I'll show you a

copy. Like I said, it wasn't PMS.

DR. COTTLE: But about punitive damages, until a doctor is sued, most physicians don't know what punitive damages are. They really don't. Because when I talked about it at a meeting, I had to define what punitive damages were to some 30 physicians sitting there, so it can't be foremost in their mind when they're practicing, because I would wager that the majority of physicians out there who haven't been sued do not know what punitive damages are nor what it implies. In fact, probably they think it's covered by their malpractice insurance, if they think about it at all.

REPRESENTATIVE PRESSMANN: How many actual numbers of claims or how many suits were brought against you, I guess, or how many actions were brought against you in last year, say?

DR. COTTLE: Against PMSLIC?

REPRESENTATIVE PRESSMANN: Yeah.

DR. COTTLE: I don't have--

MR. SMARR: I've got that number somewhere. It's 600 and some.

DR. COTTLE: The statistics man. Six hundred and something.

MR. SMARR: 677.

REPRESENTATIVE PRESSMANN: 677, and of

those, 60-some percent you said were dismissed without payment?

MR. SMARR: Oh, no.

DR. COTTLE: Will eventually be.

MR. SMARR: Oh, no. Almost all of them are open. They'll be open for years.

REPRESENTATIVE PRESSMANN: Okay. Is that an average amount per year, 677?

MR. SMARR: No. Our numbers have gone down since the 1983-84 timeframe, based upon the mixture, the specialty mixture of our portfolio.

REPRESENTATIVE PRESSMANN: Okay.

MR. SMARR: And we have, in fact, seen a reduction in the number of claims on an adjusted basis that are coming in the door. As we testified, there is a decrease in claim frequency.

REPRESENTATIVE PRESSMANN: All right. So last year, there were 677 claims. Now, in the past, 60-some percent of the claims were not paid?

MR. SMARR: 63 of those closed.

MS. LAWHORNE: At some point.

DR. COTTLE: At some point in their history.

REPRESENTATIVE PRESSMANN: All right. And you have 7,000-and-some doctors, I believe?

MR. SMARR: Approximately 7,200.

REPRESENTATIVE PRESSMANN: 7,200 doctors. You threw out the number in defending the fact that it's not a couple of bad doctors that are really causing the problem, that you've only had 17 doctors who have had more than four claims against them that have been paid? Is that correct?

DR. COTTLE: PMSLIC.

MR. SMARR: That is correct.

REPRESENTATIVE PRESSMANN: Okay, in PMSLIC. Is that in your total history, or currently with you?

MR. SMARR: Yes. No, that's in our total history.

REPRESENTATIVE PRESSMANN: Total history, and you go back what, 10 years? 1978?

MR. SMARR: To 1978.

REPRESENTATIVE PRESSMANN: And you've insured 14,000 doctors during that time?

MR. SMARR: A little over 14,000.

REPRESENTATIVE PRESSMANN: Okay. Of those doctors, and I don't know if you have this information, of those four doctors, had they come with prior experience of having claims settled against me?

MR. SMARR: I don't have that with me.

DR. COTTLE: We wouldn't have that.

REPRESENTATIVE PRESSMANN: I'm just curious

if you had 17 bad apples dropped on you.

You have said you will refuse a doctor coverage because you think he's too much of a risk because, like the 17 doctors that have had more than 4, would you have canceled them?

MS. LAWHORNE: We probably did terminate some of them. They're not all with us now.

REPRESENTATIVE PRESSMANN: Okay. All right. If you terminate them, they can go into some kind of joint underwriting?

MS. LAWHORNE: They can.

REPRESENTATIVE PRESSMANN: Are you a member of that joint underwriting? Do you have to be a member of that?

MS. LAWHORNE: No, the JUA was set up by Act 111, and it is financed on a premium basis. It has a safety mechanism so the doctors pay for it like just like they pay for any other insurance, but there's a safety mechanism in that should the JUA actually suffer a deficit, it could tap the Cat Fund, which is doctors' money, which was something else that Mr. Matusow kept talking about, this quasi-State agency. Well, just remember that it's not paid with any quasi-State dollars. It's all doctor and hospital dollars that finance that, and the same is true of the JUA.

REPRESENTATIVE PRESSMANN: Okay, the JUA, though, I think in auto insurance what they do under--

MS. LAWHORNE: You have the fare plan.

REPRESENTATIVE PRESSMANN: Yeah.

MS. LAWHORNE: Yeah, that's different.

REPRESENTATIVE PRESSMANN: You don't do that?

MS. LAWHORNE: No.

DR. COTTLE: No.

REPRESENTATIVE PRESSMANN: Okay.

MS. LAWHORNE: They also have gone to other carriers which might not be as selective. We are not the last resort.

REPRESENTATIVE PRESSMANN: So your insurance is, all right, say I'm a doctor, neurosurgeon, and I've been one for 10 years and I've never had a claim against me. You'd want to insure me, right?

MS. LAWHORNE: Sure.

DR. COTTLE: Sure.

REPRESENTATIVE PRESSMANN: And you would, right?

MS. LAWHORNE: Um-hum.

REPRESENTATIVE PRESSMANN: Okay. So it's not the kind of thing where I'm a neurosurgeon with two claims against me and my private carrier is getting a

little shaky about me because I've got a couple of claims now. I wouldn't go to you because they are no longer interested in me, though I might?

MS. LAWHORNE: We might think that those two claims were perfectly acceptable experience for the neurosurgeon and we might be very willing to write them. They might go to another competitor who would also be willing to write them, or they might go to the JUA.

REPRESENTATIVE PRESSMANN: How often does your PMS board override your insurance board?

MS. LAWHORNE: You mean the appeal process?

REPRESENTATIVE PRESSMANN: Right.

MS. LAWHORNE: About 50 percent of the time, more or less. Recently, we have been prevailing more often than we used to, but I think that is because we have been able to more closely predict what the Medical Society might think about something and try to find different ways of handling the issue. And also, frankly, we have had doctors who have been confronted with a surcharge who have left us for not the JUA but for other competition so that the appeals haven't gone, the tough appeals haven't necessarily gone. But as an overall figure, probably about 50 percent. It's not a rubber stamp.

REPRESENTATIVE PRESSMANN: How many doctors do you refuse or do you kick out?

MS. LAWHORNE: Non-renew for coverage?

MR. SMARR: In all of our experience, there have not been many. I'm guessing maybe 300, 400. That's a high guess, probably.

DR. COTTLE: That's over the 11 1/2 years.

REPRESENTATIVE PRESSMANN: And out of the 14,000 individuals?

DR. COTTLE: Yes.

REPRESENTATIVE PRESSMANN: Okay. Thank you.

CHAIRMAN CALTAGIRONE: Chris.

REPRESENTATIVE McNALLY: Yes. I wanted to ask sort of the -- follow the line of questioning that the chief counsel was asking. As I understand it, PMSLIC categorizes claims as meritorious or non-meritorious , and that of the meritorious claims, they represent something like 37 percent of all the claims. I think it's on page 15 of your report.

MS. LAWHORNE: It's hard to do. Just as was mentioned earlier, it's hard to say meritorious, non-meritorious, because we have not paid on some claims that we would have been prepared to pay on but the plaintiff was demanding too much, we've gone to trial, and then we've won. Now, we might have thought that was a meritorious case. So I would like to stay away from that, but there are some--

REPRESENTATIVE McNALLY: Well, I mean, it's your terminology.

MS. LAWHORNE: Well, we have to use it for shorthand, but since it came up at the earlier testimony, I wanted to just clarity it.

REPRESENTATIVE PRESSMANN: Let me just jump in for a second. Would you also be -- you might decide to pay something because you just look at it from a legal point of view and you say, if I take this in front of a jury, I'm going to lose, even though I think I'm right?

MS. LAWHORNE: We try to resist that because we don't want to do that, we don't want to give in to that system.

REPRESENTATIVE PRESSMANN: I understand.

MS. LAWHORNE: When there is a negligence circumstance where the insured is, for example, terribly troubled or something, yes, we can't say we've never done it, but we've resisted. We have held the hand, as we call it, of doctors who have not wanted to go to trial. We have sent doctors down, board members, to sit with them through the trial to encourage them through the process.

REPRESENTATIVE PRESSMANN: Have you ever decided not to try a case because your doctor client was so obnoxious that you knew the jury would want to take him outside and kill him?

MS. LAWHORNE: Probably should have.

REPRESENTATIVE PRESSMANN: You don't have to answer that.

DR. COTTLE: Thank you.

REPRESENTATIVE McNALLY: Well, in any event, I take it from the meritorious cases, as you call them, 92 percent roughly are settled and paid and that 8 percent are tried and paid. Now, of the 63 percent that you classify as non-meritorious cases, and incidentally, your report says that those non-meritorious cases cost a grand total of $20.4 million, what proportion of these non-meritorious cases actually go to trial?

MR. SMARR: What percent of the 63 percent actually go to trial?

REPRESENTATIVE McNALLY: Yes, approximate.

MS. LAWHORNE: Well, that would be 82 percent of 8 percent of our claims. We win 82 percent of our trials, we try 8 percent. Does that answer it?

REPRESENTATIVE McNALLY: So that would be about 6 percent, I guess.

MS. LAWHORNE: I'm not good at -- unlike my peers, I can't do that in my head.

REPRESENTATIVE PRESSMANN: That's why you became a lawyer, right?

MS. LAWHORNE: Yeah.

REPRESENTATIVE McNALLY: Hold on a second. I understand what I'm talking about, maybe you don't understand your terminology. Non-meritorious cases includes verdicts for the defendant, it includes claims that begin and were discontinued and the plaintiff didn't want to continue with them.

