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HOUSE OF REPRESENTATIVES
HOUSE JUDICIARY COMMITTEE

THE MAIN CAPITOL
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HARRISBURG, PENNSYLVANIA

THURSDAY, APRIL 22, 2010
10:00 A.M.

PUBLIC HEARING ON
MEDICAL LIABILITY

BEFORE:

HONORABLE THOMAS R. CALTAGIRONE, CHAIRMAN
HONORABLE RON MARSICO
HONORABLE DEBERAH KULA
HONORABLE KATHY MANDERINO
HONORABLE JOHN E. PALLONE
HONORABLE JOSEPH F. BRENNAN
HONORABLE WILL GABIG
HONORABLE GLEN R. GRELL
HONORABLE BERNIE O'NEILL
HONORABLE RICHARD R. STEVENSON

ALSO PRESENT:

DAVID D. TYLER, EXECUTIVE DIRECTOR (D)
KAREN COATES, CHIEF COUNSEL (R)
WENDALL HANNAFORD
CHRIS WINTERS

BRENDA S. HAMILTON, RPR
REPORTER - NOTARY PUBLIC

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P R O C E E D I N G S

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CHAIRMAN CALTAGIRONE: Welcome, committee. I'd like to welcome everybody here today to the House Judiciary Committee on Medical Liability Review. As has been my practice, you know, when I look at an issue, I like to have all sides presented so that the members of the legislature can really have a full view of -- of what these issues deal with and what we may have to do legislatively to -- to step in to help correct situations.

I'm Tom Caltagirone, Chairman. And if the members, starting with my left, would introduce themselves and staff that are present.

REPRESENTATIVE MARSICO: Thank you, Mr. Chairman. Good morning. Ron Marsico, the minority chair of the Judiciary Committee.

MS. COATES: Karen Coates, minority chief counsel to the Judiciary Committee.

REPRESENTATIVE STEVENSON: Good morning. Dick Stevenson, 8th District, Mercer and Butler Counties.

REPRESENTATIVE KULA: Deberah Kula, Fayette and Westmoreland Counties, 52nd District.

REPRESENTATIVE MANDERINO: Hi. Kathy Manderino, Philadelphia and Montgomery Counties.

REPRESENTATIVE GRELL: Good morning. Glen Grell, Representative from the 87th District, in Cumberland County.

MR. TYLER: Good morning. David Tyler, Executive Director of the Democratic Caucus, Judiciary.

CHAIRMAN CALTAGIRONE: We probably will have some additional members that will be joining us on and off during this hearing.

I -- I do want to mention that Madam Justice Sandra Newman would have been here to testify today, but she's having eye surgery so couldn't make it.

And we'd like to start off with Jim Goodyear. Dr. Goodyear, President of the Pennsylvania Medical Society.

DR. GOODYEAR: Good morning, Chairman Caltagirone, members of the House Judiciary Committee. Thank you for the opportunity to allow me to testify before you today on an issue that's been a priority for us in our Pennsylvania Medical Society since 1975.

I am Dr. Jim Goodyear. I'm president of the Pennsylvania Medical Society. I practice general surgery in Montgomery County.

For those of you that may not know the significance of 1975, it was an interesting beginning for what has become for us an endless request for fairness.

That's the year that marked the enactment of the medical professional liability law known today as Act 111.

At the time the new statute contained three very important and interrelated components. It created the CAT Fund, today's Mcare Fund; mandated that physicians carry a specific level of liability insurance, at that time $1.2 million; and enacted sweeping tort reforms that included caps on attorney's fees so that the mandated coverage would be affordable.

Not long after Act 111 became law, the Supreme Court struck down the tort reforms, leaving physicians only with the onerous burden of the insurance mandate that quickly became the target and lifeblood of many personal injury attorneys.

So where does that leave us today? Today we continue to strive for fairness in a world so litigious that our phone books are covered with personal injury ads and television commercials are dominated with enticements from lawyers asking us if we've been injured by physicians, truck, car, sidewalk, employer, even a dog.

Ironically I recently received a postcard from a class action attorney informing that I have potentially been wronged by the manufacturer of my lawn mower because the engine's advertised horsepower had

turned out to be inaccurate. The postcard specifically pointed out that the safety of my lawn mower was not in question. So I had to ask myself, just where was I harmed?

Not surprisingly, I could continue to spend the rest of the day and into tomorrow sharing examples of what I believe are absurd lawsuits. Frankly I wonder if I could find an attorney to sue my local deli because my sandwich didn't live up to the deli's claim that it would taste great.

Today's hearing is about medical liability reform. When I began thinking about what I would share with you today, I became quickly overwhelmed. As a practicing physician, specifically a surgeon in Montgomery County, I bear witness every day to how our current liability system bogs down the delivery of health care.

Let me just share with you a few areas where I believe lawsuit abuse continues to be an obstacle to the patient/physician relationship and hampers delivery of care in our health care system.

Every day physicians order unnecessary diagnostic tests for no other reason than to protect themselves in the event of a lawsuit. President Obama has already conceded that frivolous lawsuits and

defensive medicine drive up the cost of health care. A 2005 study by Kessler and McClellan, both professors at the Stanford Graduate School of Business, estimates that defensive medicine costs between 100 and $178 billion per year. That study was in 2005. If you project the same data to today, it would be over $200 billion.

If we honestly wish to effectively lower and bend the unsustainable health care cost curve, significant and meaningful reform of the medical liability system is mandatory.

Recruiting young physicians to our Commonwealth remains a challenge given Pennsylvania's reimbursement and liability climate. Competition for young physicians can be intense and many are offered many opportunities. Many of my colleagues, however, especially those nearing retirement, are greatly concerned about who will care for those patients when they are no longer practicing.

Quite honestly, I'm concerned about who's going to care for me.

It's easy for an obstetrician/gynecologist to limit their practice to gynecology only, and it's often attractive for them to do so just to lower medical liability insurance costs.

I've had friends who have done this and

while I understand their reasoning, I'm saddened because it ultimately means that patients lose the option of having their baby by that particular quality individual.

Those are just a few of the ways that lawsuit abuse has hampered the practice of medicine.

What can you as legislators and policy makers do to help level the playing field? How can you help physicians return to their exam rooms and operating suites to concentrate solely on their patients' care? How can you help us recruit and retain young and qualified physicians to our Commonwealth so that we can take and appropriately care for an increasingly aging and dependent population?

You could begin by strengthening the reforms that the legislature enacted a number of years ago. You could also close some of the loopholes that have effectively watered down the original intent of the reforms.

There are other areas of the current system that need attention that have slipped through the process in the past. I'll share with you a few items that I believe would create a medical practice climate here in Pennsylvania that might actually attract those same young physicians that we so desperately need.

Our lawsuit abuse wish [sic] includes the

following:

Number one, caps on noneconomic damages. Noneconomic damages. Runaway verdicts -- jury verdicts have given rise to a hitting-the-jackpot mentality. A healthy dose of reason, I believe, needs to be restored.

Limit on attorney fees. A legislative precedent exists, as you know, in workmen's compensation cases. Why not expand that to include all personal injury litigation?

The apology rule. For decades physicians have been advised by their attorneys to admit nothing when an adverse situation arises. Communication between the physician and the patient is the hallmark of quality care.

This positive change would allow physicians to continue to communicate openly and honestly with their patients and their families without fear that their statements will be used against them in court.

Expert witness qualifications. This is very simple, yet a very just concept. A pediatrician should not under any circumstances be able to testify against a neurosurgeon. The current rules have been broadly interpreted by the courts allowing unreasonable and unjust exceptions.

Collateral source rule. Expand this rule

to include Social Security income along with future losses paid by the collateral sources.

Periodic payment of future medical costs. This should eliminate attorney fee carve-outs.

Certificate of merit. We must immediately begin to insist that a plaintiff produce a supporting expert report and the CV of the expert at the time the certificate of merit is filed.

Now, I sincerely believe that most would consider these proposals to be reasonable, without hindering an individual's access to the courts or their ability to be fairly compensated for potential injuries.

At times, the results of thoughtful and prudent patient care by dedicated and knowledgeable, skilled physicians are still less than were initially hoped or intended. But we must all remember that the art of practicing medicine is not always predictable by its very nature. The practice of medicine is an art and not an exact science. While unfortunate outcomes and complications do sadly happen, I would challenge anyone to show me a physician who set out intentionally to harm a patient.

Unfortunately, I suspect that this issue of tort reform will likely be debated for many years to come. Perhaps I am old-fashioned, but I wish we could

return to the days when poor outcomes and unfortunate complications were just that, poor outcomes and unfortunate complications.

Today, whether it's mislabeled horsepower for my lawn mower or an unanticipated surgical wound infection, such events have instead been labeled as negligence and have become little more than a jackpot for opportunities to get rich quick.

I don't profess to have all the answers, but I do believe that our nation is the world's most litigious. And I honestly believe that we are all adversely affected by this unfortunate reality. As an American, I found that disheartening and I believe we should all work together to try to change that.

I want to thank you again for this opportunity to share my thoughts and the thoughts of the Pennsylvania Medical Society regarding this oppressive litigation.

To the best of my ability, I would be happy to respond to any questions that the committee may have for me at this time.

CHAIRMAN CALTAGIRONE: Thank you, doctor.

We've been joined by Representative O'Neill, who is a member of the committee.

There are questions? Chair Stevenson --

Representative Stevenson.

REPRESENTATIVE STEVENSON: Thank you, Mr. Chairman.

And thank you, doctor, for your time and being with us this morning.

One of the things that we continually hear about are the exodus of students after they achieve their degree leaving Pennsylvania and going to other states to practice rather than staying in Pennsylvania. You touched on that in your testimony.

Do you have any statistics or any idea about how -- how many of those students do leave for this reason and --

DR. GOODYEAR: Well, the -- the best determining factor is actually the residents, after their residency training program. Our last data shows that 80 percent of the residents trained in this state leave this state. Only 20 percent are -- stay here.

REPRESENTATIVE STEVENSON: Do you know what states they are most attracted by?

DR. GOODYEAR: Yeah. There are several. California, Texas, Indiana.

REPRESENTATIVE STEVENSON: And are those states -- their -- their tort situation is -- is -- is that the reason they go to those states, because it's

more --

DR. GOODYEAR: It's a significant part of the reason, yes, sir.

REPRESENTATIVE STEVENSON: It's more attractive to them for that reason?

DR. GOODYEAR: Yes.

REPRESENTATIVE STEVENSON: Yes. And are -- how are their -- those states different from Pennsylvania?

DR. GOODYEAR: One of the -- one of the most significant components of their tort system is a cap on noneconomic damages.

REPRESENTATIVE STEVENSON: And that was your number one --

DR. GOODYEAR: I -- I think it would be very, very high on our list of -- of -- our wish list, certainly. We recognize that it requires a constitutional change here in Pennsylvania. We're well aware of that.

We think there are other -- other things that can improve the climate. But we would also suggest that that process begin to go forward. Rather than to use it as a reason to not do it, begin the process.

REPRESENTATIVE STEVENSON: One final question, Mr. Chairman, if I may.

Several years ago we -- we passed legislation having to do with frivolous lawsuits here in Pennsylvania and I recently became aware that -- that the number of frivolous lawsuits, medical lawsuits which were proved frivolous or felt to be frivolous, has declined drastically since that -- that time. Is that your -- your understanding as well?

DR. GOODYEAR: Yeah. The number -- the number of lawsuits that have been -- the number is down. However, the -- the judgment awards has actually gone up. So it has not had a significant effect, although there was a stabilization of medical malpractice premiums. The fact that the -- the awards have continued to climb has not really lessened the burden.

REPRESENTATIVE STEVENSON: I see. Thank you.

