HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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House Bill 2122

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House Judiciary Committee

Main Capitol Building
Room 8E-A, East Wing
Harrisburg, Pennsylvania

Thursday, March 14, 1996 - 10:35 a.m.

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BEFORE:

Honorable Thomas Gannon, Majority Chairman
Honorable J. Scot Chadwick
Honorable Timothy Hennessey
Honorable Stephen Maitland
Honorable Al Masland
Honorable Robert Reber
Honorable Jere Schuler
Honorable Thomas Caltagirone, Minority Chairman
Honorable Lisa Boscola
Honorable Frank Dermody
Honorable Michael Horsey
Honorable Harold James
Honorable Kathy Manderino

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ALSO PRESENT:

Honorable Nicholas Micozzie

Brian Preski, Esquire
Chief Counsel for Judiciary Committee

Karen Dalton, Esquire
Counsel for Judiciary Committee

James Mann
Majority Legislative Assistant

Judy Sedessee
Administrative Assistant

David L. Krantz
Minority Executive Director

William Andring, Esquire
Minority Counsel for Committee

C O N T E N T S

CHAIRMAN GANNON: I'd like to call to order the House Judiciary Committee meeting for the purpose of holding hearings on House Bill 2122 introduced by Representative Scot Chadwick. I would like to ask Representative Chadwick if he would like to make some opening remarks.

REPRESENTATIVE CHADWICK: Thank you, Mr. Chairman. I will be brief because I know that everyone who's here today did not come here to hear me. They came to hear our witnesses.

Eight years ago the House of Representatives passed a Comprehensive Medical Malpractice Reform Bill. The bill had broad bipartisan support. Republicans and Democrats alike voted for it. It also had the support of the Medical Society and the Trial Bar. Unfortunately, the Trial Bar withdrew that support in the Senate and the bill never became law.

I say unfortunately because, if that bill had become law, we wouldn't be here today. The malpractice insurance crisis facing our physicians would have been averted, and there would be no 68 percent emergency CAT Fund assessment. If we fail to act today, the

situation will continue to get worse.

Does anyone doubt that a CAT Fund assessment that was 10 percent 20 years ago and is 164 percent today will continue to rise? Does anyone doubt that this malpractice crisis is having an impact on the availability and affordability of quality medical care for our citizens?

It's not too late to address this crisis. I want to commend Chairman Gannon for his willingness to hold this hearing on House Bill 2122. I look forward to obtaining a date certain in the near future when the committee will debate and vote on this bill. Again, my thanks to Chairman Gannon for the opportunity to make these brief opening remarks and look forward to proceeding with the hearing. Thank you.

CHAIRMAN GANNON: Thank you, Representative Chadwick. I would now like to call our first witness, Arthur L. Piccone, Esquire, President of the Pennsylvania Bar Association. Mr. Piccone. I believe congratulations are in order for you, Mr. Piccone. I saw in the Law Weekly you were

recognized for some achievement.

MR. PICCONE: Thank you very much, Representative Gannon. Good morning, Chairman Gannon, and members of the House Judiciary Committee: As you know, I'm Arthur Piccone and I'm President of the Pennsylvania Bar Association. I'm delighted to have been invited here this morning to present testimony on House Bill 2122 to this committee.

I also applaud the Chairman and the committee for having this hearing. With me today is Carol Nelson-Shepherd, who chairs the Pennsylvania Bar's Civil Litigation Section, which has worked very hard in formulating our association's position on this piece of legislation.

Our civil lit. section is fortunate to have the talents and expertise of members from both the plaintiff and the defense bar. However, despite historical philosophical and economic differences, both sides of this legal aisle become of one mind in the opposition to this bill.

After intense scrutiny and debate by some of the state's very finest trial and

defense lawyers, we are able not only to reach a consensus on our opposition to the bill itself, but also to stand united in the belief that House Bill 2122 is a dangerous piece of legislation, designed to whittle away the rights of our citizens to seek redress through a judicial system, while providing substantial protection to physicians, hospitals and their insurers that are not afforded to similarly situated tort feasors.

This bill is a significant departure from the time-honored legal principle of fairness on which our system is built, and that which is frequently criticized by self-serving sources. We urge you not to radically change these principles and to not abandon longstanding precedent in order to placate an angry and frightened medical profession.

As lawyers, we took an oath to defend the constitutional rights of citizens. As lawyers, we cannot watch special interest groups run roughshod over the Constitution. As lawyers, we must not allow the little guy to become the innocent victim in a battle being waged by the medical and insurance community

simply because they do not want to be held accountable for wrongdoing. We cannot support legislation that will do little more than establish a caste system in which a few control the many, a system that treats people unfairly and is completely contrary to the principles of the democratic society.

The proponents of House Bill 2122 don't want to talk about constitutional rights; they don't want to talk about patients' rights, and things of this sort. Instead, they want to send up a smoke screen by arguing that the tort system adds dramatic expense to health care. They want you to believe that high insurance premiums and unwarranted litigation has resulted from exorbitant verdicts.

The fact of the matter is that today's civil jury verdicts are not excessive. For example, a July 1995 report from the United States Department of Justice entitled, quote, Civil Jury Cases and Verdicts in Large Counties, end quote, showed that the median total award for plaintiff over a 12-month period was $52,000. That's not exactly a windfall.

Further, a November 1992 study

entitled, quote, The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims, end quote, suggests that unjustified payments to plaintiffs are, in fact, uncommon.

Yet, they neglect to mention that these awards have been awarded by that time-honored American tradition called a jury, composed of fair, honest and hardworking people who believe in the justice system and the citizens it was designed to protect.

A 1990 Harvard Medical study has shown that only 1 out of 8 malpractice victims ever files a claim. An April 1995 Department of Justice report entitled, quote, Tort Cases in Large Counties, end quote, told of a 1992 survey of 75 of the nation's largest counties including Philadelphia. It showed that:

Medical malpractice cases represented only 4.9 percent of all tort cases. It showed that the number of tort cases being filed has been relatively the same since 1986; and it showed that the average amount of time needed to process a medical malpractice case was 26.4 months.

Are these numbers excessive in light of the fact that we are talking about the health care, treatment and lives of our citizens? We think not.

Moreover, I think it's important to note that a substantial portion of litigation today is made up of commercial cases having nothing to do with injury.

The supporters of this bill want to frighten people into believing that if people exercise their constitutional rights and seek redress through a judicial system, the doctors and hospitals will refuse to treat them. They allege that the courts are being tied up by the abusers of the system, the greedy lawyers who use stall tactics and waste taxpayers' money.

Proponents of House Bill 2122 also would have us believe that there is a crisis in the medical malpractice insurance costs too. But, as Pennsylvania's Insurance Commissioner Linda Kaiser has said, our insurance rates are competitive with other states. In fact, we are in the lowest one-third of the states relative to professional liability insurance rates; thus, showing us that the so-called tort reform

enacted in other states has had relatively little effect on lowering insurance costs.

On September 20, 1995, testifying before the Senate Banking and Insurance Committee, CAT Fund Director John Reed alluded to the fact that despite, despite New Jersey's recently enacted legislation intending to limit malpractice awards, that Pennsylvania's insurance rates are significantly lower for virtually every category of the health care provider.

The impetus for this legislation is apparently the recent Catastrophic Loss Fund surcharge. This considerable surcharge is a result of a number of factors, none of which is the current legal system. First, there were artificially low premiums affecting the surcharge, due in part to an existing backlog of cases in Philadelphia. Then the implementation of the quote, Day Backward, end quote, program in Philadelphia which resulted in a large number of cases being suddenly concluded. This, in turn, overtaxed the fund's reserves, which created a shortfall in available dollars for payment; thereby, requiring a surcharge for this

year.

Additionally, in 1984-85 the Hofflander-Nye study found that there's an approximate 10-year cycle of the insurance industry in this area. It is this cycle that has given the perception of a crisis.

Moreover, when you take all of these issues together, one can see that the so-called problem has nothing to do with nor was it caused by an increase in medical malpractice claims or exorbitant verdicts.

We emphatically disagree with the sponsor's assumption that today's so-called crisis was caused by legal principles that have been in effect for decades. In fact, according to figures used in the February 1992 report from the General Accounting Office entitled, quote, Health Care Spending-Nonpolicy Factors Account for Most State Differences, end quote, personal health care spending per capita approximately doubled through the United States from 1982 to 1990, regardless of whether a state had enacted tort reform measures.

Furthermore, the 3 states with percentage increases estimated to be slightly

lower than average (Arkansas, Kentucky, and Mississippi) they had no caps on damages in medical malpractice cases. Conversely, Alabama which had a slighter higher percentage increase had caps on damages. These findings are mirrored by a March 1993 study by the Coalition for Consumer Rights entitled, quote, False Claims: The Relationship Between Medical Malpractice Reform and Health Care Costs, end quote, that state there is no indication that enacting major tort reform is positively correlated with lower health care costs.

This proposed piece of legislation fails to address these and other issues relating to insurance availability and cost. The solution to the perceived problem, if anything other than time, lies not with so-called tort reform, but with the insurance industry and its relationship with the Catastrophe Loss Fund in Pennsylvania.

Separate legislation has been proposed to alter the relationship between the primary insurance carriers and the Catastrophe Loss Fund. This legislation may be a more appropriate vehicle to address cost

considerations for medical negligence insurance instead of House Bill 2122's tinkering with citizens' rights.

This bill in its current form is replete with problems that would undermine the fundamental fairness of our litigation system, a system that currently serves as a deterrent to those who would place others in damage or cause them harm. While I will not attempt to address all of the bill's flaws, I feel compelled to point out problems with the following provisions:

Informed consent. Under present law, before undergoing surgery, a patient is entitled to be advised of any risk or alternatively what a reasonable person would want to know. This doctrine is known as the prudent patient standard, and has been our law for a long time. This bill eliminates this protection, and instead, allows the medical profession to define the standard for what patients should know. A physician would be required to obtain informed consent only prior to a major invasive procedure, except in an emergency situation or where the court would deem appropriate. If this

provision is enacted, let's not fool ourselves and call it informed consent. Rather, I suggest we should call it censored consent.

Punitive damage. Under House Bill 2122, the standard of proof for punitive damage would become clear and convincing. Under this new standard one would have to prove that a defendant acted with evil motive or a high disregard for risk. In addition, House Bill 2122 would limit punitive damages to not more than 200 percent of compensatory damage and require bifurcation of the assessment of punitive damage.

According to that Department of Justice study that I referred to, punitive damages are awarded in only 13 out of 403 medical malpractice cases. Since punitive damages are rarely awarded in medical negligence cases, how can such restrictions be appropriately justified by this bill?

Collateral source. House Bill 2122 would reverse longstanding common law and provide for a deduction of any public or group benefit received or to be received by a claimant unless a premium was paid by the claimant, or

the benefits were from a life insurance policy, a pension or a profit-sharing plan. This could have monumental ramifications on cases involving serious injury. How can it be justified that a deduction should be made for future benefits that might not be received by the claimant?

In certain circumstances this could reduce the amount of the award to little or nothing. Certainly, this was not the intent of our civil litigation system to reward the wrongdoer by lessening what he or she has to pay the victim.

Statute of Limitations. Again, this bill creates an exception for medical negligence claims. The legislation carves out an exception to the minor's tolling statute, which was enacted in Pennsylvania in 1984 and applies to all other personal injury claims. This bill would require, in cases involving minors under the age of 8, that their claims be filed within 4 years after the parent or guardian knew or should have known of the injury, or within 4 years of the minor's 8th birthday, whichever is earlier.

At a time when the legislature of

Pennsylvania is continually attempting to add protection for children, why would anyone want to destroy this protection? You want to protect them in child abuse cases by providing a screen that would safeguard them from being affected mentally or emotionally by testimony. Yet, you would deny those same children the right to recover damages for physical injury. It is inconceivable that you would want that result.

Pretreatment agreement to arbitrate. This legislation, as currently drafted, would allow physicians to require their patients, before treatment, to waive the right to a jury trial, which is one of our fundamental rights as Americans. Instead, the patient would have to agree to arbitrate any future claims arising from treatment. House Bill 2122 would also bind the CAT Fund to such agreements. I cannot overstate the importance of the guarantee of the right to a trial by jury that promotes fairness and equity. This provision blatantly takes away this right from citizens at a time when they are the most vulnerable.

It is surprising that doctors seek not only to establish for themselves a system that

would severely limit a victim's right to redress, but an additional layer of protection by eliminating the basic right of trial by jury that has been a part of this jurisprudence since the Battle of Runnymede.

Frivolous lawsuits. As you know, there's a whirlwind of discussion on this subject in both Pennsylvania and nationally. This bill would require a plaintiff's counsel to certify the existence of a pre-suit written expert report and that a properly qualified expert has concluded, based upon review, that the case has merit. Under the bill, a Federal Rule 11-type sanction could be brought for using a, quote, not qualified, end quote, expert.

In addition, this bill seems to provide that if the plaintiff fails to prove his punitive damage claim, that the court may impose an appropriate sanction upon counsel, which would include a requirement to pay the other party's expenses and attorney's fees.

Defensive medicine. One last point. Throughout these deliberations you may hear claims that physicians must engage in defensive medicine out of fear of suit that drives up the

cost of health care and insurance. Keep in mind that most parties today can't even agree upon that definition of what defensive medicine is, and that a 1994 study conducted by the U.S. Congress, Office of Technology Assessment entitled, quote, Defensive Medicine and Medical Malpractice, end quote, found that only a few clinical situations represent clear cases of wasteful or low-benefit defensive medicine.

Well, I must say, if the physician's concern about liability results in a more conscientious medical care, then defensive medicine is certainly desirable. That is exactly what the system was designed to do.

We're not unmindful and we realize that physicians are upset with many changes in our society, including the managed care atmosphere that has substantially altered the doctor/patient relationship, and fundamentally has transformed the practice of medicine. We also recognize that recent surcharges imposed by the Medical Professional Liability Catastrophic Fund had caused quite a stir, to say the least. Since doctors cannot change the managed care system which has cut their disposable income,

they have turned their frustration to the legal system. Litigation has never reduced the amount of income a doctor can earn. So-called tort reform, more specifically House Bill 2122, should not be used to correct an insurance problem.

Throughout all of your deliberations, I would ask you to recall the words of a noted statesman who observed, I quote, The threat of democracy lies not so much in a revolutionary change, achieved by force of violence. Its greatest danger comes through the gradual invasion of constitutional rights with the acquiescence of an inert people, through failure to discern that a constitutional government cannot survive when the rights guaranteed by the Constitution are not safeguarded even to those citizens with whose political and social views the majority may not agree.

If you believe that increased litigation is causing more lawsuits, more verdicts against doctors, and rising insurance costs, then what the doctors and this legislation are saying is that the medical profession is becoming more negligent in its

treatment of people. Doctors believe they need tort reform to protect themselves. To doctors, tort reform means:

1, reduce my insurance costs; 2, limit the number of lawsuits that can be filed against me; and 3, reduce the amount of money I can be obligated to pay. The net result is a profession, by its own admission, that can only exist by absolving itself of responsibility and accountability; and as a result of that, earn more money for themself. That's not tort reform; that's a government bailout. That's not tort reform; that's a government abdicating its responsibility to protect the rights of its citizens.

In conclusion, may I state again the Pennsylvania Bar Association's strong opposition to any legislation that would deny citizens access to justice and that would carve out a special protection for certain groups at the expense of time-honored legal principles. It is our belief that the so-called problem is one of insurance, and not of the legal system and should be treated as such.

For these reasons I would respectfully

urge you to defeat House Bill 2122. We would stand ready to assist you in any way you feel appropriate, and Carol Nelson and I would be happy to entertain any questions which you might have. I thank you for this opportunity and the fine attention you paid to the remarks.

CHAIRMAN GANNON: Thank you very much, Mr. Piccone. Representative Reber, questions?

REPRESENTATIVE REBER: Just very briefly. I noted with interest your comments on the last page, counsel, relative to, that the real issue is correcting the insurance problem.

I've been in the legislature for 16 years. I guess to some extent recently in the law firm that I'm a member of, we just received a 24 percent rate increase on a worker's compensation scale. I never had a claim in the 24 years I've been there. I've spoken to a lot of attorneys in western Montgomery County and they too have not had a claim filed against them in the last millennium.

It brings to my mind that, to some extent, I question the causal relationship that's always being pegged as the reason why when, in fact, that case and effect isn't really

happening at least on the workers' compensation side. Which brings me again to my inquiry of where you noted that it's a so-called insurance problem.

In a nutshell, though, what is the problem because there's absolutely an escalation in the insurance costs for these physicians as well. I think we have an obligation. I've sat here for 16 years and tried to be somewhat assistive in forging some kind of a negotiated compromise to at least alleviate some of the problem without, and I do agree with you in great part, without usurping many of the rights that you alluded to in your testimony.

What is the insurance problem? Where do we start? Where can this committee start? That seems to me to be the jugular issue that we really have to deal with. And if we're going to be intellectually honest on the issues, I'd like to move in an intellectually honest way to attempt or at least fashion some form of resolution. I am somewhat interested in the capitalized for emphasis purposes on your testimony that it is an insurance problem.

MR. PICCONE: Fair question. Can I

ask Carol Nelson-Shepherd to respond?

REPRESENTATIVE REBER: Sure.

MS. NELSON-SHEPHERD: I think that the perceived problem was escalated by the recent CAT Fund surcharge. However, you have before you some interesting documents that actually belie the increased cost as the motivating factor even behind the legislation. Although I do share your aside which is, that we have all, of course, experienced increases whether it's our car insurance, our homeowner's insurance, our health insurance, or all other lines of insurance.

Interestingly, the insurance companies in Pennsylvania are extremely profitable. It is a very competitive market in Pennsylvania. So, to the extent that the insurance premiums are going up across all lines, that's one reason why we say it's an insurance problem as opposed to a litigation problem because, if the insurance carriers are making a gigantic profit on the backs of their insureds, that's a fundamentally unfair situation that is not going to be remedied by tort reform legislation.

Let me direct your attention to the

documents. The first one starts with the caption, Medical Professional Liability Catastrophe Loss Fund. These 3 documents were attached to the written testimony of John Reed, the Director of the CAT Fund who testified earlier this month. When we talk about whether or not there is even an economic crisis in terms of the cost of insurance with the surcharge, turn please to the last page which is a summary of Medical Professional Liability Catastrophe Loss Fund, actual payments on behalf of 3 different categories of physicians. You will see there, really rather graphically, the proof of the pudding of two things:

Number 1, the validity of the Hofflander-Nye study which was done approximately 10 years ago, and which showed that there is approximately a 10-year cyclical insurance cycle. That's redundant. And number 2, that actually, the 1995 total dollars which were paid between the underlying carriers and the CAT Fund surcharge are actually almost identical to the levels that were paid in 1986 and 1987, although the surcharge was less.

Well, that doesn't make sense. Why

would that be? One of the things that Mr. Reed pointed out in his testimony is that, because of the way the insurance system is set up in Pennsylvania with relatively small underlying coverages with a $1 million CAT Fund coverage above it, it has actually become a very favorable climate for insurance companies in Pennsylvania.

None of the economic factors which precipitated the legislation in 1970's are present in the mid 1990's. We do not have insurance carriers leaving the state. We have the exact opposite. We have new carriers, more carriers I think than ever historically in 1995 coming into the state.

What has happened as a result of that, at the primary level it has actually become cut-throat competition. The prices are being discounted radically. Free coverage is being written for physician-run corporations which results in an entire other line of coverage on the CAT Fund with no premium payment; and then the surcharges are artificially elevated by the artificially low amounts of dollars that are going to pay for the underlying coverage, which

is another reason why it is an insurance issue as opposed to a true cost issue.

The other factor is, physicians are, of course, understandably concerned about the actual dollars that are going out, even though they're the same as it relates to their income. If you look at that entire period of time, however, there's a recent survey that was done by -- I believe it was reported in the Journal of the American Medical Association that said over that entire period of time the physicians median net income in the United States has been continuing to go up. 1995 was the first year that it leveled off.

The reasons why the net income have leveled off, though, are factors that go far afield for the matters that we're here to discuss. They are managed care plans, changes in reimbursement, et cetera. So the focus of concerns in terms of the economic factors should not be restricting the rights of victims of legitimate negligence claims by health care providers in order to increase the dollars that are going into the doctors' pocketbooks which are lowered by totally extraneous other economic

factors. That was a long answer. I hope it was helpful.

REPRESENTATIVE REBER: What, if anything, can this committee do to investigate or to bring to the forefront the reason why it's an insurance problem from the standpoint of moving in a positive direction to, how should I say it, place the blame where it is and attempt to remediate in that particular fashion? That seems to me to be really the issue. It's cause and effect. I want to in some way try to move, regardless of who the culprit is, in a direction that we can in some way drive down the cost, or certainly at least level it off to some extent like has happened on the automobile insurance.

MS. NELSON-SHEPHERD: Number 1, one of the other graphs that you have in the materials before you show that tort reform is not the answer to leveling off insurance premiums.

REPRESENTATIVE REBER: If we do the kind of tort reform that you continually see around, all the insurance companies will be out of business because there will be immunity for everything so there will be no need to be insured. That's ultimately where it goes. If

you sit and take a look at every piece of immunity legislation that's ever been introduced from that standpoint, putting aside whether constitutionally you could ever sustain some of those particular arguments.

MS. NELSON-SHEPHERD: Right. The second page of the documents that were provided by Mr. Reed from the CAT Fund is illustrative on that. California, for example, has one of the most restrictive, regressive forms of tort reform in the entire country. And yet, the premiums overall in California are still higher than they are in Pennsylvania.

Numerous other states which you see on the graph -- Pennsylvania, actually, premiums from malpractice are at the bottom third of the entire country, even though we are a northeastern industrial state with one of the highest cost of living, some of the highest cost for medical care. Many of these other states which have actually significantly higher premiums have tort reform. So, it shows tort reform does not result in reduction in premiums.

Some of the things that the committee might wish to look at, however, relate to the

interplay between the underlying carriers and the CAT Fund in terms of the underwriting practices of the underlying carriers, in terms of the apparent pattern of delay on the part of the underlying carriers in obtaining consent and authoring to tender the underlying coverage to the CAT Fund that then handicaps the CAT Fund's ability to respond until shortly prior to trial, and then they may actually have to pay more as a result of being in that posture than if it had earlier been disposed of.

One other issue is, would it be useful to, for example, raise the underlying limits? When the legislation was initially passed in 1970's, the underlying coverage gradually went up. It started at a hundred thousand; then it went up to 150 and then it went up to 200. That was that legislation, and so it just stopped and it remained there for a decade.

If you look at the CAT Fund statistics, they show that the vast majority of cases have a value of less than $500,000. So, some consideration might be given to whether or not it would reduce that tension between the underlying carriers and the CAT Fund to increase

the primary limits. It would also probably have some beneficial effect on the severe cost-cutting concern on that side; that would permit earlier disposition of the cases instead of the standoff between the primary and the CAT Fund. It would reduce the exposure of the CAT Fund and would put it, perhaps, where it more appropriately belongs, which is on the primary carriers.

REPRESENTATIVE REBER: Thank you very much. Thank you, Mr. Chairman. I appreciate those comments.

CHAIRMAN GANNON: Thank you, Representative Reber. Representative Maitland.

REPRESENTATIVE MAITLAND: No questions, Mr. Chairman. Mr. Reber asked my questions.

CHAIRMAN GANNON: Representative Schuler.

REPRESENTATIVE SCHULER: Thank you, Mr. Chairman. I just have one or two questions; maybe only one. Listening to your testimony, let me ask you this question. Do you feel that the legal profession has any impact on the problem?

MR. PICCONE: By litigation?

MS. NELSON-SHEPHERD: Mr. Piccone said by litigation, or do you mean by our court system or --

REPRESENTATIVE SCHULER: We have a problem in front of us. We're trying to address the problem. Do you contribute to the problem?

MS. NELSON-SHEPHERD: To the extent that the litigation system itself may contribute to the problem, I think that the answer is looking at the structures of how cases are disposed of as opposed to the substantive remedies.

For example, in the Court of Common Pleas in Philadelphia County now, the court is looking at why it is that medical negligence cases seem not to settle until the last possible moment. They have appointed a panel, a bipartisan panel of 6 lawyers, which I happen to be one, to look at that issue. Are there certain categories of cases that the court can set up different strategies to facilitate early settlement of those matters, as opposed to not intervening in any respect? Suddenly, the parties are there picking the juries and at that

late date worrying about getting consent from the doctor, worrying about the CAT Fund following their procedures for committee structure, et cetera.

So, I think that maybe we can look at alternative proposals for early settlement, expedited discovery. We're looking in Philadelphia, for example, at case management so that every case will be supervised and will have deadlines as opposed to just sort of floating along. So, to the extent that the litigation process is a contributing factor, I would think that it would be at that end.

REPRESENTATIVE SCHULER: The answer I'm getting is that, it's the process that's the problem. My question is, does the legal profession itself, you as a lawyer, do you contribute to the problem?

MS. NELSON-SHEPHERD: I obviously have a bias on that point of view, but I would say no.

REPRESENTATIVE SCHULER: I'm just trying to get to the root of the problem.

MS. NELSON-SHEPHERD: What I was trying to explain about the court system -- For

example, let's assume that there are some lawyers that sit on their files and don't move their files as expeditiously as they should. If the court system says, we're going to have case management and we're expect you to do this at 3 months and this at 6 months, it forces that lazy lawyer to do what he or she needs to do within the time frames that are set. That's why I answered the way that I did to your question.

I don't think that there's anything about lawyers per se that is in any respect a contributing factor to this issue of whether premiums are or are not too high for physicians in Pennsylvania.

REPRESENTATIVE SCHULER: Okay. Then if it's not the lawyers, who is it?

MS. NELSON-SHEPHERD: There are a number of contributing factors. It is obviously the insurance questions that we've been talking about. The other factor is --

REPRESENTATIVE SCHULER: Are you telling me it's the insurance companies?

MS. NELSON-SHEPHERD: It is primarily an insurance-driven issue. It relates in part to the interplay between the private underlying

insurance carriers and the state-run Catastrophe Loss Fund. But, there are other factors.

To the extent there may be some economic creep in terms of the cost, it is the same reasons that you are seeing economic creep in the cost of your health care premiums. For example, health care services cost more. Tests cost more.

If you look, for example, at the first page of the 3 pages of documents that were submitted by John Reed, you see that at least in some years there is some absolute increase in the amount of money that was paid by the CAT Fund before we get to 1995, which was a unique situation.

In any medical negligence claim, the person obviously has been injured. Generally, there is a claim for loss of earnings, if they've been unable to work, and we know that there have been interval increases in wages. So, the claim for loss of wages would be higher in 1992 than it would be in 1982. That's an understandable and appropriate factor that may increase the liability or responsibility of the insurance carrier responsible for that harm.

We also know that during that same period of time, that while the Consumer Price Index was increasing by 3 percent, for example, the Medical Care Index which is separately carved out was increasing in excess of 10 percent, as I recall.

To the extent that medical negligence claims also involve people who are seriously harmed, who are going to require hospitalization, surgery and other forms of medical assistance, whether it's rehabilitation, home care, institutional care, you are going to see some increase that is an economic reflection of the fact that those services to ameliorate the person's injuries are going to cost more.

REPRESENTATIVE SCHULER: Okay.

MS. NELSON-SHEPHERD: Mr. Piccone makes a good point. I think the question was asked early in the discussion, quote, is there any doubt that the payments by the CAT Fund will continue to rise? The answer to that question is yes, absolutely.

In our view and in the view also of the director of the CAT Fund, 1995 presented a unique set of circumstances that will not likely

be repeated.

In Philadelphia County there was a tremendous glut of cases across the board, and a system was set up that was called the Day Backward System to try to move those cases through the system and deal with the backlog.

One way that the court handled that was, in the first 2 years of the system they took the medical negligence cases which they perceived as hard and troublesome out of the program and they ignored them completely. When they put the cases back into the system, which was in 1994 and leading to a date of disposition in 1995, you suddenly have an artificial influx of basically a suppressed demand for payment for cases that have been in the system for, at that stage approximately 5 years, and where the events may have occurred even 2 years before that. It was those cases that hit the trial schedule and resulted in an unusually high number of settlements coming out of Philadelphia in 1995.

Number 1, those are gone, so we're not going to see that repeat itself. Number 2 -- I'm losing my train of thought. That's the main

reason in any event. It was an artificially suppressed sum of cases that you will not see in that same boom again. On the contrary, we would expect between the 10-year cycle and the Day Backward Program in Philadelphia settling down that there may be even a dramatic drop over the next few years.

REPRESENTATIVE SCHULER: We now have established in your eyes the insurance company and this process. What about the medical profession themselves? In your opinion, what do they contribute to the problem?

MS. NELSON-SHEPHERD: The Harvard study which was cited in Mr. Piccone's comments is very illustrative on that. It is a physician-run study which shows that the principal cause of medical negligence claims is medical negligence. Mistakes happen. Doctors are human beings. People get hurt. That's why we have insurance. In fact, that study showed interestingly that, as I recall, only 1 out of 8 people who the physicians felt had been the victim of medical negligence as opposed to just an adverse outcome, ever brought a claim.

I would say from the standpoint of

physicians there are 2 issues. Number 1, the main cause of medical negligence claims is medical negligence, and it does happen. Number 2, that this whole issue of, quote, defensive medicine, is another sort of illusory smoke screen. I was thinking as I was listening to the comments of -- I mean, what are some examples of defensive medicine?

I was writing a paper about cancer yesterday. I was looking at the leading text on cancer. It is a text by an editor named Devitta (phonetic). He happen to mention in the chapter on lung cancer that it's a very bad kind of cancer to have. That basically your only chance of survival with lung cancer is if it's detected early. Significantly, most cases of early detection of lung cancer happened how? On routine chest x-rays that are done for no medical reason, but just prophylactically when the person's in the hospital to have a surgical procedure.