MS. LAWHORNE: Right. Right.

REPRESENTATIVE McNALLY: You know, anything where there was an initiation of a claim and there was no money paid out. That's a non-meritorious case.

MS. LAWHORNE: Right. Right.

REPRESENTATIVE McNALLY: Okay. Now, what proportion of the non-meritorious cases went to trial?

MR. SMARR: Very few. I'd have to calculate it for you, but in looking at our total experience, we've had 639 claims which were actually closed at trial. Okay. The total number of closed claims is about 5,400, and so I will be glad to calculate that statistic for you, but the number is going to be a small number.

REPRESENTATIVE McNALLY: Okay, so it sounds like we're talking about 5,000, 4,500 to 5,000 claims that have been closed and never went to trial?

MR. SMARR: Yes. Most claims just don't go to trial.

REPRESENTATIVE McNALLY: All right, so

basically what we're talking about, you know, as I understand it, you think there's too many medical negligence claims, and apparently you're not concerned with the meritorious cases in which you've paid money. 92 percent of those claims you paid willingly, you settled. You don't have any problem with those.

MS. LAWHORNE: No, I wouldn't say that.

DR. COTTLE: No, no.

MS. LAWHORNE: I think that we have -- quite the opposite. I don't think that this legislation would stop very many of the claims being brought, but I think what we're trying to do is quite the opposite. We have to settle cases, recognizing the way the system works now, we pay a lot more on those cases that are settled than we have to. We also have this thing called bad faith failure to settle, which is another new theory which has its good grounds, but it's important--

REPRESENTATIVE McNALLY: Now, wait a second. The plaintiff is going to lose 82 percent of the claims. I mean, they have an incentive.

MS. LAWHORNE: That's because we settle the cases that have medical merit, because we take a responsible view, we look at it, if we see a medical negligence, we settle it. So we don't want to try it because we think that there is merit to it. So we move as

promptly as possible to settle the case. But we may pay much more than we think that we should.

REPRESENTATIVE McNALLY: Okay, but even by your own admission, the number of cases that are actually tried is something like, you know, out of 5,400 total claims in 11 1/2 years, you have tried something like 400, 500 cases.

MR. SMARR: Yes. Well, that have gone to trial, 639.

REPRESENTATIVE McNALLY: 639. Okay, that means that there's 4,800 cases at I think you said $4,000 to $5,000 a piece was the costs associated with those cases that don't go to trial.

MS. LAWHORNE: If there's no payment.

DR. COTTLE: If there's no payment.

REPRESENTATIVE HECKLER: That's legal cost. That's not settlement costs.

DR. COTTLE: Those are legal costs. If there is no payment.

MS. LAWHORNE: That's when there's no payment made.

REPRESENTATIVE McNALLY: I understand that. I understand that.

MS. LAWHORNE: Okay.

REPRESENTATIVE McNALLY: You know, what

you're telling me is, first of all, I don't see why we should change law, change the law of tort to take away the meritorious cases. You know, the meritorious cases are, by your definition, meritorious.

MS. LAWHORNE: We agree.

DR. COTTLE: We agree.

MR. SMARR: We agree.

REPRESENTATIVE McNALLY: Okay. Now, that means that the lion's share, the vast majority of your expenditures come from non-meritorious cases, the vast majority of which never go to trial.

DR. COTTLE: No.

MS. LAWHORNE: No.

REPRESENTATIVE McNALLY: So changing the tort system is not going to--

MS. LAWHORNE: We're not making our statistics clear to you. We're obviously failing in that.

We have a huge population of claims. Over the majority, 63 percent will at some point be closed with no payment to the complaining patient, which means that 40-some percent there will be payments on. So objection number one is that of all those ones, and some of them may be dismissed with almost nothing done within months or a year. It might have just been filed, they look into it, there's nothing, this costs us nothing. Others can go

through trial and not be paid. The ones that go through trial can cost a lot of money. So one concern we have is trying to at least, of those suits on which there's no payment, some of them are frivolous, some of them should never have been brought. For whatever reason, and I think that most of you who have experience in trial courts know that judges don't really like to throw cases out at the early stages, so they don't get thrown out, despite the fact that we have preliminary objections available to us and we have to go along and do a lot of money expense. So that's one concern that we have.

The other concern is that on the other 40 percent of the cases, although we agree that if something should go, and the Medical Society thinks that something should go, the patient should be compensated when there's an injury, what we are concerned about is two-fold. One is that there is over -- it's not even compensation; and the other is that it takes much too long to get through the process. The bulk of our dollars are spent on indemnity payments. Indemnity payments are a much larger part of our payout than our adjustment expenses.

REPRESENTATIVE McNALLY: So you just think that plaintiffs get too much money?

MS. LAWHORNE: I don't think the plaintiffs do necessarily, but I think that plaintiffs sometimes get

duplicate recoveries and the system gets too much money.

REPRESENTATIVE McNALLY: Well, as for the collateral source rule, you know, I'll tell you, my own experience is that the Blue Cross/Blue Shield letters come regularly and they notify you if there's subrogation rights. You know, I believe that the earlier testimony that 10 to 20 percent is a duplication of payments, I think that's a rather large estimate myself. But, you know, we're not arguing about the meritorious cases. It seems to me that the debate is on how do we cut down the non-meritorious cases, because that's where the expenses lie. And by your own admission, the number of non-meritorious cases that actually are litigated, you know, are rather insignificant. The vast majority of non-meritorious cases simply, you know, as you say, someone files a complaint and never pursues it any further, you know, it's not, you know, that's where the bulk of your caseload is.

MS. LAWHORNE: Well, I don't think it is accurate to say that we are concerned about just the non-meritorious cases. I think that what we're trying to make clearer to you is that the bulk of our dollars are spent on cases which we, through our own peer review, think are meritorious, and we are very concerned about that because we think that there is overpayment and we think that we

are pressured to overpay.

We are also concerned about non-meritorious cases because we think a lot of them should never have been brought and create an unnecessary expense. But I don't think that it would be fair to say that we are concerned about one or the other. We are concerned about both.

REPRESENTATIVE McNALLY: Well, you know, I'm just, you know, having a very difficult time being persuaded that somehow plaintiffs who you agree have merit to their claim are getting too much money. Especially when you settle 92 percent of them. Of the cases you pay, you settle 92 percent. It seems to me that you are satisfied with the amount of money that's being paid on a claim, so, you know, why should we have a problem with it? And of the 8 percent that are litigated and result in a plaintiff's verdict, you know, I find it hard to believe there that, you know, managing that 8 percent is going to result in some significant savings. If you have any kind of argument, I think that your argument is that there's too many non-meritorious cases, and there again, it strikes me that your own testimony is that most of the non-meritorious cases never are litigated.

REPRESENTATIVE BORTNER: Thank you.

I'd like to return to a couple of the

substantive issues, particularly talking about three of the ones that you referred to, and I don't really care who answers.

And I would initially state what Representative McNally stated. In my experience, Blue Cross/Blue Shield insurance companies exercise their right of subrogation. They write to you as a lawyer, they tell you to defend their rights, and I think that happens in most cases. I think it's very rare that it doesn't. In fact, I was surprised to hear that there were any companies that that wasn't part of their policy.

MS. LAWHORNE: As I say, it wasn't in our experience, and that's why I was very careful to say please verify it. But it was a surprise to us.

REPRESENTATIVE BORTNER: Right. I understand that.

Secondly, you listed as number one, I think, the actual trial procedures.

MS. LAWHORNE: That was just me.

REPRESENTATIVE BORTNER: I understand that. And I think part of your statement was that, you know, you felt that frankly that helped everybody.

MS. LAWHORNE: Um-hum.

REPRESENTATIVE BORTNER: It seems to me that helps everybody but the people who are trying to try or

have a problem solved that doesn't involve a medical malpractice claim, and I guess I don't understand or would ask you, how you can justify giving a medical malpractice case priority over everybody else that's trying to get their case heard in court?

MS. LAWHORNE: Well, I guess that the thought there was that by creating a lot of pretrial activity, the balancing was that a lot of the other cases would be going through while this pretrial activity which was being overseen with its timeframes and whatever else would be getting ready to trial. I think that the things that I focus on more than the early placement on trial, once it's finally ready, are the speed-up of the entire investigation because as we just finished discussing, most of our cases are not tried, in any event. So I think that all those other provisions are going to apply to a majority of our cases and we can get to know what the expert theory is, we can get to know -- and we can have to say whether or not we have any reason to rebut it. And I think we could just move the thing along much more efficiently and get to that huge bulk of cases which are settled much more quickly.

REPRESENTATIVE BORTNER: But do you see some basis for somebody who might suggest what the result is or what we're creating is two different systems, one for

doctors and one for everybody else to have their cases litigated in court?

MS. LAWHORNE: Frankly, my response to that would be that I think that all cases should be speeded up.

REPRESENTATIVE BORTNER: No problem with that.

MS. LAWHORNE: And if you have all the pretrial stuff done efficiently and promptly, most cases are settled in every field, you would have probably less cases going to court.

REPRESENTATIVE BORTNER: I'm not going to quarrel with that issue. I mean, this provides a separate set of trial procedures for medical malpractice cases and medical malpractice cases alone.

MS. LAWHORNE: We have separate insurance procedures, we have separate sort of everything. We have our own little law, and I don't want to be persuaded not to try to improve it because it hasn't been done on a general basis.

REPRESENTATIVE BORTNER: Okay. I've asked you for an explanation or justification, and you've provided it.