Thank you, again, Mr. Chairman.

DR. GOODYEAR: Thank you.

CHAIRMAN CALTAGIRONE: Certainly. Glen, then Bernie and Kathy.

REPRESENTATIVE GRELL: Over here, doctor. Over here. Thank you.

I just want to follow up a little bit on Representative Stevenson's questions. I've seen different statistics on the number of doctors that we

actually have in Pennsylvania overall, and I'm interested in what numbers you could share with us in terms of current and how that is trending. And also what criteria do you use to identify that this is a doctor who is actively engaged in practice in Pennsylvania? So we're getting the right statistics.

DR. GOODYEAR: Yeah. I'm sorry. I didn't -- I didn't bring those numbers with you [sic], but let me -- let me talk about how we look at that issue.

In general, the numbers are relatively stable and it looks -- and it -- it varies depending on how you look at that, but I think there are some issues that really need to be taken into account when you look at that number.

The number of residents that are training in this state is climbing. They are licensed physicians and they are counted as physicians within the Commonwealth. But they're not staying. They're not staying here to open practice.

We would like to measure physicians by the number of actively practicing, nonacademic or -- or academic, but actually seeing patients on a regular basis. Actively involved in patient care.

That data is very, very difficult to come

by. Because if you just -- if you just look at the number of licensed physicians in the state, that's a very, very volatile number that changes.

We think it's basically been stable. One of the significant issues is that the average age of the physician continues to climb and now greater than 50 percent of the physicians in Pennsylvania are 50 years of age or older.

There are significant studies that show that productivity and hours of commitment to direct patient care goes down at that point in time, not quality, but just how many patients you're seeing.

So these individuals are approaching retirement in a state where you will admit, I think, we have the second largest population of seniors in the country, and -- and that population is continuing to grow. Their average age continues to climb.

Baby Boomers are now reaching that age when they're going to need and require more health care, greater access to health care. That needs to be addressed by our physician population, which, by our studies, is showing is not being replaced adequately by retaining and recruiting young physicians.

I'm in a four-person general surgery practice. We've been looking for three years for a fifth

partner and cannot attract anyone.

REPRESENTATIVE GRELL: Thank you very much.

REPRESENTATIVE O'NEILL: Thank you, Mr. Chairman.

Doctor, many years ago, when I was doing a lot of research on the subject, I found that -- I believe -- I'm trying from my memory, you know -- that of all the lawsuits filed, medical malpractice lawsuits filed, only about three percent of then were truly considered true malpractice, and, you know, lawsuits, that would, you know, meet the standard or whatever it is.

Do you know if that percentage is accurate today? Has it increased, decreased? I believe it was three percent. I'm not sure.

DR. GOODYEAR: Yes, it's very, very low. I don't know the accuracy of that number. Our -- our -- and I believe you're referring to Act 13.

The number has improved, but it remains very, very low.

REPRESENTATIVE O'NEILL: Right.

DR. GOODYEAR: There is still a -- a high percentage of -- of what we consider frivolous lawsuits, which means I can -- I can explain that as to what I mean

by that, if you'd -- you'd like to take the time, but the actual true negligence, below standard of care, very, very low.

REPRESENTATIVE O'NEILL: All right. Great. Thank you. I appreciate it.

DR. GOODYEAR: Yep.

REPRESENTATIVE MANDERINO: Good morning, Dr. Goodyear. And thank you very much for being here.

DR. GOODYEAR: A pleasure.

REPRESENTATIVE MANDERINO: A couple of questions. I mean Pennsylvania has always been an exporter of new physicians because of the number of medical schools we have in our state. So it doesn't surprise me that we are an exporter.

What would be more helpful to understand is how that -- and it's not even really a percentage, I guess. The absolute -- I don't know if you have any more defining numbers.

I mean we've added medical schools in recent years that we didn't have, so we were an exporter, plus we have even more capacity in recent years. So -- so the percentage -- kind of just saying to me that 80 percent is going doesn't mean anything to me.

Can you give me some absolute numbers?

DR. GOODYEAR: Sure. But let me -- let me

just talk about the new medical school. It only has it's first class now. So that won't be graduating -- you're talking about the Commonwealth Medical School in Scranton -- will not be graduating its first class for another three-plus years and then there's a residency training. So there's certainly a delay.

But let's look at one piece of data that I think is indisputable. The average age of physicians in the state of Pennsylvania and actively practicing -- in active practice is climbing, which means we're not replacing the -- the physicians with younger physicians. That's the only way that the average age can be going up.

So you're correct. We do have it. We do have more medical schools. We have nine. We have a lot of residency programs. We -- we educate and train some of the best physicians in the country, and we should be very, very proud of that.

But we also want to also create an environment and a climate that would be attractive enough for them to stay here so that the -- the care that's being rendered to you and your family and your loved ones is by quality-trained, young physicians. Physicians need to be attracted to this state, and that's what -- that's what we're really trying to accomplish.

REPRESENTATIVE MANDERINO: One of the points that you have in your testimony that I would like a little bit more explanation of is under your wish list is the certificate of merit.

What's not worked -- obviously the fact it's on your list tells me that something isn't working about it because we already put it in place. What from your perspective isn't working?

DR. GOODYEAR: A lot of comments in some of the certificate of merits are not accurate. Just having a certificate of merit that's not vetted against accurate -- accuracy and scientific basis is a concern to us at the Medical Society.

So we would like to see that -- that it -- what is being said is in keeping with the specialty organizations that may be in -- under question and the CV of the individual be available.

REPRESENTATIVE MANDERINO: And when you mention the specialty, I guess it leads to the other question I wanted to ask about your -- your points on your wish -- wish list and that goes to the expert witness qualifications.

And I understand what it is you're saying with regard to like minded -- like trained specialists, and there's always been a desire from the -- from the

medical practicing community to have those be the only qualified experts.

But there's also been, kind of on the other side of the scale, the un -- unwillingness to testify against one of your own, so to speak.

How do we -- and I think one of the reasons why we have struggled with this whole realm of expert witness qualification is that we haven't seen proposed a mechanism whereby like trained specialists in a particular field would be willing to be on a review panel, would be willing to do something.

What is the solution to that problem if we were to be more restrictive with expert witness qualifications as you would like to see us be?

DR. GOODYEAR: Well, I'm not sure I can come up with the language right now that would help you. I understand your concern.

I think the Pennsylvania Medical Society would be more than happy to work with this committee and with you in coming up with the kind of language that we're looking for in determining the qualifications for an expert witness.

But it is actively practicing, preferably in the state of Pennsylvania, actively seeing patients, and members of their -- their specialty society, in good

standing, board certified. Those are the --

REPRESENTATIVE MANDERINO: Why? Why actively practicing in Pennsylvania? Is there a different standard of care in -- in other -- in other states?

DR. GOODYEAR: There are --

REPRESENTATIVE MANDERINO: I mean to me it seems like that might be one of the ways that you then don't have a -- a I know you; you're my buddy; I went to medical school with you or I -- I trained with you in such and such a hospital, you know.

DR. GOODYEAR: Well, I -- I -- you know, I would -- I would hate to see circumstances where the expert witness is -- that's all they do. So actively practice is what we really want. Not traveling state to state being an expert witness.

REPRESENTATIVE MANDERINO: Okay. And -- and I guess the final question or -- or point that I'd -- I'd like to ask. I readily admit that I have a much different perspective perhaps than you do in terms of what is or isn't considered a frivolous lawsuit.

But how do I phrase this? I'm thinking of the discussion you just had with Representative O'Neill about kind of only three percent being frivolous, and, again, my perspective is different, but I think the one

area that I would agree with you that juries tend to not -- tend to make a specific decision.

I think they make a specific decision not to distinguish between malpractice and malfeasance, is particularly in the area of I guess what I'll commonly call -- I hate this term but I don't know how else to say it -- like the bad baby outcome cases, cases where there may not have been any real malpractice, there may not have been any negligence, but now here's this family with a severely disabled child and society has provided no way to take care of the costs of this child throughout their lifetime, and so I believe juries make a conscious decision to shift the risk to where -- where the money can -- can pay for that child's care.

And so I do think -- I think, in fairness to you, that -- and in fairness to obstetricians, that they get hit with -- with -- with awards or -- or settlements that perhaps other practices don't get hit with because there wasn't a negligence. Okay.

That was a long intro to say, I -- I've always been interested in creative solutions of what folks think might work in those cases. I know some states have attempted to try to set aside kind of funds that would deal with that. I don't know how successful they are. I've never seen an effort talk to about that

with any sincerity or interest in Pennsylvania, and you may not feel comfortable responding to it now, but I really think that we could make a big difference if we could figure out that problem.

DR. GOODYEAR: Thank you. Let me make maybe two or three comments and first clarify if I agreed with Representative O'Neill that frivolous lawsuit were low. That's not the case.

REPRESENTATIVE MANDERINO: No.

DR. GOODYEAR: True malpractice --

REPRESENTATIVE O'NEILL: No.

DR. GOODYEAR: Okay. I just wanted to clarify. Frivolous lawsuits percentage-wise is very high. True malpractice is very low.

With regard to how that comes about, if I may, the human -- the human body is a tremendously, tremendously intricate structure with hundreds and thousands of systems and structures that interact in harmony to create health.

When disease occurs, it affects that harmony. A lot of systems within the body we don't have very much information or know much about, and every disease state is -- is separate also.

And we are asked millions of times every year to address a disease state that's very unique. The

individual is unique. That disease state's unique. And we're asked to use a body of health care information to address a disease state that may be a moving target. It may be different an hour from now than it is today.

And we do so in a circumstance where we are burdened not only by administrative and bureaucratic burdens, but sorting through a tremendous body of knowledge to try to do what we think is best for the patient.

Most of the time -- the overwhelming amount of time we are successful. But yet sometimes, despite our best efforts, due diligence, desire to help patients, those outcomes are less than successful.

The sad part as we see it is that our patients then look at us as failures, society looks at us as bad doctors, and the legal system treats us as criminals.

And yet despite that, the next day we start all over again and we do it again because it's the patients that we care about.

And I'd like to educate the public about that situation better and -- and what we face every day and yet those outcomes, those bad outcomes, those unfortunate circumstances and complications, are not negligence. They're not malpractice. But we'll continue

to keep going in there each and every day to take care of patients the best we can.

As for your statement about looking for another funding source, rather than -- than the physician for taking care of those unfortunate individuals, and babies, but it's not only babies, it's -- it's every age and -- and every station of life that can have an unfortunate outcome. It's an issue that I think is a discussion we should have. I don't have an answer, but I think it's a -- it's a good concept. Thank you.

CHAIRMAN CALTAGIRONE: Chairman Marsico.

REPRESENTATIVE MARSICO: Thank you, Mr. Chair.

Thank you, sir, for being here this morning. Appreciate your testimony and your time.

On the subject of medical liability insurance costs, premium, annual premiums, can you give us an idea of what a family -- family physician would pay annually, an annual premium, and then a surgeon such as -- like yourself or a cardio -- cardiologist?

DR. GOODYEAR: I -- I -- I can't tell you about a family physician. I would guess it's in around the $20,000 range. My malpractice insurance is about $75,000 a year.

REPRESENTATIVE MARSICO: And that's --

DR. GOODYEAR: Higher than -- above the orthopedists, neurosurgeons, obstetrics and gynecology, well in excess of a hundred thousand dollars per year.

REPRESENTATIVE MARSICO: And you had mentioned --

DR. GOODYEAR: That includes the -- the -- the base insurance plus -- plus the medical -- the Mcare Fund.

REPRESENTATIVE MARSICO: And you had mentioned that -- earlier that many physicians are exiting Pennsylvania and going to other states. And are there -- are they specialists that are leaving more than family physicians?