So, you have to ask yourself the question. Is that defensive medicine or is that good medicine if it has the net effect of giving those people who have early lung cancer a

chance?

If a doctor thinks that an infant may have meningitis, potentially life-threatening and neurologically devastating disease, where time is of the essence, is doing a lumbar puncture defensive medicine or is it good medicine?

I also happen to read a study that that was reported in the JAMA of Volume 274, Number 20, page 1608, November 22-29 (1995). What they looked at is, does a doctor's claims experience result in his or her ordering tests or doing procedures that the individual otherwise would not do? They looked at obstetricians and whether or not they did tests or did a higher rate of Caesarean sections if they had had prior claims against them. Interestingly, there was absolutely no difference.

REPRESENTATIVE SCHULER: You attribute the medical profession as negligent. I'm not sure that means our doctors are getting less education or they're more sloppy. I don't think that's the case but that's your opinion.

Okay. We have the insurance

companies, we have the process, now we have negligence on the medical profession. But, I still didn't hear any contributions from the legal profession. I must assume that you're saying, you don't contribute to the problem.

MR. PICCONE: The statistics show that there is a substantial reduction in the amount of cases being filed indicative of 2 possible conclusions: A, the doctors are less negligent; and B, there are fewer lawsuits being filed because of that. That's happening of and by itself. That's a reality.

Has this right of suing doctors for negligence made them more careful in what they do? Obviously, most people are not going to say yes to that question, but that certainly I think is the answer to your question. There is less of this type of litigation being filed. We're being literally clogged in the courts with commercial litigation, with domestic relation disputes, with business disputes. Personal injuries are down especially tort type related cases for malpractice.

I think the system does take care of itself, and that study, that 10-year cycle is

critical. You're asking, what do you look at? That cycle is going to start again. If you need some people to testify, it seems to me that the Insurance Commissioner and the head of CAT Fund can give you substantial documentation to show that it is not a tort problem; but it's an insurance problem.

In a different scenario, I guess we could come forward and give that type of testimony, but we were just addressing, Mr. Chairman, this particular bill because of the huge effect it has on the right to seek redress. If that redress, I suggest to you, hadn't been allowed in the last 10 years, there would not have been a reduction in malpractice cases because the sloppy practice would have continued. I think that tort litigation made people stand up and do the right thing.

REPRESENTATIVE SCHULER: That completes my questions.

CHAIRMAN GANNON: Representative Chadwick. Thank you, Representative Schuler.

REPRESENTATIVE CHADWICK: Thank you, Mr. Chairman. Mr. Piccone, you are currently the President of the Pennsylvania Bar

Association?

MR. PICCONE: I am, sir.

REPRESENTATIVE CHADWICK: And is the Pennsylvania Bar Association affiliated with the American Bar Association?

MR. PICCONE: No, we're not affiliated. They're 2 separate entities. You don't have to be a member of the ABA to be a member of the PBA or vice versa. They address totally different constituencies and different problems. But, I happen to be a member of both.

REPRESENTATIVE CHADWICK: You are a member of the American Bar Association?

MR. PICCONE: Yes.

REPRESENTATIVE CHADWICK: All right. Since your colleague referred to the Journal of the American Medical Association I'm going to refer to the Journal of the American Bar Association. The January issue contains an article entitled "Protect Assets Before Lawsuit Arises". And the premise of the article is that lawyers, as much as any other professionals, can easily fall victim to warrant with suits.

Here's a direct quote from the article. Quote, Expanding theories of

liability, disregard for precedent by judges and juries, and unpredictable damage awards all conspire to promote pursuit of claims that might not have been considered 10 years ago, unquote.

Now, here's a real knee slapper. One lawyer is quoted in the article as saying --

MR. PICCONE: I've read the article.

REPRESENTATIVE CHADWICK: -- I don't want someone -- Yes, but there are a lot of other people here in this room who haven't. I don't want to sue me. I sue people all day in court, I'm quoting.

MR. PICCONE: I have the --

REPRESENTATIVE CHADWICK: It's a good one. One lawyer's quoted in the article as saying, I don't want someone to do to me what I do to people all day in court, unquote. This is the really good part of the article. The solution recommended by the magazine is for lawyers to shelter their money overseas, and they particularly recommend the Cook Islands in the South Pacific whose laws offer, quote, stronger protection and greater control of assets than U.S. laws, unquote.

As an aside after reading the article,

I thought you folks sheltered your money in the Cayman Islands, but now I understand that the Cook Islands are the preferred place to shelter your money.

Now, the Wall Street Journal commented on this article in the ABA Journal and suggested at the end, we can't help thinking that rather than moving money offshore, a cheaper scheme to protect assets would be to pass tort reform in America. Maybe that way our legal system can some day measure up to the standards of the Cook Islands.

Now, Mr. Piccone, my question to you is this: How can you suggest there's not a malpractice problem in this country when your own association that you're a member of is telling you to shelter your money in the Cook Islands so that you won't fall victim to frivolous lawsuits?

MR. PICCONE: I'll be happy to answer your question. One of the great freedoms is the freedom just expressed in that article; that the ABA does allow people to express opinions. It is not necessarily the position of the American Bar or the Pennsylvania Bar, of which it is not.

That was one person's point of view. You recognize that. One of the great things of our society is that I have the right to come before you and tell you what you're suggesting in this bill is disastrous to the American system. Now, let's get back to the article that you enjoy so much.

Number 1, it's indicative of the fact that lawyers are being sued for malpractice when they never were. You don't see us in here asking you to carve out something special for us. This country is not made up of, Mr. Chadwick, a caste system where people are granted rights because of who they are and not what they are. That's what's wrong with this piece of legislation.

If lawyers are negligent, then they too should be sued for the failure to perform properly because doctors and lawyers have a special niche in our society, afforded really to no one else, that great relationship with a client where that client exposes themselves to you with such vulnerability that you have the very highest fiduciary duty and responsibility to do the right job. If you screw up, tough

luck, that's what it's all about. But, you don't take away from the innocent victim who is hurt by that and protect the lawyer or the doctor.

I happen to think articles like that need to be spoken about and need to be told because I don't think that's a representative American view. First of all, I don't know that many lawyers that have made the type of money you're talking about. I happen to be a poor commercial trial lawyer. So, it doesn't fit my gain. But, I hope I have answered your question.

REPRESENTATIVE CHADWICK: You have. Since you've made such a spirited defense, innocent and injured victims and in your testimony on this very first page talked about your need to protect the little guy, may I assume then that since your goal is to make sure that innocent and injured victims receive every possible penny that they're entitled to, that you would support an amendment to this bill capping contingent fees for attorneys?

MR. PICCONE: I don't know what that has to do with the doctor's problem. If a

lawyer does a good job and proves before a jury that someone has been injured because of the negligence of the doctor, why should you, Mr. Legislator, decide or Arthur Piccone decide what a lawyer should be paid for his services?

Another wonderful thing of our society, this great Constitution of ours is, that people enter into contracts and decide if you render me a service, I'm going to pay you X. When you buy your car, when you go buy milk, you go to the best person and you pay the price.

Now, you're not suggesting that you want to take that away from the American scene and add another catastrophe on to what this bill already has before us.

REPRESENTATIVE CHADWICK: Ah, I'm glad you brought that up. If the right to contract is such a fundamental part of the American scene, then I have a hard time understanding your opposition to the right to contract for voluntary arbitration. Let me suggest to you that the arbitration section of the bill is, Number 1, not mandatory but voluntary. Number 2, that it guarantees both substantive and procedural rights for parties who engage in it.

It would guarantee more money into the victim's pockets by having a quicker and less expensive process.

MR. PICCONE: Have you ever been involved in arbitration, about quicker and less expensive?

REPRESENTATIVE CHADWICK: Let me suggest to you, sir, that in Act 111 the legislature put together a mandatory arbitration. It didn't work very well and there were some problems with it mostly because the attorneys didn't play. All this is is a voluntary system, and I fail to understand if you have such a spirited defense of the right to contract, why you would be so opposed to the right of a patient to contract with a physician for a system that will save them money and get them their award quicker?

MR. PICCONE: You've asked me about 4 questions. First about arbitration, I really don't think you have the facts at hands and I'm not prepared -- Some day, Mr. Gannon, if you'd like me to come back with the disaster that was the Medical Arbitration Act, I'd be happy to do that. I was then, years ago, I was a

plaintiff's lawyer when all that happened. The last 20 some years I've been a commercial defense lawyer. I'd be happy to respond to that because, that is so far off the mark, I won't get into it. I'd be delighted to come back and tell you about that catastrophe.

But the other thing that is important when you're talking about, yes, there are certain good points about arbitration. As a matter of fact, in 2 weeks in this city the Pennsylvania Bar is inviting a hundred people from all walks of life to come in and tell us what's wrong with the judicial system. They're going to be users of the systems. It's not going to be judges and lawyers who are going to testify, but it's going to be the people who use the system.

We think a lot of people are going to say, lawyers, your system is a little bit too slow; it's a little bit too costly. Maybe you need, it's called ADR, alternative dispute resolution mechanisms, because there are certain things that arbitration lends themselves to, and I couldn't disagree with you more. I happen to think in commercial litigation it is the wave of

the future. I have many of my colleagues who disagree with me. I'd be happy to debate that.

But, when you talk about arbitration here, the way it's set up in your act, when was the last time you had a medical procedure and the doctor told you what your problem was, and I challenge you, any one of you, unless you might have the medical background that Carol Nelson-Shepherd has or some other people, to really say that you understood what was being said and you signed away your right?

It is not that easy. It's not as glib as you would have it be, because people are in an unequal balance position when they bargain away. They don't know what they are giving up. That's what you all, as the lawmakers, are first charged with that responsibility; to make sure that there is a level field and that people have a right to seek their redress. If they're wrong, then defeat it. But what can be wrong with people having an opportunity to say what happened and what was wrong?

I'm just appalled that in today's society what we're seeing more and more of is the clamping down on people's rights.

MS. NELSON-SHEPHERD: Can I add just one thing? Would you mind if I just added a point? I happen to find that particular provision, perhaps, the most noxious of the entire bill. But the reason for my view on that has less to do with the arbitration vehicle itself, which may be appropriate in some types of cases, than the question of whether or not a patient signing away their rights to a jury trial, which is guaranteed by our Constitution, can ever be voluntary in the context of a physician/patient relationship where that patient is dependent upon the physician for their health or their life.

I mean, query whether a patient comes into an Emergency Room threatening to have a heart attack and the doctor says, sign here, whether that is, quote, voluntary. It is clearly distinguishable from the situation where you have equals in a commercial context who have time, are dispassionate, and may agree to a procedural vehicle.

There is never an equality between a patient and a physician; and further --

REPRESENTATIVE CHADWICK: I might

suggest, if I may interrupt at this point, that that's probably a pretty good reason why we should cap attorney fees because, certainly, the attorney and his client are not in an equal arguable position either.

MS. NELSON-SHEPHERD: Well, thank you, because you gave me an opportunity to respond to that as well. It's interesting in the other comments of the director of the CAT Fund, that if you look at states which have capped attorney fees such as our sister state, New Jersey, they actually have higher premiums than we do in Pennsylvania. So, it's one more area where there is no discernible effect on the cost of insurance.

But just to finish my sentence, the other problem with this, quote, voluntary waiver of rights to a jury trial, is that it places the physician and the patient at the outset of their relationship in an adversary posture, which is hardly the position that you would wish or that either of those individuals, I suspect, would wish to be in.

REPRESENTATIVE CHADWICK: I don't want to prolong this. I don't want to get behind

schedule, but let me suggest that when you have a fee schedule that pays an attorney more for going to trial than it does for settling, that's an adversarial relationship from the outset too.

Let me quickly finish with 2 last points. Mr. Piccone, on the subject of punitive damages which you're opposed to the language in the bill, I'm told by staff that the evil motive language attracts pretty closely the language in the second restatement of torts which has been adopted by the Pennsylvania State Supreme Court.

Are you saying that you're opposed to that adoption of the second restatement by the State Supreme Court?

MR. PICCONE: If the Supreme Court has adopted the restatement of torts too, I certainly am bound by that. I have to tell you though, the standard that you define as evil motive, I'm not sure that's in the restatement. I have to tell you that. That's my sense and feeling. You may well be right, Mr. Chadwick. My sense was that it was not.

REPRESENTATIVE CHADWICK: In fairness to you, sir, my language does not precisely mirror the language, but it does use the same

evil motive language that is in the second restatement. Let me go to one last point because it probably surprised me the most about your testimony, and that's the subject of frivolous lawsuits. You seem strongly opposed to the state adopting a version of Federal Rule 11 which sanctions attorneys for filing frivolous lawsuits.

When we had our press conference announcing the introduction of this bill, we brought a physician in who was a dermatologist and she had a patient who she treated for athlete's foot and she cured and who subsequently filled a lawsuit against her for failure to find an abdominal tumor.

Now, ultimately nothing was paid out in that case, but her carrier had to hire attorneys and it cost quite a bit of money to defend that suit. I fail to understand how you can be opposed to legislation that would provide sanctions against attorneys who file ridiculous lawsuits like that.

MR. PICCONE: I'm not opposed to the concept. We have, I think it's either 42 or 48 CJS, an appropriate vehicle. Once the

determination is made to have a trial and the defendant wins, then the defendant can bring an appropriate action before an independent court claiming that there has been a frivolous lawsuit file, brought without any standing, and it can be resolved under Pennsylvania law and not the Rule 11 concept.

Rule 11 concept is a concept that there's a great dispute of in the federal system because some judges will apply it; others don't. The concept under 48 or 42 Purdon's statute--I'll provide that to you--provides, where you file a complaint and you go right to court and you try that case; if someone is deemed to have done and performed a frivolous lawsuit, there are ways to get recompense and recovery.

In addition, that type of verdict is also the type of notice that can go to the disciplinary board for that type of conduct and action. I think our Pennsylvania law covers it.

I have to tell you this, I really think Pennsylvanians should decide what we should do in Pennsylvania and leave the feds out. It strikes me the federal government is all pervasive. They're all over us in

everything. I prefer we Pennsylvanians decide and not a Rule 11 process because it really is dangerous. I don't think you'd like to be in front of it yourself.

REPRESENTATIVE CHADWICK: I have to say it's a bit of a stretch to suggest that we're imposing the federal government on Pennsylvanians if we adopt one of the rules that we like. Let me just leave you with a suggestion that my bill would have prevented that lawsuit from being filed in the first place because it would have required an expert report before the Complaint could have been filed. Mr. Piccone, thank you for your testimony. I appreciate your time.

MR. PICCONE: Thank you, Mr. Chadwick.

CHAIRMAN GANNON: Thank you, Representative Chadwick. Representative Boscola.

REPRESENTATIVE BOSCOLA: Hi, this will be quick. It was just kind of a follow-up to what Representative Schuler was asking, does the legal provision have anything to do with this problem? I would say that yes, to some extent it does, in that, there are a lot of attorneys

out there that prolong cases; feed off their clients. We all know that that exists. I don't think anything in 2122 is going to remedy that. There are bad apples in every profession, just like there is this legislature.

What I want to say is this. There was a point that you made about the CAT Fund surcharge in '95. There was a backlog of cases in the Philadelphia area. This is my plug and this is why I wanted to talk today about the judge's bill that's now siting in the legislature that needs to be out on the House floor for us to vote on. Because you asked if they had a role to play in this problem. Well, we do too because we're not getting enough judges out in these counties to hear these cases. The criminal and the domestic cases always take precedence and the civil one's language. If we're really talking seriously about how we can all play a part, we need to get that judge's bill out.

MS. NELSON-SHEPHERD: We absolutely could use more judges. Actually, that's the proof of the pudding because, at the time that the Day Backward Program started because of the

demands of domestic and criminal cases, there were initially as I recall 4 judges trying to deal with a backlog of 30,000 cases. It then went up to 8. Absolutely, I concur with what you said.

CHAIRMAN GANNON: Thank you, Representative Boscola.

REPRESENTATIVE REBER: Mr. Chairman, can I just interject something?

CHAIRMAN GANNON: Sure.

REPRESENTATIVE REBER: I've been telling for some time in some regard what Representative Boscola just articulated. I think this committee really ought to check with each and every county where the commissioners are willing to stand for the cost, where the president judges are desirous of those openings, and that we move and agree to a bill where there is no controversy, where we don't have the interplay from all the different jurisdictions that we occasionally have when this happens. If there is agreement in particular counties, let's give those counties the opportunity to move the backlog.

I just thought I'd bring it up

because, as you well know, we got hung up on the judge's bill last time because it was Christmas tree with the number of counties that were in disagreement within their own local county commissioner ranks. But, there are some counties, and I know Montgomery County is one of those, where they are in agreement to foot the cost and the president judges signed off and every player is agreeable. It might be worthwhile pursuing that.

If that's one way, and that's what I'm interested in here, is seeing all the ways we can go to remedy the problem. I think that is one way that we can all agree upon. Why not move on the agreed-to things right away and then we can deal with the artificial problems at a later date. Excuse me for interrupting. I thought that was apropos. I'd be glad to sponsor it and hold the hearings.

CHAIRMAN GANNON: Thank you for your comments. Representative Horsey, do you have any questions?

REPRESENTATIVE HORSEY: Just real quick. I, as a legislator, I'm not prepared to make medical decisions. I think in free

enterprise the lawyers and insurance companies, the doctors should be allowed to go at it. This is America, free enterprise. The insurance companies need to stop crying foul because we're dipping into their profit line.

I know a basketball player who died on a basketball court and the family sued the eye doctor because he had a heart problem. They felt that the eye doctor should have been able to determine that heart problem.

It sounds strange. It comparable to the characterization that Mr. Chadwick made a second ago about feet and the stomach. Now, I'm not a lawyer, but I've been to law school. And the correlation between eyes and heart is, the condition the gentleman died on the basketball court could be determined by looking into the eyes. The doctor could have made the determination that this person had a heart problem and the eye doctor never detected it.

The correlation here between this story and Mr. Chadwick is, we as legislators are going to be making medical calls, or you would like us to. Once again, we're going to leave it up to doctors. I wish we would leave it up to

doctors; I wish we would leave it up to lawyers. This is America. Every man for himself, free enterprise, so on and so forth, and the insurance companies. I wish the insurance companies would stop crying foul because individuals are chopping into their profit money. Thank you.

CHAIRMAN GANNON: Thank you, Representative Horsey. Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. I just want to touch on a few things because I think a lot of the issues that I was concerned about have been touched on.

Carol, you mentioned the relationship between the CAT Fund and the underlying insurer and how those 2 interplay, and at least I've been talking a lot to trial court judges in Philadelphia about how they see that interplay and how the money is divided and everything, the responsibility, feed into some very serious delay problems when it comes to cases moving through the court. I know that Representative Chadwick's bill very extensively outlines what you would consider case management, but actually

outlines in the legislation I think toward the end of getting to cutting down on some of that delay.

I guess what I'm asking you as a practitioner, can you just explain to people a little bit more because I'm not quite sure. It took me a long time to understand from the judges that I've been talking about what the real issue is and how the responsibility of the primary carrier and the CAT Fund and how that plays itself out when you're trying to settle or get to some resolution of the case. I think that's an important picture for people to understand, because I also think it gets to one of the recommendations that you made and that I've been thinking about for a long time, which is, the very limited liability under our current law because of the existence of the CAT Fund and where the limits are of the primary carrier; yet, the amount of the responsibility that the primary carrier has for moving those cases forward. If you could address how those all relate to each other concretely in the context of a case I think people will understand.

MS. NELSON-SHEPHERD: Thank you. I'll

will try to explain. The underlying carriers have responsibility for the first $200,000 of coverage. The CAT Fund by statute is not permitted to act in the absence of a, quote, tender from the underlying carrier. What that means is, they don't actually have to pay the money but they have to say, CAT Fund, we've agreed to put up our $200,000. Now you are authorized to act.

The CAT Fund then, at least in major cases, has to follow according to their own procedures a committee structure that requires cases to be conferenced before they authorize payment. What has happened is, there are several situations that have resulted in difficulty engaging in that process significantly in advance of trial and the cases are on the courthouse step, so to speak, when this process first starts. What are some of those factors?

Number 1, the federal government passed a law called the Federal National Practitioners' Data Bank. I may not have that a hundred percent right, but that's the gist of it. It is a reporting requirement that any

settlement on behalf of a health care provider must be reported to this national data bank. Hospitals must check with the data bank when they credential any new physician for their hospital staff. That has resulted in some reluctance on the part of physicians, which is understandable, to consent to settlements or at least delay, delay, delay because they find it a very unpleasant thing to do.

Interestingly, just as an aside, the hospitals have access to the information about the bad track record of physicians who may be alcoholics, may have numerous claims against them. Patients don't, but that's just an aside.

Another factor that may make it difficult to get cases settled early is cases in which there are multiple defendants. They may agree amongst themselves, this is a terrible case. It may be worth millions of dollars, but they can't get their heads together about who should contribute how much.

Because, for example, let's say is there are 3 defendants. There would be 200, 200, 200, and then there's another million dollars of coverage on each one. This defendant

may -- In fact, it may even be the same insurance company. Let's look at that.

The same insurance company has three underlying policies. The insurance company wants to say, only one of my guys was negligent. CAT Fund, I want you to pay your million dollars. CAT Fund says, no, no, no. Three of your guys were negligent. I want you to pay those three $200,000 policies. You get into a stalemate situation. If those are different carriers and let's say the case has a value within the three $200,000 policies, that's another case that's very difficult to settle because everybody is saying I don't want to pay my part.

One of the things that we're looking at in Philadelphia is, maybe those types of cases should have some earlier attention with a procedural mechanism where the case could be settled with the plaintiff if the defendants could agree on the dollar sum, but then shift it into an arbitration format that's, perhaps, run by doctors or hospitals, and they figure out amongst themselves how to divvy up the responsibility. But, in the meantime, the case

is not stuck in the system, clogging up other cases that do need to be tried and otherwise contributing to the backlog.

Another factor that contributes to difficulty in early settlement of cases is that, we do have a caste system in terms of the primary carriers themselves. We have two carriers, PHICO and PMSLIC, who have to write for hospitals and doctors in the State of Pennsylvania, pretty much irrespective of their track record, although some gets shifted into something called the JUA.

There are a number of other carriers, and primarily the newer carriers, who are often referred to as cream skimmers; in that, they are carriers who only come in and write what they perceive to be the lower risks, discount the premiums, and make it really uncompetitive for the carriers who have to write for everybody.

How those other carriers are able to discount their premiums is, in part, reducing their level of risk, but it's also by providing budget services to their insureds. They market it as saying, we're going to provide a very aggressive defense, and a lot of doctors buy

into. But we know that what is real in the term of the aggressive defense is that, they have contracts with the lawyers who represent them to pay them only a flat fee no matter what they do. So the net effect of that is that they do nothing.

Those are the cases that are very difficult to settle if one of those carriers then because, irrespective of whatever these requirements may be, the lawyer is doing the minimum possible to sit on the file and ignore it in the hopes that, perhaps, it's going to go away. Those are the cases that on the eve of trial the doctor maybe says, oh dear, this is a problem. Somebody died. The child got brain damage. Carrier, you better pay this.

Then the CAT Fund is kind of behind the eight ball because they're getting the case late. The plaintiff and the plaintiff's lawyer positions have been entrenched. They have spent all of their money in terms of their experts and all the emotional angst that goes into preparing a case for trial, and instead of settling it for maybe $500,000 five years ago, now they say, I want a million dollars.

Those are some examples that come to my mind. I hope that's somewhat helpful.

REPRESENTATIVE MANDERINO: Thank you. I guess my second question following up with that goes to, again, the issue of delay. The legislative proposal had a lot of mechanisms built in there to try to avoid delay. I feel like I can say this to someone, who, when I practiced law I did almost exclusively tort law, but almost equally divided between plaintiff and defense. A lot of defense was professional liability defense. I feel like I understand the issue and how the cases happen in a practical sense in terms of how they move.

But, one thing that I found curious about the bill is that, a lot of the mechanisms to avoid delay focused on the plaintiff lawyer, and at the same time there was a recommendation for taking delay damages which is about one of the only remedies that usually come out on the other end from the defense, out of the picture.

My experience was in most cases, the plaintiff lawyer is the one who has to be the aggressor in moving a case. I wondered if you have looked at some of the time lines that were

put in here? And some of them may actually be reasonable, but what you thought about how we can equally address the issue of delay coming from the other end?

MS. NELSON-SHEPHERD: I really have little to add to what you just said because I think you accurately highlighted the irony of the proposed legislation. I think you would find little resistance from either side of the bar to reasonable case management procedures. Plaintiffs and defense lawyers support those types of mechanisms to move cases more quickly. Insurance carriers may to some extent have a different point of view on that, but this is our legal system and our litigation process.

But the irony of this proposal is that, it's unilateral. It's lopsided. Most of the obligations are on the plaintiffs, produce early expert reports, et cetera. There is no club, no similar requirement on the defendant. On the contrary, if you slip and fall down, a community or a owner of a sidewalk would be responsible for Rule 238 damages, but some reason a health care provider would not. It just doesn't make sense.

REPRESENTATIVE MANDERINO: Thank you. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Manderino. Representative Caltagirone.

REPRESENTATIVE CALTAGIRONE: No questions.

CHAIRMAN GANNON: Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman. Miss Shepherd, while we're talking about the CAT Fund, maybe you can answer a question for me. I've never done medical malpractice work so I'm not so sure I understand well how the system works. Let's assume that I'm a neurosurgeon and I'm sued and I'm insured by Minneapolis St. Paul, an available medical malpractice insurer. They hire Mr. Reber's firm to represent me.

In some point in time he comes back after conferring with other experts who says, this case has a value in excess of the $200,000 cover that he's responsible for and the CAT Fund then gets involved with some potential exposure. Who represents me after that? Does Mr. Reber

continue to represent me? Does the CAT Fund have its own staff of attorneys? Do they assign attorneys from the general pool of attorneys out there that just hires somebody to represent me in that situation?

Is there any continuity between his representation once we get past the CAT Fund limit and that he recommends to Minneapolis St. Paul, pay the 200,000 bucks because we're on the hook?

MS. NELSON-SHEPHERD: The short answer is yes, in that, you retain the same counsel. The CAT Fund, for the most part in terms of the adjustment of claims process, does not use lawyers, although there have been over the years some lawyers who serve that function as opposed to representing the individual defendant. They are primarily claims examiners who have an insurance background. In some cases they tend to deal more directly with the plaintiffs themselves with the permission of defense counsel, or in other cases, defense counsel prefers to retaining that role.

The interesting point that was made by Mr. Reed in his testimony was that, because the

CAT Fund is not a profit center, it is not a for-profit entity, it serves some mitigating influence on the settlement process; in that, the carrier is for profit, and the CAT Fund can hopefully provide, perhaps, a more balanced perspective between the needs of the individual and the risks of trial to the insured defendant. Does that answer your question?

REPRESENTATIVE HENNESSEY: Generally, I guess. Once he's convinced Minneapolis St. Paul that I've made a mistake and that they should pay at least $200,000, what is his job then as far as the CAT Fund? Does he have to convince the CAT Fund to kick in another 150 and get this settled? Does the CAT Fund pay him? I don't think it does to do that job.

Since he's not responsible in a sense for that money, does it really matter to him whether that extra money is 150 or $350,000? And should there be any kind of connection so that he knows what he's fighting for and knows that he has some interest in keeping that number down?

MS. NELSON-SHEPHERD: One of the complaints that has been articulated

historically about the CAT Fund is a perception on the part of the underlying carriers and/or defense counsel that the CAT Fund was giving away money; throwing away money. I think that that is belied by the statistics we have before us, which actually put Pennsylvania at the lower end in terms of payouts on claims.

But, in general, the CAT Fund, as I understand it, follows its own internal claims evaluation function, although I am sure that they listen with interest to the recommendation of defense counsel. They are the ultimate arbiter of how much is offered of their coverage.

Let me mention 2 things as an aside. One thing I said is not technically accurate. There is a Section 605 in the CAT Fund legislation for claims that are more than 4 years old, in that, the events occurred more than 4 years ago. This is one of the benefits to the carriers in this state. They have no exposure. There's no tail for old events that were suddenly recently discovered, or since the minors tolling statute often in minors cases.

In those cases the CAT Fund is

defended directly by counsel that they assign, and the coverage is just the $1 million of CAT Fund coverage. There is no primary coverage. So, I think that's the only example where the CAT Fund is defended directly.

One other instance that I should have mentioned in my response to Representative Manderino's comments, one of the other instances that are difficult to settle though, because of the tension between the underlying carrier and the CAT Fund, is cases that have a value between $150,000 and $250,000.

Here's the $200,000. Primary carrier says, I don't want to pay a hundred percent of my dollars. I don't think this case is worth, you know, it's right around there. I want to save something off of the policy.

If you save something off of the policy, then you don't have a tender. Then the CAT Fund can't get involved. The CAT Fund may be concerned. They know about the case. The carriers have to notify early on the CAT Fund any case in which there may be exposure above the limits. That CAT Fund says, we're worried. We think we're the one who's going to be on the

hook if there's a verdict here. We think it could be worth $300,000. It's very difficult to get that resolved.

That was one of the other issues that we're looking at through the court in Philadelphia is, could we set up some mechanism to break that gridlock? That is a situation where there is some difficulty between the respective use of the CAT Fund and the primary carrier.

REPRESENTATIVE HENNESSEY: Thank you. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Hennessey.

REPRESENTATIVE HORSEY: Mr. Chairman, I have one brief question.

CHAIRMAN GANNON: Let me get through everybody. Then we'll get back to you. We have some other members that want to get in. Counsel Preski?