Again, and I don't care who answers this, your question about or you focussed also on the statute of limitations, and of course, you know, the statute of

limitations bars claims, period. You know, it doesn't matter whether it has merit or not, that's it. Are you bothered at all by the fact that a 12- or 13-year-old child could be barred from pursuing a claim in court or being reimbursed for damages, never having had an opportunity to bring a case?

MS. LAWHORNE: No, because I think that most 12- or 13-year-old children have responsible adults who are providing for them, caring for them, providing their education, responsible for them under the law and that they have an obligation, just as they have an obligation to feed their child or educate their child, to take care of a child's injuries, and I think that most times that's probably what, in fact, happens.

REPRESENTATIVE BORTNER: Well, I won't argue that with you. I guess I've sat in on too many -- I also sit on the Youth and Aging Committee and I've sat and listened to too many hearings on child abuse and neglect, but I'm concerned about the fact that, you know, we're departing from what I thought was a rather well-established principle of law. And to be very honest with you, I don't think -- that probably offends me more about this bill than any other provision. So I would only say that as one person, I do have a problem with that.

I also ask you about delay damages, because

I noticed in your testimony you specifically pointed to that, and again, I don't really care who answers the question, but what is unfair about a rule that says that, you know, after a year, if you haven't made an offer to settle a case and there is then an award or you haven't made an offer that's within 125 percent of the eventual award, that there shouldn't be some interest tacked onto that, which is about what delay damages are?

MS. LAWHORNE: Well, I think there are a couple of problems with it. One is that one of the reasons we have all that pretrial language in there is that where the cases are really bad, the Greater Philadelphia area, a year isn't enough time to get preliminary investigation completed. So we feel we're being penalized where we don't even have time to complete the investigation. Sometimes, our defense lawyers aren't active enough in pursuing and sometimes plaintiff lawyers aren't real forthcoming. That's one problem.

REPRESENTATIVE BORTNER: So then one of your objections would be that a year is not--

MS. LAWHORNE: The year is not enough.

REPRESENTATIVE BORTNER: That it's too short.

MS. LAWHORNE: That's right.

REPRESENTATIVE BORTNER: All right.

MS. LAWHORNE: Another problem that I have is, I mean, I don't think we have very much of a problem with it. In fact, there's a philosophical problem. I don't know why defendants have to pay for their right to a day in court, which is what I think happens here. Until there is a verdict, you can't say the defendant had the plaintiff's money, which is the argument I hear. Until there's a verdict, the defendant thinks the defendant has his money and the plaintiff thinks that he wants it. And then it's resolved by the trial.

REPRESENTATIVE BORTNER: And that is a philosophical question.

MS. LAWHORNE: Right.

REPRESENTATIVE BORTNER: Somebody would argue that, you know, the cause of action accrues when the injury is caused.

MS. LAWHORNE: Um-hum.

REPRESENTATIVE BORTNER: But you can also, I think, make the argument that until a court of law decides who's responsible, that, you know, that's all you do have in fact prior to that time, a cause of action. So you'd also say there's the time and also the philosophical question about when that actually becomes the plaintiff's money.

MS. LAWHORNE: Well, because that's what I

hear as a basis for it. Why shouldn't the insurance company pay back the money that they've kept wrongfully from the plaintiff? That's one of the arguments I've heard as for the rule.

And the third concern I have is that when we have the really big case, remembering that we don't try that many, and it's going to trial and we strongly, firmly believe that we're right, we want the case to go to trial but we're in Philadelphia and we just aren't going. I think that all of the time that is not -- if you want to blame us for delaying, if that rings true to you as legislators or to the Supreme Court, blame us for our delay, but please don't blame us for the fact that our court system doesn't work efficiently in an awful lot of counties. That is no more our fault and in fact frequently, despite the impression that insurers want to delay, we don't, and I don't know of many malpractice carriers that benefit much by delaying, because verdicts get bigger the longer you wait.

REPRESENTATIVE BORTNER: I suppose that's true. The other argument would be is that that is money that presumably you keep and is invested and continues getting interest.

MS. LAWHORNE: And with the rate that they have us paying back on, it certainly achieves a punitive

effect.

REPRESENTATIVE BORTNER: One last thing, I think. Well, I had some other questions. One last thing.

In part of your testimony, you seem to really focus on the contingency fees, and I guess would seem to have, on page 2, that seems, at least sort of to me, seems to stand out as an objection to the way the system works, and I think that's probably true of a lot of doctors. I never really understood that.

MS. LAWHORNE: On page 2?

DR. COTTLE: On page 2. Here.

REPRESENTATIVE BORTNER: "55 percent of the doctors," paragraph.

MS. LAWHORNE: Oh, okay. I'm sorry.

REPRESENTATIVE BORTNER: Maybe you'd just like to comment on that some more. You think that is an unfair or a part of the system that creates bigger verdicts?

DR. COTTLE: I feel it does. I definitely do. And it seems reasonable. If I was an attorney, I would certainly want to capitalize on it, to make more money. I don't see what there is really to say about it. The thing is sort of self-evident. This is the way it is, that 55 percent of the dollar goes to pay for deciding how the rest is going to be distributed.

MR. ANDRING: Whose attorneys, yours or the plaintiff's attorneys?

MS. LAWHORNE: We say ourselves.

REPRESENTATIVE BORTNER: The point is, what you are saying is that if you add up what goes to a plaintiff's attorney, assuming that the contingency's a third, and the fixed fees of whatever rate you pay your attorneys and add that all together--

DR. COTTLE: But this is all the attorneys. I'm not just talking about plaintiff's bar, I'm talking about but defense attorneys as well. It's a big expense for the insurance company.

MS. LAWHORNE: And other costs to the system also.

DR. COTTLE: I don't think that's a very efficient system.

REPRESENTATIVE BORTNER: Well, I guess the only thing I would say to you is--

DR. COTTLE: It's not cost-effective.

REPRESENTATIVE BORTNER: I don't know of another way for a plaintiff to bring a case to court without the contingency fee system. I mean, presumably, when you lose a case, you pay your lawyers anyway. You know, that's not true of a plaintiffs case. And judging from the statistics that you're citing to Representative

McNally, it sounds to me like some plaintiff's cases are doing a good bit of free work in the medical malpractice area.

MS. LAWHORNE: And I think the Medical Society, by not including that in their proposed legislation, I don't know that they agree, I would never say that with you, but they have chosen not to include that in House Bill 1105.

REPRESENTATIVE BORTNER: Yeah, I think that has appeared in some previous legislation.

MS. LAWHORNE: Well, it was in Act 111.

REPRESENTATIVE BORTNER: Okay, thank you very much. I don't want to delay this any longer.

REPRESENTATIVE HECKLER: At the risk of overstaying the committee's patience, I want to thank you first of all for, I think, some of the clearest and obviously most straightforward testimony we've heard today.

As Representative Hayden pointed out to you earlier, you represent a somewhat unique resource to this legislature in that you are a captive insurance company, if you will. It is more difficult for those who oppose tort reform to ascribe to you the various malign purposes of making big dollars and hiding them in various places. And in that regard, I would also urge that you take a look

at the disclosure bill that he referred to, and I say that because I have certainly been told by other insurance companies that may or may not be properly motivated that it requires disclosure of information in ways in which the insurance industry does not structure their information so that it will be burdensome and difficult to comply with, and in many cases not useful. I have no idea whether that's entirely true or not, but it may be that in looking at that bill, if nothing else, you can give us some objective view and possibly some way of resolving the issue of, you know, is this information necessary? Are there ways to extract it that aren't unduly burdensome?

Because unfortunately, I think today has been an excellent hearing from all sides because we're getting some dialogue, and unfortunately, bills can pass through at least one house of the legislature and then be stonewalled in the other and in either case, is there any dialogue about well, actually, if you changed it this way it would make some sense. So I would urge that you do that. I think that would be very helpful to us.

I'm a little troubled by that we will leave your testimony with the idea that you can pick up a file and say, this is a meritorious claim, this is not a meritorious claim. Is it fair to say that your evaluation and determination of what is and isn't meritorious is, to

some degree at least, based on your experiences in court with other claims and your assessment of the judicial process, of what it's going to make of a particular case?

DR. COTTLE: The decision is made by physicians, most of whom have not been in court. They look at it strictly from a medical point of view. The Claims Committee sits there every month and goes over the claims, and I will tell you that the physicians that are on that committee, most of whom have not been in court at all and really don't have a very good idea of the judicial process. I have to tell you, sometimes the defense attorneys get gray hairs because of what we do, but really, they're looked at from a medical point of view. And the outcome is looked at from a medical point of view,

REPRESENTATIVE HECKLER: Well, good for you. I can't even put words in your mouth. It only adds to the credibility of your testimony. I think all the other points really -- I'm sorry, one thing I did want to get into was touched on. Territorial rating. You do rate by territory as well as specialty?

DR. COTTLE: Um-hum.

REPRESENTATIVE HECKLER: What kind of -- we all have been thoroughly impressed in the course of the auto insurance debate as to what a dreadful place Philadelphia is and how if we could cut them lose from the

rest of the Commonwealth, we would.

REPRESENTATIVE McNALLY: It's because they're so close to Bucks.

REPRESENTATIVE HECKLER: Actually, Bucks and Philadelphia are both going to join Vermont, but that's another subject.

Can you share with us any kinds of percentages, and again, this might be something you want to supplement your with figures later as to how far, if I'm a neurosurgeon practicing in Philadelphia, am I going to pay 50 times as much as one practicing in Erie or in Johnstown?

MR. SMARR: Twice as much.