DR. GOODYEAR: We -- we -- we don't have a lot of data about actively practicing physicians exiting. Our problem is not being able to attract any physicians, including, but most specifically, primary care physicians.

There's a problem in the primary care physician arena. These individuals graduate from medical school with a quarter of a million dollars in debt. The reimbursement for primary care physicians is relatively low and certainly comparatively significantly lower than with specialists. So enticing individuals, quality physicians to enter a primary care area of specialty, is

very, very difficult.

So that's not only in this state, it's in every state. But when you -- when you add the other issues about generally low reimbursement here in Pennsylvania and a generally high and unfavorable liability climate, it makes it even more difficult to attract them.

REPRESENTATIVE MARSICO: Thank you.

CHAIRMAN CALTAGIRONE: Thank you, doctor. We appreciate your testimony and --

DR. GOODYEAR: Thank you, Mr. Chairman. Thank you.

CHAIRMAN CALTAGIRONE: -- we'll be reviewing your testimony certainly.

DR. GOODYEAR: Thank you very much.

CHAIRMAN CALTAGIRONE: We'll next hear from James Redmond, the Senior Vice President, Hospital and Healthsystem Association of Pennsylvania.

MR. REDMOND: Good morning. I'm Jim Redmond. I'm Senior Vice President for the Hospital and Healthsystem Association of Pennsylvania.

Thank you for this opportunity to speak to you about sort of the current state of medical liability in Pennsylvania. This panel is very familiar with many of the issues, and, to my knowledge, this is perhaps the

first time that we have had a conversation about medical liability since probably 2002 when the major reforms were enacted by the General Assembly.

Medical liability really breaks down into three basic topics: The legal system, the insurance system, and patient safety.

Act 13 of 2002 address -- attempted to address all of those areas, and just earlier this week the data from the Pennsylvania Supreme Court seems to demonstrate some of the effects of Act 13 that was passed eight years ago. Almost to the -- the same month. It was passed in March of 2002.

The data show two things, in my mind. One is that the number of medical liability claims that were filed in 2002 peaked at about 2,900 cases. For 2009, the most current data available, that dropped to 1,533 cases.

What that says to me is that there were a number of less meritorious or frivolous lawsuits that were filed prior to Act 13. And I think if I had to pinpoint one particular aspect of Act 13 that has had an effect is really the tightening of medical expert and the -- while additional reforms could be made in that area, to me that has had an effect in terms of the number of cases that have dropped.

The second reform that was enacted in 2002 was the end of venue shopping. And clearly the data show that in -- cases that were filed formerly in -- in Philadelphia have now shifted to the surrounding counties where the alleged incident occurred.

With respect to the insurance system, one of the things that I'd like to clarify is that we still have a very fragile insurance system for medical liability. For hospitals, there are -- virtually are no commercial insurers available.

Nine out of ten of our hospitals now self-insure or use risk retention groups. There are no commercial insurance companies that are actively marketing in Pennsylvania and providing insurance.

Sometimes that's contrasted with the data that is provided by the insurance department that they've had a number of -- of new insurance companies register in Pennsylvania. Those -- those companies are basically companies that are -- that are utilized by our hospitals in risk retention groups. They're very, very small market shares; but the major point is there is no commercial insurance really left in Pennsylvania for medical liability.

And we really only have two major insurers left in Pennsylvania for physicians. Many of our

hospitals have assumed many of their -- the medical staff as part of their -- their insurance policy.

One of the trends that has been ongoing in the health care field for some time, and I think the medical liability crisis has contributed to this, is that more and more physicians are being employed by hospitals or health systems.

Part of the problem that our hospitals face in Pennsylvania is recruiting new physicians to Pennsylvania, and Dr. Goodyear has -- has -- has talked about that.

Virtually every new physician coming into Pennsylvania is -- now has to be employed and their medical liability coverage paid for by the health system or the group practice or the faculty practice plan.

Pennsylvania continues to be viewed as sort of a hostile environment. New physicians don't immediately -- aren't attracted to Pennsylvania, right or wrong in terms of the perception regarding Pennsylvania.

And Dr. Goodyear, I think, has pointed out, we -- we face going forward an aging physician workforce, a need to retain far more of the physicians that are trained here in Pennsylvania to -- in order to maintain services.

Virtually every hospital outside of

Philadelphia and Pittsburgh tell us that their major problem is attracting new physicians to their communities. And as Representative Manderino touched on, the -- the problems of obstetrical care, we're seeing more and more hospitals stop their -- their -- their maternity care services, particularly in many rural areas of Pennsylvania, simply because they can't retain and keep enough obstetricians to -- to deliver babies in the -- in the Commonwealth.

One other aspect of the insurance system that I wanted to mention is that it has been our long-term goal that the Commonwealth of Pennsylvania should get out of the insurance business, and that is to end the Mcare Fund.

The Mcare Fund represents a -- a very small sliver of -- of insurance coverage that is mandated by the Commonwealth. Currently, law requires that the first $500,000 of coverage is obtained either through self-insurance or an insurance company. The second five hundred thousand dollars is -- is through the Mcare Fund. The Mcare Fund pays out claims for those claims that occur over 500,000 up to a million dollars.

But virtually all of our hospitals have insurance coverage beyond that. We've referred to that as excess insurance companies -- compensation -- or --or

coverage. That is required as part of their fiduciary responsibility to their community, to their bondholders, to provide that level of -- of -- of coverage.

And the problem that the Mcare Fund creates is that it adds another layer of bureaucracy in what is already a very complicated process of resolving claims. And as you know, we have been -- we've pushed for elimination of the Mcare Fund.

You're also aware that, as a result of the budget crisis of -- of last year, funds that we thought were going to be available to retire the Mcare Fund were transferred to the -- to the General Fund.

Hospital Association and the Medical Society filed suit against the Commonwealth with regard to:

One, its failure to properly fund the Mcare abatement program that existed between 2003 and 2007. The issue there is that during that period of time the Insurance Department says that they gave out $968 million worth of abatements to high risk physicians, at a hundred percent, the rest of the physician community at 50 percent.

Yet when that program was enacted there was an increase in the cigarette tax to pay for that. But we only found that $330 million was ever transferred to the

Mcare program to pay for that. So the difference between $330 million and $968 million was made up by over-assessing everybody else.

The second case involved the transfer of a hundred million dollars from the Mcare Fund to the General Fund. The Mcare Fund pays claims between the 500 and $1 million level. It assesses health care providers to cover that.

Those dollars that went into that fund were health care dollars paid for by hospitals and physicians and nursing homes and birthing centers and other health care providers, podiatrists.

Last week, Commonwealth Court issued two opinions, four to one in our favor, that those were inappropriate transfers. Those cases are going to be appealed or have been appealed.

Finally, the -- the last point. As part of Act 13, there was a significant program put in place in terms of patient safety. Pennsylvania was the first state to enact Patient Safety Authority and the requirement that serious events and other incidents be reported to a database so that health care providers can learn from other health care providers.

About 12 other states followed Pennsylvania's lead. So we've got a -- we're leading the

nation in terms of understanding how we can prevent serious events happening in the hospitals.

Let me stop there and take any of your questions. Thank you.

CHAIRMAN CALTAGIRONE: Thank you.

Members?

Thank you for your testimony.

MR. REDMOND: Thank you.

CHAIRMAN CALTAGIRONE: Can we get some water? I was getting you some water, but --

MR. REDMOND: Oh.

CHAIRMAN CALTAGIRONE: -- you're finished.

MR. REDMOND: Great.

CHAIRMAN CALTAGIRONE: Thank you, Jim.

MR. REDMOND: Thank you very much.

CHAIRMAN CALTAGIRONE: Appreciate your testimony.

We'll next hear from Cliff Rieders, past president, Pennsylvania Association for Justice, formerly the Pennsylvania Trial Lawyers Association.

MR. RIEDERS: Good morning, Mr. Chairman, members of the committee. My name is Cliff Rieders. I am the past president of the Pennsylvania Association for Justice, formerly known as the Pennsylvania Trial Lawyers Association.

I was president of that organization at the time of the negotiation and the passage of Act 13, and I was deeply involved in its negotiation and creation.

I am a current member of the Pennsylvania Patient Safety Authority. Although I'm not here speaking on its behalf, but I've been very involved in the creation of that organization and its work.

I was the drafter and one of the signatories of the letter, along with the Medical Society, which went to the Pennsylvania Supreme Court, which resulted in the rules that you've heard so much talk about here today, like certificates of merit.

And I also currently serve on the Supreme Court Committee for Standard Jury Instructions, and I've helped to draft those instructions in medical malpractice cases.

So I hope that I can answer questions and give you information rather than a lot of apocryphal stories.

I think the first thing to appreciate is the insurance cycle. We've had a little discussion about that. The General Assembly helped pay for a study of this cycle in 1985, and it was updated in 2001. That study was also funded by the trial lawyers and, interestingly enough, by the medical folks as well.

And what we learned from that is in a low interest rate environment there are typically low profits for the insurance companies and so what they do is they increase premiums in order to make money. They are profit making companies.

In a rising interest rate environment, their profits increase and you see some stability in the rates, which is what is beginning to happen now and what is going to happen.

The next phase of that cycle is that the interest rates become high as the economy moves along, the profits are high, and you get a lot of price cutting.

This is one of the things that brings insurance companies into the Commonwealth. During times of high interest rates, they get -- they do price cutting, they write a lot of business, and they don't have to worry about their profits because there is a long tail on claims.

And then, of course, you wound up when -- when the economy begins to tank a little bit back to low interest rates and low profits.

That's the cycle and that's what affects premiums more than anything else. And we'll -- we'll go through that a little bit further and -- and show that to

you.

There also has been disruption in the marketplace, in the insurance marketplace, which is a great factor in insurance premiums. We've had the problem of FICO's disappearing funds, the Alliance Insurance Company's collapse, P.I.E. Insurance Company's disappearing funds into an offshore entity, and, of course, PMSLIC, which was the Medical Society insurance company, selling a majority of its business to NORCAL, a California company, and getting a lot of money for its name and for that -- and for that sale which resulted in the Medical Society not reducing premiums to physicians but rather using much of that money to lobby.

Let's talk a little bit about patient safety because we've heard stories, compelling stories about doctors and the difficulties they face.

Since I've represented many doctors, I'm aware of those stories and I've gotten some of those calls in the middle of the night. What do I do? I think I killed a patient. Do I apologize? Do I go to the funeral?

So I've taken those calls. I fielded those, and I can talk about that in further detail if you'd like.

But let's talk about patient safety.

The -- the door -- the barn door which burst open on this issue in November of 1999 when the Institute of Medicine, which, of course, is a physician and a Ph.D. group, indicated that there are 98,000 unnecessary deaths in American hospitals. They published that in a report, To Err is Human, 1999. That is the equivalent of two 747s crashing every single month and killing everyone aboard.

It is one of the leading causes of death in America, are unnecessary deaths in hospital. We can't get away from that. That statistic has been repeated and has been refined and has been developed and proven by study after study after study since 1999.

I've never heard a medical group, by the way, disagree with it.

One in four records show evidence of hospital medical errors. That's from the New England Journal of Medicine, the most respected publication of the medical industry. One in four records, 25 percent of care in America, shows evidence of possible medical errors.

We know from the Archives of Internal Medicine just published in February of 2010, an esteemed publication by physicians, that sepsis and pneumonia, among 68 million discharges in hospitals, occurred between 1998 and 2006. All caused sepsis. Again, that

is infections, hospital-acquired infections. Affects 750,000 U.S. hospitalizations, half of which may be -- half of that 750 may be hospital-acquired. That's 325,000.