MR. PRESKI: No.

CHAIRMAN GANNON: Counsel Andring?

MR. ANDRING: No.

CHAIRMAN GANNON: Representative Schuler, you had a follow-up question.

REPRESENTATIVE SCHULER: My question is not directly related to the issue before us today, even though it does deal with frivolous lawsuits, which is in the bill; but, I think the whole idea is expanded into what we are talking about today.

I came into the legislation in '83 as, I guess you would say an uninformed representative. I had very high hopes. One of the first bills I put in was about frivolous lawsuits. Within 2 weeks I was brought back to the world of reality. I still have problems with these frivolous lawsuits.

As I said, this could pertain to what we're talking about. A little 9-year old boy warming up on the sideline, a baseball pitcher, and he throws a ball and it hits a woman on the head and she sues the little boy, the 9 year old, $15,000. The result of what was filed said that the young 9 year old maliciously, recklessly, and with high-speed ball did hit the woman on the head.

Then there's another case where a little lad is out in right field and a pop-up comes and hits him in the eye and he sues the

manager for not teaching him out how to catch a fly. I hope none of our pro-baseball players here today.

Somewhere there has to be some reason here. How would that be handled in Pennsylvania? Does the Bar Association approve of that type of --

MR. PICCONE: Do you mean the filing of the suit, how that would be handled, or if it were determined to be a --

REPRESENTATIVE SCHULER: We have this 9-year old boy. We'll take this from there. I'm not learned in the law. I have to be honest with you. That's not my view.

MR. PICCONE: Obviously, if the facts are as clear-cut as you expressed them to be, you'd have to say that there wasn't much substance to that type of litigation. But, the one thing I've learned in this position of practicing law for 36 years is the fact that facts aren't what they always appear to be.

That's one of the great values of the jury system; and that is, that when the jury makes the determination that there's not a sense of responsibility, then 12 people, most times

with no ax to grind on either side, call the shot. The problem with creating a, quote unquote, statute that defines frivolous litigation to be interrupted solely by a single judge without all of the facts being disclosed, that bothers me.

Could there be something resolved in that area? Possibly, but not as drafted in this bill because, what about a frivolous defense? I mean, is a frivolous lawsuit that the plaintiff doesn't win? Well then, if the defendant losses, is that a frivolous defense and should we then punish the doctor for saying, look, my best judgment he has a right to get on that stand and say what he thought was, and then if 12 people decide that he's wrong, is the decision by that jury a finding of frivolous? That's the problem with frivolous.

The federal rule normally deals with someone that you haven't followed a practice or procedure where it's pretty clear-cut. It's an application of a statute that says, you shall do this by such and such.

But, when you're determining the ultimate outcome, that's where you have a

problem. That's why, whether it's 42 or 48 Purdon statute, allows you that if you feel that strongly about it, then you file that lawsuit and you produce all of the evidence that would have established that these facts being known I never would have filed the lawsuit. That's why I always felt that's a better way to describe and answer the question frivolous.

Are you saying, do we have a procedure presently under our disciplinary rules that if a lawsuit was thrown out by a court -- I don't think that one violation would be, by my judgment, of what I understand disciplinary conduct to be, would be adequate and sufficient to punish the lawyer. I think you'd have to have a series of events where a whole host of lawsuits had been thrown out by virtue of late filing when you knew the statue had passed, things like that.

REPRESENTATIVE SCHULER: You have some good points. My concern is the parents of that young lad, they're going to have to pay someone to go through all this process which you just mentioned. I just can't accept that. That's it. I didn't mean to make a speech, Mr.

Chairman.

CHAIRMAN GANNON: Thank you, Representative Schuler. Representative Horsey.

REPRESENTATIVE HORSEY: One brief question. Do you think between lawyers, doctors and insurance industry, I understand you saying that you had a system set up in Philadelphia. Do you think between the 3 of you, whatever the problem is, you can work it out? If so, how, which is similar to Mr. Schuler's question?

MS. NELSON-SHEPHERD: If we can put partisan --

REPRESENTATIVE HORSEY: Work it out without the legislature getting into tort reform.

MS. NELSON-SHEPHERD: That's right. If we can put partisanship and high levels of individual emotion about some of these issues aside and look at the best interest of all of the parties, absolutely. That is one of the things that we're trying to do in Philadelphia.

For example, on Monday, this panel that was appointed by the court to look into this issue is meeting with, or at least we have invited, representatives of every hospital,

self-insured hospitals, the carriers and the CAT Fund to participate in the plan for how to better handle the cases in Philadelphia. There is no reason that that type of discussion and dialogue could not and should not go on on a statewide basis.

REPRESENTATIVE HORSEY: Thank you.

CHAIRMAN GANNON: Thank you, Representative Horsey. Thank you very much, Mr. Piccone, and Ms. Nelson for coming here today and offering your testimony and taking the questions from the members of the committee.

MR. PICCONE: It was our pleasure. Thank you very much for the wonderful treatment we received.

CHAIRMAN GANNON: I'd like to call our next witness, Doctor Jonathan Rhoads, Jr.

DR. RHOADS: I am Jonathan Rhoads, Junior, a surgeon from York and President of the Pennsylvania Medical Society, the largest physician organization in Pennsylvania. With me on my right is Betty Cottle, an anesthesiologist from Hollidaysburg. On my left is Ken Jones, General Counsel of the Medical Society.

First let me thank you each one of you

for attending, and especially you, Chairman Gannon, for holding this hearing. It starts a process to fix a problem which physicians across our Commonwealth tell us is of great concern in the practice of medicine, and that is the current medical liability situation in Pennsylvania. The points in my testimony, I may deviate from my written remarks and embellish them somewhat. Please do not be concerned if I do that.

Medical liability has been governed by Act 111 since the mid '70's. Initially, it required all cases to go through arbitration panels, and the Catastrophic Loss Fund was to be funded by a 10 percent surcharge on the basic premium. The arbitration panels were subsequently struck down by the courts, and the requirement to carry insurance as a condition of licensure and the CAT Fund remained without the protection that arbitration panels afforded the physicians.

Since that time, the amount of basic insurance required has been doubled, and the surcharge from the CAT Fund in 1995 was 170 percent of basic premium, and this year is 164

percent versus 10 percent when the system was first established. The magnitude of settlements and awards has grown dramatically.

You heard in the previous testimony that the median settlement last year in the courts in the large cities, or awards maybe it was, was $52,000. I believe that was for all awards. For medical issues it is much higher. We heard Mrs. Shepherd recently, just now, speak glibly of amounts of 200,000, 300,000, 500,000, a million. So that, 52,000 is patently a low figure for medical liability settlements and awards.

I have no doubt that the CAT Fund surcharge is what has got us to this point today, but the CAT Fund itself is not the whole problem. It is basically a funding mechanism that camouflages a very serious underlying problem, the current medical liability system.

The rewards of medical practices and legal risks are seriously out of balance. A physician may expect to receive 40 or $50 for a service such as an office visit, but is required to carry insurance up to 1.2 million per defendant for liability arising from that office

visit. I know a dermatologist whom you heard about earlier this morning who saw a patient for athlete's foot and was later sued for failing to diagnose an intra-abdominal cancer.

Physicians have been deeply concerned about liability for many years, and several times have proposed legislation to reform the current system. In fact, the House passed legislation very similar to House Bill 2122 8 years ago with strong bipartisan support.

According to a Rand Institute study, 57 percent of the premium goes for legal and administrative expenses, and only 43 percent to the allegedly injured party. I don't think anyone would disagree that a system in which only 43 cents out of every dollar collected goes to injured patients is a system which is broken. That means that 57 cents out of every medical liability insurance dollar goes to lawyers for both sides and also for administrative costs. A system in which only 43 percent goes to the injured party is unacceptable.

This is the inequity which House Bill 2122 is attempting to rectify.

Of course, this doesn't even scratch

the surface on the subject of defensive medicine. I know what the trial attorneys are going to say about the issue of defensive medicine. They will say, what we are practicing isn't defensive medicine, but good medicine. But, I think that only a physician could know what's really happening out there, and I can tell you with complete certainty that we are doing tests and procedures now to cover ourselves in the event of a malpractice suit-- procedures and tests which have little or nothing to do with improving the care we give patients and which sometimes have their own risks.

For example, tests such as an arteriography and pneumoencephalography pose risks to the health of the patients who undergo these tests. One of my colleagues says that if he orders a test, the patient's insurance pays for it. If he fails to order the test, his liability insurance may have to pay for it. He orders a lot of tests.

Let me emphasize right away that House Bill 2122 will not fix all the problems with the medical liability system, but it is a moderate

first step to leveling the playing field for patients and physicians. It does not contain caps on awards for pain and suffering, a provision which has worked very well in other states to help contain the ever-increasing cost of health care. We know that the cap has been a stumbling block in past negotiations in this process, so although we believe it would help, we are not advocating its inclusion in House Bill 2122 at this time.

Let me review a few features of the bill which would help to fix the current broken system.

House Bill 2122 would impose sanctions on attorneys who file frivolous lawsuits. Sanctions like this are not new. The provision in House Bill 2122 mirrors Federal Rule 11. The principle is very clear. Litigation is extremely costly and time-consuming. The court's time is too precious to be wasted by foolish lawsuits. Nationally, some 80 percent of all cases are closed without payment.

The trial lawyers use this as an example to show that the system is working. They say the system culls out unfounded cases.

We say that this very fact is a disgrace and is a reflection of a system that needs to be fixed. It is very expensive to defend a nonmeritorious suit. The 80 percent represents time and money that is wasted and could be well used to provide more health care for our patients.

The frivolous lawsuit portion of this bill would simply require attorneys practicing in the state courts to perform at the same standard as they do in federal court. The courts will be allowed to impose sanctions against attorneys who file frivolous lawsuits, including paying defendant's reasonable expenses such as court filing fees and attorneys' fees. This hardly seems unfair. In fact, the current system is the one that seems unfair.

House Bill 2122 would require a certification that an expert has reviewed the case and is prepared to testify on the plaintiff's behalf. This requirement would help eliminate frivolous suits early in the process.

House Bill 2122 would require that an individual testifying as expert witness must have a similar medical license or Board certification as the defendant. In today's

legal environment, there seems to be no shortage of medical experts. This bill would require the expert to be licensed and have been actively engaged in the direct patient care in the same medical specialty.

In addition, if the defendant is Board certified, the expert must also have that designation. 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 the defendant.

House Bill 2122 would eliminate duplicate payments for the same injury. Under present law it is not possible for defense attorneys to inform the jury of all the sources of compensation available to the plaintiff. The result is that, frequently, plaintiffs are compensated a second time for expenses already paid under some form of insurance. This might be called double dipping.

This bill would allow defense attorneys to inform the jury of compensation already received by the plaintiff. Benefits from life insurance, a pension or profit-sharing

plan could not be considered duplicate payments.

Approving this provision will actually translate into an important policy decision. It would show whether the legislature wishes to compensate a plaintiff twice for expenses incurred or whether once is enough.

House Bill 2122 will clarify informed consent requirements. Physicians will continue to be required to maintain informed consent prior to a major invasive procedure except in an 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.

Patient consent is always necessary, but the question centers around when we need to give detailed information on treatment risks and alternatives. We must have a clear description to help resolve if appropriate consent has been given.

House Bill 2122 places reasonable limits on punitive damages. Currently, punitive damages are intended to be a deterrent and punishment for outrageous conduct and they are

currently unlimited. Instead, they are used by attorneys to intimidate defendants. This tactic is abusive since punitive damages cannot, by law, be covered by insurance or the CAT Fund.

House Bill 2122 says that punitive damages can only be awarded if there's clear and convincing evidence that the defendant acted with an evil motive or ignored a high degree of risk. It further limits the damages to not more than 200 percent of compensatory damages. It does not eliminate punitive damages, but it does limit the opportunity of the attorneys to demand punitive damages without sufficient grounds.

House Bill 2122 strengthens the definition of Statute of Limitations. Under current law, an action can be brought within 2 years of discovery regardless of when treatment occurred. This means that the tail which must be insured is indeterminable.

This bill would require medical negligence claims to be filed within 2 years of discovery or 4 years from the act which caused the injury, whichever is earlier. The 4-year limit would not apply to injury caused by foreign objects left in the body. In cases

involving children under age 8 would have to be filed within 4 years after the parent or guardian knew or should have known of the injury or within 4 years of the child's 8th birthday, whichever is earlier.

The main purpose of these provisions is to reduce the very long tail for medical liability which complicates reserving for possible future claims. A shorter tail would allow more accurate reserving and reduce guesswork in setting rates.

House Bill 2122 would permit periodic payment for future damages. Under present law it is possible in the case of a large lump sum for the plaintiffs to receive a windfall because all future damages are received before they are incurred. This bill would allow awards with future damages exceeding $200,000 to be paid in periodic or installment payments. This would assure that money is there in the future when expenses arise.

House Bill 2122 will allow patients to arbitrate medical malpractice claims. Many patients and physicians would prefer the simplicity and less adversarial nature of the

arbitration process. This provision would give them the option while putting safeguards in place to assure that patients are not coerced into signing such agreements. It even guarantees patients the opportunity to reconsider such agreements after receiving treatment and would require the CAT Fund to be bound by such agreements. Those who take advantage of this option should be able to receive more of the award more quickly. It is entirely voluntary and does not remove the right to a jury trial.

These are the highlights of the bill you are considering today. I do not think they can be considered radical by any means. We think this bill is a moderate step to achieving some sort of parity in a system that is tilted against the majority of patients and physicians.

It is also a system which seems to be synonymous with the lottery. It is a system where people with injuries may or may not be compensated. Two people with identical injuries may come out of the system with completely different awards, or worse, one of them with no award at all.

I remind you, we are dealing with a system where 57 percent of the premium dollar is going for legal and administrative expenses, and 43 percent to the aggrieved parties. At best, this system is inefficient and expensive, and in addition, is not guaranteed to be fair to those with alleged injuries.

I believe that a government that allows this system to persist is a government that is abdicating its responsibilities to its people.

Furthermore, some cases are patently ridiculous. For example, the case of a woman who was a reader and advisor. Following a CAT scan she sued for loss of, quote, psychic powers, unquote, and she was awarded $600,000. To the medical community this is clearly a travesty.

Medical liability tort reform is a contentious issue to be sure, and one with a long and sometimes ugly history. Everyone in this room knows that it has historically been categorized as the trial lawyers against the doctors with both of us claiming to have the patients on our side; and honestly, that may be

correct. I cannot speak for the Trial Bar, but I am sure that they agree with us that injured patients deserve to be compensated, so we both agree with that basic premise. But, it is beyond that premise that the disagreements begin.

We have been at this long enough to know that it will be said that this is a pocketbook issue for physicians. And I would be less than honest if I did not admit that cost is a piece of our concern. But, I must also tell you that we are to the point that if we had a commitment from you that nothing would be done to make the cost of malpractice insurance more reasonable, but that in return a fair portion of the money collected would go to injured patients instead of to lawyers on both sides and administrators, we would support it wholeheartedly.

The bill will not impair an aggrieved party's right to sue. It will level the playing field. It will limit lawyers ability to threaten defendant physicians with punitive damages. It will recognize a reasonable informed consent. It will require plaintiff's

experts have credentials similar to the defendant's physicians.

Again, Chairman Gannon, I commend you for giving this issue a fair hearing. I was especially heartened to learn of this meeting after I read in a recent issue of the Central Penn Business Journal, a comment by a representative of the trial lawyers, that H.B. 2122 didn't have a chance of passing the Judiciary Committee.

Physicians view this hearing as the committee's willingness to address in a moderate way the inequities of the current system for our patients, your constituents, and the difficulties physicians are facing. We are glad you are willing to hear both sides of this difficult issue. And I thank you.

I would now like to ask Betty Cottle to offer some additional remarks before we have questions.

CHAIRMAN GANNON: Fine.

DR. COTTLE: Thank you. Good morning. My name is Betty Cottle. I am an anesthesiologist from Hollidaysburg. Some of you may remember me through my involvement with

the Pennsylvania Medical Society's liability insurer, PMSLIC.

I come before you today as a veteran of the battle for meaningful tort reform. I was involved in this 20 years ago when the issue was last debated at this level. Act 111 as originally enacted contained a good balance of insurance and legal reform. Sadly, essentially all of what you did regarding tort reform was gutted by the courts because of lawsuits from the Trial Bar.

Gone are the provisions of Act 111 that prevented claimants from receiving a double recovery, the collateral source rule. Gone are reasonable limits on plaintiff attorney fees. Gone is an arbitration process that, while admittedly not perfect, had the promise to reduce the costs associated with getting injured persons a reasonable recovery for their injuries. Gone is a relatively clear standard for informed consent.

What physicians were left with is mandatory insurance and required limits of insurance above the national norm of $1 million per occurrence and $3 million annual aggregate.

Also remaining is the authority for the Medical Board to investigate claims of physician misconduct. We support the efforts to discipline physicians who practice in an inappropriate manner.

I note, however, that attempts to discipline physicians usually result in the parties getting lawyers and going to court. This is an example of legislative judgment being eviscerated by the courts. It is time for the patients and physicians of this Commonwealth to get some relief. This is a plea for sanity in a system that has gone awry.

From the first day of medical school until the very last day of our residency when we enter practice, we are taught to do no harm; primum nolle nocere. This becomes an integral part of the physician's present and future actions, so if a patient has been truly injured, we believe there should be a system to make sure that the costs are covered and the patient made whole.

Now, I am concerned about patients and I'm also concerned about my younger counterparts. Let me focus for a moment on the

young physician who will probably be practicing in a world of managed care. The young physician will be told that decisions with respect to treatment opportunities will be made by others, most often not other health care providers. In fact, in many cases they will be told they are not permitted to discuss with their patient other treatment options or alternatives outside the managed care system, the so-called gag rule.

Yet, at the same time they will be told that they will be personally liable for any injury to the patient, even though the physician was constrained in a treatment decision.

I know that the plaintiff trial lawyers are practically drooling with glee and anticipation at the liability prospects which are now going to be opened to them. This will be a big moneymaker for the legal profession. Therefore, the reforms which we reference here become all the more important. They are reasonable, thoughtful reforms which adjust the system to enable physicians to practice medicine without constant fear of unreasonable litigation coloring their judgment. All we ask now is that the basic tort system be adjusted to reflect a

more thoughtful and meaningful approach to professional liability litigation, protecting the rights of patients and assuring that physicians will be available to provide the care that patients need.

Again, though, I return to the observation that patients suffer under this current system. Your constituents, be they physicians or patients, are not helped. The public agrees that the legal system needs to be changed. In one recent poll, more than 80 percent of the Pennsylvania voters said the legal system needs to be changed. Seventy-seven percent said that too many people are abusing the legal system by suing in order to get large damage awards. We have said it before and it has to be said again, the constituents who benefit most from the current system are the plaintiff and defense attorneys.

Yet, this is not a physician and consumer versus lawyer issue. Within the legal community there are even voices calling out for change. When there is such unanimity that change must occur, and given the leadership role that this legislature has demonstrated in the

past, I believe it is time to step up to the plate and make the kind of changes that will enable health care to be provided in a meaningful way by dedicated professionals, unhampered by irrational threats of litigation.

When I refer to irrational litigation, let me clarify. We have a system in which physicians successfully defend over 80 percent of the professional liability cases brought against them, but the costs are extraordinary. On top of the psychological stress for patient and physician, there are court costs, loss of income and, of course, defensive medicine, to say nothing of the insurance costs. I will share with you PMSLIC's experience.

From 1987 through 1995, PMSLIC has spent an average of $8,000 per case to defend 9,000 claims that were closed without any payment to the party bringing the lawsuit. This means we have spent $72 million and not one cent to an injured patient. It went to lawyers, witnesses and the system. With a more reasonable litigation system, more of this money can be used to provide patient care and compensate for the truly injured patient.

Also, the reforms of House Bill 2122 will speed up the resolution of claims. Deserving patients wait many years before they receive any compensation. Lawyers are busy searching for experts and posturing for trial and limitless discovery. Time has come to demand that the investigation, evaluation and resolution of claims be done expeditiously as possible to afford timely payment to the patient when appropriate and closure for all involved.

We all know that there is a finite pool of money available for health care. Money wasted in our tort system could be put to much better use to provide health care for the elderly, the indigent or to conduct medical research. Ultimately, the current system will affect access to care, especially for residents in underserved rural and urban areas of Pennsylvania.

These are serious considerations and I'm sure you will give it their just due. Thank you again for allowing me to speak.

CHAIRMAN GANNON: Thank you, Doctor Cottle. Representative Reber, any questions?

REPRESENTATIVE REBER: Real quick, Mr.

Chairman. Doctor Rhoads, in your testimony when you spoke about 57 percent of the premium dollar going to legal expenses, do you have any breakdown as to that 57 percent? How much of it was plaintiffs? How much was court costs?

DR. RHOADS: I'll ask Mr. Jones to answer that question.

MR. JONES: I will defer and say we have those figures back at the office but I did not bring them with me. We'd be happy to provide what is essentially the Rand Institute study.

REPRESENTATIVE REBER: That's empirical data emanated from that?

MR. JONES: Yes, it is.

REPRESENTATIVE REBER: Secondarily, as somewhat of a follow-up to that, Doctor Cottle's testimony at the end was talking about approximately $8,000 per case in the PMSLIC experience was allocated for defense costs. Do you have any idea as to what was the hourly rate that was charged by defense counsel in those cases?

DR. COTTLE: I don't have that handy.

REPRESENTATIVE REBER: Mr. Jones, do

you have any feel for the average hourly rate on --

MR. JONES: Again, those are PMSLIC's figures which we'd be very happy to provide you, sure.

DR. COTTLE: We'll be happy to provide them for you if you would like us to do that. I would like to make one comment, if I may. PMSLIC has not operated for a profit. We insure 7,000 of the doctors in Pennsylvania. We do everything to benefit the ah-h -- reduction of premiums wherever possible. I've been associated with the company for a long time. I can tell you, it is the servant of the physician. It is not a profit source or a center.

REPRESENTATIVE REBER: I understand that. If you could gather that, it would be appreciated. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Reber. Representative Hennesey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman. Doctor Rhoads and Cottle, I think both of you made reference to, and I'll quote from Mrs. Cottle's testimony, money wasted in

the tort system could be put to better use to provide health care for the elderly, the indigent or to conduct medical research. That certainly seems to be a noble goal.

Tell me how the money gets from -- the money that PMSLIC saves or some other medical malpractice insurance company saves gets to be invested in medical research or health care for the elderly?

DR. COTTLE: It's not a direct relationship as you might see.

REPRESENTATIVE HENNESSEY: That's what I'm getting at.

DR. COTTLE: Certainly not.

REPRESENTATIVE HENNESSEY: If we cap the systems or if we put in some different structure to the system than we have now, and we save insurance companies money and we save doctors money because of the premiums, that doesn't necessarily correlate into increased money for medical research or something, unless we somehow find a way to drive it there. I don't see the correlation in the testimony, although it's easy to say that's a noble goal and let's pass the legislation. Tell me how it

works.

DR. COTTLE: All physicians' expenses, I'm sorry to say, are passed on to patient care and patient costs. Certainly, anything that drives the cost of health care up is going to impact on people who have less money to afford it. It would be an indirect cost.

The money is provided by the medical profession for this system. If the medical profession doesn't spend it there, it certainly could deal with lower fees for patients and provide other services. But we're caught up in an expensive situation and a time-consuming situation whenever litigation takes place. Doctors lose enormous amounts of time away from practice and care of patients.

REPRESENTATIVE HENNESSEY: So decreased premiums or increased services -- or say decreased premiums to doctor might interpret down to lower fees for office visits, but in terms of the decision to fund medical research or do that kind of stuff is still going to be done on a legislative basis?

DR. COTTLE: It would have to be, yes. But the other thing is, I would like to point

out to you that we have, not my generation of physicians, but we have young physicians coming out with enormous debts from medical school; tremendous debts. I thought I had debts when I got out of medical school; nothing like what the young physician is experiencing. He walks into this awful situation of high liability cost, time-consuming efforts of defending himself in frivolous situations that take away from his practice. He's going to be caught up in this whole managed care business which is untenable.

Talk about legislative relief, if there was ever legislative relief that's necessary for managed care, because some of the stipulations are really horrendous. The gag rule is just one thing, and it goes on.

We have young physicians who are saddled with high premiums and difficult situations. I think they deserve a break. They are the future of medicine in this country and we're really giving them a very poor start.

DR. RHOADS: If you'd like, I can amplify on that a little bit. Hospitals pay a certain amount of this liability cost. They adjust their rates annually, if not more

frequently. If they knew they didn't have to spend as much money on liability, they would be in a better position to fund care for the indigent or to hold down increases in their own rates.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Hennessey. Representative Maitland.

REPRESENTATIVE MAITLAND: Thank you, Mr. Chairman. Doctor Cottle, you mentioned in your testimony Act 111 and judicial decisions that have gutted favorable provisions of that. Would you go over that again for me in maybe a little more detail?

DR. COTTLE: Well, I will have to refer to my notes a little bit here. In Act 111 we did have a rule that prevented double recovery, which was the collateral source rule. That was, I believe, shot down and is unconstitutional, or whatever the legal terms are by the Trial Bar.

There were limits on plaintiffs' attorneys' fees. That's gone. I did mention

the arbitration process. It was never really given a fair shot to get going. The Trial Bar shot that down.

Informed consent is long gone. Let me just elaborate a little bit on informed consent. I'm an anesthesiologist. If I come to your room the night before surgery and I have to give you an informed consent for the epidural that I'll give you tomorrow morning for your lapchole (phonetic), it would probably take me half the night and 6 or 7 type-written pages, single-spaced to name all the possibilities that could happen to you when you come from an epidural from me.

Yes, they exist. They're mentioned maybe once or twice in this literature, but if I haven't mentioned them in the courts and something goes wrong, I am hung because I failed to mention some obscure complication. That makes it very confusing to the patient.

I think there are ways to provide the patient with explanation of the risks and informing them of what happens to them in a much better way than the way the informed consent -- Well, it doesn't exist. It's not an informed

consent. It's a recitation of what the literature has, and God forbid you miss one of the references.

REPRESENTATIVE MAITLAND: Does that have to be in writing, that informed consent, or can it be oral? Do you need to have a witness if it's oral?

MR. JONES: As a practical matter, you need it in writing. As a practical matter it's awfully nice to have a witness. Theoretically you can do it orally, but these become proof issues. You had asked for cases and there were 2 important ones, Mattis versus Thompson, and I think that was a 1980 case, and Heller versus Frankston, if memory serves, which is a 1984 case, both Pennsylvania Supreme Court decisions.

DR. RHOADS: I might amplify on the informed consent. Any physician who doesn't want to deliver a service to a patient can usually scare the patient away by emphasizing all the bad things that could happen. But as you know, on the average case, the patient's best chance is really to go for the procedure with its attendant risks.

Certainly in my practice I would

mention some of the risks. I would not go about mentioning all the obscure and very unlikely risks, but the common ones and the things we see most often we would certainly mention to the patient.

REPRESENTATIVE MAITLAND: I have one other question. Doctor Rhoads, in your testimony you talked about a shorter tail would allow for more accurate reserving and reducing guesswork in setting rates. Do you see any harm to injured patients if we were to do that? Can you say how many cases, what percentage of cases go back beyond 4 or 5, 10 years, whatever tail you would set on these cases?

DR. RHOADS: It's hard to answer that exactly. I know of a case and a very distinguished surgeon who is held in very high regard; never been sued up to a point in his life with many, many years of experience, and one day he was served his suit for events that had occurred 15 years previously. Basically, he was involved in on the basis of lack of informed consent.

It had to do with a growth in the lower part of the patient's spine and this was

removed and it came back. The type of tumor was such that the surgeon thought that the patient would be dead in 2 years; but, in fact, this patient did not die. He survived. The tumor did come back; it was removed again. But the second time it was removed the patient suffered some neurologic deficit as a result because it was a little bit higher up and getting into the nerves a little bit. After a number of years the suit was filed. I mean, so many years had passed that it seemed unreasonable to be filing a suit at that point. So, that's an example.

There can be very late problems without becoming treatment. For example, I am seeing a patient at the present time who had an infection in his chest when he was 2 years old. Now he's 80 years old and he's got a recurrence. Was that related to the treatment in the process at that time or not? I don't know. I tend to think it is, but it may not be. It would be very difficult to prove.

We know, for example, that if you have a coronary artery bypass graft, for example, that after a number of years the grafts will deteriorate and you may have to have another

operation. The same thing for heart valve replacements; same thing for major joint replacements. It is not malpractice. These are just the sorts of things that happen in the natural course of the conditions and the treatments involved.

REPRESENTATIVE MAITLAND: Thank you. One last question, Mr. Chairman, for Counsel Jones. On the case of the psychic who was awarded $600,000 for loss of her psychic power for a CAT scan.

MR. JONES: Yes.

REPRESENTATIVE MAITLAND: Was that a jury trial or was that a settlement?

MR. JONES: No, it wasn't a settlement. I can't imagine defense counsel settling that case. No, that was a jury verdict out of Philadelphia.

REPRESENTATIVE MAITLAND: Was it appealed?

MR. JONES: It was appealed and the ultimate result was that the courts reduced or eliminated that award entirely. There was a great deal of public outcry when that verdict came down. I don't think it's surprising that

the appeals court decided that something needed to be done about that.

On the other hand, if your view is that the jury is always right, that's a good case to suggest that the jury isn't always right.

REPRESENTATIVE MAITLAND: Would you care to speculate on what the jury saw in the case that led them to grant that award?

MR. JONES: I don't know. There's a number of jury verdicts that I've heard over the last couple of years which I have a little trouble understanding.

REPRESENTATIVE MAITLAND: Is it true that that's a very rare exception to the rule, such an outrageous award?