REPRESENTATIVE HECKLER: Well, that's at least a little bit better than auto insurance. Now, if I have to insure my automobile, and I resist at saying BMW, that presents an even worse problem.

Thank you. That's all I have, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Thank you very much for your testimony.

DR. COTTLE: Thank you.

CHAIRMAN CALTAGIRONE: Miss Barbara DeVane.

MS. DeVANE: Good afternoon. My name is Barbara DeVane, and I am the Executive Director of Lawyers for Consumer Rights, and I'd like to thank Chairman

Caltagirone for allowing me to come here today and I would like to congratulate all of you who have stayed to the end.

At the beginning of the day, Representative Chadwick said he was not a doctor to one of the questions, and I would like to make it perfectly clear, I am not a lawyer, so I brought along William Archibald, who is a member of ours at LCR and is a practicing attorney in Delaware County, and I thank him for coming.

Also earlier in the day the statement was made that the only ones opposing House Bill 1105 are those who make contingency fees. I guess he means the trial bar and that sort of thing, and I'm here to put that at rest. When I came to this State in 1986, and that was the formation of LCR's year, it was sort of like all the world against the trial attorneys or the doctors against the trial attorneys, and my job has been to show that a lot of that world is against tort reform, and that's just -- I wanted the make that statement and I can prove that to you today through a poll that we commissioned earlier in the year.

We were established in the spring of '86 by approximately 250 trial lawyers in the State of Pennsylvania with a goal of preserving the civil justice system in Pennsylvania. And I might add, we are now up to

316 members contributing members, and it's strictly voluntary contributions that they make. LCR directs its efforts towards the education of the public, media, political and community leaders, public officials and voters regarding the dangers of limiting individual rights. The thrust of LCR's efforts has been to stop all tort reform legislation that would limit individual rights and allow wrongdoers to escape their responsibility to their victims.

Lawyers for Consumer Rights is here today to oppose House Bill 1105 which would limit the rights of individuals but does not address the cause of the medical malpractice crisis. The medical malpractice crisis has one underlying cause, medical malpractice itself. The vast majority of Pennsylvania's doctors are caring and competent people, but the health care system has failed on both the supply and demand side of the issue.

On the supply side, the system has failed to remove incompetent and negligent doctors from the profession. From the demand are consumer's point of view. The system has not provided the consumer with adequate information on the past performance of doctors, upon which reasoned decisions could be based. The lack of self-imposed doctor discipline has allowed a small group of incompetent and negligent physicians to continue

practicing at the expense of the rest of the medical community and certainly at the expense of their victims.

The lack of a professional discipline is found in both the attitudes of the voting public and the findings of nonpartisan researchers. In a poll commissioned by LCR in May 1989, 701 randomly chosen voters in Pennsylvania were asked to respond to the following question: Do you think the medical profession does a good job of disciplining those doctors who commit malpractice or do you think the medical profession is reluctant to crack down on bad doctors? Those answering good job, 19 percent; reluctant to crack down, 68 percent; don't know, 14 percent.

In their 1985 study of medical malpractice in Pennsylvania, Alfred E. Hofflander, Ph.D. and Blain F. Nye, Ph.D. found that an analysis of multiple malpractice offenders, i.e. physicians with more than one claim against them by specialty, reveals that 228 physicians, or 1 percent of all physicians that pay Cat Fund surcharge premiums, are responsible for over 25 percent of all Cat Fund loss payments, actual and expected, on claims reported to the Cat Fund since its inception.

It is time to address the cause of the problem rather than its symptoms. LCR believes that strong doctor discipline would address the supply side

problem by removing from the profession those physicians that repeatedly harmed their patients. The true problem of malpractice would have been addressed and therefore the symptom of high insurance rates would have also been addressed. This projection was borne out by the experience of Massachusetts where in 1986 a strong doctor discipline bill was passed. Similar legislation should be given the careful consideration of this committee prior to limiting the rights of victims. This approach to the supply side of the issue has a comparable consumer's, or the demand side, approach.

Presently, consumers of medical services must make their decision as to a physician in an atmosphere that is characterized by a conspiracy of silence. The citizens of Pennsylvania need to know who the doctors are that are repeat medical malpractice offenders. Christopher Farrell, writing in the August 3, 1987 issue of Business Week, argues that the free market should end medical malpractice warfare. Farrell states, and I quote, "The market can work only with adequate information. Yet, despite numerous studies by blue chip panels, the dearth of reliable information is shocking. For too long, anecdotes and political power, not facts, have guided policy. Instead, the Federal government could use its unmatched ability to gather information nationwide

to create a Federal malpractice data bank and make it available to the public." And I believe there was a bill that passed Congress that did this. The only problem was, it doesn't make that data available to the public, and we should amend that and correct that. "The information could include actions taken against incompetent doctors and the details of malpractice suits. It shouldn't be limited to doctors however. It could also list lawyers who file frivolous claims, or those, for instance, caught bribing a nurse to keep an eye out for potential malpractice cases. Moreover, it could include data on insurance premiums and claims. Collecting good data is only a start. Using the data comes next. Corporate consumers of health care, the insurance industry, government, and finally, individual consumers, could all use the data bank to make informed health care decisions. For example, insurance companies, armed with reliable statistics, could set more realistic premiums," end of quote.

The consumers of this Commonwealth have a right to know which physicians have a record of incompetence and negligence. Given this information, the citizens of Pennsylvania will reduce medical malpractice by their only health care decisions. Before rights are taken away from the voters of Pennsylvania, they should be

given the information they need to make a reasoned decision. I would encourage this committee to pass legislation that would collect this type of information and make it available to the general public. Both of these measures would address the true cause of the medical malpractice problem in Pennsylvania, malpractice itself. But there are measures that can be taken to address the symptom of malpractice, high insurance rates.

The issue of medical malpractice insurance reform was addressed in great length in the 1985 Hofflander and Nye study cited above, and I would be glad to provide you with a copy of this study. In fact, Hofflander and Nye found that medical malpractice insurance rates had risen at a rate entirely compatible with growth of the general medical care index. These findings should be considered in light of a September 7, 1987 article that appeared in the magazine Medical Economics. Medical Economics stated that while the inflation rate was 1.1 percent in 1986, doctors' net income rose 10 percent, more than 9 times the rate of inflation. In 1986, the median net income of doctors was $112,790, a jump of $10,270 from 1985. During the height of the medical malpractice crisis, '84 to '86, the total increase in the cost of living was 9.14 percent. Contrasted with the total increase of doctors' net

earnings of 24.5 percent. These outrageous increases in net, after insurance expense, income are not representative of a profession being crushed under the weight of a so-called lawsuit crisis. Nor do these justify the establishment of a medical class of limited responsibility at the cost of their victims. House Bill 1105 would create just the situation.

House Bill 1105 seeks to bar an individual's right to bring a legal action, limit resources with which victims can argue their case, and reduce the compensation a victim receives. A provision of House Bill 1105 would bar illegal action by changing the statute of limitations and medical malpractice cases. The qualification of expert witness provisions in this legislation would make it even more difficult to find a doctor who would be willing to testify against another doctor and thereby limit a victim's ability to argue their case.

And Representative Pressmann mentioned this and I wanted to make this remark to Representative Hagarty, and I will provide her with this. I saw that same newsletter when I came to this State in 1986. It was outrageous. I could not believe it. And it was either a local county's branch of the PMS or some section of medicine, I'm not sure which one, some specialty section that has a newsletter, and on the front page it did, and

I'm paraphrasing, but it did say, there was an article that said, there's this problem among our profession. Some of our fellow doctors are testifying against other doctors, and we're setting up a task force to study this problem. I read that and I can provide that to you if you would like it.

Provisions covering informed consent would reduce the information that a doctor is required to give a patient regarding the risk of the procedure. A victim's ability to receive compensation for their losses would be reduced by provisions that address the collateral source rule, structured awards, and the abolition of joint and several liability. The public policy deterrent aspects of punitive damages in cases of medical malpractice would be reduced by requiring evil intent and by capping the amount of damages. House Bill 1105 strips away the rights of innocent victims to bestow immunity on a class of professionals whose profitability continues to grow at a rate nine times greater than the Consumer Price Index. House Bill 1105 treats the symptoms of medical malpractice - victim's claims for compensation. House Bill 1105 does not address medical malpractice insurance reform nor does it address the cause of malpractice. House Bill 1105 does not seek to reduce the incidents of malpractice in Pennsylvania, which is the true cause of the crisis.

I urge this committee to consider measures that would truly reduce malpractice and not just the legal manifestations of this problem. And this is not in my written testimony, but as I was listening all day to other people who testified, I had to take a few notes because, you know, some people talk about we've got to cut down on the costs. Well, there's a good way to cut down on the costs, and a lot of it would come through this bill. Cut out all lawsuits. There would be no costs, but then there would be no justice. And if people in this society want no justice, I would suggest that they can go to another country where they have no civil justice system.

I would also suggest that other speakers have talked about we need all sorts of tort reform in this Commonwealth and they have this Civil Justice Coalition that, yes, the tobacco industry is involved in, and I just find it horrendous that health care providers would be sitting at the same -- in the same coalition with the people who cause damage to our health. You know, the tobacco industry sells us the goods that give us the cancer and then we have to pay for that and then we have to pay to go to the doctor, the hospital, so that they can treat that same cancer or emphysema, as my father is dying of right now and is still addicted to smoking as he draws his last breath.