What is the cost of this? The cost of unnecessary hospital-acquired infections and injuries in hospitals that should not be occurring, but for issues of patient safety, cost us, you and me and all of us, $8.1 billion.

This is according to a medical group. Not a legal group. I will cite in my materials, which you can read, okay, I cite no legal organizations in terms of what they say about these things. There's plenty of data from them as well. Let's rely on the medical folks.

18 -- $8.1 billion in unnecessary hospital costs attributable to healthcare-associated sepsis and pneumonia in '06, including 2.3 million patient hospitalization days and 48,000 deaths.

Now, sitting in front of you is a man named George Goliash and his wife, Janenne. He's a victim of a devastating infection for which there is no remedy. We've passed the Pennsylvania Act 52, which is a great piece of legislation. And I thank all of you for having helped pass that.

And, unfortunately, if an individual

acquires an infection in a hospital that is not considered negligence per se. You have to prove negligence above and beyond the acquisition of that infection in order to effectuate a recovery, which means effectively that cases are not brought, are never brought, merely for the fact that a person acquired an infection in a hospital who had been pre-screened and found not to have it when he went into the hospital.

George Goliash, who came down here on his own, by the way, on his own expense, on his own ticket, with his wife, so that you can have an opportunity to talk to him after this hearing and find out how many of these matters are uncompensated.

We've had the discussion about so-called frivolous litigation, which in my view is a fiction. Here is an example of uncompensated injuries because of the current restrictions in the legal system.

According to the New England Journal of Medicine adherence to process involved in care range from 52.2 percent for screening to 58 percent follow-up.

What that means, if you have an opportunity to read the article, which is attached to the materials, is about half the people receive the care they're supposed to receive. A little bit more than half. That's a patient safety issue and a serious one.

Let's just summarize the results since the early 2000s when this bill was passed, Act 13. A dramatic drop in the number of claims shown by both the insurance industry and the Mcare Fund ranging between 11 and 70 percent depending on what you -- on what you review, and we'll review some of those specifically, a drop in coverage to 1 million from 1.2 million. Five hundred thousand is primary, 500,000 through the Mcare Fund. And huge insurance company profitability in the last reporting period. And we'll go over some of those figures as well, if time allows.

Insurance company profitability. Let's talk a little bit about that.

The average return on equity is 8.7 percent which is very favorable in any industry in the United States. For the latest reporting period it was 12.6 percent.

If you want to know why doctors, like Dr. Goodyear, pay high premiums it's because the insurance industry makes money. If you want to know why hospitals self-insure and have risk retention groups like Jim Redmond talked about it's because they can cut their costs by doing that and that's why they do it. And they should be encouraged to do it as they were with Act 13.

There's been an improving ratio for the

insurance industry. Ratio means the relationship between premiums and profits. In '02 the ratio was 111.48 percent. The report -- for the reporting period ending June 30th, '09, the loss ratio was 43.95 percent.

What that means is that approximately of all the premiums they take in, they pay out 43 percent and the rest is presumably profit, overhead, administrative costs, whatever they use the money for. That does not count -- that does not count investment return. That's only based upon premiums. And believe it or not, insurance companies do not make money on premiums. They make money on what they do with the premium dollar.

There's a publication in the materials called The 2009 Pulse of Pennsylvania's Physicians and Physician Assistant Workforce. It is must reading. Because it answers many of the questions that were raised here by the prior witnesses that you asked about and I hope you will press me about as well.

The number of physicians continues to grow in Pennsylvania. It is a fiction, it is absolutely a fiction to say that we cannot or do not recruit physicians in Pennsylvania.

And here are the numbers. 88.2 percent of Pennsylvania's populization -- population resides in

urban counties. 92 percent in -- I think that's 92 percent of physicians report practicing in urban counties.

In 2006, there were 208.1 physicians -- now, this is the important number, by the way; this is the number you want to know -- there were 208.1 physicians per hundred thousand population in Pennsylvania. That rate increased to 248.4 physicians per hundred thousand in '08.

Now, that's a -- that's a fantastic statistic when you realize that as a rust belt state we are losing population, as you know from -- as you know from looking at reapportionment, for example. We're losing population. Yet we have more doctors to population than we did formerly, in spite of a drop in population generally.

The rate per hundred thousand population in urban counties increased from 217.8 to 261.5 from '06 to '08. In rural counties where, by the way, the verdicts and payouts are almost nonexistent, if you look at the figures from the Administrative Office of the Supreme Court, the rate of physicians increased from 135.6 to 150.7 physicians per hundred thousand population.

37 percent of Pennsylvania physicians practice primary care. Nationally the rate is 40

percent. So we're very close to the national rate. And, by the way, our rate of physicians to population by hundred thousand is also very favorable.

Why are there not more physicians? Because the medical societies and medical schools restrict the number of doctors in order to keep compensation high.

Okay. Physicians in Pennsylvania are here to stay. The survey shows among physicians who plan to practice zero to five years, 99.2, those are the young ones we heard about, 99.2 intend to practice in Pennsylvania for the same amount of time.

So that's the truth. Those are not apocryphal stories.

The physician survey license -- you heard that there's lots of different ways to measure physicians. Well, I looked at every one of those that we can find in the Commonwealth. So let's look at them together.

In 2002, the renewal rate was 43,858. In 2008 it increased to 47,224. The renewal rate for physicians in Pennsylvania is 90.6 percent. It compares, very favorable, with the southern states and the other states you've heard about.

The history of Mcare claims payout is also very important. The Mcare Fund, of course, was the old

CAT fund originally created in '75, renamed in '96 and again in '02, and altered somewhat the payout in '03, which, by the way, was considered low nationally, by national statistics, for a state of our size, was 300 and -- almost 379 million with 701 claims. In 2009, it was 178 million with 396 claims, the largest drop in the nation for any excess fund.

Pennsylvania medical malpractice case filings. And, again, you've got the materials -- the materials -- you got the materials. There's a lot -- a lot of information there. I'm just trying to summarize it for you.

The state total in 2000 was 2,632, the number of filings. Now, think of the size of this state. In the entire state, in '09, 1,533, a drop of 43 percent.

Why is this significant? You will soon have an opportunity to read. Now, listen to me once. You will soon have an opportunity to read the -- the report to the legislature by the Patient Safety Authority. I just reviewed the final draft myself.

They will show the number of incidents and serious events in a year reported as 300,000. Not all of those are negligence. I repeat, not all of those are negligence. We don't know which are or are not

negligence.

But we know that 300,000 represents under reporting. That means that one-half of one percent -- one-half of one percent of all serious events and incidents ever result in a lawsuit. You will find no smaller number anywhere in the industrialized world.

Total verdicts, in the state's latest reporting period between January of '09 and December of '09, the state showed 131 cases, 85.1 percent of those were defense verdicts. In '03 it was 73 percent.

More doctors are winning more cases because of artificial barriers and hurdles created to bringing legitimate claims, most of which have to do with secrecy, secrecy of peer review, secrecy of reporting to the Patient Safety Authority, secrecy in the reporting to the Department of Health, and the great difficulty in obtaining expert witnesses who will testify against other doctors because many of the medical groups, many of the medical associations will blackball, absolutely blackball physicians who testify truthfully against other physicians.

And that's a great problem, and I'm hoping that we'll consider legislation to ban that blackballing. That should actually help both sides.

Now, I made a long laundry list -- and I

don't want to use the time to talk about this -- of changes that have occurred since 2002. All of these are civil procedural rule changes, and we -- it's in the materials, and I'll leave that to you to -- to look at in greater detail. I'll be happy to answer specific questions about it.

These are various pieces of legislation in the Mcare Act which also restricted the right to sue and make much more difficult recovery of legitimate claims. And, again, that's all in the materials.

List of reforms needed. We do need reforms, absolutely, because the pendulum has swung so far to stigmatizing those who bring cases, basically saying that you're chasing doctors out of the state. Untrue. Raising premiums. We know now that's untrue. That jurors in general look askance and in a very hostile way at people who bring legitimate claims.

And we need to bring it -- bring it into balance. I don't want to see a situation where there are frivolous claims, but I don't want to see cases where there are frivolous defenses either. And the pendulum clearly has swung too much the other way. We need to right that balance.

We absolutely ban predispute arbitration clauses. A person should not be forced or required to

give up their rights before an incident occurs and in order to get medical care. That would be a terrible thing.

We see that, by the way, in the financial industry and hopefully that will be banned soon, where if you open up an account with any financial advisor, they will have you sign an agreement where you agree to industry arbitration before any dispute happens, before they steal your money. Okay?

That's a bad practice, and it should not happen in the medical field. It's bad for patients and ultimately it's bad for the medical care and for the trust between doctors and patients.

We need medical malpractice insurance reform. I've written such a piece of legislation. It's in the materials. You can take a look at it.

We need to freeze primary limits at 500,000, Mcare limits of 500,000. The reason why we need to do that is to have a marketplace where the primary carriers are able to write coverage of $500,000. It's a system that's working well now. Particularly since the doctors won their lawsuit and are going to have a lot of money in that Mcare Fund. Money that's not being spent on claims payouts, by the way.

I won't go through all the rest of it, but

there are two pages of suggestions that I have. They're in the materials. We need to improve some of the language in the Mcare Act.

We need to have a medical malpractice small claims court, which I proposed and wrote the language for back in 2000 and in 2001. And like I said earlier, we need to do something to ban the blacklisting of doctors who testify against other doctors.

Defensive medicine, all the studies that have looked at this, and many studies have, physician studies, federal government studies, and the lawyers' groups, and it's very hard to get a handle on, because it's usually about asking doctors if they sent people for extra tests because they are afraid of a lawsuit.

They never ask the doctors if it's because you make more money on this. And, by the way, among the survey of professionals, physicians are still the highest paid profession in the United States.

And unfortunately so-called unnecessary tests are about advances in technology and about physician advertising.

I did my own little survey, and I'll end on this note. Driving to visit one of my kids in college along Route 80, it was about a 180-mile trip, my wife and I counted the number of physician and hospital ads that

we saw on billboards and on the radio and the number of lawyers ad -- ads we saw on billboards and radio.

And we counted 16 ads on billboards and radio, and we stopped counting, for medical care, everything from cancer cures to knee surgery, OB care, you mention it.

This is driving Route 80, which is, you know, through rural Pennsylvania and we saw three ads, billboard, radio ads for lawyer groups.

So I don't feel sorry for the medical community that gripes about lawyer advertising. They do much more of it, and that is part of what drives the cost and drives the incentive for -- for extra tests to be given. They -- they are advertising to people, get these tests, use our MRI machine, we have a better MRI machine, a faster one, more accurate one, 3D one.

This is part and parcel of the medical industry today, to sell more medicine.

So I'd like to answer questions. I hope you have some hard questions for me.

CHAIRMAN CALTAGIRONE: Thank you.

Richard.

REPRESENTATIVE STEVENSON: Thank you, Mr. Chairman.

And thank you for your testimony today.

Just one question. If you could respond to the testimony that we heard earlier from Dr. Goodyear about the rising average age of physicians. How do you see that and could you address that issue for us?

MR. RIEDERS: I think we have a rising of age of everyone. The -- the information on the physician survey, which is in the materials, is illustrative of the fact that we do not have any faster, quicker rising age for physicians than for lawyers, legislators, or anyone else.

We have an aging population, and it's particularly aging in Pennsylvania and in Florida, and we have difficulty in interesting -- we have difficulty in recruiting young people to a variety of professions. Medicine is one of them.

But we can solve that problem by -- by legislation which would prevent the prohibitions that hospitals and medical groups impose on medical schools. They could take more people and some medical schools would like to. But the profession wants to see that restricted.