MR. JONES: I can't speculate. If the question is, is the Medical Society opposed to the jury system, the answer is no. But, we think that for many patients they would prefer and physicians would prefer to use arbitration systems or other sorts of alternative dispute resolution systems which are faster. We think they're going to cost less. We think they're good systems to be using.

REPRESENTATIVE MAITLAND: Thank you. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Maitland. Representative Schuler.

REPRESENTATIVE SCHULER: Thank you, Mr. Chairman. Let me ask you some of the same questions I asked the lawyers. Do you feel that you may have some degree of responsibility in the problem that we are now confronted with in the medical profession?

DR. RHOADS: The medical profession, of course, is accused of being a source of the problem by being less than perfect in the treatment of patients. We do the best we can. I don't know of anybody that has any evil motive or intent.

As Doctor Cottle said, our first directive is to do no harm. But, we know that not everybody has a good outcome from medical treatment. We don't know always know in advance who will and who won't. Maybe if we knew that, we would not offer certain treatments to people who would not likely to have a good outcome.

How much more do you want me to say on

that?

REPRESENTATIVE SCHULER: Therefore, you do not see anything within the present practice of the medical profession that contributes to the problem that we're confronted with? Let me just give you an example. The lawyer said negligence. The other individual said, well, negligence has gone down as far as the -- I'm a little confused on that.

DR. RHOADS: Negligence is a little bit like some other attributes that it may be in the eye of the beholder. What one person thinks is proper care, another person thinks is negligence.

As you may know, you work pretty fast and furiously taking care of patients, and you document that reasonably at the time. But then, if somebody goes through the chart with a fine-tooth comb and finds certain omissions or maybe certain misspellings, or whatever, they then build a case of negligence on the basis of that.

For example, I was asked to review a chart of a child who had come in seriously ill with lung troubles, and they started an IV and

administered some medication and the IV quit working and they started another one. And the second IV, the child developed a problem where the IV was put in and lost a little skin and ended up having to have a skin graft, and they sued.

Now, the child survived the serious illness but had some problems for which they sued. Was the treating physician negligent or not? I say no, but obviously, the attorney for the case and the parents thought that maybe there was some negligence.

REPRESENTATIVE SCHULER: Okay, that's all I have.

MR. JONES: Mr. Chairman, may I comment briefly on that question?

CHAIRMAN GANNON: Certainly.

MR. JONES: I note the bill contains at least 2 provisions that attempt to address the medical side of the problem. One provision essentially says that all malpractice payments or awards are to be reported to the Medical Board, and that there is an oversight over that by the Committee on Professional Licensure.

So, the hope is that, to the extent

that we can identify physicians who are practicing substandard care, we can begin to address that problem through the licensure process.

The other thing that the bill provides is that, hospitals, nursing homes and insurers are required to identify and put into place risk management programs, and the risk management programs are obviously designed to reduce the incidents of malpractice to the extent that can be done. To some degree, at least, there's an effort made in the bill itself, which we support, to provide part, at least, of the medical side of the solution.

REPRESENTATIVE SCHULER: Thank you.

CHAIRMAN GANNON: Representative Chadwick.

REPRESENTATIVE CHADWICK: Thank you, Mr. Chairman. I'm glad that my good friend Tom Previc (phonetic) from the Trial Lawyers is in the back of the room because he'll appreciate this baseball analogy. He and I are both baseball fans.

I think everyone would agree that I served up to Mr. Piccone my best fast balls,

curves and sliders, evil though they may have been. Probably, most people would perceive the questions I would ask these witnesses to be something akin to lobbing softballs. I'm not sure that that's the best use of the committee's time given that we're a half an hour behind schedule. So, I think I'll pass on asking any questions.

CHAIRMAN GANNON: Thank you, Representative Chadwick. Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. Doctor, you have made the comment that negligence oftentimes is something that's in the eye of the beholder. I would agree with you and I think that's why things get litigated.

I guess I want to suggest that I think the word frivolous also is often in the eye of the beholder, and it depends from whence you sit whether or not something would be perceived as frivolous. Assuming that we could identify upfront and before all the facts of a case have been brought out through the discovery process whether or not something was frivolous so that -- My point is, assuming we leave some

component of that into a bill like this, my question goes to the point that Mr. Piccone made in his testimony about no one really asks about a frivolous defense.

My question to you is, as a tradeoff would you be willing to not only put the burden of attorneys' costs and all other things of filing a frivolous lawsuit on the plaintiff lawyer if they are unsuccessful, but would you be willing to put the defense, if you lose, the defense of a lawsuit and all the costs involved there on the defendant in those cases? Is that a fair tradeoff in a bill like this?

DR. RHOADS: The defendant is already paying those costs.

REPRESENTATIVE MANDERINO: But he's not paying the plaintiff's costs.

DR. RHOADS: Maybe you're saying that the contingency fee should be added to the award instead of subtracted from it in the event that it was decided that the defense was frivolous. Is that what you're saying?

REPRESENTATIVE MANDERINO: No. What I'm saying is, the 2 most expensive kinds of tort claims to bring as a plaintiff are medical

malpractice and product liability. The reason for that is because, those are 2 unique areas of tort law, probably more than anyone else, that hinge on expert testimony and expert testimony that costs money to put together.

So, when you say to us that 53 percent of the costs of what is awarded to a plaintiff don't make it to the plaintiff, it's very obvious to me who has practiced this on both sides of the fence why that is. Because, in a typical med/mal or product liability claim your cost, your cost before you talk anything about attorneys' fees, could be anywhere between one and $300,000; your costs on that case.

So, if you get an award of $650,000, almost 50 percent of it could be taken out in costs before the plaintiff gets any money and before the attorney gets any money for legal fees.

What I'm saying is -- And we can argue about the equities in the system, about who has the most chance. I think both sides can run up those costs the way they pursue the case or the way they defend the case. Both case sides can contribute to running up those costs.

My whole point is, if we're recognizing that that is something in the system and we're saying that the plaintiff attorney who brings the frivolous case should be liable for those costs -- I guess what I'm saying is, is it fair to say -- And if they win on the other end we should assume, just like we're going to assume in this bill that if they brought the case and they lost, they brought a frivolous case. I think it's a bad assumption. But, if we're going to assume that, isn't it fair to assume that if they defended the case and they lost, it was a frivolous defense, and it should go 2 ways. That's the point that I'm making.

DR. RHOADS: My understanding is that insurance companies will not go to the expense of defending a case they think they can't win; right upfront.

I mean, I sat on the claims committee of PMSLIC a few weeks ago. If it didn't look like a very sound defense, they were recommending to settle; settle, settle, settle.

One of the problems that physicians have had with other insurance companies other than PMSLIC is that the insurance companies were

willing to settle many cases for small amounts quickly to avoid the cost of litigation. PMSLIC doesn't do that.

REPRESENTATIVE MANDERINO: Let me ask you --

DR. RHOADS: I am not really prepared to answer your question because I don't have an authority on that. Doctor Cottle would like to take a crack at it.

DR. COTTLE: First of all, at least as far as the Medical Society Insurance Company is concerned, we do ride herd on defensive expenses very hard. In fact, we have shown that in the last 7 to 10 years our defense expenses have consistently gone down. We make an effort to do that.

REPRESENTATIVE MANDERINO: But you're not in the case from first dollar, correct?

DR. COTTLE: Oh yes.

REPRESENTATIVE MANDERINO: I'm sorry. I was thinking of the --

DR. COTTLE: I'm not the CAT Fund. No. The CAT Fund isn't an insurance company.

REPRESENTATIVE MANDERION: I understand. I apologize.

DR. COTTLE: No. We're in from first dollar; we certainly are. If we were to show you our statistics on the control of our expenses for defense attorneys and on expediting cases to get into court and to get settled, you would be amazed at the progress we have made just from within the company.

I really feel that, the big thing you talked about frivolous suits, I don't understand how you cannot believe there aren't frivolous suits? I think there are statistics that support it just from my company alone. We spend $72 million on cases that didn't go anywhere, that nobody got anything. When we go to court -- and I didn't give you this before. But, when we go to court with a case, we win before a jury more than 85 percent of the cases we take to court.

REPRESENTATIVE MANDERINO: You're translating that into 85 percent of the cases were frivolous?

DR. COTTLE: No, I'm not translating that. What I'm translating is that, the 9,000 claims that we had that resulted in $72 million spent that didn't go anywhere may be frivolous.

I'm also saying that we do defend doctors, and the business of going to court means that we had justifiable cases that we defended. Only a small portion of them were not won in the court system.

REPRESENTATIVE MANDERINO: I defended a lot of lawyers and I know that lawyers have, I guess what you would call the right of refusal, so to speak, on whether or not you can consent to settle. Doctors have the same?

DR. COTTLE: In our company they do.

REPRESENTATIVE MANDERINO: Okay. Thank you.

MR. JONES: Just quickly, the bill defines frivolous for the purpose of expenses, recovery, as without reasonable basis in law or fact. It's not a question of simply losing or winning the case. It's a question of whether you proceeded--I don't know how to say it any better--without any legal basis to do so.

REPRESENTATIVE MANDERINO: On the issue of the shorter tail, I understand the problem that you were raising. The solution proposed, though, through the bill is to cut off, particularly in the case of minors, cut off

their substantive rights at some point when they are still minors.

I guess most professional liability insurance in the medical industry must still be written on an occurrence basis. I know in the legal professional liability area the insurance is written on a claims-made basis. Won't a claims-made basis type of a policy solve your problem with regard to the tail without substantively taking away the rights of a younger minor?

DR. COTTLE: Except for PMSLIC most of the policies are claims made. We happen to offer both types of policy.

REPRESENTATIVE MANDERINO: But if a claim is being made then, and that's when the coverage kicks in, you don't have this -- or am I misunderstanding the issue? You don't have this issue of this long tail hanging out there because your liability is rated totally differently.

DR. COTTLE: I'm not sure I understand your question.

DR. RHOADES: There's always going to be a tail. For example, suppose you have

claims-made policies, say you're in a practice for 30 years and you have a claims-made policy every year. But, on the 30th year you're going to retire. Then you still have an ongoing liability. Either you buy a claims-made policy in your retirement each year or you buy a tail. Basically, the occurrence gives you claims made for that year plus the tail for that year. The tail is always there.

REPRESENTATIVE MANDERINO: What I'm saying is, that is not cutting off somebody's right to bring a claim. Whereas, what you're proposing in the bill is.

DR. COTTLE: You're talking about 2 different kinds of tails, I believe.

REPRESENTATIVE MANDERINO: Okay. Maybe I am.

DR. COTTLE: Some of us are talking about tails as it applies to the coverage against the risk of liability by the physician. The tail that is mentioned when talking about the Statute of Limitation, or whatever you want to call it legally, is the tail that the time it takes to tell the insured and the insurance company that they have a case that they have to

deal with.

In other words, unlike automobile accidents, which we know everything that happens in this year, unfortunately--and you know this as well as I do--that the liability for something that happens today in practice somewhere will not appear anywhere from 5, 6, even 7 and 8 years. All that time reserves have to be allowed. This adds to premium requirements. The money has to be constantly allocated to meet the requirement at that distant point in time.

That's the tail they're talking about. It prolongs that tail. It makes the economic arrangements to cover that need much more difficult and expensive. That's why we see the need to have a better handle on the Statute of Limitation.

But, also I will tell you that my experience within the insurance company is that, I very rarely see anything come beyond the time that the statute tolls. Almost everybody knows they have an injury and seek redress for it within that time sooner or later.

The pediatric one has been extended

because of pediatric conditions being a little different. But even then, that amount of time is really very reasonable from a medical point of view and from the ability of people to perceive that they have an injury.

I don't think we are trying to shortchange anybody or shut anybody out from an injury. I think we're trying to make the system more effective and economical so that there is more money to pay for injury and less money that has to be wasted on the time frame of providing for reserves. I don't know whether I made myself clear or not.

REPRESENTATIVE MANDERINO: Well, you did. I guess I philosophically still have a problem with your saying that we're going to take an 8-year old child who today under current law that, God forbid something happened to him and his parents just didn't know any better or didn't know to do anything and who now has -- when he or she reaches maturity has an ability to bring a claim on something that has substantially affected his physical well-being. Right now we're being asked to make that decision through action of law to cut him off at

12 years old. So, if he had ignorant parents it's like his tough luck. That's the one part that I'm having a bit of a problem with that I was trying to address.

On the informed consent issue, Doctor Cottle, you were the one that went into detail about what you perceived the law to require you to do today. I am not an expert on it. I don't mean to profess that I am. My reading of what the law requires today with regard to informed consent is not what you described with regard to it taking several hours of meeting to bring in the treatise. That's not the standard that I understand that you're held to.

I thought the biggest change being made with what was being proposed in this bill with regard to informed consent was not necessarily what was outlined in defining what informed consent is now, but this distinction for major invasive procedures, where major is not defined, as compared to an obligation now to do informed consent for any procedure whether we call it major invasive or not.

MR. JONES: We took that language major invasive procedure out of the existing

case law. If we have it wrong, we'd be happy to correct it. My understanding is, that is the law in Pennsylvania now.

REPRESENTATIVE MANDERINO: Then let me rephrase my question. Then what is it with regard to, so that I can understand, with regard to what you're proposing in the bill with regard to informed consent that is different -- Which are the critical clauses that are giving you additional protections or clarity that are not in the law right now? Which of those line items on this bill?

MR. JONES: I think Doctor Cottle identified one. Right now the law says that you look at what informed consent has to be given from the patient's standpoint. The difficulty from the physician's standpoint is, it's not clear exactly. If we could come up with a standard that physicians could agree to and we could get expert testimony on them. I'm not talking about any group making the decision, but a more or less objective standard where we could narrow the list. Then the attorneys who are advising physicians as to what they need on their informed consent forms can start to come

up with what I would think would be a reasonable list of things.

So, A, there is that; and B, there has been a debate for some time now as you know as to whether Pennsylvania should be a battery state or a negligent state as far as informed consent. At the moment we're a battery state.

I don't know if that means anything to nonlawyers, but the lawyers it means they're confused because negligent seems to be the more logical approach here, as you know. The suggestion is, we move over to a negligent standard which we hope will take care of a variety of difficult questions that are hard to resolve under the battery standard.

REPRESENTATIVE MANDERINO: Thank you. My last is just a simple request since many of us seem to be intrigued by the lost of psychic power cases. If you can forward to me either the citation or the copy of the case, I'd appreciate it. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Manderino. Counsel Preski?

MR. PRESKI: No questions.

CHAIRMAN GANNON: Counsel Andring.

MR. ANDRING: I have a few brief questions. Thank you, Mr. Chairman. Doctor Rhoads, there's reference in your testimony to a fact that, nationally, some 80 percent of all cases are closed without payment. Is that the experience also in the Commonwealth of Pennsylvania?

DR. COTTLE: Yes.

DR. RHOADS: Yes.

DR. COTTLE: Just a minute. Let me find my statistics here.

MR. ANDRING: That's on page 3 of the testimony. Yes, of Doctor Rhoads' testimony.

DR. COTTLE: It's your testimony.

MR. JONES: I believe those are national statistics and Pennsylvania's are probably a little lower. I don't think PMSLIC's are. I think PMSLIC's are reflective of the 80 percent.

DR. COTTLE: Ours are 80 percent. That wasn't in my testimony.

MR. ANDRING: You're indicating that it's PMSLIC's experience that approximately 80 percent of all the claims are closed without any payments being made?

DR. COTTLE: No, I'm not saying that. I'm sorry. I'm not saying that.

MR. ANDRING: That's the number I'm referring to, a claim here --

DR. COTTLE: I don't have that in my testimony.

MR. JONES: That's a national figure, Representative.

MR. ANDRING: Perhaps, you could tell us from PMSLIC's experience, do you know what percentage of the claims PMSLIC receives that it ends up making payment on?

DR. COTTLE: I guess we don't make payment on 80 -- 80 percent of those cases that go to court, more than 80 percent actually for PMSLIC, about 85 percent that go to court we do not pay on.

MR. ANDRING: Excuse me. That's not the question. This says, nationally some 80 percent of all cases are closed without a payment. Now, I'm trying to find out if that's a valid number for Pennsylvania.

DR. RHOADS: We don't have that information this morning.

MR. ANDRING: Would PMSLIC have

available information on the percentage of cases that you close without any payment going to the plaintiff?

DR. COTTLE: Absolutely, and I'd be very happy to provide you with it.

MR. ANDRING: Okay. Thank you. I would like that information. You made reference in your testimony as to $72 million approximately paid out to settle 8,000 cases for PMSLIC in which no recovery was made by the plaintiffs. Would you have an idea of the approximate total amount of premiums that you received over that time period?

DR. COTTLE: No. Right now, no.

MR. ANDRING: Could you get that information so we could see the percentage? You're giving us a raw number. I have no idea if that's 10 percent of your premiums or 50 percent of your premiums that you're spending on disposing of these cases.

DR. COTTLE: I'm hard-pressed because that's a large space of time. If you gave me a year or 2 recently I might be able to.

MR. ANDRING: I understand. There were at several points in Mr. Rhoads' testimony

where reference was made to the mandatory insurance requirement. I just want to clarify this. Does the Pennsylvania Medical Society oppose or support the current mandatory insurance requirement?

MR. JONES: I'm afraid the answer is, it's been mandatory for so long that I don't know if there's been actually any recent consideration of whether it's a good idea or a bad idea. I know there's a substantial number of physicians who are unhappy with mandatory insurance.

DR. RHOADS: Our point of view has changed from the time this act was enacted. At the time mandatory insurance was a condition for licensure. We have since clarified our view on licensure to indicate that licensure should indicate competence and experience, to be able to practice with reasonable safety and that it should not be tied to what insurances you accept or what liability insurance you carry, or things like that.

For example, in the Physician Fee Control Act a couple years ago which insisted a physician will accept Medicare payments as

payment in full for patients to Medicare beneficiaries, initially that was proposed with threats upon one's license. Subsequently, that was rewritten with monetary penalties instead of threats on the license. So, we would certainly in this day and age not support reenacting this bill with that kind of a threat on the license, although there might be other penalties that might be offered instead.

MR. JONES: I stand corrected.

MR. ANDRING: But you're not proposing that mandatory insurance be repealed?

DR. RHOADS: The bill does not touch that.

DR. COTTLE: No.

MR. ANDRING: Is that something that's on the burner, so to speak, or not with the Medical Society?

DR. RHOADS: No, it's not.

MR. PRESKI: I'm simply trying to identify the specific nature of the problem here.

DR. RHOADS: It is not. Some of us have individual opinions about that, but it is not Medical Society policy to impose that.

DR. COTTLE: The corruption of the license requirements would be, though.

MR. ANDRING: At a number of points in the testimony there were references to, that there was one specific reference to the system being tilted against the majority of patients and other references about treating patients fairly. Could you specifically describe those aspects of the current malpractice system which treat a patient unfairly and the provisions in your bill that would correct that situation?

DR. RHOADS: The specific problem is the amount of money that does not get to the patient, that is set aside for handling patient's injuries. It gets diverted to legal and administrative expenses. This is the part that we feel is unfair. We believe that some of the provisions of the bill, for instance the arbitration panels would allow payments to be made more promptly and probably with a higher percentage going to the patients.

MR. ANDRING: So, the patients themselves -- Again, I'm trying to focus this specifically on a patient. Your concern is that out of, say a hundred dollars paid in premium,

only apparently $42 of that goes to the patient. That's your concern?

DR. RHOADS: That's a major concern. Yes, it is.

MR. ANDRING: In looking through the bill, a great many of these provisions, and again that $42 was your figure; 57 going for attorneys, administrative, and I assume that includes insurance company costs also?

DR. RHOADS: That's the administrative part.

MR. ANDRING: Okay, and $42 to the patient. When I look through the bill at many of these provisions, collateral source rule, informing a jury of other benefits, informed consent, limits on punitive damages, Statute of Limitations, periodic payment of damages, I don't see how any of those provisions are going to change that 42 percent figure that the patient is receiving right now. It seems to me the only effect of those is going to decrease the total amount of money that injured patients right now receive. Could you explain why that would not be true?

DR. RHOADS: I think there's another

issue that we really haven't spoken about yet, and that is access to care. Let me see if I can explain what happens. In Massachusetts a few years ago they had an insurance, a liability insurance law that said that if the payouts from liability insurance year exceeded the premium that was put in, they'd go back to the providers and ask them to give more money. One year came along, they did this for the obstetricians and immediately half of the obstetricians quit delivering babies.

In my hospital we are a trauma center and a number of the surgeons take trauma call. One of the surgeons who was taking trauma call was involved in the care of 2 patients that had bad outcomes, related basically to the bad injuries they had. He was named in suits that were filed and he quit taking trauma call.

In Syracuse, New York, some years ago there was a dramatic increase in the liability insurance premium for neurosurgeons, and six neurosurgeons in the City of Syracuse as soon as these insurance premiums came through all decided to leave the state at the same time. This is the kind of access problem that I think

is a serious potential problem. We haven't had it in a big way yet, but it could come.

We haven't talked yet about some of the things that are coming down the pike. We heard earlier from the Bar that the current high rates or the surcharge for the CAT Fund are a temporary thing. But Mr. Reed of the CAT Fund came to a Medical Society meeting last fall and he said, you can expect this year after year after year for the next several years.

So, I don't think this is a temporary thing. We know there's a huge liability out there that nobody has funded that the CAT Fund could be called upon to pay. I believe enormous amounts of money are going to be called upon.

We haven't yet heard about the impact of the breast implant litigation. But, I can assure you that an enormous number of suits has been filed against plastic surgeons who implanted breast implants really to help people psyche following treatment for breast cancer. Then there was all the flap about how these breast implants were causing all kinds of symptoms call adjuvant disease.

By and by, some lawyers got a hold of

a list of all the people who had the implants and called them up and asked them, wouldn't you like to file a suit? One of the plastic surgeons in my community received 32 suits in one day.

If these things come to court and the lawyers are skillful in getting the sympathy of the jury, there's going to be an enormous amount of money asked to be paid and that's going to come through the CAT Fund.

So, access is a real problem. There comes a time when young people who finish their residencies what to decide where to practice. If they're asked to pay this huge unfunded liability from the CAT Fund if they practice in Pennsylvania, they may decide to go someplace else. Some of the senior doctors have written to me saying that the liability costs are so much that they're thinking of closing their practices and retiring.

You've got these problems that are just around the corner; they're just over the hill. They're coming. It has to do with the amount of money that's having to be paid for this liability process which you think is

terribly flawed right from the start.

MR. ANDRING: Doctor, I asked you a question about specific provisions that would actually lessen the amount of money received by injured patients. The way you responded, truthfully, I think indicates the crux of your problem. It is not as you state, I don't think, in your testimony here that you wouldn't care about the cost of malpractice insurance if, quote, in return a fair portion of the money collected would go to injured patients instead of to lawyers on both sides and administrators.

We're not talking about a problem of allocating the insurance dollars among injured patients and other costs of the system. The problem that you are presenting here is that, malpractice insurance cost too much for the physicians. Isn't that essentially the problem that you believe needs to be addressed?

DR. RHOADS: That is certainly a part of it.

DR. COTTLE: But it isn't the only part. It really isn't the only part. Certainly, patients have every right in the world to be justly -- If you go to sue somebody

for a thousand dollars and you don't get it, what's the point? Your expenses were a thousand dollars and you want to be reimbursed them and you're going to have to pay for the system and the attorney and you only get less than half of it to meet your expenses. That's unfair. That's unfair to any citizen in this Commonwealth.

MR. ANDRING: But conversely, that would seem to be an argument for having contingent fees added onto a judgment rather than subtracted from the plaintiff's share, and that's not what we're here about.

DR. RHOADS: It's a good argument to reduce the contingent fee.

MR. ANDRING: Quite possibly also. But again, that's not what your testimony has represented as being the problem. Your testimony speaks continuously about this 57/43 split, and the problem is that the patients aren't getting enough and the lawyers and the administrators are getting too much. And you respond to that with provisions that are simply going to reduce the amount of money being received by patients.

Which leads me to my final question; if the problem, which I believe it really is, and I think if you would be entirely straight-forward, you would concede this, the problem is the dollar amount of the insurance the physicians are being required to paid. And if that's the problem, then what percentage are you looking for in a decrease that would solve that problem for physicians in Pennsylvania?

DR. COTTLE: I would like to answer that. As an anesthesiologist, I belong to a specialty that has so improved its performance that, as a risk, we have moved into a much lower category. When I first started in practice I was grouped with the high-risk doctors and paid enormous premiums as far as I was concerned. At the present time, anesthesiology has done a marvelous job in improving its care and its physician performance and we are in a lower group.

This is fine, but we do care about what happens to patients. We want to improve our performance. We want to see them get a fair shake. In here is an arbitration panel concept that would certainly make it easier for

physicians and patients; not just doctors; patients.

I don't think you can appreciate being a physician or a patient and being in the courtroom. To me it is one of the most devastating things. I personally have never been on the receiving end of either one, but I have been present where some of our insureds and I have watched patients there. It is not a pleasant situation.

The other thing, as a physician, this is what I'm looking for. I'm looking to have a reasonable situation. I am tired of sitting in my office and viewing every patient that comes through the door as the next lawsuit before I even know what's wrong with them.

We are constantly threatened. We live under the gun. This is no way to practice a profession. This is no way to start off taking care of somebody with a serious injury or illness. You can't have a sword of Damocles hanging over your head. This is not right. That's what I'm fighting for. I really am. I want to see patients get a fair shake and I want to practice in a fair environment.

I'm tired of having the knife at my back saying, you know, we might be able to get something out of this one. I'm tired of that. I've been practicing medicine for 35 years and I can tell you, it is devastating.

You talk about defensive medicine. I don't have time to tell you about what I do to practice defensive medicine, and I'm a good anesthesiologist. I defy anyone to say otherwise, because I'm sick of this uneven playing field.

MR. ANDRING: I have no further questions.

CHAIRMAN GANNON: Thank you, Counsel Andring. Just a question. Do the policies that PMSLIC issue in order for a case to be settled, does it require the permission of the insured?

DR. COTTLE: Yes, it does. We have a consent to settle. That's PMSLIC. I cannot speak for the entire industry.

CHAIRMAN GANNON: Are either of you involved in the day-to-day operations of PMSLIC? I know you're Chairman of the board. Are you involved in the day-to-day operations?

DR. COTTLE: Weekly, but not

necessarily every single day.

CHAIRMAN GANNON: No, I mean -- You know what I mean.

DR. COTTLE: Yes. I'm involved. I'm intimately involved.

CHAIRMAN GANNON: In the day-to-day operations?

DR. COTTLE: The C.O.O. would be more involved than I am.

CHAIRMAN GANNON: There's an arbitration provision in this bill. Is this similar to common law arbitration?

MR. JONES: The bill attempts to define what sort of an arbitration system it is. Frankly, I'm not sure whether it's closer to common law or to some of the statutory approaches, but essentially it calls for one arbiter selected by each party to select a third with all the protections that are available under the usual due process court system. It's that basic approach.

CHAIRMAN GANNON: My reading of that is, it was probably common law arbitration.

MR. JONES: I think you're right, but I'm not sure.

CHAIRMAN GANNON: You're aware that there's no appeal from common law arbitration?

MR. JONES: I believe the idea here was to settle the case, make the payments and do it in a quick time frame. That means binding arbitration.

CHAIRMAN GANNON: I'm getting a scenario, for example, the psychic disorder. You could have a scenario where that would have been heard by a panel of arbitrators and the award could have been just the same as we now know that that award was reduced to, I believe zero by the courts on appeal. In a situation under this bill you could still have the public outrage or perceived outrage, but you wouldn't have any right to appeal to get that award reduced to zero.

MR. JONES: I would hope there's still an appeal for errors in the law which is what happened --

CHAIRMAN GANNON: Not under arbitration. It's only -- not for errors in law or in fact; not under common law. Thank you. Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you,

Mr. Chairman. I'll try to make this quick. I think our stenographer needs a break. The consent to settle provision, Doctor Cottle, you referred to, let's assume in PMSLIC -- What's the company you sit on the board for?

DR. COTTLE: PMSLIC.

REPRESENTATIVE HENNESSEY: You have a chance to settle that case for a hundred thousand dollars. You presented it to me and I'm a doctor and I say that's crazy. I didn't do anything wrong. I refuse to settle. It goes to trial and the verdict comes in at $175,000.

What's PMSLIC's liability? Do you have to pay the full 175 because, in many cases insurance companies, once they've established a threshold of what they can settle the case for, then they're out of it and I have to, in a sense, self-insure for my intransit --

DR. COTTLE: I think I need to give you a little more background. We do have a consent to settle. All our cases go past a physician committee that reviews the cases for the quality of the medicine that is practiced. We have a slogan in the company, if it's good medicine we'll defend it no matter what it is.

If it's a 15-cent case, we're going to court if it's good medicine.

But, if it's bad medicine, we take a position. We take a position that we don't think it's defensible. Our insured will say, I won't give you a consent to settle. There is a line of appeal for him within the company and within the Medical Society. He can have a hearing in front of his peers on this subject. He comes before the Claims Committee, oftentimes presenting additional material that we didn't have or that the defense attorney didn't have. It expands our knowledge and information. Sometimes the Claims Committee will reverse itself.

On the other hand, if the Claims Committee stands firm, they have also the right to appeal to an appeals committee of physicians and their peers in the Medical Society. That becomes binding on the insured. If those doctors, the second tier of doctors, also feels it's not defensible, we will not defend it. We will settle it. Or, if we feel --

REPRESENTATIVE HENNESSEY: So, the situation I presented to you never occurs unless

your initial decision is --

DR. COTTLE: I must have rotten luck.