Also, the previous speaker said the claims are going down without tort reform. If the claims are going down, why do we need tort reform? Why do we need to limit justice, to limit access to the courts, to cut down on compensation, fair and just compensation to the victims of malpractice? And I have -- the same poll that I referred to that talks about doctor discipline, I would be glad to give you all a copy of the poll, every member of this committee. And it says that the public does not want any group in our Commonwealth to have any kind of special immunity or special protection from liability and accountability for their products and for their services.

Do you have anything you would like to say?

MR. ARCHIBALD: I, of course, am here as a practicing attorney. I do a lot of medical malpractice, but I do it in Delaware County. Ours is a general practice law firm, but I am knowledgeable in these areas and without giving you a statement, in the interest of the shortness of life itself in terms of time, I am here to answer any questions that you might have in a number of subjects that have been raised. If you have any questions, I would be glad to address them.

MS. DeVANE: And I would, too, if you have any.

CHAIRMAN CALTAGIRONE: Jack.

REPRESENTATIVE PRESSMANN: Does your organization object to the bill as a whole or parts of the bill, or other parts of the bill, particularly frivolous lawsuits? Do you oppose that section of the bill?

MS. DeVANE: We are against frivolous lawsuits, however, you might want to speak to how that affects you in court. As long as it was evenhanded and as long as it didn't stop somebody from bringing a legitimate case to court, and I'm not sure how that works because I'm not a lawyer.

MR. ARCHIBALD: No one brings frivolous lawsuits in medical malpractice cases. They are exceptionally expensive pieces of litigation. You can't afford to bring frivolous lawsuits after all as has been developed by PMSLIC, they'll ferret out the frivolous lawsuit and stamp it out and you'll go slinking off with a big loss. Someone has already said from your committee members that some lawyers seem to be financing a great deal of litigation at their own personal expense. Well, that's a non-habitforming proposition. You just don't do that.

First of all, they're not motivated by malice. A lawyer isn't going to file a lawsuit for the joy of embarrassing a member of the medical profession, although you may have detected some animus in this room

today. Believe me when I say that a lawyer, we go to doctors, as was said by Representative McNally. I mean, I like my doctor very much and I like the surgeons that have operated on me, and they've even made mistakes and I still like them. You know. And it is only the meritorious case.

In Mr. Matusow's printed material he said that medical malpractice is not a bad result; medical malpractice is neglectful conduct. Well, frivolous lawsuits, sir, Representative Pressmann, are not brought. I mean, I think I can literally say that they're simply not brought.

REPRESENTATIVE PRESSMANN: Well, I think the definition of frivolous is probably maybe what's at question here. I believe the people from PMSLIC said that 60-some percent of their claims are dismissed or whatever, they're never paid, they don't make a payment on them, but it costs them around $4,000 for each of those. And I guess what one of the things that has disturbed me for a long time is that idea that there are attorneys out there who do play a game of, you know, throw a bunch of cases up and hope one you hit some money on it. I mean, that happens.

MR. ARCHIBALD: Well, I can address that. You see, in a case such as PMSLIC is talking about, their

particular insured out of an array of five or six or seven health care providers may indeed have been dismissed. I, within the last two weeks, have dismissed actions in a big death case. This poor woman dies at 41 years old, anesthesia. I sued a lot of people involved in her death with varying degrees of responsibility, and more importantly, culpability. You don't chase every doctor that you can make a technical case against because you're not going to win the case in front of the jury. The doctor is going to be excused, even though he's legally liable. Maybe he's the captain of the ship.

In the case I'm referring to, I didn't even sue the captain of the ship, that is, the attending physician who was doing the hip operation while the woman was having her lungs destroyed. I didn't sue him. I could have made out a case against him, but I didn't. I didn't bring that action. I like to sue culpable doctors. And in the case I'm referring to, I let out these doctors because for one reason or another, they were acting under the aegis of other physicians in the course of this operation so that if they did something wrong, the physician who had charge would still be responsible. Now, that might go in the win column for PMSLIC. They might say, oh, that was a frivolous suit or that was a non-meritorious suit. Maybe that's how they make their

statistics. That's a pretty high statistic, 63 percent.

REPRESENTATIVE PRESSMANN: Well, I think the thing, and I think actually probably you led to one of my problems, is that approach that you just mentioned of suing everybody in sight when an incident happens, and one of the things that brought home to me this issue in a very personal manner, which is anecdotal, which I think also the anecdotal materials also is human experience, which I think law in many ways is nothing but human experience, is my wife's a registered nurse and there was an incident that happened on her floor and the family decided to sue everybody -- well, the lawyer decide to sue everybody in sight, including all the nurses on the floor, including the nurses who weren't attending that patient. They decided to sue everybody on the second shift. My wife was on the first shift. She kept waiting to be sued, but she wasn't. And so we went through that experience together. But the whole idea of naming everybody in sight I find objectionable. I think that's frivolous, and that happens a lot.

MR. ARCHIBALD: I agree with that.

REPRESENTATIVE PRESSMANN: And what my problem is, is this, if PMSLIC, say, represented a doctor who happened to be on the floor in that case at the time who had nothing to do with that patient and they were

named in the suit and it cost PMSLIC money to defend him, if nothing else than that they have to consult with a lawyer, or someone who's paid by the hour, someone has been made unwhole. I mean, somebody has had something taken from them, that the insurance companies had money taken from them because they have had to pay an attorney to consult with this doctor only to have it be dismissed or whatever. I think somebody has to be made whole, and I think right now the system doesn't allow that, or it doesn't do a very good job of making the person whole who has lost something out of it. But, you know, that's where I'm coming from.

MR. ARCHIBALD: Well, don't misunderstand what I said. I didn't sue everybody in sight in the instance I gave you. Those people that I sued deserved to be sued, but I didn't think that I could win the case against them. Things appear in a hospital chart. In two of those instances it said that this particular patient was given glasses of water while she had an endotracheal tube down, and this caused the water all to go down into her right lung. That's what the hospital chart said. When I took the depositions, no one would admit that it happened. I couldn't prove it happened. Even though it said that the patient herself, now dead, said, I was given two glasses of water last night, no one would own up to

it, and I couldn't prove it. And I wanted to get rid of those defendants on the record, but the chart said she got the water, and that definitely was contraindicated, and I definitely had medical testimony that would have said that is medical neglect, and in fact it spoiled her right lung. Since they'd already destroyed her left lung, she was losing her spare and expired, but I couldn't prove it.

So I got them out of there because I, as a lawyer, don't want two extra lawyers in the courtroom biting my ankles when I can't prove a case against them, because then they'll work on the other parts of my case. So that's why I did it. But I didn't sue them frivolously, and I don't sue everyone in sight, and there's no percentage in that because you just pick up a whole bunch of enemies, people who can make the case miserable for you. They let pleadings fall on you like hail. They send out these printed forms of interrogatories, they ask for the deposition, and you're in trouble.

So I don't think it's productive to sue frivolously, and I don't think that people find it profitable to sue everybody in sight. If that is a situation that you've encountered, I share your feelings. People shouldn't be sued for reasons like that. Sometimes you have trouble getting the records. Remember that a

dead patient or a maimed patient, or a patient who's been under anesthesia, they don't have the evidence, and the person that doesn't spring forward to say, I just committed malpractice on your body, is the person that committed malpractice on your body. It isn't the way it works. It's human nature. I'm not challenging their voracity, their truthfulness, their morality, I'm just saying people don't fall all over themselves to take blame. Take the automobile accident fender bender as an example we're all familiar with. Who jumps out of the car and says, oh, my God, I ran that light? You know, they always blame the other guy, or frequently do. It's human nature. But the victim of a medical malpractice incident is not equipped with the facts. They are not given the facts and they fight for the facts and they probably never get all the facts.

REPRESENTATIVE PRESSMANN: The issue of collateral sources, what is your objection to making it available at the time of the trial, what the other sources of compensation or redress in this incident would be?

MR. ARCHIBALD: Well, there is a well-known doctrine in the law that says if I am careful enough to insure myself against an eventuality, why should that redound to the benefit of the wrongdoer if I've taken my funds or 50 percent of my funds to go along with the terms

of the bill and purchase the policy to guard myself with after tax dollars in the unlucky event that someone malpractices upon me? Why should the wrongdoer get the benefit of that?

I don't choose to put medical bills into evidence in every medical malpractice case. I'm now paying subrogation to an entity that I didn't prove the bills in but I still have to pay them back their money. But my objection is it's contrary to accepted law regarding a person's self-insuring, so to speak.

I'll give you an example. If you had two life insurance policies, it would be very unpleasant to have the one company tell your widow, I'm sorry, but you've got double coverage here and you can only recover for one death. I know that sounds facetious, but really, I've always made that analogy in my mind. If you've got two losses, if you've lost the money and the loss is there, why should you be penalized by being cautious? You're worse off than the next person who wasn't cautious. They get the full boat and they haven't lost the premium that they've paid all of their life against the day when somebody hurts them. I mean, that's my general feeling on the collateral source. It's just ingrained in our law.

MS. DeVANE: Or you may have negotiated that for your members, if you're like in a labor union or

something, your employer may be paying the benefits but you negotiate away some of your salary to get that benefit in collective bargaining.

REPRESENTATIVE PRESSMANN: This is a question that I don't know the answer to. Pain and suffering awards, are they insurable?

MR. ARCHIBALD: Well, yes, that's covered -- well, no, I can't get insurance on my own pain and suffering. I beg your pardon.

REPRESENTATIVE PRESSMANN: No, no. I mean the doctor.

MR. ARCHIBALD: The doctor's insurance policy pays for the pain and suffering liability exposure that he would undertake if he committed malpractice on someone.