So that's one thing that could help, and that's something you need to look into. And I suggest maybe you want to have some separate hearings on that. Because it's been -- it's been written about. It's been

-- there's been some empirical data.

But it is not correct to suggest that the age of physicians is rising in Pennsylvania any quicker or any more dramatically than any other profession or any other group.

REPRESENTATIVE STEVENSON: Thank you.

Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: I want to recognize Representative John Pallone who has joined us. Thank you, John.

REPRESENTATIVE PALLONE: Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: You're welcome.

Ron. Chairman Marsico.

REPRESENTATIVE MARSICO: Thank you, Mr. Chair.

Thanks for your testimony today.

MR. RIEDERS: Thank you.

REPRESENTATIVE MARSICO: You threw out a lot of numbers at us. A lot of numbers were given to us by -- and it's an extensive report.

Jim Redmond from the Hospital Association in his testimony mentioned --- it's in his written testimony -- that the cost of an obstetrician's annual medical liability premium in Delaware County in

Pennsylvania is approximately $169,000. Okay? And then just across the Delaware River in Dela -- the state of Delaware that same physician pays $68,000 annually in premiums.

How do you account for that? Any reason? Do you -- do you have any idea why it would be so much lower in Delaware?

MR. RIEDERS: Yes. Having looked at that over a number of years, and I suggest -- I can lend you a book called The Survey of Medical Malpractice which looks at every state in the Union by Professor Bhat, B-H-A-T-T [sic]. He's an actuary in the state of Connecticut. A very fine resource book on all of this.

One of the reasons for that dramatic difference is that physicians make so much more money in Pennsylvania, and there is so much less regulation of -- of the insurance market in this Commonwealth.

Remember, half of that, according to the statistics I showed you, half of that $169,000 is profit. Okay? That's why risk retention groups and self-insurance have become a big deal. That's why a lot of physicians have given up their practices and prefer to work for hospitals, which self-insure, so they don't have to worry about those kind of expenses.

So I think that's accounted for by lack of

insurance company regulation.

Now, for example, in preparing for this testimony, it is extremely difficult to get data on what insurance companies are charging other than, you know, asking somebody in one state versus another what the ratios are, and to get that as public information, unless the insurance company wants to raise or lower its premium and needs permission to do that.

So what insurance companies in Pennsylvania do is they don't do anything. They freeze their rates while they make money, and we don't know and you can't really know what the profit ratios are or why that physician in Pennsylvania is paying so much more.

So we know the insurance companies are making a lot of money. We know that the claims payouts have dropped dramatically and in my view that physician should not be paying $169,000, but not because of claims by innocent, injured, malpractice victims.

REPRESENTATIVE MARSICO: With your -- one of your -- the section here in the book here, you talked about the physician workforce. Where did you get those numbers? I -- I can't find them. Where did you get --

MR. RIEDERS: Well, that -- that --

REPRESENTATIVE MARSICO: -- those numbers from?

MR. RIEDERS: That number is from that survey.

That's a --that's a Commonwealth --

REPRESENTATIVE MARSICO: And who did the survey?

MR. RIEDERS: Physician groups and they're also relying upon the information from the state. That's -- I'll be happy to go over that with you, if you want to take a moment.

REPRESENTATIVE MARSICO: If you would.

MR. RIEDERS: Yeah.

REPRESENTATIVE MARSICO: While you got the numbers.

MR. RIEDERS: Yeah. Yeah. The Pulse of Physicians and Physician Assistant Workforce, 2009, is from the State Health Improvement Plan, the Pennsylvania Department of Health. That's from your and my Department of Health.

REPRESENTATIVE MARSICO: Okay. Thank you.

MR. RIEDERS: Anything else?

CHAIRMAN CALTAGIRONE: Counsel?

MS. COATES: Again, thank you for coming and thank you --

MR. RIEDERS: Yeah.

MS. COATES: -- for your testimony.

I had a question on the -- the malpractice figures and the filing that was recently made by the

administrative office of the Pennsylvania courts.

MR. RIEDERS: Yes.

MS. COATES: It shows that 1,533 cases were filed and of those cases 154 went to verdict. But that doesn't provide any explanation as to what happened to the other 1,300 cases. Correct?

MR. RIEDERS: Correct. Well, what we know about them is they were settled or dismissed.

MS. COATES: And we don't know which were settled or which were dismissed?

MR. RIEDERS: The administrative office does not keep that information. In order to know that, you'd have to look at insurance company and Mcare information, and they have not been terribly forthcoming with that information.

I've asked for it. I know members of this committee have asked for it.

One of the things I'd love to see you do is some insurance disclosure, including from the government agencies. Our own agencies ought to be giving us more information, the Insurance Department, the Mcare Fund about rate filings, about claims payouts, so we could know which are settled, which aren't, what those settlements consist of.

That would be valuable information, and I

think -- and I think we all should know more about that.

MS. COATES: It is your testimony that information is currently available but just not being disclosed?

MR. RIEDERS: It's all available. The insurance companies certainly know what they pay in settlements. The Mcare Fund certainly knows that.

But just try to get that information. I mean I've tried. What you have here is anything that was available. I've tried for 15 years.

MS. COATES: And your testimony was that more doctors are winning cases because of secrecy?

MR. RIEDERS: I think because of secrecy. Every bill that's passed, including Act 13, imposes secrecy on reporting. If a hospital finds that a doctor is a drunk and they do a peer review, the patient cannot get that information. That peer review information is totally secret.

If that's reported to the Patient Safety Authority, it is totally secret. Every piece of legislation that I review -- and I've reviewed hundreds over the years that comes down the pike -- has secrecy built into it. Sometimes it's the only way you can get support of the medical groups for this legislation.

When we were debating -- when you were

debating the Patient Safety Authority as part of the Act 13, which trial lawyers insisted upon in return for tort reform, the only way that could get passed is if secrecy was inserted so that the public cannot know problems with specific hospitals or specific patient reports.

MS. COATES: Wouldn't it be just as reasonable to infer that the defense is trying more cases that may be questionable or questionable negligence? I mean you look at these figures, it appears that 85 percent of the cases that were tried last year resulted in defense verdicts.

It is your inference that that's as a result of secrecy or could it also be inferred from that that they were questionable cases to begin with from the plaintiff's perspective?

MR. RIEDERS: Again, my experience in the field, looking at the studies and writing on the subject, teaching it, traveling throughout this Commonwealth, it is -- it has become more difficult to prove claims because of increased secrecy and because they -- the poisoned jury pool atmosphere.

Now, obviously you can argue, anybody can argue anything they want, but that's -- that has been my experience and what I have seen in the field.

MS. COATES: Thank you.

MR. RIEDERS: Anything else?

CHAIRMAN CALTAGIRONE: Any other questions?

Thank you. We do appreciate your testimony.

MR. RIEDERS: Thank you very much.

CHAIRMAN CALTAGIRONE: And thank you for the work you did in this.

MR. RIEDERS: Thank you.

CHAIRMAN CALTAGIRONE: We'll next hear from Clifford Haines, President of the Pennsylvania Bar Association.

MR. HAINES: Thank you. Mr. Chairman, good morning. Can I keep Mr. Rieders here? He's got the facts and figures, and I am -- I'm nowhere near as competent as he is when it comes to that.

I thank you for the opportunity to appear in front of you. I have to tell you that I was in Washington. It was the American Bar Association Day on the Hill yesterday, and I was coming back on the train saying, well, what exactly is it that this committee is looking at?

And I had an -- an opportunity -- I'm delighted to know that --

CHAIRMAN CALTAGIRONE: The truth. We're

looking and searching for the truth.

MR. HAINES: Well, I was delighted to see that Dr. Redmond and the Pennsylvania Medical Society is doing so well that they can publish a glossy, three-page, colored printout for you all just for this testimony. Things are going better at the Pennsylvania -- Pennsylvania Medical Society than they are at the Pennsylvania Bar Association in -- in these tough economic times.

And I -- and I can tell you that the thought occurred to me last night on the train coming back that there's a piece of me that wants to go to the membership of the Pennsylvania Bar Association and say, you know what? The legislature is at it again. They want to talk about tort reform.

And I'll tell you why I want to do that. There is nothing, nothing, other than a tax on legal services, that will mobilize the trial lawyers and the lawyers in general if you all want to talk about tax -- tort reform again.

And that is wonderful for me as the president of the association because two things are going to happen. My membership numbers are going to go skyrocketing, and the contributions to the PAC are going to be off the charts.

As you well know, this is a subject on which the legal community in Pennsylvania has stood together consistently. It's not just the trial lawyers, but it is all of the lawyers in Pennsylvania.

And -- and at -- at one level we have acceded to and accepted all of the changes that have occurred as a result of Act 15 [sic] and as a result of all of the things that the Supreme Court has done.

At another level we have stood strongly in opposition to caps on damages and will continue to do that ad infinitum.

I think the reasons are obviously before you. You've heard them all. I'm happy to repeat them or accept your challenges or the medical community's challenges on those -- those issues.

I will tell you that I recoil, absolutely recoil at the term frivolous lawsuit. I would like someone to tell me what that means. As I understand the Constitution of this United States and the Constitution of this Commonwealth, the right to a jury trial is inviolate.

Anybody can sue anybody for anything. And the person who brings that suit believes that he or she has a legitimate basis for doing that. I've never seen a doctor look in the eye of a plaintiff and say, this is

frivolous. Because no one who brings a lawsuit believes it is frivolous.

In the minds of someone else it may not have the same merit as others, but lawsuits that are characterized as frivolous are just being characterized in an inflammatory way that has no legitimate predicate in the law or in the history of this Commonwealth.

I can't tell you that the Pennsylvania Bar Association is in possession of detailed studies on the subject that is before you today. In fact, I can tell you that we are not.

But I can pass on to you at least one anecdotal story. And I'm sorry that Mr. Rieders isn't here to have the benefit of it.

But let me tell you that I left a law firm that I was in in 2004. I was a partner in the law firm for 22 years, and I went out on my own.

At the time I left that law firm, I was not only a trial lawyer but a good 90 percent of the business that I did was medical malpractice litigation. I left that law firm because I saw no future from a business standpoint in medical malpractice litigation.

Today, if ten percent of my business is medical malpractice litigation, I would be surprised. I practice law in Philadelphia County. I do not have one

medical malpractice case presently pending in that county.

Pennsylvania has as severe a tort reform policy as any state in the union, and it's tort reform in the jury box.

It has nothing to do with whether I can get a certificate of merit. It has nothing to do with whether or not my case is pending in Philadelphia or a surrounding county. It has to do with the fact that the public has been convinced, rightly or wrongly, that the cost of medical care is directly related to the liability crisis.

So we look at the numbers from 2004 until today. The filings have gone down dramatically. The number of verdicts that exceed $10 million have dropped off the table. People like me are no longer handling medical malpractice cases, because you can't win them in Pennsylvania today.

You don't need to do anything. The public has taken care of this issue.

Representative [sic] Coates, you asked the question about outcomes, and I will tell you that the number of verdicts in Philadelphia County that are defense verdicts are now reported in the range of 80 percent. When a case actually goes to verdict, 80

percent of the time the defendant wins those cases.

All of those numbers have had an impact on Mr. Rieders and the trial lawyers and lawyers throughout the Commonwealth of Pennsylvania and medical malpractice lawsuits are not -- not the preferred way to go for lawyers.

I can't speak for clients. I can tell you that I get calls all the time. I can tell you that I get people coming in all the time.

And I can tell you that it's frequently difficult to sit and look at somebody and say, I'm sorry but I'm not willing to bring this lawsuit on your behalf because it economically makes no sense. Yes, you were injured. Yes, it appears that someone did something wrong. But the cost of filing this case, the cost of pursuing this case, the likely outcome of this case is probably in the neighborhood of a hundred thousand dollars. It doesn't make economic sense.