REPRESENTATIVE HENNESSEY: -- unless your initial decision is reversed by the peer review --

DR. COTTLE: By the peer review process. There are 2 levels of peer review process and it always involves the peers and the experts of that person's field of endeavor.

REPRESENTATIVE HENNESSEY: I was just trying to get to the point of, you know, consent to settle oftentimes leaves the person insuring the overage by themselves. You don't have that situation. You resolve it before it even gets to that.

DR. COTTLE: We try, but if it does go to court and it is over what we had originally thought it was going to be, we still pay it no matter what.

REPRESENTATIVE HENNESSEY: Thank you. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Hennessey. Thank you, Doctor Rhoads and Doctor Cottle, for being here today to offer your testimony and take the questions

from the committee. We appreciate it.

DR. RHOADS: Thank you, Chairman Gannon, for allowing us to testify.

CHAIRMAN GANNON: We're going to take a 10-minute break.

(Recess occurred)

CHAIRMAN GANNON: We are going to reconvene the Judiciary Committee hearing on House Bill 2122. Our next witness is Joanne Hamill-Flum, President of the Pennsylvania Trial Lawyers Association. Welcome, and you may proceed.

MS. HAMILL-FLUM: Thank you. I'm glad to see there are some people remaining here today. I would again like to introduce myself. I am Joanna Hamill-Flum. I am currently President of the Pennsylvania Trial Lawyers Association. I would like to thank Chairman Gannon and the other distinguished members of this committee for permitting me to testify here today. I'm accompanied by Mark Phenicie, our legislative counsel.

The Pennsylvania Trial Lawyers Association, through its several thousand members, is the only statewide bar association

that speaks exclusively on behalf of injured and innocent consumers and workers of this Commonwealth. Therefore, it is with a profound sense of duty and commitment that I testify today concerning how House Bill 2122 would drive a stake into the heart of rights currently guaranteed to injured patients.

CHAIRMAN GANNON: Ms. Hamill, may I please interrupt just for one second. I really apologize. I wanted to welcome the Chairman of House Insurance Committee, Representative Nick Micozzie, who also has a deep interest in this issue from another aspect. I apologize for the interruption. Thank you.

MS. HAMILL-FLUM: May I initially state that there are many fine physicians and other health care providers in this Commonwealth who every day deliver superior services to their patients and often perform acts of heroism in saving lives. I salute those physicians.

However, physicians, as all of us, sometimes make mistakes and, just as you and I and every other citizen must be held accountable for our mistakes, so must physicians.

Any system of accountability must not

be a sham and must not protect the wrongdoer to the detriment of the innocent. There is nothing as magnificent or as fair as the common law in dispute resolution.

Our current system is equitable and protects the rights of both plaintiffs and defendants. However, House Bill 2122, which is nothing more than special interest legislation protecting physicians and limiting patient's rights, would drastically tip the scales in favor of wrongdoers permitting them to evade accountability for their mistakes.

Permit me to point out to you that, according to extrapolations from the Harvard Medical Practice Study, approximately 80,000 Americans die and hundreds of thousands more are seriously injured each year due to medical negligence. While the Harvard Study is the most comprehensive study produced to date with respect to the incidents of malpractice, Harvard only studied malpractice in hospitals and counted only cases where the negligence was blatant and resulted in serious injury or death. More than a million other Americans who experienced unforeseen injuries during

hospitalization were relegated by the Harvard to a benignly described category, adverse incidents.

Recent headlines tell the tragic story: A Tampa, Florida, man had the wrong leg amputated. A Boston Globe reporter died of an overdose of chemotherapy. An 8-year old Colorado boy died when his anesthesiologist put him under and then fell asleep. A New York neurosurgeon operated on the wrong side of a patient's brain.

A Caesarean section was not timely performed on a Pennsylvania woman, causing permanent brain damage to her baby. A Pennsylvania physician ignored the repeated reports of a lump in a woman's breast which the physician misdiagnosed as a cyst, without proper testing. She was belatedly diagnosed as suffering from breast cancer.

These are only the reported cases. Many of you may not know that when a medical negligence case settles, the injured patient is forced, as a condition of the settlement, to sign an agreement that he or she will not discuss the case or in any way publicize it.

So, there are many more egregious cases of medical negligence about which we never hear because of this restriction.

The fact that a physician commits medical negligence does not mean that he or she is a bad or incompetent physician. It means in that instance he or she made a mistake and fell below the applicable standard of care. However, because physicians do make mistakes, patients must not be deprived of their rights against these wrongdoers.

As I am sure you can appreciate, a patient suing a physician is akin to David fighting Goliath. A conspiracy of silence, wherein physicians do not want to testify against their colleagues, and the battery of lawyers that health care providers retain in order to defend themselves, work to the advantage of physicians.

Despite this, physicians have requested the legislature to pass special interest legislation that would limit the patient's rights while providing physicians with virtual immunity against their negligence. Certainly, any fair-minded, reasonable person

must abhor the mighty sword that the physicians are attempting to use against injured patients.

You have already heard testimony today concerning the Medical Catastrophe Loss Fund, the CAT Fund, and the fact that there really is no crisis in Pennsylvania so I will eliminate that part from my testimony.

Let me now turn my attention to specific sections of this bill that would essentially emasculate the rights of injured patients and make it virtually impossible to maintain a cause of action when they have suffered because of medical negligence. I will not discuss every section in depth. I have provided the committee with a written, in-depth and detailed analysis for your review at another time. However, I believe that after I discuss with you how this bill robs injured patients and rewards negligent doctors, you will have to agree that it is unfair and ill conceived.

Under present law, before undergoing surgery, a patient is entitled to be advised of any risk or alternative which a reasonable person would want to know, this is known as the prudent patient standard. This has long been

Pennsylvania law. This bill eliminates that protection, and instead, allows the medical profession to define the standards for what should know. This has been specifically rejected by our courts, and I have cited cases for you in the testimony.

Under this bill, doctors would be permitted to withhold information from patients, based upon their concepts of what is important, and thereby define the scope of their patients' right to know. This is poor public policy, because patients, as consumers of medical services, should be entitled to whatever information the average person would consider important.

One of the most outlandish issue and even ridiculous proposed provisions on informed consent in this bill is the one that states that, and I quote, nothing in this section on informed consent shall be construed as imposing a duty on a physician to apprise a patient of information the patient knows or should know.

Now, what this provision does in essence is, it shifts the duty to be informed from the physician to the patient. Can we

tolerate a law that places the burden on the patient to independently research and inform himself or herself about the risks of treatment? How is the physician supposed to know what the patient already understands about the procedure? Who is to determine what the patient should already know? To state the question is to highlight the absurdity of the proposition inherent in this section.

The danger in permitting a physician to hold such power over a patient has been made starkly clear in a case, that has been widely reported, involving the Hershey Medical Center, wherein, a physician unilaterally decided to remove life support from a 3-year old girl with a brain tumor without the family's consent or court order. We must never permit physicians to forget that it is the patient who must have ultimate control over his or her body.

If the Hershey Medical incident can occur under our present system, imagine the flagrant disregard of patient rights that could prevail if this particular bill were to become law.

House Bill 2122 reverses the

traditional common law rule under which a party found liable for wrongful conduct is not, as a matter of fairness, entitled to a credit against the damages owed, simply because benefits are available to the victim from another source. By abolishing the collateral source rule, it provides a windfall to culpable defendants, at the expense of the plaintiff or a third party providing benefits; nor, does it bar subrogation. Thus, an injured patient may be in the inequitable position of not being able to recover an item of damages for which there is a subrogation interest asserted.

The collateral source rule is not repealed in instances where an injured patient paid for premiums out of pocket, but this limitation fails to recognize that fringe benefits are an important part of most employees' compensation package, and often the subject of bargaining. Particularly in the case of union employees, wage concessions will often be made in order to secure better benefits. Such benefits ought not to be devoted to subsidizing wrongful conduct of physicians.

As written, the bill is particularly

onerous, because a negligent physician benefits not simply from payments already made to a victim, but also from any payments which the victim may receive in the future. This bill fails to take into account the fact that under many policies of insurance, particularly health insurance, there is a lifetime maximum provided to the injured patient. Why should a victim's long-term protection under health or disability policies be eroded for the benefit of a negligent physician?

You have heard testimony today concerning the Statute of Limitations in this bill. I would just like to point out to you that this particular part of the bill would abolish case law dating back to the 19th Century which extends the Statute of Limitations when the plaintiff lacked knowledge of his or her injury.

Under this bill, claims would be barred, even if the defendant made misrepresentations or committed fraudulent acts such as altering or falsifying medical records to prevent the plaintiff from learning of the malpractice. Therefore, the bill both penalizes

innocent patients and protects physicians who hide acts of malpractice.

The statute also erodes protection for minors enacted by this very legislature in 1984, by establishing a 4-year Statute of Limitations. Virtually, every state protects children by tolling the statute through the period of their minority. If the proposed legislation is adopted, Pennsylvania would become one of a handful of states which does not provide full protection to the rights of children.

In Pennsylvania, were this proposal to be in effect, a brain damaged baby would be obliged by statute to act by age 4 or be forever barred. This does not make any sense.

The proposed legislation establishes unreasonable and burdensome requirements upon counsel representing malpractice victims. It provides that a suit may not be commenced unless counsel already has assigned expert report identifying deviations from the standard of care. Such a requirement is unworkable.

First of all, I've already told you about the conspiracy of silence which still protects negligent physicians. Many physicians

serving as an expert witness on behalf of the plaintiff will do so only on a confidential basis. Such physicians will evaluate potential claims, and confirm their validity but refuse either to testify or to be identified in any way with the case. If experts who perform such review on behalf of patients are subject to a certification requirement, patients will be deprived of an invaluable resource, and ultimately, it will be more difficult to screen for meritorious claims.

Secondly, at the outset of a case, it is often difficult to determine with precision all of the acts of malpractice which occur. Medical records and hospital records are voluminous and it takes a long time to get hospital records; many times several months, and they're often sketchy, and in some cases have even be altered.

In cases where there was a problem with patient care, many times critical events are simply not recorded in the chart. I think you heard testimony today from one of the physicians who said, they do not document everything on the chart. It is not until

discovery proceeds and witnesses are required to give sworn testimony that many cases can be fully evaluated.

Forcing the patient to have a written expert report before litigation even begins is not only impractical, but also unfair, in that, the plaintiff's experts will be forced to commit themselves to an opinion without a full record in this case.

Likewise, the time limitations upon discovery are wholly unrealistic. The patient is expected to serve an expert report within 3 months after filing suit at a point in time where it is highly unlikely that testimony has even been heard from the defendant health care providers. In 3 months' time, counsel for the defendant may not have even identified all of the various physicians and nurses involved in caring for the patient. This is particularly true in large teaching hospitals where residents involved in patient care have scattered throughout the country.

This bill provides what is known as an affidavit of noninvolvement, which is really a safe harbor for negligent physicians. It

requires the court to dismiss a case whenever a physician files an affidavit verifying that he or she did not treat, or was not otherwise involved in caring for the patient.

Significantly, although such dismissals without prejudice, there is no provision tolling the Statute of Limitations with respect to a physician who is dismissed. As a result, there is a serious risk that culpable defendants could secure dismissal from a case, and have the Statue of Limitations against them expire, if they are not reinstated in time.

Furthermore, as drafted, there is no provision through which the patient can challenge a physician's assertion of noninvolvement. As everyone knows, one cannot cross-examine an affidavit. The bill only provides a remedy for other health care providers seeking to reinstate a defendant. It gives absolutely no rights to the patient. All the rights and remedies under this section are given to the physicians.

Under present law, a witness is qualified to testify as an expert if the witness

possesses specialized knowledge concerning a subject, either by experience or education. Pennsylvania courts have consistently held that a physician who is familiar with the medical issues involved need not be in the same specialty as the defendant to render expert opinions.

The proposed legislation establishes a special rule for malpractice cases, requiring as well that the witness has personal experience and practical familiarity with the medical subject in question. The difficulty with such terms is that they have no defined meaning under the law and could result in qualified experts being precluded from giving testimony.

The statute also provides that where the defendant is Board certified, a witness may not testify as an expert against him or her unless the witness is also Board certified, reversing well-established principles which leave issues of expert credibility for the jury.

In many cases, experts in several different medical specialities will testify, many of whom are not certified in the same specialty as the defendant. To preclude such

testimony makes no sense, particularly because an expert in a different field may actually have greater knowledge than the defendant in a case.

For example, an orthopedic surgeon may have negligently undertaken procedures which would have been better performed by a neurosurgeon. To suggest that a neurosurgeon could not offer testimony against an orthopedist under such circumstances simply makes no sense.

The bill treats health care providers as a privileged class, exempting them from damages for delay, when every other party to a civil litigation is subject to such a rule. There is no justification for conferring such a privilege.

The principle behind delay damages is to compensate the plaintiff for money he or she could have earned on his or her award if it had been promptly received; while simultaneously preventing a defendant from being unjustly enriched by interest earned during the pendency of litigation on money rightfully owed to the plaintiff.

Furthermore, an attempt to limit the imposition of delay damages has been rejected by

the Pennsylvania Supreme Court as a violation of the doctrine of separation of powers.

The bill further penalizes malpractice victims by leaving them dependent upon the defendant even after a judgment has been won. Under the proposed legislation, the courts are required to restrict payment of future damages in any case where the amount at stake exceeds $200,000. As a practical matter, this may leave a prevailing patient virtually penniless, because in complex, multiparty cases, the costs of litigation alone could exhaust a substantial portion of the first $200,000 awarded.

Beyond that, the rights of the victim are then contingent upon the court's determination as to what the patient's future needs will be. Under present law, the plaintiff is free to invest funds and spend them as need requires. Under House Bill 2122, the plaintiff is deprived of such flexibility and left at the mercy of the court's prediction as to what future needs will be.

However, there is no provision in the bill to permit any adjustment of the amount or timing of future payments, or no provision that

the plaintiff can come back again and ask for more money.

More importantly, the plaintiff remains financially dependent upon the defendant's ability to pay. Although there is a provision for the judgment debtor to post security, this obligation can be fulfilled through the purchase of an annuity. As was demonstrated by the numerous failures of insurance companies through the late 1980's, and in particular Executive Life, a large annuity carrier, purchase of an insurance contract is no guarantee of future security.

Furthermore, annuity payments are made in fixed monthly or yearly amounts, leaving the victim without a pool of resources to tap in the case of emergencies or special needs. There is no justification for subjecting an injured plaintiff, who has prevailed under the law, to future risks by blocking access to the judgment won.

One of the most appalling parts of the section on periodic payment of future damages is Section 404-A(d), which provides that, and this is very unique and really appalling. If the

plaintiff dies without dependents, all payments cease and the remaining money reverts back to the negligent physician. This means that all single people without dependents, married people with a spouse, such as myself, but no dependents would be treated as less than second-class citizens.

Under the bill, the estate and heirs of the injured patient would be robbed and the physicians would receive a windfall because of the death of the patients whom they injured. The moral to that story is, it's better to kill your patient than just to maim them.

The proposed legislation contemplates a system of arbitration which would destroy the injured patient's constitutional right to trial by jury. Under the bill, a patient who signed an arbitration agreement at the outset of treatment would be precluded from bringing a claim in court if the malpractice later occurs. Although the statute states that the right to receive care cannot be made dependent upon the patient's agreeing to arbitration, there is no practical means to police such a system, and little question but that patients would

surrender valuable rights with little knowledge of the consequences.

As with informed consent forms, the reality is that, most health care providers simply shove a piece of paper in front of the unwary patient and ask him or her to sign it without the patient being advised that very valuable rights are being waived.

Astonishingly enough, the bill does not provide that a person receiving emergency medical care may execute an arbitration agreement only after emergency care is completed; nor does it take into account that a patient may be too sick to knowingly waive the right to trial by jury.

These are only a few ways in which this bill would further disadvantage the most vulnerable in our society; those who have been injured by physicians through medical negligence. May I assure you that there is not one comma in this bill that the Pennsylvania Trial Lawyers Association supports because of its devastating effect on the rights of injured victims.

Before I conclude, if you would permit

me, I would like to mention the Rand Study because that has been mentioned by other testifiers here. I have the study, and I know the study, and the study has been misconstrued woefully. Let me tell you what the study shows.

It's a 1986 study. This study does not focus primarily on medical malpractice cases, but all torts. Forty-three cents, they figure -- Someone said the injured patient receives only 43 cents. That is incorrect. Forty-three cents is what the plaintiff received to the total litigation expenses, including defendant's expenses and fees to defense attorneys. If you take out, as we all know maybe some people don't know, when you get an award or you settle a case, what comes out of that award or that settlement is the attorney fee and costs. Of course, not the defense attorney's fees.

When the defense attorney fees and cost of litigation are taken out of that total litigation expense, the plaintiffs received 68 percent of the award; not 43 cents. The Rand Study also showed that plaintiffs average legal fees and expenses were only 21 percent of the

award. That was the average. I do want to clear that up so there would be no misunderstanding insofar as the Rand Study is concerned.

I want to thank you for your indulgence in permitting to testify at length about the bill. I hope when you have more leisure time, which I'm sure many of you do not have, that you would review the complete analysis or maybe your staff can. I would be very pleased to take any questions.

CHAIRMAN GANNON: Thank you. Representative Reber, any questions?

REPRESENTATIVE REBER: If you can get in front of you a copy of the bill. If you don't have one, we'll provide you with one. I refer your attention to page 9, Section 206-A, so-called frivolous lawsuit section, et cetera. I was happy that your testimony did not, at least as I heard it, and I was trying to do an awful lot of things, it did not really tear into that particular aspect of it.

Short of the fact that with the doctors I've spoken to over the last millennium, it seems like, relative to this issue, obviously the cost factor is predominant in their minds.

But I think something that I hear as much, if not more, is this so-called concern or hysteria that somehow we have to cut out these frivolous filings.

I, as an attorney, besides finding advertisement by attorneys to be abhorrent, I also find the filing of questionable I'll use. I won't even go so far as saying frivolous-- questionable pleadings abhorrent. I think if they is anything that we may do to certainly dispel some of the misconceptions and certainly some of the concerns that I have had very vehemently argued to me, is to move in some type of direction to put into Title 42, or frankly to be very specific, to put into legislation that at least would target in the area of the medical provider area, something along the lines of comfort on this frivolous lawsuit section.

I'm not so sure whether we need it or not. I'm not so sure whether it would withstand Supreme Court concerns of us abrogating their rule-making authority, which with their past track record in so many things, I think is a reasonably fair assumption. But I do think we, as a legislature if we want to be intellectually

honest on attempting to resolve that particular aspect of the issue, we ought to give some serious consideration as a committee to at least delve into that particular area.

The fact that your testimony was devoid of point counterpoint on that particular issue, I feel I certainly am in a position to say, I'd like to aggressively look into that area. Your thoughts on that?

MS. HAMILLL-FLUM: Certainly. Thank you, sir. As I said in my testimony, I would only hit parts of the bill. I didn't want it to be too long. When I originally wrote my testimony it was I think 40 pages and I didn't want to bore all of you.

REPRESENTATIVE REBER: I assume that you prioritized your concerns?

MS. HAMILL-FLUM: I did.

REPRESENTATIVE REBER: This certainly isn't paramount problem number 1 or you would have referenced it, correct?

MS. HAMILL-FLUM: Let me tell you that words, sir, are very important. I will not accept your question as phrased, if you don't mind, because I do not believe the word

frivolous should be used in the same breath as a lawsuit.

First of all, there is no court yet that has defined what frivolous is. Secondly, sir, may I tell you that what one person thinks is frivolous may be another person's attempt to advance the state of the law. The first Ford Pinto case was considered frivolous. The first thalidomide case was considered frivolous. The first tobacco case was considered frivolous.

May I tell you that in the case of Amodeo versus Levin (phonetic), which is a malpractice case, that was the first case involving the rights of a stillborn child, that was considered frivolous. The Supreme Court said that is not a frivolous case and created a new cause of action.

I think that because frivolous is not a word that I like to use or I think should be used because those are fighting words, and that is a word that's really derogatory of what we try to do as attorneys every day in protecting innocent victims.

Furthermore, insofar as medical negligent cases are concerned, the current

system has a way of weeding out those cases. That is, if you do not have an expert report as a plaintiff, you cannot proceed with your case. Now, let me tell you another way that these cases are weeded out.

REPRESENTATIVE REBER: Let me interrupt for a second. Those particular cases that you highlighted, the Pinto case, et cetera, was there an action filed based on Federal Rule 11 and a determination made and an award entered that they were frivolous, or were we just talking about some form of frivolous --

MS. HAMILL-FLUM: No, not that I know of, sir. But, I'm telling you that the first of of any kind of case many times is considered frivolous; the first unusual or unique case.

REPRESENTATIVE REBER: I understand that.

MS. HAMILL-FLUM: I doubt that there was such a Rule 11.

REPRESENTATIVE REBER: I'm sorry to interrupt.

MS. HAMILL-FLUM: Let me further state that the system also has in it, and it was referred to by Mr. Piccone, what is known as the

Dragon-Eddy Act, wherein, if a physician is sued and he or she prevails, then he or she under the law can sue the plaintiff because he or she may feel that he was unwrongly sued.

But let me give you a practical answer to what you are asking. Anyone who handles these cases, and my firm and I do this -- Ninety percent of my practice is this practice. I know what these cases are about. I can tell you firsthand that any lawyer who does this for a living will very carefully screen his or her case before he brings it or she brings it because these are very expensive cases to prosecute.

I will tell you that I don't believe my experience is any different from any other attorney who practices in this field. If we get 10 inquiries on malpractice cases, we will bring one into the office to interview them. Out of the 10 we interview, we will reject 9 of them because we really act as our own in-house peer review system by very seriously challenging these cases because they are expensive to bring; and we don't want to go forward unless we feel we can be successful for our client.

Furthermore, beyond that, when a defense lawyer gets a complaint from my firm, or I will venture to speak for other firms that do this kind of practice on a day-by-day basis and know what they're are doing; when he or she gets a complaint, that defense attorney knows that we have a very good faith basis on which to go forward because they know we have done the in-house screening process.

REPRESENTATIVE REBER: I'm glad you said it that way because I think that's emblematic, frankly from my perspective, and I know that to be the case anytime in any kind of civil action on which I sign as counsel for the moving party, I go through that particular type of screening process. Certainly not with the expert analysis and in-house review that, obviously, is necessary in some of the kind of cases that you're talking about, but I think we analyze it from that particular perspective.

I certainly do it when I go in federal court because of Rule 11. I guess what I'm saying is and to some extent I think you made the case for the direction I'm moving, that, if in fact, the legitimate analysis and review that

should be carried out as detailed by you that your firm does, there seems to me that there should not then be some form of language that you could agree to on this particular issue, if, for no other reason, then it's probably never going to come into fruition anyway or the need for it's going to be there to defend as a result of. But most importantly, to dispel what then apparently exists as a hysteria in the medical community that these things are going on every second case that's filed. How do I respond to those constituents?

MS. HAMILL-FLUM: Sir, let me tell you that I have heard doctors when they lose --

REPRESENTATIVE REBER: They talked about it when they were fixing this finger when it was broke. It's kind of ridiculous. I don't really want to talk business; just fix it doc. He's beating me up over this.

MS. HAMILL-FLUM: Is that Exhibit A?

REPRESENTATIVE REBER: He broke it because I wouldn't listen to him and then I reset it myself. (laughter)

MS. HAMILL-FLUM: I think we should not hamper the system we have now by putting

arbitrary limits into it and by suggesting that just any case that is filed is frivolous. I believe that physicians think that every case that's filed is frivolous. I will tell you that every doctor I speak to and every doctor that I've been privileged to represent as a plaintiff, because I have represented doctors when they have sued other people, they think every lawsuit is a frivolous lawsuit.

I don't think that writing into this bill is going to change the way we do business because it will hamper people who really have cases that they do not believe is frivolous, they go to court and they win. If you're going to win a case in court, the jury has said it's not frivolous.

REPRESENTATIVE REBER: Let me ask you a final question. I'm sorry to belabor this, Mr. Chairman. From your experience, I assume that you filed actions in federal court, medical/mal cases?

MS. HAMILL-FLUM: I try to stay out of federal court as many as I can personally.

REPRESENTATIVE REBER: Because of Rule 11?

MS. HAMILL-FLUM: Not because of Rule 11. I've just found that, especially in malpractice cases, and in the garden variety of cases that come up, the judges in the federal court sometimes want to spend their time on more esoteric cases, let's put it that way, civil rights cases and those kinds of cases.

I do try to stay out of federal court. I don't get into federal court that often, I must tell you, especially in malpractice cases, because in Pennsylvania you wouldn't get the diversity that you would need for federal court.

REPRESENTATIVE REBER: Thank you very much.

CHAIRMAN GANNON: Thank you, Representative Reber. Representative Maitland.

REPRESENTATIVE MAITLAND: I'd just like to make a comment that I think the words frivolous and lawsuit do belong in the same sentence when you're suing over the loss of your psychic powers due to a CAT scan.

MS. HAMILL-FLUM: I deal with facts. I've tried to be factual with you, and my analysis contains documented facts you can go back and look up in the sources which I

referenced and the cases which I referenced.

Let me speak to that case which seems to be the poster boy case for the medical profession because, certainly, I can tell you about cases of egregious incidents of malpractice. I won't do that because I don't think that's why we're here to do today. It does not enhance this dialogue that we're having. But, I must tell you I know about that case because that case was widely reported in Philadelphia County. I know the judge who heard that case. There is a jury who heard that case. That jury decided that was a meritorious case.

Now, when you talk about that case, you are denigrating the jury. Who are the jurors? The jurors are your neighbors and your constituents. You're saying the jury didn't know what it was doing. Well, for some reason or another the jury did believe they knew what they were doing.

Our system has within it a way to remedy those rare occasions when you might get a jury who wants to go over-board, let's say, or above and beyond. That is remitter and that is what happened in this case. Exactly why Mark

Phenicie reminds me the judge remitted the case to a dollar. So, there in the system is an inherent way to control that kind of situation. I'm sorry if I cut you off. I did want to make the record clear on that issue.

REPRESENTATIVE MAITLAND: That's fine. I would say out of all your testimony, Mrs. Flum, the one thing that I don't understand is in Section 401-A, the qualification of the expert. You used an analogy of an orthopedist doing nerve damage and having a neurosurgeon testify. I don't see why another orthopedic surgeon who's Board certified, the same kind of practice, couldn't come in and give expert testimony on what they are or are not trained to do around nerves.

MS. HAMILL-FLUM: That could very well happen, but there's no reason why a neurosurgeon should be prevented from giving such testimony also. Let me give you some examples.

For instance, believe it or not, there are still family physicians in Pennsylvania who deliver babies, especially in smaller communities. Now, if a physician decides that he want s to practice essentially as an

obstetrician, that physician is held to the standard of care of the obstetrician. That physician, that family physician who is still delivering babies, has to know how to manage prenatal care; has to know how to manage labor; has to know how to read and interpret electronic fetal monitoring strips; has to know how to deliver the complicated as well as the uncomplicated babies.

Now, is there any reason to preclude an obstetrician from testifying against a family physician who is performing services that an obstetrician would perform? None whatsoever. Likewise, I will tell you that it would be very difficult, if not impossible, to find a family physician to testify against that family physician who is delivering babies, because the fact of the matter is, 99.9 percent of the family physicians do not deliver babies; probably could not find someone to give that testimony.

Another example. This might even be a better example because these are real cases that I'm referring to, sir. A physician, for instance, an neurosurgeon or any other

physician, who prescribe the wrong drug, it could very well be and in most cases is true that a pharmacologist is better qualified to testify about the effects and need for a drug than someone in the specialty of the physician who prescribed it.

Finally, in some areas of Pennsylvania because of the conspiracy of silence among physicians, it is very difficult to get experts on behalf of the plaintiffs to testify. So, therefore, one may have to cross specialize.

MR. PHENICIE: I'll help to answer that also. I'll show my age here, Steve. I'm a little older than you are. Many of you might have seen the movie "The Verdict" featuring Paul Newman in the middle '70's, or since coming out. That's a good example of the expert witness provision that would be in there.

The malpractice occurred in a Boston hospital and all the people who were Board certified of the same profession in the same specialty of the alleged wrongdoer or alleged tort feasor here would not testify. He had to go to New York City to get the doctor who came in. His qualifications were discredited at

trial, but he was certified as being an expert on this particular case. The result was in this case that justice was done. If such language like this would be in there, you would basically in a lot of cases be eliminating an expert.

MS. HAMILL-FLUM: Furthermore, in the process of a trial, the issue of credibility of the witness, and that goes to whether or not he or she is competent to testify on a certain issue, is really left to the jury once the expert qualifies otherwise.

REPRESENTATIVE MAITLAND: I understand what you're saying. It doesn't seem compelling to me to hold the practitioner of one specialty to the standards of another specialty.

MS. HAMILL-FLUM: That's not the issue. You're not holding the practitioner of one specialty to standards of another specialty. That's not it at all. You are getting an expert who has knowledge of the area of medicine to that issue to testify as an expert.

Again, I go back to my examples. I can give you 50 more examples of the same thing. In many areas the expert who may not be the same specialty, may or may not be, but may not be of

the same specialty would have more knowledge.

When you get out of medical school, you can do anything you want. There is no law, there is no regulation that says a family physician couldn't do brain surgery. It's just that he wouldn't do it because it's not something he's used to doing.

What I'm saying, if a physician who is certified in one specialty, as an example, decides to do a practice or a procedure that really is better done or better known by another specialty, why restrict the testimony to only the one specialty when now we know under the law that if you're qualified and have some knowledge of the specialty or the area in which to testify, you're qualified to testify.

Beyond that, believe me, I will tell you, defense attorneys are smart and aggressive people and they will -- If they believe your expert is not proper or the right expert, they will tear that expert apart and the jury will decide what the truth is.

