Testimony of Betty L. Cottle, M.D., Chairman of the Board
Pennsylvania Medical Society Liability Insurance Company
on House Bill 2122 before
house Judiciary Committee
March 14, 1996

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 Act 111 as originally enacted contained a good faith balance of insurance and legal reform.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 provisions in 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. 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.

Now, I am concerned about patients and I am concerned about my young counterparts. Let me focus for a moment on the young physician who probably will be practicing within

the 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 that 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 held liable for any injury to the patient, even though the physician was constrained in the treatment decision. I know that plaintiff trial lawyers are practically drooling with glee and anticipation at the liability prospects which are open to them now. This will be a big money maker 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 which patients need.

Again, though, I return to the observation that patients suffer under this current system. Your constituents, be they physicians or patients, are <u>not</u> helped. The public agrees that the legal system needs to be changed. In a recent poll, more than 80 percent of 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 plaintiff and defense attorneys. Yet, this is not a physician and consumer versus lawyer issue. Within the legal community voices are crying 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 to the plate and make the kinds 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 legislation, let me clarify: we have a system in which physicians successfully defend over 80% of the professional liability cases brought against them, but the <u>costs</u> 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 insurance costs. I will share with you PMSLIC's experience. From 1978 through 1995, PMSLIC has spent an average of over $8,000 per case to defend over 9,000 claims that were closed without any payment to the party bringing the lawsuit. This means that we

have spent over $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 truly injured patients.

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

There is a finite pool of money available for health care. Money wasted on 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.

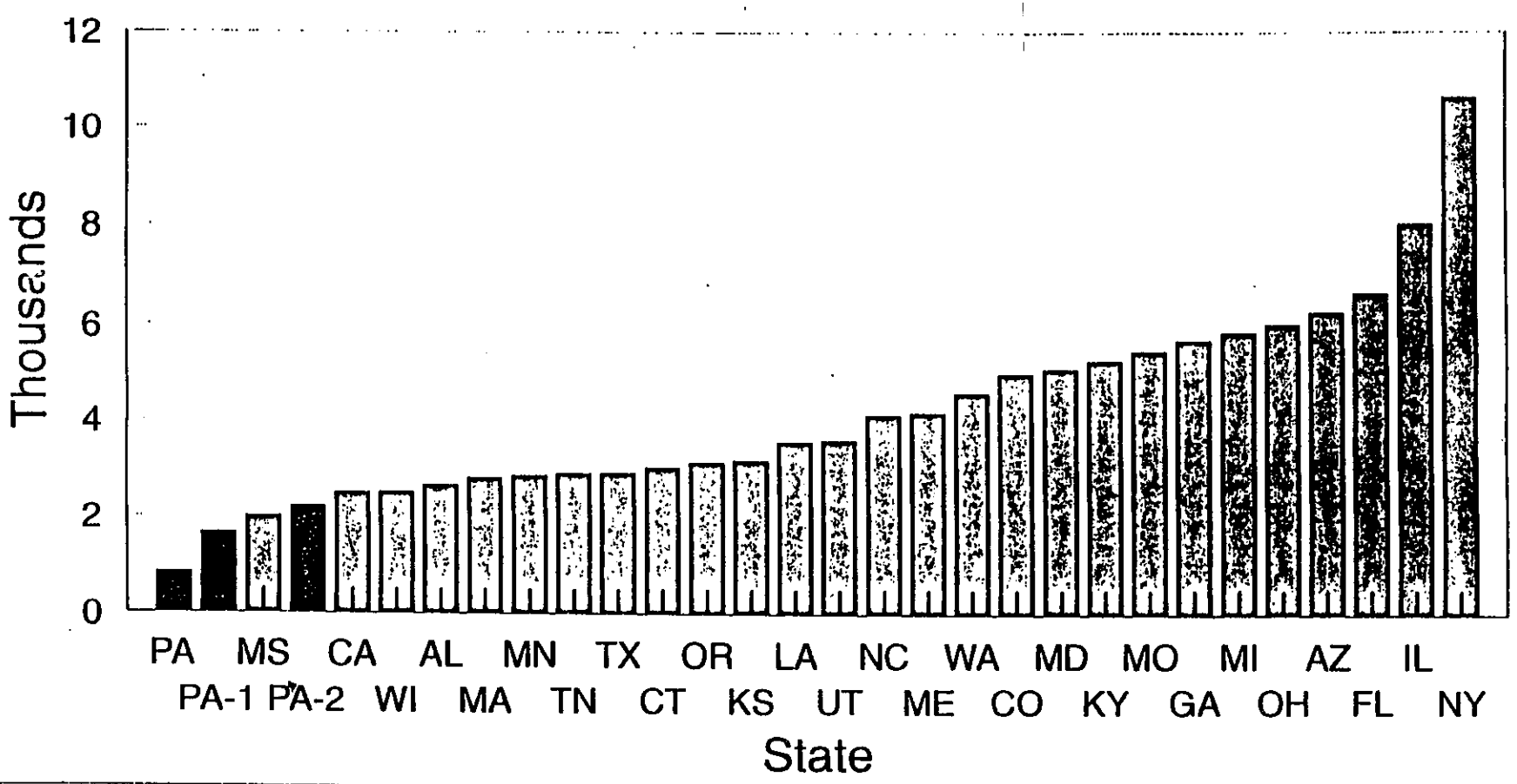
Medical Professional Liability Catastrophe Loss Fund