That's a sad comment to -- to an individual who has been injured and hurt as a result of medical mistakes.

So while I applaud you for reviewing the subject of where are we, I think the answer is whether it is the result of Act 15 [sic], whether it is the result of the Supreme Court rule changes, whether it is just a

general social phenomena, there is no medical malpractice crisis in Pennsylvania.

I can't speak to a liability insurance in crisis -- crisis, because I don't know the answers to those questions. I think the doctors have good reason to look at the insurers and say, what are you doing to us and why are you charging so much money? And Mr. Rieders has given you some indication of the explanation for that.

But -- but I would submit to you, and it is anecdotal, from my personal standpoint, I would submit to you that the idea that there is some crisis in medicine because of lawsuits in 2010 simply is a disconnect.

So with that, I'm happy to answer your questions. I hope I didn't take more than my allotted time. And I'd be delighted if you had none.

CHAIRMAN CALTAGIRONE: You did good.

I do want to mention Representative Joe Brennan, and I think -- did you have your son here with you, Joe?

REPRESENTATIVE BRENNAN: Yes.

CHAIRMAN CALTAGIRONE: Bring Your Son To Work Day and representative in training.

You did very good, by the way. And the reason that I -- that I decided to hold this -- and,

look, I have friends in both camps, in the medical camp and in the legal camp, and, you know, from time to time we have to air these issues.

Whether or not we can come to some conclusions to try to make our life and our systems work better, you know, that's what I think we're all about.

I think the docs and the hospitals do an excellent job in this state, and God knows we need them, we need the attorneys, too. You know, you have the scales of justice. You always want to balance things.

And the previous testifier was saying, and I was just curious, that maybe the hospitals and doctors are doing a much better job now at defensive medicine and the number of cases -- there may be some correlation there, that they're doing a better job at taking care of us when we go into the hospitals or the doctors.

And -- and we all have our own doctors and we -- most of us at one time or another have been in the hospitals. So God knows we need them.

And -- and we certainly want to try to, I think personally, keep the high quality of care that we've been receiving in the country at the highest standards. We certainly don't want to slip and fall and become a third world nation.

We've seen on TV what can happen, and God

knows we need each other. And if there's problems that we can resolve, I never hesitate to bring these issues forward so that we can have a open dialogue. I think that's what we're all about as a Commonwealth and a legislature, to see how we can come together to solve some of the problems, if there are any problems.

And let's see if there are any of the members that have any questions. Representative Pallone.

REPRESENTATIVE PALLONE: Thank you, Mr. Chairman.

And thank you, Mr. Rieders [sic]. It's good to see you again and, as you know, I'm an active member of the Pennsylvania Bar Association.

MR. HAINES: I heard that.

REPRESENTATIVE PALLONE: Yeah. So nobody likes a lawyer till they need one, including the doctors. So with all due respect, I think I agree with you that -- that there are no truly frivolous lawsuits until you're the defendant and then they're all frivolous.

But that being said, my thought is even beyond the malpractice thinking, and I'm anything but anti-insurance because they certainly protect me and many others in a number of instances.

But it's been my experience in the last 20

years that the entire insurance market, in terms of defense, has really driven the cost of litigation up and has reduced the success percentage, or whatever you want to call it, to the plaintiff's bar, and it's not just medical malpractice but it's in -- it's in almost every discipline of the law.

Have you looked at any of the data or statistics that go that route?

MR. HAINES: I haven't. That's something that Mr. Rieders likely has a number on and I don't. I can tell you that -- that, you know, again, from a personal standpoint, the ability of a physician to control his insurance may be the single biggest impediment to resolving litigation that is out there.

And I've often wondered why it is that the insurance commissioner allows those policies to be written. As you know, a doctor is required or is -- is entitled to consent or not to resolution. So that if the doctor himself or herself says, no, I don't agree that this case should be resolved, it can't be resolved, and that is unfortunate.

Doctors -- and I don't mean this in a critical way, doctors -- because it's an important fact. Doctors have strong egos. They have to to do the kind of work they do. They are dealing with life and death every

day.

And -- and so because of that strong ego, it is very difficult for them to acknowledge that they make a mistake or acknowledge that they are responsible for a bad outcome.

I -- I've never had a doctor come to me and say, you know, your lawsuit was well-founded, I made a mistake and -- and -- I've never heard that. It is unusual and a difficult process to get a doctor to consent.

So I think there are aspects of the way insurance is written that are an impediment to resolution and probably resolution at a far lower number. I think the costs could be reduced just by taking -- by saying to the insurance commissioner, you can't accept a policy that has that provision in it.

You know, you have an automobile accident, you have nothing to say about whether or not your carrier settles your lawsuit. They frequently do that and don't even tell you. That's not true of a professional liability policy and that makes no sense in my view.

REPRESENTATIVE PALLONE: Well, and I -- I don't disagree with you and, again, I'm anything but anti-insurance. Particularly because I wrecked my car yesterday. So I'm glad that I have insurance.

That being said, a true anecdote, though, is when I first came to the legislature, I have a cousin who is in a very narrow medical field, and he approached me as a legislator and he said, hey, you know, you're my cousin, can you help me out here? My malpractice insurance in the last five years went from 18,000 to in excess of 120,000. He said, I have zero claims and I have zero even letters of intent that there might possibly some day in the future be a lawsuit. How come my premium went from 18 to 120?

And I said, well, it's the market. You got to talk to your carrier, not the legislature, about that.

But I -- I think what you're suggesting, if I'm hearing you right, is we maybe need to look at, if regulatory enactment is the right word, but some type of a control so that we don't see a 500 percent increase in premium when there are zero claims.

MR. HAINES: Well, I think you were here when Mr. Rieders explained that the $189,000 in Delaware County in many respects represents profit.

And one of the things that you don't know and we don't know and no one else knows is what's the profit margin in an insurance company. What -- what kind of profits are they making?

And nobody can get that data. And nobody knows the answer to those questions. And I suspect that if you had the opportunity to see those numbers, you would likely be appalled and if you weren't appalled, you'd be shocked, and if you weren't shocked, at least you'd have some data to work from on this subject that you don't presently have.

Because you don't know how profitable those insurers really are. I mean people aren't writing medical malpractice in Pennsylvania because it's a losing proposition. They're here because they can make money doing it.

REPRESENTATIVE PALLONE: Well, again, thank you for your information.

And thank you, Mr. Chairman.

MR. HAINES: Thank you all.

CHAIRMAN CALTAGIRONE: Thank you, sir.

We'll next hear from Samuel Denisco, Director of the Pennsylvania Chamber of Business and Industry, and Jonathan Greer, the Insurance Federation of Pennsylvania.

MR. DENISCO: Mr. Chairman, good morning. I'm Sam Denisco. I'm the Director of Legislative Affairs, Government Affairs for the Pennsylvania Chamber of Business and Industry.

The Pennsylvania Chambers is the largest, broad-based business advocacy association in the Commonwealth. Our thousands of members represent Fortune 100 companies to sole proprietors and we cross all industry sectors.

Again, thank you for the opportunity to present testimony on the issue of tort reform, medical liability reform.

The Chamber supports a health care system in the Commonwealth that provides the necessary, appropriate and accessible, effective health care to employers and employees at a reasonable cost.

Rapidly rising health care costs interfere with the ability of the business community to maintain existing jobs and create new jobs. One well-documented phenomenon in this, that it greatly contributes to escalating costs of health care, not only in Pennsylvania, but across the nation, is the nation's liberal liability systems which have spurred providers to err on the side of caution and provide unnecessary services.

Not only does this have a serious and immediate impact on patient access to care, but it also has a long -- long-term impact on the economic development of our communities.

Without access to high quality medical facilities, physicians, and other health care providers, communities will endure greater difficulties in attracting new businesses to the areas and recruiting talented employees for their existing businesses.

In the face of a liability crisis that continues to erode patient access to care, stall the creation of jobs and job opportunities, halt business retention, expansion and attraction, the Chamber recognizes that steps have been taken to address the concerns of Pennsylvania physicians and prevent any disruption of patient coverage.

We have seen a sharp decline in medical liability claims since the enactment of the 2002 medical liability reforms. The business community strongly feels that these reforms must be followed by long term, broad-based systematic changes to the Commonwealth legal system.

We need additional meaningful changes to our civil justice system to further reduce the costs incurred by businesses, encourage expansion, and make our state more attractive to new business. Many examples exist where businesses have been adversely affected by the inequities of our current legal system.

However, most businesses find it easier and

financially advantageous because of the unpredictability of our system to settle, rather than paying legal costs to defend themselves.

In fact, studies have shown large increases in productivity and employment associated with liability reforms. There's little doubt that adopting such reforms in Pennsylvania would produce gains in employment, productivity, and total output.

Numerous studies of the impact of reforms on labor productivity and employment have demonstrated that states which changed their liability laws to decrease levels of liability experience greater increases in aggregate productivity and employment than states that did not. At the same time, states adopting measures which increased liability often see productivity and employment fall.

An unbalanced litigation environment can cause serious dislocations with significant economic implications. If awards are disproportionate to, or irrespective of, actual injury or harm, attorneys and plaintiffs respond to these incentives to pursue excess -- excessive litigation and potential defendants divert resources from more product -- productive purposes to invest in avoidance strategies.

That being said, joint and several

liability reform is greatly needed in Pennsylvania in order to fairly and proportionately allocate liability based on percent -- percentage of fault attributed to each party's negligence. Under our current scheme, a defendant found to be one percent liable can be forced to pay a hundred percent of the damages.

The repeal of joint and several liability will correct a fundamental unfairness by tarerling -- tail -- tailoring the law to have defendants pay only the percentage of fault for which they're responsible and not for the damages attributed to others.

In addition to the repeal of joint and several liability, other changes that the business community is strongly advocating for and recommends to help improve the legal climate in the Commonwealth are:

Amending the Pennsylvania Constitution and provide for caps on noneconomic damages;

Setting strict -- strict standards on the imposition of punitive damages and limiting the -- limiting the amount of punitive damages that may be awarded without taking away the excessive -- the access [sic] -- punitive damages on those that deserve to be punished;

Enacting a statute of repose for products manufactured long ago that worked without problems or

incidents;

Protecting innocent sellers who are sometimes sued for simply selling a product later claimed to have been defective;

Requiring plain -- plaintiffs filing a product liability action with the complaint a certificate of merit containing an expert opinion from a licensed professional that there exists a reasonable probability that the product in question is defective and such defective state, quality, or condition was a cause in bringing about a harm to a plaintiff;

And, finally, establishing a tort action for damages which alleges a personal injury may only be filed in the common -- in the county where the cause of action arose, and judgment upon that action may only be entered within that same county.

Most of the above-referenced reforms have been enacted in the state of Texas, a state the Wall Street Journal once dubbed the lawsuit capital of the world. Lawsuit -- lawsuit reforms enacted in Texas have helped make their economy one of the strongest in the nation.

A variety of measures from the CEO Index to the Bureau of Labor Statistics show that Texas leads other states in job growth, business creation and

expansion. A 2008 economic impact study by the nationally recognized Perryman Group determined that lawsuit reform in Texas have resulted in a $112 billion annual increase in annual tax revenues and almost 500,000 new and permanent jobs.

A comprehensive analysis by the Pacific Research Institute in 2007 concluded that the Texas civil justice reforms have created the best legal model in the nation.

The Pennsylvania Chamber respectfully urges the General Assembly to consider the steps Texas has taken and restore fairness in Pennsylvania's civil justice system.

With unemployment continuing to steadily increase, putting Americans back to work and Pennsylvanians back to work must be our top priority. But the litigation climate threatens to champen -- dampen job creation and economic growth just when we need it the most.