REPRESENTATIVE MAITLAND: Thank you. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you,

Representative Maitland. Representative Hennessey.

REPRESENTATIVE HENNESSEY: No questions.

CHAIRMAN GANNON: Representative Chadwick.

REPRESENTATIVE CHADWICK: Thank you, Mr. Chairman. In view of the fact that most of this testimony was duplicate of what we heard from Mr. Piccone, I'll try to keep my questions brief. First, I guess a comment; not a question. Ms. Flum, you refer a number of times to this conspiracy of silence that apparently exists among physicians. You jogged my memory.

I've been in the legislature now 12 years. People come into my office all the time with all kinds of different complaints. You reminded me that over the years I probably had 10 or 12 constituents who've come in and said that they felt they had been the victim of legal malpractice and couldn't find a lawyer to take their case. None of the other lawyers in town would do anything. I see one of my colleagues here nodding his head.

It seems to me if this conspiracy of

silence in the medical profession exists, that it may also exist in other professions. Maybe some day I'll give you a call and ask you if there's a way we can improve the ability of people to get a lawyer when they've been victimized in an area like this. I may call you some day.

MS. HAMILL-FLUM: Is that a question? My number is 215-568-7771. I'll be waiting for the call, sir.

REPRESENTATIVE CHADWICK: I should say, I have no idea whether any of those claims had any merit at all. That's not my job as a legislator. Often I'm reduced to simply giving them the names of lawyers they haven't yet tried or referring them to the disciplinary board. Some of those people who are of low income, it's kind of a hardship for them to travel long distances to find a lawyer. So, I may call you some day. We'll leave that for another day.

MS. HAMILL-FLUM: I'm not afraid to sue lawyers, by the way. If you do something wrong, you should pay for it. The wrongdoer should be held accountable.

REPRESENTATIVE CHADWICK: Thank you.

Let me ask you one of the questions that I did ask Mr. Piccone. On the very first page of your testimony you, like he, speak of your duty to represent indigent, innocent consumers and workers and how important that is. If that is so important, why has the Trial Bar over the years consistently opposed efforts to restrain attorney fees, and why shouldn't we add that as an amendment to this bill?

MS. HAMILL-FLUM: Well, sir, restraint of attorney fees, you're talking about contingent fee?

REPRESENTATIVE CHADWICK: Yes, absolutely. I'm not against contingent fees. I understand why they exist there. It's especially important when people are of low income and unable to pay on an hourly basis. It's very important.

MS. HAMILL-FLUM: I would say that there are very few people in Towanda who could afford to pay my hourly rate, or any other attorney's hourly rate.

REPRESENTATIVE CHADWICK: That's why I support contingent fees.

MS. HAMILL-FLUM: The only way, the

only key to the courthouse for someone who is injured and these people who are injured, whether they are by medical negligence, auto, products, whatever, are most often people of modest means. The only way to the courthouse is by way of contingent fee. The contingent fee attorney --

Actually, I wear with pride and I consider it a badge of honor that I'm willing, and every single one of my members is willing every day to be in the trenches and fighting for their clients, not knowing whether or not they're going to get $10, a hundred dollars, or a hundred thousand dollars, or no dollars, that's correct; and also, bearing the burden of the expenses of the suit. This is the only way we can do it where we can get justice to the average person.

REPRESENTATIVE CHADWICK: You're a very good attorney. The issue is not whether or not contingent fees are a good idea. The issue is whether or not we ought to cap them to assure that injured and innocent victims receive as much as possible of a meritorious award.

MS. HAMILL-FLUM: Sir, may I tell you

and suggest to you that that is just your way and a very clever way of restricting access to the courts. Because, the fact of the matter is, unless we have a contingent fee agreement or unless we have fair fees for the attorney who is bearing the burden, who's going ahead, no attorney is going to want to take the case.

REPRESENTATIVE CHADWICK: How high is fair?

MS. HAMILL-FLUM: I don't know how high fair is. That's between the attorney and the client.

REPRESENTATIVE CHADWICK: I'll leave that subject. You got into a discussion with Representative Maitland about frivolous and lawsuits and indicated that you didn't think the words frivolous and lawsuit should appear in the same sentence, and you discussed the Philadelphia case. Let me ask you about another case.

What would you call it when someone who appears in a dermatologist office with athlete's foot and is treated and cured of the athlete's foot and has no other complaints and who subsequently is determined at a later date

to have an abdominal tumor, sues the dermatologist? If you don't use the word frivolous, what word would you use?

MS. HAMILL-FLUM: Sir, I would not use the word frivolous because, when you give me examples of cases and people who, just as the study that the doctors referred to, and they misconstrued the study, left out certain facts, I suggest to you that people who give anecdotes are suffering from a lack of information.

I do not know what that case is about. I do not know what anybody else's case is about. I have to have a complete set of facts to know whether or not that is a lawsuit that should not have been brought. I do not know whether or not this patient had other complaints. I do not know whether or not other tests should have been done, and neither do you.

Beyond that, I say to that doctor who feels he or she was sued improvidently that all he has to do is bring his own lawsuit under the Dragon-Eddy Act against the person who sued him.

REPRESENTATIVE CHADWICK: Let me just finish that subject by suggesting that your own testimony is full of anecdotes. I rather doubt

you have all of the facts on all of those cases. I think it was fair for me to use an anecdote in response.

On the subject of pretrial procedures, the sections in my bill are not primarily directed at the plaintiff's bar. As we both know, you are paid on a contingent basis. The length of time that it takes to get to trial and the amount of work that it takes you to get to trial have no bearing on the amount you ultimately receive.

Those sections are primarily directed toward the defense bar. We've all heard the allegations of file attorney by defense attorneys who are on an hourly basis running up the costs. That section is not directed to the plaintiff's bar at all, but is directed at trying to hold down the costs ultimately to the insurer of providing coverage. That's what really the problem is here, the cost of malpractice insurance.

My question to you is, if you are opposed to the sections in this bill, do you have a proposal that you could provide this committee with for improving the efficiency of

case management, which is something we talked about with prior witnesses, in an attempt to expedite these matters, handle them more efficiently and hold down costs?

MS. HAMILL-FLUM: Initially, the premise of your question is the cost of malpractice insurance. That has been testified to exhaustively today. In fact, John Reed who is an employee of this Commonwealth, and a former defense lawyer by the way, also testified that there is no malpractice insurance crisis in Pennsylvania.

But beyond that, I don't know whether or not you -- Let me ask you this. Are you a practicing attorney, sir?

REPRESENTATIVE CHADWICK: No longer. Up in the northern tier where our districts are pretty large, the few days that we have at home we tend to spend driving around our districts trying to handle constituent problems. I practiced for about 6 years before I was elected. In fact, at one time--this will horrify you--I was a member of your association.

MR. PHENICIE: I told her in advance.

MS. HAMILL-FLUM: I am not horrified

at all, sir. As a matter of fact, I recall you as a member. In my previous life I was the Executive Director of the Pennsylvania Trial Lawyer Association. I know you were a member.

REPRESENTATIVE CHADWICK: I should say this silently. I hope to practice again. I don't intend to do this for the rest of my life.

MS. HAMILL-FLUM: Sir, if you practice litigation on a day-to-day basis, you will understand. You of all people should understand this section, and let's not be disingenuous about it. It's not fair as far as defense lawyers are concerned.

I mean, the regulation concerning having an expert report before you file suit; the rule about serving an expert report 3 months after suit is filed; that, if you understand the practice, does not work to the benefit of the defense attorney, but works to the detriment of the plaintiff's attorney.

What you're referring to probably is about the discovery being completed within one year. That may be what you are referring to. There are ways that can be handled. That can be handled on a county-by-county basis. Carol

Shepherd today testified how we're doing it in Philadelphia County.

Beyond that, let me tell you, that practically speaking, in some counties, even in smaller counties--and I do a lot of practice in small counties--because there are not enough judges, you can't get to trial within a year when you have to have your discovery done. And, even today when you have prompt discovery, when I have finished my discovery, and I try to get my discovery done in 6 months if I can, a year if I can, I have yet, yet, to have a doctor after the close of discovery tender his policy. The reality is, they wait.

So, having a year for discovery or having to do discovery within a year is not going to make certain the system is going to move. Beyond that, I believe we should leave this to the courts in each county to come up with programs that are unique to that county to move cases along. We cannot hamper what a judge in Bradford County would like to do versus a judge in Philadelphia County.

MR. PHENICIE: They have a similar system, Representative Chadwick, dealing with

workers' compensation cases right now in Delaware. One day, one trial; if you're there in a month, if you're not there you lose or you win, whatever side it might be. That's been established by the workers' compensation feds down there.

REPRESENTATIVE CHADWICK: Let me suggest to also that I will be first in line to co-sponsor the Reber Judge Bill which will probably be forthcoming shortly. I think that's a fine idea.

I was going to go in a couple more sections. I really don't see the benefit to it since, Ms. Flum, you said that there is no malpractice crisis. We probably would just disagree about those sections as well. At this point in the interest of time, I'll finish my questions. Thank you very much.

MS. HAMILL-FLUM: According to John Reed there isn't. I'm only quoting John Reed.

REPRESENTATIVE CHADWICK: Thank you for your time.

MS. HAMILL-FLUM: Thank you.

CHAIRMAN GANNON: Thank you, Representative Chadwick. Representative

Micozzie.

REPRESENTATIVE MICOZZIE: I heard all the negatives about the bill. Is there anything in that bill that you agree to?

MS. HAMILL-FLUM: Absolutely not.

REPRESENTATIVE MICOZZIE: Even the periods and the commas.

MS. HAMILL-FLUM: Absolutely not, sir.

REPRESENTATIVE MICOZZIE: As far as John Reed, the director, that's one man's opinion about the CAT Fund. The CAT Fund is a crisis. Those of us who receive the phone calls from our docs in Delaware County, you try to explain to them that it's not a crisis. In fact, we're going to have a hearing down in Delaware County of the 5,000 doctors in Delaware County to talk to Director Reed about the CAT Fund.

I think that somehow there has to be a compromise, and I know there's been efforts in the past, some kind of compromise between the trial lawyers and the medical PMS.

My reading, and I have been here 18 years, my reading it's coming to a head. The docs are being hit from all sides with managed

care, they perceive to be a problem. They're being hit by the surcharge with the CAT Fund. Unless something happens, we are going to do it for you. If we do it for you, you're not going to like what's going to come out of it, per what's happening here with the bill that Representative Chadwick is doing. I think that somehow there has to be some kind of compromise in this whole situation because it is coming to a head.

When you start hitting people's pocketbooks, and that's what you're doing with the docs in so many areas, unless there is a compromise, there's a groundswell in the General Assembly that's going to solve the problem for you.

MS. HAMILL-FLUM: I'll take your comments under advisement, sir.

CHAIRMAN GANNON: Thank you, Representative Micozzie.

REPRESENTATIVE MICOZZIE: I'm going to have to leave. I have a meeting in Upper Darby at 6. Thank you for having me. I'm pleased that you're on my committee. Would you schedule your committee around my committee so I can be

here?

CHAIRMAN GANNON: Would you schedule your committee around my committee? It's a compromise. You're welcome any time. Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. Before I start with the few questions that I have, I actually would like to answer and have you comment, because I think a question that Representative Chadwick asked about, why resist a cap on attorney's fees, because I think we need to have an open dialogue about how the system really works, particularly for the nonattorneys or the people who haven't practiced in this area.

Whether it's a legislator or a trial attorney, I would resist a cap on attorney's fees out of protection not of attorney income, but out of protection of the right for injured people to actually get into court. Here's why.

From my experience when I was practicing in this field is, most attorneys go through the analysis that Ms. Flum talked about with regard to evaluating a case. One of the things that you did when you evaluated it is

knowing the kind of case it is. You also looked at what you anticipated your cost on that case to be, as well as whether or not your rights to recovery are good and how egregiously injured the person was. You weigh all of that together and decide whether or not you're going to take that case or not.

I think it's fair to say that for the average attorney, just the cases that they've taken, if they're lucky -- we're talking the average attorney. The good attorney might have a better batting average. But the average attorney is going to lose money on 5 to 8 of the cases that they took. Not lose money totally in the whole, but barely cover costs and come out with something when attorney's fees are in there but it's much less than what they would have made on an hourly basis, et cetera, and oftentimes lose money in the wholesale case even though they won for their client because it was such an expensive case to bring. But they still fought in there for the plaintiff's rights and they got a recovery for the plaintiff, even though they might have lost wholesale monetarily or had a very large recovery after all the cost

were out.

Every once in a while you're glad when you get that gland slam that balances out all those cases; that keeps you working and keeps you and your firm lucrative so that you can afford to take the other 5 or 10 cases that are going to walk in the door the next year that you may not make money on. Because you know every once in a while you're a risk taker and in the law of averages you're going to have a grand slam case that's going to make up for those other cases that were truly meritorious cases. And even though you won an award, you didn't cover costs or you barely covered costs and you didn't really make enough money to sustain yourself and your family on.

That's the reality of I think a typical practice of a plaintiff lawyer. If you're really, really excellent plaintiff lawyer, your batting average is a little bit higher and your ability to pick those grand slam cases is a little bit better and so you may be making a lot of money.

But, the reality of it is, if you cap a fee on a case where you think that every

individual case we're going to look at whether or not the amount of fees that you recover, or the amount of award that you recover based on your contingent fee pays for more than just the cost of your case and what your hourly rate would have been had you billed it hourly.

Then the reality of it is, all the access to the court for people is going to disappear because not everyone gets a grand slam on every case. Those grand slams carry you until the next grand slam, and in between you've helped 10 or 15 or 20 people, depending on your practice, get access to court and get recovery on a meritorious claim.

That's what I think capping contingent fees when you hear of one case that seems so extraordinary. I think that's how it translates back into denying access to the courts for everyone. Every client comes into your office, if it's no longer going to be a grand slam because of these cases, that person is not even going to get access to the court.

That's my analysis of why I wouldn't support capping fees. But, I think that's a realistic analysis of what happens out there in

terms of trying to gain access to the court. I think you've got to talk about that in that regard and really just put the numbers and the realities on the table if you expect people to understand it.

MS. HAMILL-FLUM: I thank you very much for your comment. You're absolutely right. In fact, the cases that you describe, the smaller cases that come in or the cases where you're maybe going to get something out of it, the large cases really subsidize those smaller cases. It's important to have a cross section of those cases.

More importantly, I'm not certain this committee understands that the court in minors and in competent cases, we have to get court approval on our attorney's fees whenever we settle a case. That also acts as a safeguard against attorneys charging what some people might think are not an appropriate fee.

REPRESENTATIVE MANDERINO: One of the points, though, that I think Representative Chadwick made that is well-taken, and while I did legal malpractice defense so I know that there were plaintiff attorneys out there who are

willing to sue other attorneys. I think his point is well-taken by both professions, meaning the legal and medical community, about the fact that we probably bring some of these problems on ourselves by our lack of self-policing. And whether it's self-policing by the medical community with regard to someone who is not practicing up to standards or self-policing by the legal community as to someone who is not practicing up to standards, I think we can all do a better job.

I guess my point is, should we let -- For example, this bill had made a suggestion that any settlements must be reported to the Medical Board, or whatever, although that information isn't made public to anyone unless there was some disciplinary action taken. I guess plaintiffs lawyers -- I can understand why you want that protection in there; not the doctors. Plaintiffs lawyers would love to know who just had a claim made against them.

But, isn't there some area with regard to self-policings of the profession that both attorneys and doctors can take to help remedy this, but attorneys can take to somehow have

some sort of disciplinary practice when there are attorneys who seem to file numerous claims that never go anywhere that are creating this perception that people are complaining about? Do you have any suggestions in that front?

MS. HAMILL-FLUM: Insofar as the reporting of claims in medical negligence is concerned, we already have a national data bank where you have to report all your settlements or awards when the physician does to national data bank. Since that's been in existence, I have not seen any more policing or disciplining of doctors in the Commonwealth of Pennsylvania.

As you know, there is a very, insofar as attorneys are concerned, there's a very, very active and strong disciplinary board in Pennsylvania. That disciplinary board meets regularly and it has various panels throughout Pennsylvania. They have monthly meetings to go over cases and they actively, actively discipline attorneys all the time, suspending their practice, taking their license, or whatever. It's done all the time.

In fact, that is every attorney's fear that there will be some discipline imposed on

them. I think it's a good sword to hold over an attorney's head so he or she practices within the rules of canons of ethics that are imposed upon us by the Pennsylvania Supreme Court.

REPRESENTATIVE MANDERINO: I hear you. I think it's also fair to say that a doc disciplined by his board is perhaps with the same hammer. But, neither of those hammers get to the issue of --

I mean, if I missed the Statute of Limitation and I blew your right to bring your lawsuit and you bring me before the disciplinary board, the disciplinary board is going to act on that and I'm going to get sanctioned or suspended, or whatever that's going to be. But, if I filed 25 medical malpractice cases last year, none of which went anywhere and most of which I had to withdraw after I caused everybody a bunch of headaches because I didn't have anywhere to go with any of them, that doesn't go anywhere. Do you know what I'm saying?

Actually, I don't want an answer right now because I think it takes some thought. We need to give some thought to whether or not that is something that can be remedied without

substantially stepping on the rights of victims. I know it's a hard balance, but I think that at least desires some thinking on our part as lawyers as to whether or not there's some way to accomplish that.

I guess I'm commenting more than questioning, but the one area that I was mistaken about this morning, have a little bit better understanding of it based on yours and prior testimony is the issue of informed consent and what was being recommended to be changed in the legislative proposal before us.

MS. HAMILL-FLUM: By the way, I just want to interject one thing. I would like to point out to Mr. Jones that he is incorrect. Cooper B. Roberts has said that major invasive procedure is not the test for informed consent. He might want to look that case up which he's talking about.

REPRESENTATIVE MANDERINO: I kind of thought you had to have informed consent in all respects and that the real problem with what was being proposed here was that we were kind of trying to classify that you only need an informed consent in some respects. You're now

saying you agree with my understanding.

MS. HAMILL-FLUM: That is correct. Any surgical procedure you need informed consent. Might I add that, I believe that if this part of the bill would become law, there would be more litigation over what is major; what is invasive. A tonsillectomy may arguably not be a major invasive procedure. But you and I do know, I know but you don't know, there have been many children who have been injured during tonsillectomies.

The current state of the law is that you have to have informed -- what a prudent patient would want to know. It's not every single risk, every single thing than can go wrong with you. It's not a 50-page informed consent. It's what the prudent patient would want to know.

As a practical matter, let me tell you, I think everyone here if you ever had health care, if you've ever been in the hospital or been cared for by a doctor or if you've had to have a surgical procedure, the fact of the matter is, that what happens is a nurse will put in front of the patient a form like this with an

X and say sign here. That is what happens.

That is what has happened to me when I've gone into hospitals. That is what has happened to my family when they've gone into hospitals, and I presumably am an informed consumer. That is what happens.

REPRESENTATIVE MANDERINO: My last question on the issue of Statute of Limitations. I'm looking at your testimony that said, as written in the proposed legislation that it would eliminate what is, in essence, I guess the Discovery Rule for injuries. When I read it, I didn't really see that in the bill. I kind of thought we were still, even as written, we were still retaining the Discovery Rule in Section 2501 where its says, negligence claim must be commenced within 2 years of the date of injury. The individual knew or should have known by using reasonable diligence of the injury.

I guess my question is, I thought that meant that the Discovery Rule was still in there. If you think it isn't, what am I not understanding about the language in House Bill 2122?

MS. HAMILL-FLUM: Currently, the rule

is knew or had reason to know.

REPRESENTATIVE MANDERINO: So you're saying that right now it's reason to know and that should have known is changing the standards.

MS. HAMILL-FLUM: Exactly.

REPRESENTATIVE MANDERINO: That's all I wanted to know. Thank you.

CHAIRMAN GANNON: Thank you, Representative Manderino. Counsel Andring, any questions?

MR. ANDRING: Just very briefly. Do you have any idea or are there numbers available which would indicate the actual cost of physician malpractice insurance in Pennsylvania, perhaps as a percentage of total medical care expenses to somehow quantify the size of the situation we're looking at?

MS. HAMILL-FLUM: Sir, I don't have that figure. I would not have access to that figure, but I do have access to rates. I think we can probably all maybe take an educated guess as to what kind of money certain specialties make.

I'm referring to an ad in the

Physician's News Digest of April 1995 where the Physician's Insurance Company, we call it PIC, advertised that it lowered malpractice rates 10 to 38 percent for 1995. It advertises, for instance, anesthesiology, and we had a anesthesiologist testify today, and the rate for an anesthesiologist with claims-free 4 years is $9,800 for insurance coverage. Of course, it is the primary, but --

MR. ANDRING: The CAT Fund charges --

MS. HAMILL-FLUM: Yeah, the CAT Fund then would have a charge on top of that. But certainly that shows that the insurance market for this line of coverage is very competitive in Pennsylvania and that the rates are not as onerous as reported. Actually, I would be very interested, sir, in finding out myself what the percentage of the malpractice premium is to any individual coverage or total health care costs.

MR. ANDRING: That's really my question. Are we talking about insurance coverage that cost one percent of total medical care spending or 10 percent of total medical care spending? I have absolutely no idea.

MS. HAMILL-FLUM: There was a study.

If you'll indulge me just a minute, because I do have information on that particular -- The United States Congressional Budget Office did a study in 1992 and they determined that payments for malpractice premiums amount to less than one percent of national health care costs. I do not have with me the figure for national health care costs, but we know that is a large amount.

MR. ANDRING: Thank you.

CHAIRMAN GANNON: Thank you, Counsel Andring. Could you, perhaps, maybe to help the committee understand this issue a little better on the expert witness issue give us a brief comparison or distinction between a fact witness and an expert witness? What would be the purpose of each and the limitations of their testimony?

MS. HAMILL-FLUM: In the context of a medical negligence case, you will have medical providers who are fact witnesses and you will have medical providers who are expert witnesses.

The medical provider who is a fact witness can only testify to the kind of care that was rendered, the kind of care that he or she rendered, what kind of tests were done.

Unless the plaintiff is going to use that health care provider as an expert witness, he or she cannot testify as an expert witness.

In order to testify as an expert witness, you have to have an expert report prepared. Practically speaking, what happens is, and I can speak for myself and I believe most attorneys who practice this specialty do the same thing, what you would do is, before you can get your expert to give a report or to give an opinion, the expert has to have all the facts. Therefore, you have to take discovery of all of your fact witnesses. That could be the defendant doctor; that could be the nurses in the hospital; could be the lab technician in the hospital. It could be any other fact witnesses such as treating physicians because, you cannot bring an expert to trial and have him or her testify unless he has a factual basis on which to testify.

In order to do that you have to go through discovery. You have to find out all those facts that would be pertinent to the expert in rendering his or her opinion.

You then give all of those facts,

along with the medical records to your expert, and you ask your expert to tell you whether or not the physician or the health care provider in that instance fell below the applicable standard of care. We're talking about the standard of care. We're not talking about what some doctor thinks he or she did right or wrong, but what the standard of care is.

The standard of care can be things such as, for instance, in an obstetrical case, there is an organization called the American College of Obstetricians and Gynecologists They publish what they call bulletins. Those bulletins set out the standards of care for obstetricians. If you have a patient who is hypertensive, it tells you how you're suppose to treat that patient. That is a standard of care.

If I have a case involving a pregnant lady and she is hypertensive or has a high blood pressure and other indicia of something going wrong with her -- I won't get into the medical part of it, I'll try to keep it as simple as possible. But, if she has certain indicia of what we call hypertension of pregnancy, you go to the standard and you see what that doctor is

suppose to do. You get an expert who can testify that that doctor in that instance did not follow the ACOG standards in caring for his or her patient. You can't get to that point until the doctor has all of the facts. Then the doctor has to be qualified at trial. The doctor has to have some knowledge of the medicine involved in order to testify as an expert.

Then the court will either accept or reject him as an expert. If he's accepted as an expert, then it's up to the jury to decide the credibility of that particular expert witness. That was a long way to answer your question.

CHAIRMAN GANNON: That was a very good answer, it helped. I hope it helped the members of the committee. It helped me a little bit.

Let me give you a hypothetical. Suppose you have an instance where you have a patient that has a horrendous outcome as a result of treatment. After completing all your discovery both by deposition and medical records, and whatever, you then have your expert in that particular area of medicine look at all the facts.

Then the expert gives you an opinion

that the provider, even though the outcome was horrendous and totally not expected and a great consequence to the patient, that the provider met the standard of care for the practice of medicine in that area of treatment, and has given you a report to that effect, first of all, what do you do in that type of situation?

Secondly, is that report available to the defendant physician or health care provider?

MS. HAMILL-FLUM: I will tell you what I do. I can't tell you what other lawyers do. Again, I say that lawyers who do this kind of work all the time, I believe we all practice the same.

First of all, as the committee knows, a poor outcome does not necessarily mean medical negligence. You can have a poor outcome to any kind of a procedure, even though all the standard of care was followed. Poor outcome does not equate to medical negligence. People who understand this kind of practice will understand that.

What I do in my office, I prescreen cases to the extent I can. Now understand, that before you start trial, it sometimes is

difficult to prescreen a case because you don't have all of the records. What I normally do is, I write to the health care provider before I start suit, assuming there's no statute running. I ask the health care provider to send me the records. Sometimes health care providers don't want to send the records. Sometimes I have to start suit just to get the records because there is nothing under the law before a suit is started that provides that a health care provider must provide records.

Most often the health care provider does provide the records, although in a few instances I have had to start a suit. The records, for instance, in a hospital case could be voluminous, especially if you have a poor outcome. If the patient has been in the hospital for 3 or 4 month, the records are voluminous. What I do is, I get every single page of that record. It could be a thousand pages. It could cost me a lot of money to get those records because hospital charge by the page. They would charge me an enormous amount of money. It also takes a long time to get records.

I will tell you that I have had cases where a patient has been out of the hospital for 5 or 6 months and no Discharge Summary has been dictated by the attending physician. The Discharge Summary is that part of the hospital record that, in essence, gives a summary of what happened while the patient was in the hospital. Under the Joint Commission of Accreditation of Hospitals and Health Care Organizations Discharge Summaries have to be done within a certain period of time, 30 or 60 days. Hospitals do not enforce that.

I have gotten records where a patient might have been in the hospital for a period of time and out for maybe 6 months and still no Discharge Summary.

So, I try to get all the records in advance to the best of my ability. I then personally read those records. When I started practicing law, my senior partner, David Schwager, who some of you may or may not know, fairly well-known attorney in Pennsylvania, he made me take an anatomy and physiology course at Temple Medical School for a year. I had to cut up cadavers and things like that. I was not

permitted to take a deposition for 2 years.

What I had to do for the first six months of my practice was read medical records and I said to him, why did I go to law school to do this? Because you have to understand the medicine.

What I do is, I read all the records myself; I digest them. I then turn them over. In our office once a week we sit around and discuss these cases with some input from medical people. We look at the cases and decide whether or not, on the state of the record we have before us, there's a good faith basis to go forward. And if there is, we do. If there's not --

It doesn't matter that there was a terrible outcome to us. It matters insofar as the client is concerned, but in the analysis of the case, to me if it's a horrendous outcome that is not relevant to my analysis. My analysis is, was this horrendous outcome because of the failure of the doctor to practice according to the standard of care?

Then, when I have that input from the doctor I start my suit and I do my discovery.

It could very well be that some of the records has been altered. I have had cases where there have been 3 sets of records by the defendant physician; the unaltered set, and then 2 altered sets. That happens sometimes and that's why it's important that we don't have this kind of Statute of Limitations in the cases because a patient can be misled.

Records can be altered. You have to go through the records with the witnesses and take them through the records page by page. If you know how to ask the questions of these defendants who understand the medicine, you try to get them to commit to what was done. And then only after you've gone through that discovery process, and it's a tedious process, can you or should you turn your case to your expert who is going to testify.

Insofar as the case where you go through the discovery and to the best of your ability you thought you have a case but you never know what happens in discovery. You find out you don't have a case, and you can't get an expert, you know what I do? I dismiss the case. That's what I do. That's what any attorney who

knows what they're doing will do.

Insofar as the bad expert report is concerned, under the rules in Pennsylvania you only have to turn over the report of an expert who is going to testify at trial. Again, a long-winded answer.

CHAIRMAN GANNON: Thank you very much for your testimony today. We appreciate your coming here --

MS. HAMILL-FLUM: Thank you, sir.

CHAIRMAN GANNON: -- and answering questions from the committee. Thank you.

CHAIRMAN GANNON: The next witness is Doctor Okin, President, Pennsylvania Orthopedic Society.

DR. OKIN: Good afternoon, Chairman Gannon.

CHAIRMAN GANNON: Doctor Okin, thank you for coming, and thank you for your patience. I know we're behind schedule and I appreciate your patience. You may proceed.

DR. OKIN: I appreciate the panel sitting and waiting throughout this whole afternoon. Good afternoon, Chairman Gannon, and members of the committee. I'd like to introduce

Tom Malin, who was Past President of the Pennsylvania Orthopedic Society and member of the Board of Directors; Doctor Bruce Vanett, who is our Tort Reform Committee Chairman. I'd like to begin now.

I'd like to take this opportunity to thank you for allowing me to speak today on House Bill 2122, and the topic of medical malpractice tort reform.

By way of introduction my name is Michael Okin, as you already know. I am President of the Pennsylvania Orthopedic Society, which represents over 700 practicing orthopedic surgeons in the State of Pennsylvania. I am a practicing orthopedic surgeon in the City of Philadelphia, where I have been for the last 23 years serving the citizens of the Commonwealth who live in Northeast Philadelphia. Prior to that I did my training at the University of Pennsylvania.