There's an interesting facet on that. It's sort of an aside, but it's not been mentioned this whole day long so I'll just say to you that the Cat Fund is the deep pockets in this scenario. They are the ones that carry the burden of paying the sums after the first $150,000 or $200,000. The initial $200,000 is the responsibility of PMSLIC and the other carriers, but what happens is those companies don't negotiate settlement if they see that the case is going to near $200,000. Therefore, the delays, although it has been put to you in

a slightly different context, you don't get to negotiate with a company that sees their liability as $150,000 or $175,000 or $125,000 because the worst that can happen to them is that they pay $200,000, and all the while you're going through that five years of time. And while that five years is going on, this victim is losing the value of what they lost in terms of their employability, their earning power. Yes, sir.

REPRESENTATIVE PRESSMANN: All right, now let me get this straight. Say we got a death.

MR. ARCHIBALD: Yes, sir.

REPRESENTATIVE PRESSMANN: And we got malpractice, and somebody comes up with the figure of $1 million?

MR. ARCHIBALD: All right.

REPRESENTATIVE PRESSMANN: All right. $200,000 of that you say approximately would be paid by my insurance carrier?

MR. ARCHIBALD: Yes, sir.

REPRESENTATIVE PRESSMANN: And $800,000 would have to be paid by the Cat Fund?

MR. ARCHIBALD: Right.

REPRESENTATIVE PRESSMANN: If we settle this out of court, all right, without going to a trial and all that, it's not a jury trial, we agree that it should be a

million dollars, who negotiates for the Cat Fund?

MR. ARCHIBALD: What happens is before the Cat Fund will take any interest whatsoever in the claim, the PMSLIC or Med Pro or St. Paul has got to what they call tender their full $200,000. When that happens, then for the first time the Cat Fund familiarizes itself with the file and one of their negotiators comes in to handle it from there on out.

Now, once in a while the Cat Fund will designate the lawyer that represented PMSLIC or Med Pro as their designated hitter, but they will still have a negotiator in the Cat Fund organization. But, you see, these delays don't really burn the Pennsylvania Medical -- they don't get hurt that bad and they don't have bad faith refusal to negotiate settlement in the medical malpractice milieu unless it's something that went off for under $200,000 and you don't have awards given for that. You don't have punitive damages awards. You've already pointed it out, it's a big stick, but they're not awarded. It's a great rarity and I've never had one and there's never been one in my county where punitive damages are awarded in a medical malpractice case.

REPRESENTATIVE PRESSMANN: Thank you, Mr. Chairman.

REPRESENTATIVE BORTNER: One or two things.

I'd like to make one point which follows up on something Representative Pressmann was getting on. I think it's a point you can make better than I could, but concerning who you sue and when you make that decision, and the way you get information in a lawsuit is through the discovery process, and that doesn't become available to you until you've already filed a complaint. So frequently as you go through discovery and take depositions and get records through subpoenas, you learn more about the case.

MR. ARCHIBALD: That's true.

REPRESENTATIVE BORTNER: And I think that may be the point you're trying to make as that happens.

MR. ARCHIBALD: That's 100-percent true. I mean, it is a fact that I find that I may have sued someone that was perfectly innocent without knowing that I had done that, and I have apologized to that physician. In fact, one of them is now my physician that wasn't my physician before. I felt terrible that I had blamed him for an unnecessary operation that subsequently developed he had opposed, and it was a general surgeon that had conducted the unnecessary operation. I found out in the discovery process just by taking his deposition. The physician I'm referring to, I listened to him, I looked at him, I said, this is a truth teller. He's really right. He shouldn't been in this suit, and I dismissed forthwith.

And just a thing on witnesses. This thing about intimidation does happen. I had it happen to me this past week. We called a surgeon we didn't sue to ask him to testify at a deposition. He said, yes, and I'll meet with you. Then he said, who is the lawyer for the defendant physician? We advised that surgeon who it was. Ten minutes later his secretary called back to say he will not meet with you, he will not discuss the case with you. We have written a letter to him advising him that it is our surmise that he made that phone call and was told not to talk to us. We don't know more than that at this time, but it was devastating to us because we didn't sue the surgeon believing that he'd at least come in and tell the truth about what had occurred. We got hurt.

REPRESENTATIVE BORTNER: Two quick questions. What's your experience with -- we've been kicking around this issue of subrogation. The cases you handle, do the insurance companies request subrogation for damages for amounts that they've already paid?

MR. ARCHIBALD: Well, I want to be candid with this committee and tell this committee that in my world, this is not a big deal. I'm just giving you a straight answer. I don't encounter this, and it may be where I am, it may be the kind of insurance that my clients carry. I know that the reference has been made to

Blue Cross and Blue Shield. I am paying a subrogation claim on a case, as I mentioned earlier, but it is not a big deal in my world, the item of subrogation. That's the best answer I can give you.

REPRESENTATIVE BORTNER: Okay. Oh, one last thing. You've talked about awards for punitive damages and not having any. I do understand, I think, part of the concern of doctors and that's not so much that awards are going to be granted but the fact that they have no insurance protection in the event that -- that they have to face the fact that they have no insurance protection for those kind of claims. In your experience, are punitive damages frequently sought?

MR. ARCHIBALD: They are often claimed in a pleading. They are usually abandoned. They are, in my case, I claimed them, I have been asked by the lawyer for the doctor to abandon the claim, I abandon the claim because in getting into the case I see that this is not a case of outrageous conduct. I have one now that I am seeking punitive damages, but it is not productive monetarily because why would we bother to claim against a physician for punitive damages that he doesn't have insurance for when if the claim is worth its salt, the jury is going to make the award on the basis of the facts anyway? Now, just think, suppose you had a jury that

became angry at the doctor, so they said, well, we'll give this plaintiff $50,000 in compensatory damages and $150,000 in punitive damages. What happened? The victim is going to get $50,000. The doctor is married to his wife, their property is in joint names. You just lost $150,000, whereas that same cross jury would have awarded probably the $200,000 as compensatory damages if they weren't confronted with punitive damages.

So there's no percentage in a lawyer putting in a claim for that. Where are we going? There's already $1.2 million in coverage. Why would you mess up a case by asking for punitive damages in front of a jury? It doesn't make sense. And I know of no doctor who has had to pay out of his own pocket sums of money beyond that $1.2 million. Most of them carry umbrella coverage, but if they didn't, I repeat, I know of no doctor who has had to cough up money from his own personal resources beyond the $1 million of Cat Fund coverage and the $200,000 of underlying coverage that he carried himself.

REPRESENTATIVE BORTNER: Thank you.

Mr. Chairman, thank you.

REPRESENTATIVE McNALLY: Perhaps, too, one other item that I think many people are unaware of is that punitive damages, for example, you know, probably doesn't come into play often with physicians but are perhaps the

only item or one of the few items of damages that could be recovered if a defendant declares bankruptcy, for example. And in fact, there are circumstances when limiting punitive damages or eliminating them actually does a disservice to the plaintiff because otherwise they'd collect nothing. I know of cases myself where a defendant, you know, knew that he was going to lose and eventually did lose, then promptly filed for bankruptcy and the only money that could have been recovered was punitive damages awards against him. You know, apparently it's become more and more common for defendants to file bankruptcy in order to avoid having to pay.

MR. ARCHIBALD: Well, there's a percentage of doctors, and we don't know what it is and we didn't learn it in today's testimony, that go naked or bare, as they say. I don't know how many there are, but they would fall into that category and as was mentioned by the general counsel for PMSLIC, an impaired doctor, you know, if you've got a drunk doctor, I mean, let's take a drunk, impaired, you know, drugs, why wouldn't you want to go for punitive damages if you're doing a social stroke?

Now, as far as money is concerned, my statement stands as it was before. You wouldn't go for punitives because you'd want to get the money out of the Cat Fund and the underlying coverage. But if the doctor

was someone such as you are describing who may very well be the same guy that's going naked or bare, sure, you'd go for punitive damages for someone who's intoxicated.

REPRESENTATIVE PRESSMANN: I thought doctors, in order to be licensed, had to have medical malpractice in Pennsylvania. If they're in practice. So the only doctor that would be going naked would be a doctor who is out of practice, who is no longer in practice or is operating illegally?

MR. ARCHIBALD: There have been some gaps. There's a thing called gap coverage when you change from a claims made basis to an occurrence basis, sometimes things happen. There's a monetary consideration--

REPRESENTATIVE PRESSMANN: You mean between insurance or something like that?

MR. ARCHIBALD: Yes.

REPRESENTATIVE PRESSMANN: Okay.

MR. ARCHIBALD: In between the applicable date of two different insurance policies you could be without insurance.

REPRESENTATIVE PRESSMANN: You're not supposed to practice during that time though, right? Is that correct?

MR. ARCHIBALD: No, and let me go further. Doctors who have left the State, this is the long-tailed

discussion, doctors who have left the State and have gone to other States to practice have the opportunity to get gap insurance or long-tail insurance. If they don't get it, you've got doctors who used to be here, maybe the impaired doctors who have left town and gone to practice someplace else who will not have coverage for those claims that come to light and are reported, you know, long after the event occurred, but when it comes to light what that person has done, then they'll get the claim and they won't have coverage. Now, you'll say, well that's a small percentage because they've already left the State, but I've seen it happen.

REPRESENTATIVE PRESSMANN: Okay.

CHAIRMAN CALTAGIRONE: Thank you very much. We appreciate your testimony.

MR. ARCHIBALD: Thank you, Mr. Chairman.

MS. DeVANE: Thank you very much.

MR. ARCHIBALD: Thank you very much.

CHAIRMAN CALTAGIRONE: Andre C. Blanzaco.