Enacting civil justice reforms will have real world consequences that improve access to health care and make Pennsylvania a more attractive state to do business in.

I thank the committee for its indulgence in expanding the scope of the testimony beyond medical

liability. We are broad-based in nature and all of these issues touch all our members.

So with that, I will yield to Jonathan.

MR. GREER: Good morning. My name is Jonathan Greer. I'm the vice president of the Insurance Federation of Pennsylvania.

I'm here for Sam Marshall, who was unable to attend. He sends his regrets.

And at the outset I'd like to say that we don't have a color printer at the Insurance Federation, so perhaps some of the profits that have been attributed to us aren't necessarily at least trickling down to us.

Now, as to my comments, we appreciate the committee's interest in Pennsylvania's medical liability insurance system and possible means of improving it, recognizing that improving it can be a subjective term.

From an insurance perspective, improvement means a few things. Making the liability system more predictable and stable and making sure it adequately compensates victims of malpractice while providing affordable coverage for providers and avoiding a system that makes health care services more expensive but not better.

To that end, we have a system in Pennsylvania that is better than it was a decade ago, or

even five years.

First, we have fewer insurers. The ones who are here -- and the ones who are here are better. Our industry is only as strong as its weakest link, and unstable markets tend to attract and create bad insurers, because they can make money in the short term and leave the eventual insolvency of under-pricing and poor risk management to others.

We got rid of the weak links the hard way. It wasn't so much any malpractice reforms, as a number of insolvencies and some regulatory scrutiny on the solvency end.

Second, we have some rating stability, because we've not only gotten rid of the weak links in our industry, but we've also instituted some reforms that have worked.

But we still have a ways to go. We need to focus more on improving the system than in subsidizing it. From a medical malpractice insurance perspective we need to make this a market that attracts additional qualified insurers, we need to figure out what to do with Mcare, both in funding it and resolving whether and how it should be a permanent part of the liability system.

And from a health insurance perspective, we need to recognize the cost of a flawed liability system

isn't felt just in malpractice premiums and the vagaries of Mcare abatement programs and subsequent court rulings that create havoc for the Commonwealth budget.

It is in the cost of defensive medicine, treatment and tests that are provided not to help the patient but to protect against potential lawsuits. That's a hard number to pin down, but every study suggests it is significant.

We also need to recognize that the medical malpractice system shouldn't be considered in a vacuum. Any malpractice reforms need to be integrated into broader efforts to improve our health care delivery and financing system, and especially efforts for improving patient safety, reducing medical errors, and having more efficient means of resolving and compensating for those errors.

That was recognized in the federal reform debate and kind of addressed in the bill that passed. The Patient Protection and Affordable Care Act dedicates $50 million for a five-year period beginning in 2011 that the Department of Health and Human Services can award to states for implementing alternatives to standard malpractice litigation. These, I think, are referred to as demonstration projects.

The standards for awarding the grants

aren't limited to what we usually consider when talking about malpractice reform, lowering costs. They include the impact on broader health care delivery issues such as patient safety and reducing medical errors and adverse events, as well as improving access to liability insurance.

Now, that sounds exciting, although $50 million spread over the entire country for five years isn't much. We should be considering possible proposals and grants.

One idea that we've long suggested is a special medical malpractice court within the current judicial system, recognizing that judges with special expertise may help ensure both efficiency and uniformity in rulings across the Commonwealth.

There are others I'm sure, and we hope Pennsylvania comes with possible grant -- with possible grant applications and does so in conjunction with all the so-called stakeholders, which the federal law requests.

But at the risk of criticizing the prospect of grants for innovative alternatives, even before we try it, I'd note the federal law seems almost doomed to be ineffect -- to ineffectiveness, if not failure. On the one hand, it encourages and offers funding for

alternative programs; but on the other, it allows patients using an alternative to opt out at any time, presumably even after the alternative approach reaches its verdict.

Our experience is that this open-ended approach, which a few states have tried, doesn't work. It turns the alternative into test -- a testing ground not for innovations but for -- for particular cases and it only delays outcomes and increases expenses.

So if we're going to look for grants and innovative alternatives, we have to recognize the alternatives be ones that are truly alternatives to the current system, not expansions of it. In essence, ones that will least likely be -- at -- least likely be abandoned if the patient decides he doesn't like the result.

We don't have anything particular in mind that will require some collective barn [sic] storming with the type of people you have on today's agenda. But that's the potential in the federal law and it may help in coming up with programs to help make Pennsylvania's liability system better for patients and providers alike, and all of us who pay for the liability system.

That's the conclusion of my prepared comments, and I think Sam and I'd be happy to take any

questions that the committee has.

CHAIRMAN CALTAGIRONE: Thank you.

We've been joined by another member of the committee, Representative Gabig.

Questions from members? Will? Sure.

REPRESENTATIVE GABIG: Sorry. Now, rather than talking over that stack of light reading, as Representative Pallone described it as, the -- I'm sorry I got in here late.

But I think I was getting some of the gist of the testimony. And so if my questions repeat anything, I apologize for that. But it's sometimes good to repeat things and make sure you understand them better. In my case anyways.

Can you tell us approximately how much money in Pennsylvania, say, for example, goes to benefit medical liability? How much does it sort of cost, if you will? Does anybody know the answer to that?

MR. GREER: Do you mean aggregate payouts?

REPRESENTATIVE GABIG: Yes, say, for example. Or any way you can describe it that would help us put it in perspective.

MR. GREER: I don't know offhand that number, and I'm not sure what Mcare's numbers are either. But we can go -- I -- we can go back to our

members and -- and give that to you. And if we -- if we can aggregate it.

REPRESENTATIVE GABIG: Okay. Well, I guess the sort of general idea, as I understood it, is there's a certain -- you describe it as a liability system. There's a certain amount of money that goes to pay people that are injured by negligence, or otherwise, in the -- in the medical system. And it goes to help compensate them for this damage and injury, et cetera, that they sustained out there.

And then so I'd like to know how much money that is approximately maybe in some kind of manner. I know it's hard to -- to sometimes measure.

And then I'd like to know this -- this question. People are always asking in my district this question. It seems like a lot of that money doesn't go to the person that's injured, to the patient, so to speak. It goes to, say, the plaintiff's lawyers, sometimes called the trial association. They have an association called -- a trial lawyers association I think it's called, but there's also defense lawyers, too, that defend insurance companies and others.

And so I'm just trying to get a feel how much money that goes for attorneys, to pay both on the defense and the plaintiff's side. Of the total amount,

approximately how much that would be?

Do you know the answer to that? Like what the percentage would be? For example, the money that's supposed to be going out and taking care of injured -- injuries in medical negligence, et cetera, how much percentage-wise is actually going to attorneys? Do we know?

MR. GREER: Well, we would -- we would only know on our end, the defense costs. I don't -- the relationship between the -- the injured patient and their attorney, that's a -- you know, whatever that percentage is of the outcome is -- I don't know what it is.

It probably is in a range, but I'm hesitant to say just because I don't know.

REPRESENTATIVE GABIG: You said you would know something else?

MR. GREER: I may -- I may be able to get for you what our defense costs are.

REPRESENTATIVE GABIG: Okay. Well, that would be very helpful. Because sometimes you hear out there, people come up to me and they say like -- they hear like a -- a third of that money is going to the plaintiff's attorneys or the plaintiff's lawyer. And I'm not sure if that's true or not.

But then there's the additional money of

the defense bar. So if you could just sort of get -- you know, say it's a, you know, a billion dollars, just to throw out a number, and if a third of that money is -- is going to the plaintiff's lawyer and another additional money is going to the defense, I think that's something we need look at when we're talking about policy.

And so if we could get those numbers, that might be helpful for us to -- to make some decisions up here.

So thank you very much.

MR. GREER: Okay.

CHAIRMAN CALTAGIRONE: Representative Stevenson.

REPRESENTATIVE STEVENSON: Thank you, Mr. Chairman.

I think you were both here hearing -- and you heard most of the testimony earlier this morning. I'd just invite your response to some of the things we heard this morning from the other folks who were testifying, both the -- from the trial lawyers association and from the bar association.

To be specific, things about in the insurance industry, the mass of profits that are there and that's -- and that's driving the problem -- driving this issue as much as anything.

And with regard to the issues about physicians, I missed part of your testimony. I'm sorry, Mr. Denisco. But I understand part of it had to do with the medical climate in Pennsylvania and the loss of doctors and those kind of issues. And they were both addressed by the two testifiers I'm speaking of.

In any order but I invite your testimony on those -- those two issues.

MR. GREER: I'll -- I'll go first. I -- I was sort of interested in hearing some of the prior testimony, too.

It almost made Pennsylvania sound like today from mal-insurers what California was in 1849 for gold miners. And if that were true, we'd have more than a handful of commercial carriers writing business here.

I mean typically we have -- we have four members writing business, two of which are the largest, PMSLIC and MedPro. And if it were so insanely profitable, there would be a rush for people to get here, other insurers, and that's simply not the case.

Part of that is the unpredictability of -- of the system, the ongoing uncertainty surrounding Mcare and the Mcare abatement program. That is a barrier to entry for insurers looking to come to Pennsylvania, because what Mcare does is that we as the insurer have to

basically be Mcare's agent and we have to collect and remit Mcare assessments. And every insurer that operates here has to set up a system unique to Pennsylvania in order to fulfill that obligation under the law. So that is -- that is a barrier.

But one of the things that we say -- and it's not just confined to med mal -- but the only thing worse than a well-off insurer is one that's broke. Because if you're broke, you're not paying claims and eventually you go insolvent.

And that's something that is -- we unfortunately have a history of in Pennsylvania. In the last ten years we've had a number of very large med mal insolvencies that have ultimately -- ultimately resulted in only a portion of claims being paid and a drain on the guaranteed funds to pay them, the remaining benefits.

So that would be my initial response.

REPRESENTATIVE STEVENSON: Thank you.

MR. DENISCO: And -- and, Representative Stevenson, you know, my testimony really tried to get at that we're really in a health care crisis with regards to costs. We hear it every day from our businesses that are struggling to provide affordable health care to their employees.

We see our businesses really trying to --

making strides to come up with different innovative ideas to keep that benefit and allow -- and market that to their employees, whether they're moving to a high deductible plan or whether they're using spousal exclusions and so on and so forth.

And working through the federal health care law, too, that's something to see how that evolves also in the implementation phases.

With regard to the loss of doctors, you know, the way I would have a comment to that is I think we need to make Pennsylvania a much more attractive state to keep our physicians in Pennsylvania after they receive their training here, much like we need to make Pennsylvania more attractive to businesses, to allow them to come in, stay here, come in, create new jobs, and -- and grow.

REPRESENTATIVE STEVENSON: But I guess I'd respond, the testimony we heard was that the medical malpractice climate in Pennsylvania has changed drastically since Act 13 was passed and that now, by Mr. Haines' testimony, that's really no longer an issue here in Pennsylvania, that claims have dropped off drastically and attorneys are no longer handling those cases and so forth.

From your membership, that's not the

climate that you're experiencing? Is that -- is that your testimony?

MR. DENISCO: From our membership, we're looking at the changes in Act 13 and saying if they were so much of a -- of a success, why not expand it to broad-based business.

Let's bring venue reform, not only to the medical liability field, let's bring it more broad-based, product liability actions and things of that nature.

When we look at certificate of merit, let's expand that also.

So if we're seeing successes in the medical arena, I think those same successes could be seen in a more broad-based level.

REPRESENTATIVE STEVENSON: Thank you very much. And thanks for your testimony.

Thank you, Mr. Chairman.

MR. GREER: Thank you.