Not long after I entered practice in this Commonwealth in the early 1970's, this state, as well as many other states, were undergoing a malpractice insurance crisis. Argonaut Insurance Company was leaving the

state, this being the major insurer for medical malpractice at that time. The major problem at that time was that malpractice awards were skyrocketing causing similar increases in malpractice insurance and threatening the availability of insurance at any cost.

To meet this crisis, the Pennsylvania legislature enacted Act 111, which theoretically was supposed to make professional liability insurance available at reasonable costs. In so doing, they established a system of arbitration panels to screen medical malpractice claims. They also instituted a collateral source rule as well as a cap on payments for attorneys fees for medical malpractice damage awards pursuant to a sliding scale. They made medical malpractice insurance mandatory for health care providers.

Act 111 also established a catastrophe fund to cover awards and damages higher than the basic coverage. The law mandated that the CAT Fund maintain a $15 million balance at any one time. The fund would be maintained by assessing an annual surcharge to the health care provider's basic malpractice premium. The original surcharge in 1976 was 10 percent. It

should be noted the surcharge today is 164 percent.

In the ensuing years, all provisions of Act 111 were basically invalidated, as we heard earlier in the day, except for the preservation of the Catastrophe Fund and the need for physicians to maintain malpractice insurance coverage in order to maintain their license to practice in the State of Pennsylvania.

Initially, after the establishment of the fund, insurance premiums and malpractice rates leveled off, and then in the 1980's malpractice awards began to skyrocket and by 1995 the CAT Fund, along with the insurance carriers in the State of Pennsylvania, paid out $436 million to settle 665 claims. This amounted to an average settlement of $656,000 for each claim settled. Two hundred eighty million dollars of the monies used for the 665 claims came from health care providers in the State of Pennsylvania as a surcharge on their annual insurance premium.

According to his testimony given before the Senate Banking and Insurance

Committee in September 1995, John H. Reed, the Director of the Catastrophe Fund, reported that the number of unclosed cases in the State of Pennsylvania represent an unfunded liability of $1.9 billion. This unfunded liability falls on the shoulders of the health care providers of the Commonwealth. It is an untenable figure, and the purpose of my testimony today is to show how the need for tort reform in the State of Pennsylvania is so imperative at this time. We have to get a handle on the liability crisis as it exists.

At the present time, in the State of Pennsylvania, the health care delivery system is in crisis. Physician reimbursements have been capped in this state as opposed to other states. We are capped on the revenue side by governmental Medicare reimbursements. Act 6, the No-Fault Act, has capped our reimbursement rates to Medicare.

Act 44, the Workers' Compensation Act, also capped our reimbursement. Managed care has also capped physician/health care provider reimbursements. At the same time, our overhead costs are not capped. The largest single

expense an orthopedic surgeon has in this state is his malpractice insurance premium and the Catastrophe Fund surcharge.

This situation has a direct impact on your constituents. In the last 3 years I have had to lay off 5 personnel in my office in order to meet my expenses. This trend is happening throughout the entire Pennsylvania health care community. These are people whose health benefits and salaries I paid.

If you would speak to these people, you would see the tremendous impact losing their jobs in this economy has had on them. If the present crisis persists, there will be more belt-tightening and more people losing their jobs, and ultimately forcing the closure of many medical practices, which, on an economic scale, are nothing more than small businesses.

I, as well as the other orthopedic surgeons in the State of Pennsylvania, strongly feel, and I'll reiterate, strongly feel, the patient who has been injured in a medical malpractice incident should be fairly compensated. The question is, what is the most effective way to fairly compensate this

individual? The present system is not working and it must be fixed.

I propose to you today the problem is not with the health care delivery system, but with the legal system which allows and even encourages lawsuits to spiral out of control. If one goes to the literature, we can easily see there are only a few studies that have been performed on the subject of medical malpractice. The statistics below are derived from a study reported in the Annals of Internal Medicine, 1992, Volume 117.

From 1977 through 1992 there were 8,231 closed malpractice cases reviewed in the State of New Jersey. Of these cases, 4,730, or 57 percent, were closed without payment and 43 percent were closed with payment. Of these cases closed with payment, only 12 percent required trial. The cases perceived to be indefensible by the insurance carrier were settled 91 percent of the time, without the need for a jury trial. Only one-fourth of the cases requiring a jury verdict resulted in payments to the plaintiff.

What this study showed was that, the

majority of cases in medical malpractice tort can be successfully settled by arbitration panels. Very few cases are required to be litigated in courts. This study points out the feasibility for an arbitration panel to be set up to settle many of the malpractice claims that are brought in the Commonwealth. This would expedite just compensation to the injured party.

One of the questions we have to ask ourselves is, what is the present liability crisis costing us? In terms of manpower, the best physicians coming out to practice medicine today will be discouraged from choosing the State of Pennsylvania as their place of practice.

For example, a friend of mine, an ear, nose and throat specialist was looking to bring a new associate into his practice. However, the salary package he could offer could not be competitive with the States of New Jersey, Maryland or Delaware. He could not afford to hire a third person in his practice because the expense in Pennsylvania is so prohibitive, that his practice could not be competitive with other states in the surrounding area.

As a second example, my daughter Cynthia is graduating this year from the Medical College of Ohio in the top 5 percent of her class. She was considering going to Jefferson University Medical Center for her residency in obstetrics and gynecology. Her husband is a young general surgeon who has been in practice in Ohio for 4 years. She had to eliminate Jefferson University Hospital from her selection of residency because her husband could not afford to practice in the State of Pennsylvania.

In that same vein, the expense is too high for an orthopedic surgeon entering practice today in the City of Philadelphia. He is faced with a malpractice premium of approximately $60,000 before he can open his door. He is then faced with the unknown business expense of further surcharges for the CAT Fund during that year, which he cannot budget for. This includes his basic fee plus his surcharge, before he can open his door. This happened in the year 1995 for orthopedic surgeons in the Commonwealth, all physicians in the Commonwealth. He will not choose the State of Pennsylvania but will most likely pick the State of New Jersey, where

malpractice rates are known to be approximately $30,000 a year for an orthopedic surgeon.

Additionally, regular malpractice premiums and the CAT Fund surcharge are typically due on the same date. At the beginning of this year, I borrowed $128,000 to cover these charges plus the emergency surcharge; and yet, we are facing another surcharge at the end of the year according to Mr. Reed.

Secondly, physicians in high-risk specialties are performing less and less risky procedures because of the fear of liability. Many orthopedic surgeons are no longer performing back surgeries or treating trauma, which we were well-trained to do. Obstetricians have stopped delivery babies. Physicians in the height of their career are retiring early or leaving the state because they cannot afford the malpractice premiums in this state.

On a national basis, over $20 billion is spent on unneeded tests designed to guard doctors and hospitals against malpractice suits. Three thousand dollars of an $18,000 pacemaker is used to pay for the liability tax on that

piece of instrumentation. A 2-day maternity stay averages $3,367; $500 of which is a lawsuit tax.

In 1992, the American College of Obstetricians did a survey and 12 percent of the obstetricians surveyed had stopped delivering babies; 10 percent decreased the number of deliveries because of high-risk malpractice suits.

The CEO of Biogen Industries testified at the U.S. Senate Commerce Committee in September of 1993 that he could not undertake the development of an AIDS vaccine because of the inherent liability of billions of dollars involved in that pursuit. Ninety-six percent of the diphtheria vaccine cost goes to product liability. Chemical companies and manufacturers of materials used to make heart values, artificial blood vessels and other implants have been quietly warning the medical equipment companies that they intend to cut off deliveries because of the fear of lawsuit.

On that note, I would like to know how many of you have had or know someone who is in need of artificial joint replacement? At the

most recent meeting of the American Academy of Orthopedic Surgeons, it was noted there is only one company left in the country producing polyethylene, which is the major component of artificial joint replacements. It is easy to see that this problem transgresses more than just the medical liability tort system. It goes throughout many other industries.

Since 1976, 60 percent of the medical malpractice lawsuits in the State of Pennsylvania were closed without payment. It must be noted that almost half of all medical liability insurers defense costs are spent defending cases that ultimately are closed without compensation made to the claimant. A more efficient mechanism for early identification of nonmeritorious claims would reduce these excessive litigation costs.

Only 43 percent of every dollar spent on medical liability litigation reaches the injured patient as compensation according to estimates of the Rand Corporation which was alluded to. The rest is spent on attorneys fees on both sides, litigation expenses and insurance administration costs.

It should be noted that tort reforms are not anti-patient. It allows the injured party to receive a larger portion of the award payment. Seventy-eight percent of American's physicians report the threat of medical liability suits causes them to order tests they might otherwise consider unnecessary. The AMA estimated that $15.1 billion in non-premium defensive medicine costs were incurred in 1989.

They revised that in 1993 to a figure of $20,000. Nationwide the cost of physician liability insurance premiums tripled in the 1980's, rising from 1.7 billion to 5.6 billion in 1989.

Between 1982 and 1989 liability premiums outpaced all office practice expenses, growing annually at a rate of 15.1 percent. This was 4 times the general inflation rate. In 1989, 17.6 percent of the total expenditures of physician services was due to liability payments in defensive medicine.

One of the major studies concerning malpractice which is always alluded to is the Harvard study. This study which appeared in the New England Journal of Medicine in February

1991, investigated the incidence of hospital medical malpractice in the State of New York in 1984. The investigators of this study originally created their methodology from a pilot study which appeared in the Journal of Medical Care in December of 1989, Volume 27.

As a result of that pilot study, the investigators were unable to establish a relationship between negligent adverse events and malpractice litigation. With this methodology, the authors were unable to show any reliability of judgment when it came to medical negligence.

This, in my opinion, is one of the major flaws in the Harvard Study. Any conclusions drawn from it will be unreliable. The study itself stated there are many sources of potential errors within the study. The reliability of physician's judgment and negligence had a low degree of reliability statistically. In fact, in that study, physician-trained reviewers were only able to agree on findings of malpractice in 8 of 47 actual claims that were identified in the study population. This represented only 17 percent.

In 1975, the State of California introduced the Medical Insurance Compensation Reform Act known as MICRA. This was their answer to the medical malpractice crisis of 1970's when the State of Pennsylvania instituted Act 111. MICRA has basically 7 components. With these 7 components, the State of California created a system of medical liability insurance that allows an individual injured as a result of medical malpractice to be justly compensated.

In doing so, it has created a system that has brought stability to their insurance market and allowed them the ability to perform this service for their citizens for the last 21 years. In spite of the Trial Bar trying to invalidate MICRA, the citizens of California have time and time again voted them down. The State of California has shown that MICRA does work.

The components are as follows:

Evidence of collateral source payments are allowed in medical malpractice trials. Under this law, health care providers defending malpractice actions are permitted to inform the jury of collateral source payments. These are

insurance benefits and other plans that pay for the plaintiff's care and can be deducted from the award given to the plaintiff as damages. This, in effect, shifts some of the cost of the health care providers away from the limited number of medical malpractice carriers in California to the more numerous health care and disability insurance providers who have already paid to provide this coverage. This, in essence, helps spread out the risk.

Component 2, a $250,000 limit on noneconomic damages. This cap only applies to noneconomic damages, i.e., pain, suffering and loss of consortium. It allows injured parties to receive compensation for all economic damages such as medical expenses, loss of earnings, et cetera. It is inherently difficult to place a monetary value on such intangible injuries as noneconomic damages. This is the one component of malpractice insurance costs that has tremendous variation from jury to jury and awards for similar types of injuries vary tremendously.

The study by the Rand Corporation issued for civil justice showed that jurors are

more sympathetic to plaintiffs injured by medical malpractice than any other type of cases. Among plaintiffs with the same type of injury, the study found malpractice claims received awards almost twice as large as the awards going to work injury or product liability plaintiffs, and 5 times the size of awards going to a jury on property plaintiffs.

The MICRA cap on noneconomic damages, the most variable component determined by juries, has moderated the size of awards, made the degree of risk involved in underwriting malpractice insurance more predictable, provided greater overall stability in the medical malpractice marketplace.

Component 3, periodic payment for future damages over $50,000. This allows a structuring of judgment paid over a specified period of time and insures that the plaintiff will have money for health care as needed for the rest of his or her expected life. The payment schedule is flexible to accommodate the plaintiff's needs at different times in his life in the course of the rehabilitative process.

It establishes a Statute of

Limitations.

There are contracts requiring arbitration of medical malpractice claims. This MICRA statute allows for the written contract for medical services to include a clause which requires both parties to resolve any dispute regarding medical malpractice through binding arbitration governed by California law. Arbitration allows most of the disputes to be quickly resolved and often with less expense than traditional court cases. This part of the law is substantiated by the study alluded to earlier in New Jersey.

Component 6, limitation on plaintiff attorney contingency fees. The MICRA provision prohibits lawyers for medical malpractice plaintiffs from collecting contingency fees in excess of 40 percent for the first $50,000, 33 and a third percent for the next 50, 25 percent of the next 500, and 15 percent of any amount over $600,000. In effect, in a million dollar verdict, the plaintiff would receive $278,000 more than he would have under the typical contingency fee personal injury case.

However, the attorney would have

received $231,000 on a million dollar award. Again, one sees that the injured party receives $278,000 more under this system. He is the one who rightfully deserves it.

Component 7 will require the 90-day prior notice period before commencement of the lawsuit.

What MICRA has done is assure payments for legitimate losses; reduced the cost of health care in the State of California; maintained the access to health care for risky procedures that otherwise doctors would not perform for fear of being sued; removed the trial lawyers financial incentive to pursue the nonmeritorious cases.

The MICRA cap discouraged dollar-driven lawyers from preying upon the sympathy of jurors to win run-away pain and suffering awards, a large percentage of which goes to the lawyer, without taking into consideration the increased health care costs for all consumers as a result of excessive malpractice awards.

The United States is the home of the only justice system in the world that allows juries to award unlimited recoveries for

subjective losses which need not be quantified in terms of actual monetary loss.

Before MICRA came into effect, California had the highest malpractice premiums in the country. MICRA's cap on pain and suffering created predictability where there cannot be insurability. According to Patricia M. Danza, Ph.D., a well-known academic expert on medical malpractice liability issues, I quote, awards for damages should be restructured to reassemble more closely the insurance people buy voluntarily. After all, in its compensation function the tort system is simply a form of compulsory insurance which people are required to buy when they buy health care.

When faced with a choice, most people do not buy insurance against pain and suffering. The tort system would provide compensation for a loss of earning capacity after taxes and for reasonable medical expenses, rehabilitation and other monetary costs with a special provision for persons with no reported wage loss, such as housewives. Pain, suffering and other nonmonetary losses are real losses but money cannot replace them. That is precisely why

people do not choose to ensure themselves against them and the tort system should not force them to.

One factor we can't lose sight of is that MICRA maintained the predictability of both jury awards and out-of-court settlements. It should be noted that 80 percent of all medical liability cases filed in California were proved to be without merit. Ninety-seven percent of the remaining cases involved indemnity and are settled short of trial, which leaves only 3 percent of the cases determined in a trial.

About 70 percent of the cases tried are won by the health care provider. The question is, why worry about the few cases that result in jury awards? Because the amount paid for the many cases that are settled out of court is driven by the amount of the few cases that go to trial.

In other words, a few jury awards drive all the costs of the medical malpractice compensation system. MICRA's cap on noneconomic damages holds down the excessive awards for cases decided in court which, in turn, affect all the dynamics and amounts paid in cases

settled out of court. Without a cap on noneconomic damages, all the indemnity for medical liability becomes unpredictable and the system careens out of control.

What did MICRA do for California? The number of million dollar plus malpractice awards are substantially lower in the State of California than all states that don't have MICRA reform. It has decreased the number of frivolous lawsuits, slowed the rate of health care expenditures in the State of California by stabilization of the health care liability exposure. Health care expenditures in the State of California have not increased as rapidly as expenditures in the rest of the country. MICRA has cut medical liability insurance premiums by 50 percent in 1994 dollars as compared to 1976. It has assured that the injured party received just compensation.

Finally, in a statewide Pennsylvania survey the constituents speak. More than 80 percent of the voters in Pennsylvania say that the legal system needs to be changed. Support for change cuts across partisan and demographic lines. Voters say the present liability lawsuit

system has problems that should be improved. My home district is in Montgomery County and my local representative, Ellen Bard, did a survey. The result of that survey showed that 85 percent of the people supported limiting lawsuits and awards.

Finally, House Bill 2122 deserves your support. It doesn't include all the reforms that are needed in the Commonwealth for medical liability tort reform, but it is a good beginning. It redefines the doctrine of informed consent; introduces collateral sources; limits punitive damages not to exceed 200 percent of compensatory awards; redefines the Statue of Limitations in a more reasonable manner; requires that the expert for the plaintiff be a Board certified expert practicing in the same field as the person who is the defendant if that person is Board certified.

It limits discovery time so the claim can be expedited to the benefit of the plaintiff. It requires that the plaintiff's attorney distribute the trial expert reports within 3 months of commencement of the action; requires the mandatory conciliation conference;

provides for periodic installment payment for future damages in excess of $200,000; provides for written valid arbitration agreement which, from what I have said previously, can be a very viable way of resolving a malpractice case as only approximately 13 percent of the cases that are brought ever go to court.

This bill does bring some stabilization to the market. It is not the total answer, but is a beginning and I think we should support it.

CHAIRMAN GANNON: Thank you very much, Doctor, for your testimony. Representative Hennessey, do you have any questions?

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman. Doctor Okin, I was a little intrigued. You gave us a bit of the history of the CAT Fund back in the early '70's. On page 2 you allude in your first paragraph that the original surcharge in 1976 was 10 percent.

DR. OKIN: Correct.

REPRESENTATIVE HENNESSEY: There was a surcharge on what? Did the CAT Fund start with a surcharge?

DR. OKIN: The surcharge started in

'76. You have a basic premium --

REPRESENTATIVE HENNESSEY: The surcharge of what?

DR. OKIN: On your basic premium.

REPRESENTATIVE HENNESSEY: And that basic premium was determined by PMSLIC or --

DR. OKIN: The primary carrier that was there at the time. If I remember correctly -- it's a long time ago. You're jogging my memory. The initial premium I think was about $15,000 and we paid $1,500 surcharge.

REPRESENTATIVE HENNESSEY: I'm sorry

DR. OKIN: The original premium I believe for orthopedic surgeon was around $15,000, 10 or $15,000, and 10 percent surcharge was only $1,500, in dollars and cents.

REPRESENTATIVE HENNESSEY: The unfunded liability that you talked about in terms of the present status of the CAT Fund, let's try to put that in some perspective. Isn't that if every claim is considered to be fully meritorious and is maximized out at the amount that is being asked for?

DR. OKIN: I think that's correct.

REPRESENTATIVE HENNESSEY: But,

history tells us that that doesn't happen, number 1. First of all, you don't win a hundred percent of your cases.

DR. OKIN: But we pay out $479 million in 1995 in settlement suits. That's almost a half a billion dollars. So, it's not considered unthinkable.

REPRESENTATIVE HENNESSEY: I wasn't here in the early part. I had a meeting this morning down in Oxford today, so I didn't hear Mr. Reed and some of the earlier testimony about the CAT Fund.

There has been some indication, at least from what research I've been able to do myself, that there has been a backlog of cases that has developed, and the reason that we were paying out a lot more in the CAT Fund this year than last is because we tried to address that backlog and pay out and settle cases that otherwise would have just stayed in the system. Somehow we have a bubble in the pipeline.

DR. OKIN: It's more than a bubble, I think. Chairman Reed came in and talked to us at the Orthopedic Society meeting in November in Philadelphia. His talk then alluded to the fact

that that surcharge is going to be present until the year 2000. That's what he alluded to us at our meeting. The surcharge of that magnitude will be present until the year 2000.

The other thing you have to hear is that, going through this year I pay personally $128,000 to stay in practice to have my license not lifted from me. That was a threat because we have to have a license in order to practice medicine. I'm going through this year with a $128,000 loan and I'm going to get surcharged again sometime during this year. I don't know what that surcharge is going to be. It's very hard to run a business not knowing what your liabilities is going to be.

So, it's a real figure. When people say there's not a crisis, it's a crisis. It's a crisis because it's a crisis that is very, very difficult to fund.

DR. VANETT: I have some more things that may explain that.

CHAIRMAN GANNON: Can you identify yourself for us?

DR. VANETT: I'm sorry. I'm Doctor. Bruce Vanett. I'm Chairman of our Task Force

for the Pennsylvania Orthopedic Society on Tort Reform. I do have the testimony. There was some mention before that there was not a crisis. The number of claims are going down. I have the testimony of John Reed, who, as you know, is the CAT Fund Director, before the Senate Banking and Insurance Committee from September 20, 1995. He was not here today.

He says, there appears to be an almost geometric rate of increase in the number of new catastrophic claims. In calendar year 1994, the year before '95, the fund opened 3,419 new cases which was 105 percent increase over the number of cases reported during 1993. The rapid growth in reported medical malpractice claims had outstripped the presence of building the fund to manage its liabilities.

So, it's not just that the cases were postponed which was the problem in Philadelphia and why we had the surcharge this year, but the number of cases has tremendously increased as you can see. A hundred and 5 percent in '94 and we don't know the numbers in '95 yet. He hasn't given his report yet. So, it's not just a backlog. There are new cases, and a geometric

rise in the number of new cases.

REPRESENTATIVE HENNESSEY: Is that cases that are being opened at the CAT Fund level or that a tracking of cases that are being filed at the county court level?

DR. VANETT: That's the CAT Fund case. As you heard earlier, only the cases that have a potential liability over $200,000 even get reported to the CAT Fund. We don't know the true number of the cases that have been reported to the primary carriers.

REPRESENTATIVE HENNESSEY: Doctor Okin, you mentioned New Jersey, Maryland, Delaware as having more competitive or lower insurance rates. Do those states have arbitration?

DR. OKIN: New Jersey just recently got tort reform. The cost of an orthopedic surgeon across the river, if he goes across the Ben Franklin Bridge is $30,000 a year. The cost of an orthopedic surgeon's malpractice premium in Philadelphia is $60,000 a year. There is a little discrepancy across the border.

REPRESENTATIVE HENNESSEY: The reason I'm asking whether they have arbitration or not,

earlier legislation was invalidated by our Supreme Court because of constitutional protections to a right to a jury trial in Pennsylvania Constitution. We can argue about whether or not we should even pass this bill, but it seems to me that if we're going to try to impose in this bill an arbitration system, and if we don't change the Pennsylvania Constitution, the Supreme Court at some point in time is going to have to throw that one out again because we haven't addressed the biggest hurdle, which is to change the Constitution.

Has your association done anything or tried to move in that direction?

DR. OKIN: To change the Constitution?

REPRESENTATIVE HENNESSEY: Yes.

DR. OKIN: Not yet.

REPRESENTATIVE HENNESSEY: If the constitutional provision says you have a right to a jury trial is the reason we threw out the earlier arbitration panel, why are we doing it again?

DR. VANETT: Yes, I believe in the original Act 111 it was a mandatory arbitration panel and House Bill 2122 it's voluntary. I

believe that is one of the differences. None of us are lawyers so we don't understand all of that, but to my knowledge that is a major difference. It is voluntary on the part of the patient and the physician.

REPRESENTATIVE HENNESSEY: We had a hearing on a totally different bill a couple weeks ago dealing with allowing immunity, granting immunity to former employers in terms of references; in terms when a person applied for a new job because the employers are saying, we don't want to tell people how bad this guy was when he was our employee because he might sue us. We just give him some sort of nondescriptive job reference for recommendation. Basically, let the new employer on his own.

What was interesting about that is, the courts have recognized a new cause of action by that new employer saying, you didn't tell me something that I should have known. The example that was given was a person who had been convicted of molesting women or young girls being dismissed by one hospital, but as part of the termination agreement the hospital agreed not to disclose that; allowed him to be hired by

another hospital to be in charge, believe it or not, of the student nursing dormitory.

As I understood that explanation, the courts allowed a lawsuit to be filed and successfully prosecuted because the first hospital failed to disclose something that they should have disclosed.

How does a doctor, and I'm alluding to page 6 of your testimony. You saying that high medical malpractice insurance costs are causing doctors not to do things that they would otherwise do. Aren't you letting yourselves open for that kind of claim that says --

DR. OKIN: No.

REPRESENTATIVE HENNESSEY: Maybe I'm misreading something?

DR. OKIN: What, paragraph 2 of page 6?

REPRESENTATIVE HENNESSEY: I guess it's in your second paragraph. Secondly, physicians in high-risk specialties are performing less and less procedures because of the fear of liability.

DR. OKIN: Exactly. I reiterated that. Orthopedic surgeons are not required by

law to do back surgery. We're trained to do it. We're trained as a specialists to do spine surgery but it limits our liability if we don't do it.

In fact, one of my colleagues at the hospital I'm at receives a 10 percent discount on his premium from his primary carrier if he doesn't do back surgery, because back surgery is a very litigious area. We're traumatologists. I'm in a level 2 trauma center. I go in every other night to take care of patients.

REPRESENTATIVE HENNESSEY: If you choose not to do back surgery, then a neurosurgeon could do it?

DR. OKIN: If he's available. I'm a traumatologist. If I choose not to go and do trauma surgery because someone gets wiped on I-95 on Saturday morning at 4 o'clock in the morning, there may be someone else to take my place. But, if the 11 orthopedic surgeons on our staff decide that they're not going to do it anymore because the liability exposure is so high, then you have a problem. Then you have a problem of access to care.

REPRESENTATIVE HENNESSEY: Then it

falls to the neurosurgeons.

DR. OKIN: Neurosurgeons can't put bones back together, sir, and they can't put pelvics back together.

REPRESENTATIVE HENNESSEY: I thought we were talking about back surgery.

DR. OKIN: What I was explaining to you is that, physicians are going to stop performing certain procedures that are high liability, high risk procedures.

REPRESENTATIVE HENNESSEY: What I'm asking you is, doesn't the same theory of the law scare you that if a hospital can be sued for failing to disclose information that should have been disclosed, can't an orthopedic surgeon be sued for failing to do an operation within your capabilities that should have been done but you choose not to do it because you tell a jury I don't want to pay a higher insurance premium?

DR. OKIN: Now wait. Let's get something straight here. Back surgery is elected. You rupture your disk and you need surgery done on your back. It's elected back surgery. I can say I don't want to do that anymore because it's a high-risk procedure.

You come to my office and say, you have a back problem, you have a ruptured disk, you have to go somebody else because I don't do that anymore.

I can decline to take trauma call at my hospital. I provide a service, but if the service becomes too expensive to provide, I won't be able to provide that service anymore. That's what I'm saying. There's an access problem with it.

When a gynecologist and obstetrician stops delivering babies, he's not at risk. He just stopped delivering babies. His malpractice premium goes way down.

REPRESENTATIVE HENNESSEY: I guess where I was confused, I think what you're saying in your testimony here, it's not all physicians in high-risk specialties that are refusing to do this.

DR. OKIN: Not all of us, no. I'm just saying individual physicians are choosing not to do certain things because it's a high risk.

DR. VANETT: It truly is a problem. It's not so much of one person in general. It

may be hard to get neurosurgeons to come to your area. In rural Pennsylvania there's a definite access problem with OB-GYN, with heart surgery, chest surgery, and things like that. So, to try to induce people to come to Pennsylvania, obviously, they don't want to come when they've going to pay the same malpractice premiums that are much higher than in other states. It's more of an access problem than it is with one person not doing a specific procedure.

None of us would ever turn a patient away in trauma no matter what type of insurance they do. When they come in with a broken leg that's sticking out through the skin, we come in and do it.

DR. OKIN: I hope I didn't mislead you. As Bruce said, we come and do it.

REPRESENTATIVE HENNESSEY: I guess what misled me was the fact in the beginning it looks like, when you're talking about physicians you mean something less than all physicians.

DR. OKIN: Yes. I don't mean every physician in this Commonwealth.

REPRESENTATIVE HENNESSEY: One of the statistics that somebody cited was that, 43

percent, 44 percent of those cases that are actually closed with payment to the patient.

DR. OKIN: That's the Rand study, but that's also in the New Jersey study we see the same thing. In the New Jersey study, they studied 12,000 cases, closed cases. That's a statistic that's not out of the Rand Corporation, and that was their percentages too. That's out of New Jersey.

REPRESENTATIVE HENNESSEY: The 43/57 percent seems like a spread which is understandable if you're taking risks and going to court or analyzing risks before you get to court. I would point out that in terms of the attorneys' fees in those cases, insurance companies attorneys were the attorneys hired by the insurance companies to defend doctors get paid in a hundred percent of those cases, right.

DR. OKIN: But it's costing the system.

REPRESENTATIVE HENNESSEY: I understand that. But, 40 or 50 percent don't get paid if they represent plaintiffs and they lose.

DR. OKIN: I think that's speaks to

the problem that the present system is inefficient and needs to be fixed.

DR. VANETT: That's absolutely right.

REPRESENTATIVE HENNESSEY: I agree with you we need to agree what to do; not just to do something.

DR. OKIN: There's something awry here when you have attorneys sitting at a table completely on one side of the field and you have doctors sitting at the table an hour later, you're completely on the other side. There's got to be some area in-between where we can meet.

Somehow, this panel has to be able to judge that and come up with some reasonable resolution to the problem, because there is a problem. You have one group of individuals saying there's not a crisis and there's not a problem. We've got 30,000 doctors in the state saying, hey, you know, you got have 2,000 attorneys, there's no problem. You have 30,000 doctors who are going to march on Harrisburg because there's a problem.

Obviously, somewhere in the middle of that there's a problem. You people have to

recognize it. Otherwise, you're going to be without access to care.