DR. BLANZACO: Thank you, Mr. Chairman. Being down on the agenda is like waiting out a lady in labor - you never know when the delivery is going to take place.

My name is Andre Blanzaco, and I'm chairman of the Department of Obstetrics and Gynecology at Chestnut

Hill Hospital in that notorious city of Philadelphia. I am also Assistant Clinical Professor of Obstetrics and Gynecology at the Medical College of Pennsylvania, and although I am a very active member of the Pennsylvania Medical Society and the Philadelphia County Medical Society, I come here today representing myself as an individual practicing the specialty of obstetrics and gynecology. I'm in an active private practice with two partners and I supervise the teaching program of resident physicians in obstetrics and gynecology.

Our specialty is probably the most sued specialty in the country. Our specialty deals in perfection. Every baby we deliver must come out perfect or suspicious eyes focus on the obstetrician. The glut of lawsuits stems from the fact that you have a damaged baby regardless of what you do, and someone wants a reason for it. We do not deny that malpractice does exist nor that medical accidents do occur. All human beings are subject to imperfection. Factors of fatigue, boredom, inattention, haste, misinformation, faulty judgment, and occasionally impairment may lead to an injurious outcome. When the object of one's efforts is a fellow human being, the injury may be grievous, and that is the burden of the physician and society.

We totally support a system which adequately

compensates a person injured in the aforementioned ways. We do, however, strongly differ with the system that becomes a lottery on physician's insurance policies, trying to collect for maloccurrence rather than malpractice, or for no occurrence at all. The mind set in this litigious society of ours today in which greedy persons and greedy plaintiff attorneys try to shoot the moon with seven and eight figure demands must be regulated by the provisions which are included in bill 1105.

Our specialty is faced with a problem of splendidly talented men and women dropping obstetrics from their list of procedures because they are fed up with the present situation. They may find the increasing premium a burden, but even more so, they find that the constant threat of a lawsuit or the time spent defending a frivolous case much too distracting to enjoy a once satisfying specialty of medicine. We work on the average of 80 to 100 hours a week. We face each day no longer with the thoughts of how many patients we can help but rather with how many patients will be potential plaintiffs in a lawsuit. We are practicing more and more defensive medicine, ordering many more tests than are needed, but enough to have available should the records be subpoenaed. This adds to the booming inflation of medical care which both you and we are trying to combat in this State.

The plaintiff attorneys would have you believe that maintaining the present system is necessary to weed out the so-called bad doctors. On the contrary, it is the conscientious, hard working, talented physicians who are being sued for various and sundry reasons. Figures show that 80 percent of all Ob/Gyns have been sued at least once in this country. Approximately 50 percent have been sued multiple times. In my department of 23 physicians who, without bias, are very talented and knowledgeable individuals, not one has been without a lawsuit at the present time. Most lawsuits on malpractice which go to court are successfully defended, but it is the time and the expense involved, and in addition, the increased load on the court calendar.

We physicians have begrudgingly conceded that the price of malpractice insurance is part of the cost of doing business. But who really pays? The patient and the insurance plans of the employers are the ones who absorb the increasing rise in malpractice insurance. Physicians avoid the poorly insured or the uninsured patients and cover themselves with all possible consultations and laboratory tests and conduct expensive searches for the rarest of explanations for the patients' symptoms. With more and more family practitioners and obstetricians giving up delivering babies, patients must

travel farther to receive adequate care, and many patients with high-risk pregnancies get less than needed attention. The cost of medical care is greatly escalated at a time when we all need to contain the costs of medical care.

The training of new physicians in obstetrics is suffering. There is now too much reluctance on the part of physicians to allow residents in training to do too much for fear that it may result in a malpractice suit. As a result, these young physicians, on starting their practice, are not adequately experienced in handling complicated labors, forceps deliveries, and vaginal breech deliveries as we all once were. They rely too heavily on the Cesarean section in order to facilitate a delivery without complication, causing an increased rate of C-sections to over 25 percent, which is a concern to us all. When I was a resident, a rate of 5 percent was accepted. The fear of litigation has had its place in causing the rate of Cesareans to soar, resulting in longer hospital stay, increased morbidity, and more money spent on health care, not even regarding the temporary incapacity of the patient. The art of obstetrics is slowly dying. Physicians are not even attempting to learn anesthesia techniques which would enable their patients to have more comfortable labors and deliveries for fear of exposing themselves to another field where there is a high

rate of litigation.

We need to look to you as the lawmakers of the State to create parity and install common sense in tort law. Eventually, the costs involved will force business to insist that something be done to straighten out this problem. If we wait that long to awaken the public, we will lose more talented individuals and end up providing a below-par medical service in this State. We need reform now not only to eventually lower the costs of malpractice insurance but also to allow the courts to deal with malpractice sensibly and fairly. The so-called bad doctors will be attended to through our increasing involvement in quality insurance and risk management. Too many good doctors are being hurt by the system as it presently stands.

I'm reminded of an incident that happened in a fairly recent suit against me. The patient was a young woman for which I had delivered two children and with whom I had a good doctor/patient relationship. It involved a situation for which I was neither consulted in the office or over the phone, and it was quite a surprise to me when I was served with a complaint. Contrary to what we're told by our attorneys, and because I wondered what I had done, I called the patient on the phone, and her answer was one that I will never forget. "I like you," she said.

"You're a good doctor, but my husband thought it was a way that we could make some money."

On another front, we are finding out through research today that the cause for cerebral palsy is due to a lack of oxygen during the fourth and fifth month of pregnancy and not due to birth trauma, as has been thought in the past. How many physicians who have done their best to manage a pregnancy and delivery have had to be stigmatized by losing a case where an infant developed cerebral palsy and was subsequently paraded in front of a sympathetic jury who was eager to give an award to the plaintiff, regardless of the involvement of the obstetrician?

We need protection against situations like this. We need you, the legislators, to give us this protection. We need to prevent those of our profession who will testify to anything to make an easy fee. We need to have juries know if a patient has been compensated before delivering a windfall verdict. We need to protect the physician with the big pockets who may have had little or nothing to do with a case. We need to be protected against the threats of punitive damages or violations of consumer protection laws in order to intimidate physicians into making settlements, and we must stop the lottery attempts of bringing frivolous suits against physicians.

We need you to see and understand our side of the story.

I thank you for the opportunity, Mr. Chairman, to give testimony before you and your committee, and I hope that you will look favorably on sending the entire House Bill 1105 to the House floor with a positive recommendation.

CHAIRMAN CALTAGIRONE: Questions?

Jack.

REPRESENTATIVE PRESSMANN: Yeah.

BY REPRESENTATIVE PRESSMANN: (Of Dr. Blanzaco)

Q. Doctor, you mentioned that you were the chairman of the Department of Obstetrics and Gynecology at Chestnut Hill Hospital and Clinical Assistant Professor of Obstetrics and Gynecology at the Medical College of Pennsylvania. Have you ever been named in a suit where because you had taught a doctor?

A. No, I haven't.

Q. Okay. I've heard of that happening. I don't know if that was one of those stories.

A. That does happen. That happens in the tertiary institutions quite a bit, the medical schools.

Q. It happens when someone is still there or during the residency?

A. Well, the professor at the university usually gets the brunt of that on his residents or whoever

may be the clinical chief at the time.

Q. Do you practice in private practice as a group with some other--

A. I have two other physicians, yes.

Q. Okay. How many babies do you deliver in a year?

A. 425 a year.

Q. Can you tell me what percent of your gross income is your medical malpractice insurance for your group?

A. For the group?

Q. Yeah. Do you do it as a group or by individuals?

A. Well, we pay each individually, but--

Q. Does the insurer insure you as individuals or as a group?

A. The insurer does each of us individually and we have to cover each other as partners, because we can get cross-sued.

Q. Right.

A. So we have to have that taken into consideration.

Q. Right.

A. $150,000 out of $600,000 gross.

Q. $150,000 out of $600,000?

A. Right.
Q. 25 percent?
A. If that's what it is.
Q. That's a lot. How many times have you been sued?
A. How many times have I received a complaint?
Q. Yeah.
A. I have been in court once.
Q. Okay.
A. I have had at least three other suits that have been dropped by the patient.
Q. That are dropped by the patient without a financial settlement?
A. There is no financial settlement at all. It never even went beyond the complaint stage.
Q. Okay. What happened when you went to court?
A. I won the settlement.
Q. Okay.
REPRESENTATIVE PRESSMANN: Any other questions?
(Whereupon, Representative Wogan assumed the Chair.)
ACTING CHAIRMAN WOGAN: I'll just ask a question.

BY ACTING CHAIRMAN WOGAN: (Of Dr. Blanzaco)

Q. Dr. Blanzaco, I realize that you're here, as you say, for the entire package contained in House Bill 1105, but you're here because of a dissatisfaction within your profession with the current status of Pennsylvania law. If you could point to one element of the law that you would regard to be the biggest problem and that if you had your choice would be changed, what part of Pennsylvania law would that be?

A. That's a little hard to narrow it down to one, Mr. Wogan. I would think in our field, where the awards are huge, if something happens to, if there's a neurological deficit to a baby, I would think that the -- I'm really trying to have a tough one to pick one. But I would guess that the one that would be the best one would be to cover the amount of money over a longer period of time, the payout, rather than one huge lump some.

Q. Talking about the discount factor?

A. Yes.

Q. Okay. And I understand what your specialty is, but is your specialty the specialty that is sued to, I would say, are you sued more than any other specialty? And does that include, say, anesthesiologists?