Historical Claim Experience

Accident Year	Fund Paid	Average Claim	Claim Count
1978	$2,450,717	$350,102	7
1979	$2,265,000	$90,600	25
1980	$16,333,839	$526,898	31
1981	$19,555,472	$253,967	77
1982	$38,076,060	$271,972	140
1983	$54,169,175	$320,528	169
1984	$66,786,997	$342,497	195
1985	$97,724,928	$387,797	252
1986	$136,064,199	$338,468	402
1987	$136,050,829	$381,095	357
1988	$168,327,197	$471,505	357
1989	$143,613,571	$443,252	324
1990	$132,059,492	$394,207	335
1991	$150,053,687	$451,969	332
1992	$153,221,558	$454,663	337
1993	$164,495,505	$495,468	332
1994	$171,842,345	$464,439	370
1995	$279,884,000	$507,956	551

Average Annual Premium for Most Prevalent Limits

Per PIAA (Claims-made) - Lowest Class

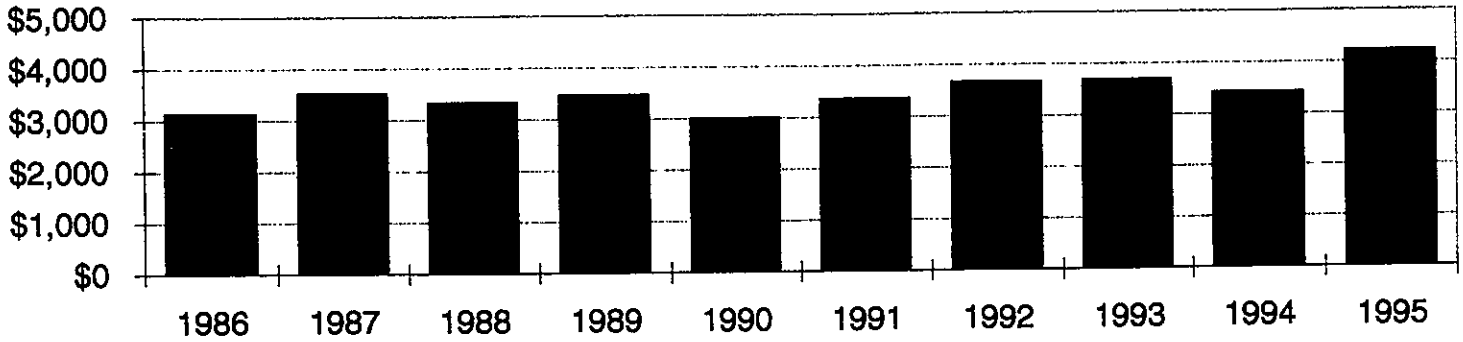


PA: without surcharges, PA-1: with 1995 surcharge (102%)
PA-2: with 1995 (102%) and emergency surcharge (68%)