REPRESENTATIVE HENNESSEY: Representative Micozzie alluded to earlier, our phones are ringing off the hook from doctors and we're getting lots of letters from doctors. I suggest if we do the wrong thing here, we're going a lot of phone calls and letters from patients who are saying, why you did cap my return, my award? I lost a leg or I did this and suddenly I can't get compensated from it. I'm trying to just find the balance and that's why we're here today.

DR. OKIN: That's what I'm saying. There's a problem, congressman, and it has to be resolved. I think it's your job to do that; not us.

REPRESENTATIVE HENNESSEY: We'll do the best we can. That's why we're holding hearings. Thank you. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Hennessey. Representative Chadwick.

REPRESENTATIVE CHADWICK: Thank you, Mr. Chairman. I guess under the heading of,

It's a Small World, I should point out that Doctor Vanett's brother Todd and I were law school classmates at Villanova. I haven't seen Todd since we graduated in 1978. I hope you'll pass along my greetings and best wishes to him.

Mr. Chairman, I don't have any questions. I just want to make one comment. We heard from some of the prior witnesses, particularly from the Bar Association and the Trial Bar, that House Bill 2122 is some sort of a radical proposal.

However, as you can see from the testimony here, what's in my bill doesn't even go as far as some other states have already gone. My bill doesn't cap pain and suffering awards. It doesn't place any limitations on attorneys' contingent fees. So, I want to bring that up to try to put my bill back into some form of perspective because we had heard from some other witnesses that my proposal was somewhat radical.

Clearly, if you look at what some of the other states have done, rather than be radical at all, it is more of a balanced and compromised approach in an attempt to find some

middle ground. I have no questions at all, so I'll pass it to Manderino.

CHAIRMAN GANNON: Thank you, Representative Chadwick. Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. Doctor, you may not know some my first answers, but if you do I'd appreciate some help since I was still in grade school in the early '70's when Act 111 was established.

Do you know what the threshold level for the primary carrier was back when it was first established?

DR. OKIN: Yes. The threshold was a hundred thousand dollars.

REPRESENTATIVE MANDERINO: Do you know what the progression of that was over the years that gets us to where we are today at $200,000?

DR. OKIN: Yes. It was 150,000 in 1980, and in 1984 I believe it went to 200,000. I might not be quite exact on those dates, but that's close.

REPRESENTATIVE MANDERINO: Since the mid '80's, it's been at $200,000, which is exactly the time period that you pinpointed in

your testimony as the beginning of the skyrocketing of malpractice awards. Isn't it fair to at least acknowledge that there is some correlation between the payout on malpractice awards and the increased skyrocketing that we saw in the whole cost of providing health care during that same time frame?

DR. OKIN: I think the rate of inflation was not as great in the general economy than it was in the malpractice awards.

REPRESENTATIVE MANDERINO: Thank you. The inflation rate was also not the same in the health care G.M.P. as it was in general G.M.P., isn't that correct?

DR. OKIN: That's the filtered-down theory.

REPRESENTATIVE MANDERINO: Okay, that's the filtered-down theory. Thank you. We talked a lot about what the California MICRA program is. Do they have a CAT Fund type of situation?

DR. OKIN: No, they don't.

REPRESENTATIVE MANDERINO: They have a primary insurer insuring all of the risks?

DR. OKIN: Exactly.

DR. VANETT: In fact, Representative, we are 1 of only 2 states in the country that has a CAT Fund. I think it's Kansas has a modified one. We are the only one where the state funds an insurance company for malpractice.

DR. OKIN: I think one little point here. I was thinking about what happened to Act 111. A good analogy would be, if you have the Eagles football team on the field and you have Randall Cunningham out there, he's going to throw a pass and his line leaves him, he has no protection. What happened with Act 111 in the courts was, you have the quarterback with no line to protect him. I think that's what the California experience didn't do.

REPRESENTATIVE MANDERINO: I realize now, based on your testimony, that you are an orthopedic surgeon.

DR. OKIN: That is correct.

REPRESENTATIVE MANDERINO: I realize that that is probably the specialty in Pennsylvania that, I think it's fair to say, has among the highest premiums when it comes to how you rate it.

DR. OKIN: That is correct.

REPRESENTATIVE MANDERINO: Do you know in New Jersey, which you refer to 68,000 here versus 30,000 in New Jersey, whether or not they experience rate their specialties and particularly orthopedic surgery the same way that we do in Pennsylvania?

DR. OKIN: They do. They have the same type of rating system.

REPRESENTATIVE MANDERINO: Would their premiums for other specialties parallel Pennsylvania's; meaning, they're not shifting any risks or costs onto other specialties that you're bearing?

DR. OKIN: I can't answer that definitely. I don't know that.

REPRESENTATIVE MANDERINO: This poor guy from the CAT Fund who's been quoted to death today in abstentia, I'm going to do it again. I'm looking at one of the charts that was given to us that was part of his testimony. I realize that this is not for orthopedic surgeons; that this is a chart of average annual premiums for most prevalent limits, saying the lowest class. I don't know if that means general practitioners

or whatever.

I'm looking at Pennsylvania rating in there even with surcharges lower than California and the system that California has. So I'm sitting there saying, gee, is maybe the issue in Pennsylvania the connection that we have between the CAT Fund and how much of the risk the CAT Fund is bearing versus how much the risk is limited; that the primary insurers is carrying. Therefore, when you add them both together, you're still at what is relatively low given our 50 states.

DR. OKIN: I think, read at the top of the chart. It says average annual premium for most prevalent limits per PIAA (claims-made). In the State of Pennsylvania, most of the dollars in current policies will cover the tail.

REPRESENTATIVE MANDERINO: Well, thank you. That actually then brings me back to a question that I asked one of the previous speakers, which was, maybe the way to fix the system is to also shift to look at --

I hear what you're saying. Please understand. I hear what you're saying about the cost, what they've done to you, et cetera.

It's like my impression that I had from the employers who were in last week telling Representative Hennessey and I and the rest of the committee about their fear of lawsuits driving them not to give recommendations. They were creating their own problem. I said to them, if we pass this legislation for you today, you're still going to have that 3 percent chance of being sued. That's going to be out there whether you're afraid today under this legislation or afraid tomorrow under a different piece of legislation.

What I'm trying to get to here is, all of the solutions proposed in 2112 (sic) as Counsel Andring pointed out don't get to that issue that you keep saying that you want the truly injured person to be able to be compensated. It's everyone else we want to take out of the system.

But, when we look at what we're proposing as solutions, it's not getting to getting more money to the injured person. I'm rambling. Let me just ramble for a minute. I know you're dying to respond to 16 things I probably said.

But, the reality of it is, if we -- I'm really trying to understand. Let's assume that we say we're going to get rid of all the lawyers and we're going to set up this arbitration panel. If you think you were injured, Kathy Manderino, by some negligence of some doctor, you just come before us.

Now, you're not going to have a lawyer. You're not going to have an expert witness who's done the discovery, bought those medical records and analyze those medical records and look to see whether or not there was true negligence. You're not going to have the benefit of all of that stuff which is what cost the litigation system, but you're going to be able to get truly compensated for an injury that we're now going to tell you didn't happen because of negligence. I don't see how it's going to help the patient.

DR. OKIN: In the Chadwick bill I think you have an opportunity to have a lawyer and go before the arbitration panel. You're not denied that. The opportunity is there.

REPRESENTATIVE MANDERINO: Thank you. But my point is, because of that you're not

taking out -- You're coming in here and telling us what's eating the costs in the system are all these lawyers and all these experts and we want to drive more money to the patient. But, we're not changing the system that way and we're changing the system that's going to cut off the ability of the patient to get in.

DR. OKIN: The system is inefficient. It's inefficient. It doesn't allow the monies that are put into the system to go out where they should properly be going. I don't know how to fix that system. I don't have that answer for you.

But, you as legislators are going to have to find an answer that will satisfy the medical community and the legal community. That's not my job.

My job, I was trained. I spent many, many years, more than half my life doing what I do, and I do it well. But, I'm not a legislator and I can't answer your question because I don't have the answer. But you know what, you have a whole panel up there and you don't have the answer either.

REPRESENTATIVE MANDERINO: I think I

do have the answers that are a little bit different than what's being proposed here. I think we have to look at things like, does it still make sense for us to have a CAT Fund insuring what is probably a hundred percent of all the cases? What medical malpractice claim that gets filed today probably doesn't have to immediately notify the CAT Fund of a potential liability because any medical claim right now given the cost of health care is going to bump you, I would suspect in 90 percent of the cases, close to that $200,000 threshold where you're going to put somebody on the line.

I want to say, let's look at whether or not that CAT Fund limit is still an appropriate limit. Let's look at whether a CAT Fund is still an appropriate vehicle. If we're 1 of only 2 states doing it, then maybe there's some reason the other 48 aren't doing it, and no one has come before me and told me of the great benefit that they've derived from the CAT Fund. You're only coming to tell me of all the detriment you've derived from the CAT Fund.

DR. OKIN: But I think one of the answers that you're trying to get at is that, in

order to bring private enterprise insurance companies in to do insurance ratings in the State of Pennsylvania, as the other states have it, you have to bring in tort reform. Because, every state where it's worked, they've had tort reform. They have it in California; they have it in Indiana; they have it in Alaska. There's 21 states that have it and it works.

But, you can't bring a malpractice carrier into this state and tell them, okay, you're here. We want you to write the insurance. Because, the way the system is set up it's unaffordable.

REPRESENTATIVE MANDERINO: Somebody explain to me then, because obviously I'm still not understanding, what is deceiving about this chart that shows Pennsylvania below California and below probably some of those other states that you talked about.

DR. OKIN: Number 1, it's a family physician. Number 2, it's a claims-made policy so that means it's the lowest type of policy you can have. None of those policies are really sold in this state. You maybe have 5. Maybe 1 percent of the policies are sold like that. Let

me explain to you something.

A colleague of mine had a claims-made policy. He bought it in 1980. In 1985 he wanted to get out of the policy. It cost him $125,000 to insure his tail in 1985 dollars.

REPRESENTATIVE MANDERINO: He's an orthopedic surgeon. That's less than what his surcharge would have been, right?

DR. OKIN: There's an inherent risk with that, because now what you're doing is, you're funding your tail when you're retiring. That's what Doctor Rhoads was explaining to you. That tail coverage, you have to pay for it somewhere along the line. If you don't pay for it upfront, you pay for it at the end. The more years you have that tail coverage, the more cases that are liable to come up, the more expensive it's going to be. That's not a tenable answer.

REPRESENTATIVE MANDERINO: I'm sorry. I know you've been chopping at the bit --

DR. VANETT: No, no,.

REPRSENTATIVE MANDERINO: -- and I brought a lot of stuff out there so it's only fair to let you --

DR. VANETT: I'm not going to comment on all of them. So you understand, the claims-made policy is artificially low and you pay same the amount at the very end. The occurrence is higher but it's stable the whole time. The total amount of money that you pay at age 50 or 60 whenever you retire or whatever is going to be the same, whether you pay it on an equal basis over time or whether you pay it all at the end.

That's the problem with the CAT Fund is that, it kept it artificially low and now all of a sudden with this geometric rise of cases, it has gone completely out of control. What's happening is, you're contracting the total amount of money available. There just is not going to be enough money. That's why there's $1.9 billion because there is no money to cover that. If that number is right or wrong or whatever, this is what is quoted, but there's not going to be enough money to fund that over time.

That's why people are not coming to the state. That's why people are laying people off. That's why there's a significant uproar

about this, because the CAT Fund is just like claims-made. It doesn't work that way. You have to keep a balance over time. That's why the CAT Fund initially thought to be a good idea is turning out to be a very bad idea as the legal climate has not changed.

If you got us tort reform, then that unfunded liability will drop tremendously, and would make a significant difference in the unfunded liability and the ability to practice in Pennsylvania.

REPRESENTATIVE MANDERINO: For the sake of agitating you more, one other thought. Everyone brings their own perspective to it. I guess I look at it and I understand how various parts of the legal system or how we bring claims might offset other areas.

For example, Representative Chadwick's bill doesn't deal with eliminating pain and suffering. But, the reality of it is, when you talk about most tort reform measures and that's in there, my general reaction is that, again, that sounds like a good thing in theory, but in practice that eliminates, again, access to the courts because the reality of it is, if you have

a legitimately injured person who we're all saying, no one is denying that they don't want the money to get to the legitimately injured person, and particularly don't want the legitimately injured person to not to be made whole. Then, by the time the legitimately injured person is made whole -- the reality of it is, he's made whole through the -- through the -- whatever you want to call. What's the word that you use to all the basic costs, the medical costs, et cetera, of your claim and pain and suffering is basically covering his costs of having brought that case to trial.

DR. OKIN: The California system there's a $250,000 cap on pain and suffering. The Indiana system, there is a $750,000 cap on all awards. There are some systems that only go past the $500,000 cap on pain and suffering.

Now, even in the California system, which is $250,000, there are million dollar awards there and an attorney walks away with $278,000. That's a pretty good fair piece of change for a day's work.

REPRESENTATIVE MANDERINO: Assuming that that was all fees and not --

DR. OKIN: But everybody has expenses.

REPRESENTATIVE MANDERINO: Let's be fair. When you bill for the work you do, you bill for your time and you also bill for your equipment and your other related costs.

DR. OKIN: I don't get paid a lot for that time. It's different. There are a lot of cases that orthopedic surgeons do in this Commonwealth that we never get paid for. We go on and do it all the time. It's part of our Hippocratic oath. It's different.

Attorneys don't very well do that. In your conversations today it doesn't appear that they do that. It appears that they're not going to take those cases unless they're going to make a big pot of gold; whereas, the Pennsylvania Bar Association put it at their meeting, the goose that laid the golden egg is called the CAT Fund.

We have different perspectives. Somewhere along the line we have to try to bring our perspectives together for the common good of the Commonwealth.

DR. VANETT: It's not just the fees that are charged. That's part of it. But the problem is that, we are just looking for limits

and some guidelines on what to do. You're from Philadelphia and you quite well know that 60 percent--you may not know--of the money from the CAT Fund goes to Philadelphia. The reason is, and all the trial lawyers know, including Ms. Flum who was here before, that they want to push all their cases to Philadelphia because it's a very favorable place to be for plaintiffs, mainly because you're not being tried truly by a jury of your peers.

What happens is, when complex medical malpractice cases come before the jury and they have experts here, and you have experts here and the experts don't agree obviously, the doctors don't agree, it's becomes more of a theatrical circus than it does a true trier of the facts.

I think it's very unfair, as you saw with the CAT Fund case, you know about the Philly fanatic who bumped somebody and the person who was injured, the plaintiff got $150,000 and there's a multitude of cases like that from people who have injuries 2 years later and decide that you should have known it. So, there's a multitude of examples. I won't get into anecdotes.

We just want the juries to have some guidelines on what to do. We are not against an injured person having the ability to sue for damages. We have never said that. We are not against that. We would never say that. That is not right and we don't agree with that. We think that people that are truly injured have the right to sue.

However, however, there has to be some guidelines in our society. We are becoming a no-fault society where, if something happens, if you fall you should sue. If you're hit by a baseball because you're in the stands watching your son, you should sue. We have become out of control. The system is out of control of what we're trying to do.

We're not asking to eliminate the system. This is what the trial lawyers say and that's not true. Putting guidelines, having some true realistic moderate reforms so that there are guidelines on what to do would make sense. And that's what the caps, which is not in the Chadwick bill by the way, but the caps on noneconomic damages is trying to do. It's trying to give juries some guideline instead of

some pie in the sky.

As you well know, the damages in malpractice cases are determined by actual things that actuaries can look at. How much time off from work, how much medical cost, how much this, that, the other and they're actual numbers. They're real numbers. They're adjusted for inflation for the life of the patient. You are quite well aware of all of this. I wasn't, but we are. They are adjusted. They are financially reproducible numbers. We may not agree with them, but they're reproducible.

This noneconomic damages which you were just asking Doctor Okin about is just a pie in the sky number. There is no way that money is ever going to compensate somebody for a child who's truly injured, for a skin loss, for a heart attack, for a misdiagnosis. There is no way that money is ever going to compensate a truly injured person for that.

But, if you make the numbers unrealistic, $10 million, $5 million, it throws the whole system out of control. The same thing happens with this punitive damages. No doctor,

no doctor ever goes with an evil motive to try to hurt another person. If that were proved that they did by any of the examples they've shown, you don't have to slap punitive damage on them. You should take away his license to practice forever. We would totally be in favor of that. We don't do that.

This punitive damages, as you well know, being on both sides of the fence is simply used as a threat against doctors, because as Michael said, it is not covered by any insurance at all. You are personally liable for all those things.

We're just asking not to abolish the system. We don't want to say there's no comma in the bill that we won't support. We want to say that there has to be some realistic, some rational approach to doing this. That's what the caps do, which are not in the Chadwick bill, but what's the whole idea of tort reform is. Not to limit the patient's ability to did it and those 10 suits that Ms. Flum reviewed and she takes 1, I can guarantee the other 9 are going to people less scrupulous than her. I can tell you.

REPRESENTATIVE MANDERINO: That gets back to the self-policing of the profession which both of our professions have to do a little better job of.

DR. VANETT: Absolutely.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Manderino. Counsel Andring, any questions?

MR. ANDRING: No.

CHAIRMAN GANNON: Thank you. Just to finally clarify, there was a chart that was handed out in prior testimony. It shows that California's premium is a little higher than Pennsylvania's even with the surcharge. There's no surcharge in California.

DR. OKIN: Where is that chart? I don't see that.

CHAIRMAN GANNON: I don't know if we have a copy.

DR. OKIN: I'd love to see that chart.

REPRESENTATIVE MANDERINO: That's the one that I had asked you about and you said that was the --

CHAIRMAN GANNON: Let me ask a question. As I look at this chart, it shows with the emergency surcharge and the 102 percent normal charge, I guess, for 1995 and the emergency surcharge of 68 percent it shows that Pennsylvania's premiums for medical malpractice are somewhat less than California's. California does not have the surcharge?

DR. OKIN: California doesn't have a surcharge.

CHAIRMAN GANNON: Now, my next question is this, I want to find out whether we are comparing apples with oranges. In the California, does California have a claims-made policy?

DR. OKIN: They may have them, but a very rare one.

CHAIRMAN GANNON: Does Pennsylvania have the claims-made policy?

DR. OKIN: I don't think anybody that I know has one.

CHAIRMAN GANNON: This says claims-made. I'm assuming from this chart that we're talking about claims-made policies in California and claims-made policies in Pennsylvania.

You're saying that that's not the case?

DR. OKIN: I question the liability of of the entire study. If you poll a thousand physicians, nobody has a claims-made policy.

CHAIRMAN GANNON: You still didn't answer my question. I want to make sure I'm clear on this. What I'm simply asking is, you're telling me is that this chart does not show a comparison between the same types of policies?

DR. OKIN: I didn't make this chart up. All I know is, I don't know of --

CHAIRMAN GANNON: You're saying that the chart may, in fact, be correct then?

DR. OKIN: What I'm saying is that, there are no physicians that I know in the State of Pennsylvania walking around today --

CHAIRMAN GANNON: That's not my question. I don't know of any either. I know that was an issue at sometime.

DR. OKIN: Statistically this chart is meaningless.

CHAIRMAN GANNON: Let's get back to find out whether it has any element of truth in it. That's what I'm trying to clarify here is

whether or not we're comparing apples with apples or apples with oranges. My question is, in this particular chart it says, the source is says per PIAA. I don't know who that is.

DR. OKIN: I don't know how that is either. I think you'd have to go back to --

CHAIRMAN GANNON: What I'm simply saying is that, it looks from this chart that even with the surcharge that Pennsylvania has put on, for this particular type of policy, irrespective of the numbers that are out there in the marketplace, that the premium in California is higher than the premium in Pennsylvania. What you're saying to me is, if you looked at other relevant data that we're both equal, that would not be the case.

DR. OKIN: I would say that, yes.

CHAIRMAN GANNON: Now, just a question on the CAT Fund. This is probably the most troubling area of this whole inquiry. Although this wasn't the purpose of the testimony, I just wanted to see what your views were on one aspect of it.

The CAT Fund receives a notice from the primary insured that there is a claim that

would potentially impose liability on the CAT Fund.

DR. VANETT: I think they're notified of every claim that is made.

CHAIRMAN GANNON: Let's assume they're notified of every claim that is made. That is irrespective of whether or not potential liability is in excess of the primary limits. In that particular instance, would you have any trouble with the proposition that when the CAT Fund receives that notice and then gets some idea of the injuries involved and what the claim is all about, the CAT Fund says, our potential liability here is X number of dollars?

Let's assume it's a hundred thousand dollars. That the CAT Fund would then take a hundred thousand dollars out of one fund and put it in another fund, set it aside if you will to pay that hundred thousand dollars whether it was tomorrow or next month or next year or 10 years down the road. Then base its surcharge to its physicians, its members, on how much money was set aside on the basis of claims that were reported to it.

In converse, when cases are closed,

that if the payment is less than the sum that was set aside, that it take the balance or the remainder out of that fund and put it back into another fund and then give its members a credit for that.

DR. OKIN: Let me try to answer that question as best I can.

CHAIRMAN GANNON: It's a complicated question.

DR. OKIN: One of the problems that you have to realize, the CAT Fund is not an insurance company. You see, an insurance company can do that.

CHAIRMAN GANNON: I'm suggesting, I'm asking you if the legislature dare --

DR. OKIN: There's another part to it. Let me finish what I have to say before you draw. The CAT Fund is not an insurance company. An insurance company would take those monies and put them aside and invest them. If they invested them in the market this year, they would have made 40 percent of those monies. The hundred thousand dollars would be worth a hundred and 40 thousand. If it went 10 years, that hundred thousand would be worth over a

million dollars. The CAT Fund doesn't do that. It's not making money on the money that's there. It's just paying it out. It's a wrong venue.

CHAIRMAN GANNON: My question to you was, do you have any trouble with that proposition? I know the CAT Fund doesn't do that. That's not my question. What I'm asking is, do you have any difficulty with the proposition that the CAT Fund does do that?

DR. VANETT: Yes. There's a problem with that, Mr. Gannon. The problem is, the CAT Fund no more than our defense attorneys or the plaintiff's attorneys have any idea what the value of the case is going to be.

When the Philly fanatic bumps somebody and gets paid a hundred 50 thousand dollars and the psychic loses her memory for $600,000, there is no way that the CAT Fund could have put aside $400,000 in some other fund to understand it. This is the problem. This is why we want some caps or some limits.

When you bring a case to Philadelphia, as Ms. Manderino knows, the awards can be astronomical. If you bring that same case to Towanda or somewhere else in Pennsylvania, the

awards may be much more reasonable. This is the big variability; that pain and suffering component. Not the money that we can figure out by wage loss, that's easily calculable and that could work in your system.

If we have caps on noneconomic damages so that the maximum you could lose would be $250,000 plus that, then for every case they could put money away which is what they do in other states and why they're able to keep their malpractice premiums at a reasonable and controllable level. This is what we want because then, they can put the money away and then it will do exactly what you're suggesting.

But right now, they have no idea whether a broken needle in Philadelphia left in the knee is going to cost a million dollars while in Pittsburgh it may cost a hundred thousand dollars. So, they don't know how much to put away. At least I think that's one of the problems with what you suggest.

CHAIRMAN GANNON: Then you're suggesting if, for example, we decide to place a cap on pain and suffering of $500,000, that every time a claim was reported $500,000 would

have to be set aside because you just said we have no idea how much it's going to cost? So, whatever the cap is that was set, if we set a million dollar cap, every case that was reported would have to have a million dollars set aside.

DR. VANETT: Obviously, that's not what they do in other states that have caps. I don't know how the insurance company decides what to put in reserves. In question you said, we'll put away a hundred thousand dollars because that's the value you put on it. You can't put a value on it in Pennsylvania.

I don't know what they do in California, how they decide. Does every case that comes in then get $250,000 potentially put aside? I don't know how the insurance companies -- There's someone here who can tell you. I don't know how they put money away.

CHAIRMAN GANNON: I'm getting to your original premise which was, we don't know how much they cost. If we don't know how much they cost, or the potential cost is going to be, if I agree with you then I have to say, well, whatever cap is put on is the amount that has to be set aside, because that is our maximum

liability; not our potential liability, but that's what you're saying.

Then you get total predictability in the system. We set a cap of a half million dollars or a cap of a million dollars and add in all the costs and potential attorney fees and whatever that's going to be, that's what you set aside. Then you guys get charged for whatever that amount is. You don't complain anymore because now you've got predictability.

Another premise, as people can make reasonable estimates over the long term as to what the value of the case is, based upon a number of factors that you and I would be familiar with, but I won't go into, there can be some reasonable degree of predictability as to what a particular case is going to cost, and that is what you set aside. It may not be a half a million dollars; it may be less than that. It may be more than that depending upon what the circumstances are.

But, what I'm suggesting is that, assuming that that could be done with a reasonable degree of certainty, you're not going to be right every time. You may not be right in

the psychic. You may be very right in the psychic, zero. Ultimately, that's what you paid out, zero, because that's what happened in that case.

My point is, and I go back to my original premise. Would you have a problem or what would be your position -- I really don't want to ask your position. I'm being hypothetical. But, if that was the case, what would be your thoughts on that? That is, getting back to this, the sum is set aside to pay for that CAT Fund.

DR. OKIN: I don't think you can answer that question as answerable. In medicine we have a model. If there's a disease we're studying, we make up a model of that disease and you do it in rats, you do it in horses, whatever you want to use; and you try out on some experimental model and you see how that works. If it works, then you'd say, well, we'll try it on a person.

Well, in the United States we have models. We have California which is a model. They set up a system that works. You can easily go to that system and find out what it cost them

and how they set aside their funds to fund that system. You can go to Indiana, and you can find out how that system works.

There are 21 states. There's Alaska. Each one of those states have a system in place which is a model, an experimental model that we can go to and use that information. It's valuable, and then set up some type of system that would work in Pennsylvania. You're asking a question. There's no model.

CHAIRMAN GANNON: I'm asking the question about the CAT Fund. I prefaced my remarks --

DR. OKIN: But the answer to your question is that the models in California and the models someplace else, you've got to look at those models and decide what's the best system for the Commonwealth. It may not be the CAT Fund.

CHAIRMAN GANNON: My original question, maybe I'm not making myself clear here. I'm simply asking the question, if you had a system under the CAT Fund for every claim that was reported was required to set aside a reserve, if you will, for its potential

liability, and at the time it's set aside the reserve you then charge back in the form of a surcharge whatever that would be to a participating physician on that reserve. If the claim was paid and it was less than that reserve amount, it was credited back. If it was more, there would have to be additional monies set aside. I agree they're not right every single time.

But, what I am getting to, in my view, that may be some predictability and stability in the CAT Fund, which is really the major crux of the problem that's before us right now. That's the immediately pressing problem.

You've got a hundred thousand dollar loan that you've taken out or more than that to pay the CAT Fund liability. You told us you're already getting ready for another possible surcharge.

To me, at least, I believe that that's more pressing and I think you'll agree than whether or not tort reform goes into place in 4 or 5 years down the road, I'm more concerned about the immediate problem and how that addresses.

I apologize. I didn't want to get into a colloquy on the CAT Fund, but I simply wanted to ask the question and see where you were. And I guess the answer is, we don't know.

DR. OKIN: I don't think anybody has the answer to that question. It's a many faceted question. I don't if you can answer that. You have to tackle all the problems at the same time. You can't tackle one and not the other. They're interdependent on each other. You can't fix the system by just fixing one part of it.

DR. VANETT: The other thing I think is very important that you understand as legislators is that, this CAT Fund surcharge is just a catalyst of a problem that's been simmering for many years. So even though this is the immediate problem, tort reform is the long-term answer. We don't care what happens in 6 months. If we have to pay another surcharge, we have to do that if that's what the law is. But, the ultimate solution is not just to deal with the CAT Fund. That's only a symptom of the problem.

The overall problem is this inequality

of the tort system in Pennsylvania, and it's affecting not just us. As you well know, it affects Little Leagues; it affects bar owners; it affects schools; it affects the state government; it affects everybody. This thing with runaway liability in Pennsylvania is a pressing problem, not just the physicians, but also small businessmen and, in fact, all the constituents in Pennsylvania.

CHAIRMAN GANNON: I want to thank you for coming today and presenting your testimony and taking questions from the committee. It was very interesting.

DR. OKIN: Thank you, Chairman, and thank you panel.

CHAIRMAN GANNON: Our next witness, Senator Henry Hager, had to leave because of a pressing engagement. I'm going to at this time offer Senator Hager, unless there's an objection from any of the committee members, as an exhibit to the testimony that was presented today. I'm going to circulate the transcribed testimony to the members of the committee for comment and we're going to include Senate Hager's comments as part of the record of today's hearing.

REPRESENTATIVE MANDERINO: Mr. Chairman, not an objection, but I just want the record to reflect that I stayed to the end just so that I could question Mr. Hager and I'm so disappointed.

CHAIRMAN GANNON: You will get another chance. Now you'll have time to think up more questions. Thank you very much.

This meeting of the House Judiciary Committee, public testimony on House Bill 2122 is adjourned.

(At or about 5 o'clock p.m. the hearing concluded)

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C E R T I F I C A T E

I, Karen J. Meister, Reporter, Notary Public, duly commissioned and qualified in and for the County of York, Commonwealth of Pennsylvania, hereby certify that the foregoing is a true and accurate transcript of my stenotype notes taken by me and subsequently reduced to computer printout under my supervision, and that this copy is a correct record of the same.

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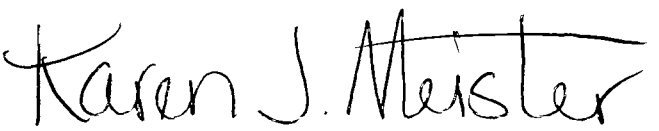

Karen J. Meister - Reporter
Notary Public

My commission
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