A. I would think that it would be more than anesthesiologists. I would say that we are up with, and

if not surpassing in total number of suits, the orthopods and the neurosurgeons.

Q. Okay, and so the four specialties we've mentioned are the specialties where the most severe problems exist?

A. The high risk in that area, yes.

Q. Okay.

ACTING CHAIRMAN WOGAN: Thank you, Dr. Blanzaco.

Any other?

BY REPRESENTATIVE McNALLY: (Of Dr. Blanzaco)

Q. Doctor, how long have you practiced medicine?

A. I have been in private practice since 1965.

Q. I take it that when you began the practice of medicine that lawsuits were rather infrequent, or at least compared to the way they are now?

A. They seemed to be at that time, yes.

Q. You know, I guess you would agree that there's too many lawsuits against doctors, generally speaking?

A. I would agree with that.

Q. Well, at what point, in your opinion, during these past 34 years, when did you see the number of lawsuits as too many?

A. I think probably over the last 10 years it's really been very evident that it's gotten out of hand.

Q. So, you know, 10 years ago the number of lawsuits--

A. Ten years ago was about the time when--

Q. It was still pretty reasonable?

A. It was still reasonable, but it was just about starting. I have noticed that as far as the number of times the people in our department have been cited for complaints of one type or the other.

Q. Do we know how many suits there were, negligence suits, in 1979?

A. I would say somewhere around 1977-78, we started noticing a lot more than usual.

Q. Okay, that's all I have.

ACTING CHAIRMAN WOGAN: Thank you, Dr. Blanzaco.

DR. BLANZACO: Thank you, gentlemen.

ACTING CHAIRMAN WOGAN: Is Michael Rooney present?

MR. ROONEY: Thank you.

I realize it's late in the day, so I'll try to make my statement rather brief and not add too much in the way of side comments. I did want to say that I'm very

happy to be here and that the organization I represent, the People's Medical Society, is a national consumer organization. I also want to say that we are a 501(c)3 not-for-profit charitable Pennsylvania corporation, and with that I'll get into the rest of my comments.

I am here today to talk about House Bill 1150, -- 1105, rather, excuse me, and one of the reasons I'm here is because as an organization, we believe in consumerism in the health care field, and our major goal is the empowerment of the consumer, and I would just add this, the consumer is the one who bears all the burden, we pay all the costs, and we suffer all the consequences when things go wrong. And I realize you heard from the lawyers today, you heard from the doctors and the insurance people, but we consumers are the ones who ultimately pay all the bills. We encourage our members to become more active and become advocates for themselves, and we do this by providing materials for them. We also speak out on related issues that might have an ultimate effect upon the health care consumer.

That is why I want to thank you for giving me this opportunity to address you today on the issue of medical malpractice and tort reform. The bill you are considering will indeed have an effect on all health care consumers, and I am sad to say I think a negative effect.

As Yogi Berra said, "This is just like deja vu all over again." I get the distinct impression that we consumers have been down this road before and faced the same issue. The players may change, but the tune stays the same. Once again, we see a special interest group coming before this body seeking exemption from the law. In fact, they wish to be placed above the law, since they claim some special place in our society. I don't know about you, but I've never heard of any other professions who have been granted virtual immunity from legal actions. Why is it that physicians must receive special treatment when they are no different from lawyers, plumbers, and other trades?

The provisions contained in HB 1105 and are certainly not in the public interest and are downright anti-consumer. The major problem with House Bill 1105 is that it fails to address the underlying cause of malpractice suits, and that is physicians who malpractice. In addition, it also fails to recognize that you must deal with two other issues - insurance reform and reasonable tort reform.

HB 1105, just like the allopathic medical community it is designed to protect, treats the symptom and ignores the cause of the problem. I will not refute House Bill 1105 on a line-by-line basis, since that would take too long and would also serve no useful purpose.

Instead, I would like to call your attention to certain sections which clearly demonstrate that this bill is anti-consumer and will not accomplish what was intended.

On page 2, line 17 makes reference to the cost of doing business as a result of increases in the malpractice premiums. Just recently, St. Paul lowered premiums, and other companies as well. According to a survey completed earlier this year and reported in January, it was reported that the cost of malpractice insurance takes about 4.5 percent of a physician's gross practice receipts, and that was from Medical Economics. It was also reported that a wide variation in premiums exist upon specialty, location, and whether or not the practice is unincorporated or a professional corporation. We recognize that the surgical specialties do incur higher premiums. However, for the 1 neurosurgeon in 15 who paid out $100,000, 1 in 13 paid less than $16,000. The median for the nonsurgical specialties was between $5,000 and $6,000 per year. Surgical specialties, about $24,000.

One solution will be to create larger risk pools, thereby spreading the risk over a greater number of specialists. Where in this legislation does it mandate a roll-back in the cost of premiums? What guarantees does the medical community present that if this legislation is passed it will reduce its charges to the public?

On page 7, Article II, Section 202A, proposes a change in the informed consent procedure that would just about render null and void any consumer rights. It abrogates a physician's duty to fully inform his or her patient. It denies the patient the right of freedom of choice, and at worst, it punishes a patient for not knowing what he or she could not be expected to know. This section goes against the growing trend of full disclosure and making the patient a more active partner in selecting medical care services.

Six years ago, the People's Medical Society called for complete and full disclosure of information to the medical consumer. We have been fighting for that ever since and we are winning. In fact, because of our efforts and others, the Joint Commission on the Accreditation of Health Care Organizations is now proposing that standards would be based upon outcomes. This means that a patient consumer would know the chances for success before agreeing to a procedure. There is a movement to more information for the medical consumer, not less. Don't give away the consumer's right to know to benefit a profession that should know better. And by way of comment, I might add that the People's Medical Society is a participant in the Joint Commission's efforts at rewriting its accreditation standards.

Section 203-A on page 8, the collateral source rule, is also an abrogation of patient's rights. It has the chilling effect of punishing the innocent and rewarding the guilty. Why should an injured party need to reveal all their sources of payment when the person would have never filed a claim were it not for the actions of the physician who caused the problem? It's blaming the person for becoming a victim and permits the guilty party to escape paying his or her fair share of the compensation.

The final item I wish to address is section 207-1, statute of limitations. The most unfair provision is subsection (c), dealing with minors. How can a child of 5 know what the physician did when he or she was 1 will affect his or her life at a later date? It's well known that certain conditions don't manifest themselves until the child is older or is entering adolescence.

It is also unreasonable to set a statute of limitations at two years for the remaining population. Very often, a person who has become the victim of malpractice may not know it for at least two years. During this time, they usually seek the assistance of the physician who caused the problem. They do this because most people really don't want to think that their physician, or one who was highly recommended, could do

something wrong. A two-year statute of limitations is the equivalent of granting immunity, and once again permitting a malpracticing physician to continue on his or her way. Do you really want to punish the victim twice while the guilty party is rewarded?

We are not asking for special treatment under the law, just fair treatment, and we ask that you not consider physicians to be above the law. What other profession has been granted such a privilege? We call upon you to reject House Bill 1105 as being totally anti-consumer and incapable of accomplishing what its sponsors claim. If you are serious about addressing this issue, then we ask that you begin anew and address the three issues of malpractice reform by strengthening the medical licensing boards, reform the insurance system in such a way that physicians and other medical providers can purchase liability insurance at reasonable rates, and reform the tort system to make it easier to settle legitimate complaints and discourage frivolous suits.

The People's Medical Society would like to see this issue settled once and for all. We believe it can be resolved if all the parties, especially the physicians, will be responsible and reasonable. And finally, we ask you, where is the constituent support for this measure? Where are the crowds of voters demanding

that their right to a fair hearing be eliminated? Where are the crowds of voters demanding that their access to the court system which is guaranteed by the Constitution be abrogated? Who supports this proposal, other than those with a vested financial interest in the outcome? It's one more case of certain physicians ignoring their oath for a monetary gain.

When you debate this issue, please remember the victims of these malpracticing physicians and then ask yourself, what would you do if you or your spouse or a family member were the victim? Wouldn't you want justice? Wouldn't you want your day in court? Please, don't take that right away from your constituents, the people who elected you. Vote for the people, not the special interest groups.

And I want to thank you for giving me this time. I would also say that we've had a lot of comments on who pays what, wherefore, and how heavy is the burden of malpractice. I have some articles which I have from professional journals that I will send to the chairman that he may share with the rest of the committee members. It talks about the percentages, what the physicians are paying for their insurance. It takes it by practice, on a practice basis. It compares it to the entire cost of doing practice. I also have another article that I will

also send along and it had to do with increased costs by physicians because of fear of malpractice suits. I took it from an article that appeared about two weeks ago in a medical publication, and it clearly indicated that up to 75 percent of all physicians indicated they are ordering additional tests because they do fear a malpractice suit.

(Whereupon, Chairman Caltagirone resumed the Chair.)

CHAIRMAN CALTAGIRONE: If you could leave that information with the stenographer, she'll be able to duplicate that, which will be shared with the committee.

MR. ROONEY: Okay.

CHAIRMAN CALTAGIRONE: Questions?

(No response.)

CHAIRMAN CALTAGIRONE: Thank you very much.

MR. ROONEY: Thank you.

CHAIRMAN CALTAGIRONE: This will now conclude the hearing today on House Bill 1105.

(Whereupon, the proceedings were concluded at 3:50 p.m.)

* * * * *

The following pages are submitted testimony and exhibits entered at the direction of Chairman Caltagirone.

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me during the hearing of the within cause, and that this is a true and correct transcript of the same.

Ann-Marie P. Sweeney

ANN-MARIE P. SWEENEY

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