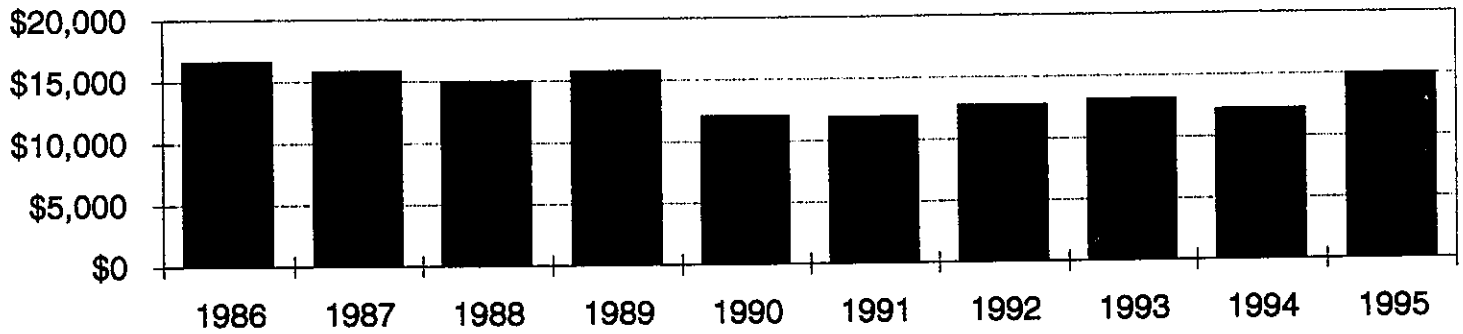
ATTACHMENT B

Medical Professional Liability Catastrophe Loss Fund

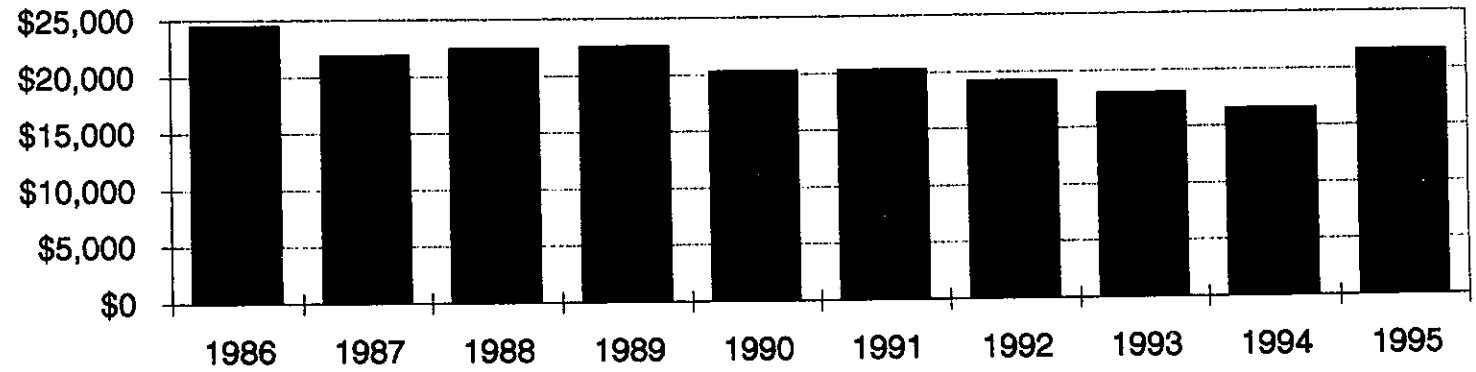
Average ACTUAL Premium Paid
Family Physician



Average ACTUAL Premium Paid
General Surgery



Average ACUTUAL Paid Premium
OB/Gyn.



Surcharge	1986	1987	1998	1989	1990	1991	1992	1993	1994	1995
	87%	87%	61%	60%	50%	68%	90%	91%	93%	170%

$200,000/$600,000 (Primary)
$1,000,000/$3,000,000 (MPLCLF)

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