MR. DENISCO: Thank you.

CHAIRMAN CALTAGIRONE: John.

REPRESENTATIVE PALLONE: Thank you, Mr. Chairman.

I'm trying to understand the -- the issue as best I can and, you know, I guess as a side note, the whole industry is part of a stimulus package, because it

puts people to work, lawyers, court reporters, investigators, people who duplicate records and things like that.

So in a strange sense the whole litigious component of the insurance industry puts agents to work selling it, adjusters to work reviewing it, you know, a whole series of people to work.

So kind of a weird nuance to the good news and the bad news, I guess.

But what I'm -- what I'm trying to grasp more clearly is, I guess the separation, because you seem to suggest that -- that the health care crisis is somehow related to medical malpractice either insurance and/or litigation, and I think they're kind of mutually exclusive.

And maybe you can clarify for me that, because the cost of health care and the delivery of health care systems, how is that related to the malpractice industry? Other than I think we all have a suspicion that because there's a -- a market trend, if you want to call it that, to shorten stays in hospitals and kind of limit or restrict certain treatments and testings, that sometimes things slip through the cracks that didn't slip through cracks maybe a decade or more ago.

But -- but I'm looking at it almost mutually exclusive. I'm trying to understand that better.

MR. GREER: Well, the -- representative, it's a good question and thank you for it.

The connection is in the -- in the area of defensive medicine in that -- in that when a physician is presented with a patient and there's a judgment call as to whether or not a certain -- a certain test or subsequent test should be prescribed, with the -- with the -- the thought is that with the concern of somebody possibly in the future looking over their shoulder and saying, well, why didn't you prescribe this -- these tests so that -- that the -- that that judgment call goes in favor of prescribing tests that may not have otherwise been necessarily needed.

That -- that's the connection between cost of health care and the cost of -- of -- of administering that -- that test or exam and -- and liability reform.

REPRESENTATIVE PALLONE: Not to be circular in thought, and this is where I'm trying to clarify this, because the insurance industry is controlling both ends of that. They're controlling the delivery of service for those who have medical insurance and then are holding the liability ball in the event that there's litigation over

treatment or failure to treat or whatever.

And that's the cycle that I'm -- I'm wondering. I think it puts maybe you in kind of a diabolical spot because you can't argue both sides of the equation. But -- but I'm -- I'm an advocate for preventive medicine, that if we can do the -- you know, do something as simple as colorectal screenings, if the insurance would pay for colorectal screenings at a younger age, which now we do, then there's an argument that there will be prevention of cancers and there's a benefit to the cost.

And that's where I'm trying to follow your cycle that you're saying on one end that we're not delivering services that maybe we could or should relative to preventive medicine, but it's coming out of the same industry but two different branches on the same tree.

How do -- how do we balance that? Is there any thought coming from the industry that we can balance that off?

MR. GREER: Well, it's -- it's the insurance industry, but it's two very diverse segments of the industry.

REPRESENTATIVE PALLONE: Right.

MR. GREER: You have the health insurers

and the -- and the professional liability insurers and they are not one and the same.

And it's not that services aren't being provided. It's that potentially too many are. That's -- that's the issue, is that instead of doing five tests you do eight tests and those extra three, maybe they weren't warranted, maybe they were, but in the -- in the abundance of caution for any potential lawsuit down the road, you will prescribe those eight, just out of caution so that, you know, you're not second guessed six months, a year later. That's -- that's the connection.

And that has an -- that has an adverse impact on the cost of health care.

REPRESENTATIVE PALLONE: It drives the costs of health care up, which, again, looking at it -- with maybe my distorted logic affected, is if we're -- if we're doing extra testing as a precaution, then the incident of medical liability should go down because we're overprotecting.

You know, if I put on -- I don't know if it works -- but I put on two layers of insulation in the cold weather I'm theoretically going to be warmer than if I only have one layer on.

MR. GREER: Maybe.

REPRESENTATIVE PALLONE: So we're

putting --

MR. GREER: Yeah, I mean maybe. I mean, yeah, not necessarily. I mean you could still prescribe eight tests and still have a bad outcome. You know, maybe it will revert --

REPRESENTATIVE PALLONE: And that's the accidental. I think we're all human and we understand that, doctor, lawyer, Indian chief, we're going to make mistakes and that happens.

Notwithstanding the legitimate, if there is such a thing, the legitimate mistake like that, I'm looking at it, if we're over-testing, as you just suggested, then wouldn't we be -- our -- our incident of malpractice would -- would be proportionately going down because we are being more cautious?

MR. GREER: Potentially. I mean yes. I mean but that is whatever -- whatever costs -- whatever benefit you derive from that potentially are offset by increased costs in health care.

REPRESENTATIVE PALLONE: Okay.

MR. GREER: That's the connection that -- that -- that the Congress and President Obama made in the -- in the federal law, was that if we -- if we reduce liability concerns, that that will reduce the cost of health care.

REPRESENTATIVE PALLONE: And we're -- we're still, I guess, cautiously optimistic to see what happens with that. So --

MR. GREER: Yeah. Well, it's -- it's a -- we're still just trying to figure out exactly how it works ourselves.

REPRESENTATIVE PALLONE: I think everyone is.

MR. GREER: Exactly.

REPRESENTATIVE PALLONE: All right. Thank you. I am not -- I'm not entirely clear, but I'm following your logic better. Thank you.

Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Ron.

REPRESENTATIVE MARSICO: Thank you, Mr. Chair.

One quick question. You were here for the $169,000 premium question regarding in Pennsylvania an obstetrician pays a $169,000 annual premium in liability insurance and in Delaware it's 68,000.

And it was insinuated that the insurance companies in Pennsylvania -- the reason for that difference is -- is in profits. Could you respond to that?

MR. GREER: Well, it's -- it's a little bit

of an apples-and-oranges comparison, because Philadelphia is a highly -- highly litigious environment. I don't know if in Delaware if it was Wilmington or if it was Dover or if it was down somewhere by Rehoboth.

But if you are a high-end specialist, neurosurgeon, OB-GYN, or something like that, and you're in Philadelphia, you pay a lot for medical malpractice insurance. That is because of the litigious nature of the city of Philadelphia as it compares to some place like Delaware. And I think that's -- I think that's pretty well established.

Now, in terms of the costs that are associated between the differences, when claims go down -- and this has been evidenced in recent years, claims have gone down. And some of the prior testimony have -- we don't dispute that.

So too have premiums. Premiums have flattened -- have reflected a lot of the reduction in costs, at least from the two largest med mal carriers that -- that we represent. They have been steady, if not slightly under -- a slight decrease.

So I can't really speak -- I can tell -- I can tell you if medical malpractice insurance in Pennsylvania were a highly profitable line of business, we would have more than just a handful of insurers

writing it here and we would have somebody more than RRGs insuring hospitals.

REPRESENTATIVE MARSICO: Thanks.

CHAIRMAN CALTAGIRONE: Thank you for your testimony.

We'll next hear from David Fallk, The Committee for Justice for All.

REPRESENTATIVE O'NEILL: Mr. Chairman, before -- before you go on, I just wanted to point out that Representative Brennan, for Bringing Your Child to Work today, wasn't the only one that brought his child. Representative Stevenson brought his daughter with him today. I just wanted to point that out.

CHAIRMAN CALTAGIRONE: I apologize. Oh, okay.

MR. FALLK: It's -- well, let me be the first to wish you good morning. My name is Attorney David Fallk, and I'm here today with our coordinator, Paul Lyon, on behalf of The Committee for Justice for All, and all the people of the Northeastern Pennsylvania whose rights our organization promotes and defends every day.

We wish to thank you for the opportunity to address the issue of medical liability and proposals to limit the rights of injured patients and their families.

I come here today to advocate for real reform, not tort reform. And there is a difference. Real reform addresses real issues and promotes safety. Real reform provides information that enables every patient to make better choices for his or her family or themselves.

Real reform not only promotes responsibility, it holds wrongdoers accountable for their actions. In contrast, tort reform diverts attention from the benefits of real reform and, as we heard here today, results primarily in higher profits for insurance companies.

By way of background, and as Attorney Rieders stated, a little more than a decade ago the Institute of Medicine issued a shocking report which found that medical errors were killing as many as 98,000 Americans every year.

A few years later, HealthGrades, which is an independent evaluator of hospitals and health care providers -- and, by the way, it's also cited by doctors and hospitals as to how they're -- as to how they're performing -- issued a study find -- finding that the annual number of malpractice deaths could be almost double the IOM figure or 195,000.

However, consensus seems to have centered

around the upper reaches of the IOM figure and most reporters will say the 98,000 figure is correct.

Sadly, a follow-up report by Consumers Union, the publisher of Consumer Reports, found that little has been done to implement the Institute of Medicine's recommendations and that the annual death toll for medical malpractice has continued virtually unabated.

By that reckoning, in the last decade or so, while political efforts have focused almost entirely on enacting various schemes to limit the legal resort -- resource -- recourse of injured patients and their families, more than a million Americans cumulatively have died unnecessarily at the hands of our health care system.

That's the slide, Paul.

MR. LYON: Okay.

MR. FALLK: Okay?

Nevertheless, tort reformers remain unabashed in their attempts to curtail injured patients' rights, as we've seen here today. The result of those efforts is that 46 states, including our own, have enacted some form of tort reform.

Yet, no state that has placed its priority on tort reform has recorded a decrease in either injuries

or deaths caused by malpractice. Nor has any state shown a decrease in the cost of health care resulting from tort reform.

Instead, as we see from the annual reports of the Pennsylvania Patient Safety Authority and the Pennsylvania Supreme Court, the number of errors and serious events -- and the difference is serious events actually result in injury or death -- in the Commonwealth's hospitals has steadily grown while the number of lawsuits has steadily dropped.

The folly of pursuing tort reform at the expense of real reform may better be illustrated by taking the issue out of the context in which we are now engaged and by looking at other more successful programs that have addressed public safety, transparency, and accountability.

Let's look at drunk driving.

Just over 20 years ago, in 1989, the National Highway Transportation Safety Authority, recorded -- Administration recorded 22,404 alcohol-related deaths. A decade later, the same year as the IOM report was issued, drunk driving deaths had dropped by 30 percent to 15,786.

The latest statistics avail -- available from NHTSA found that in 2008 traffic deaths related to

alcohol had dropped significantly again to only 11,773.

No doubt, the efforts of Mothers Against Drunk Driving and other groups that call attention to the problem, identify wrongdoers and demand accountability have had a salutary impact.

So too has the action of government. Legislatures have lowered the blood alcohol level needed to be declared impaired. They have increased penalties and they funded education and prevention programs.

However, the courts have also played a large part by enforcing the laws. Wrongdoers are not protected by secret reviews, nor are they shielded from full accountability by limitations on damages for harms done. During court proceedings, victims and their families, rather than the tortfeasors, are given community support.

Thus, here in 2010, we sit at a perch from which we can see two societal problems and two completely different approaches to addressing those problems. Each involves negligent conduct resulting in serious injuries and death.

In the case of alcohol-impaired drivers, the death rate has been driven down to almost half of what it was two decades ago and the trend line is clearly downward.

However, in the case of medical malpractice, serious death and injury continue unabated and in Pennsylvania is documented to be rising. Sadly, Americans are now more than eight times more likely to be killed by their trusted health care provider than they are by a drunk driver.

Nor is the drunk driving comparison a singular case. Our society rightfully regards breast cancer to be a grave concern. The death rate from that disease is just over 40,000 a year, mostly women, and it has remained fairly stable.

For those 40,000 or so victims, we have a large national organization, the Susan G. Komen Foundation, that promotes public awareness, coordinates fundraising to help eradicate the problem, and supports victims of the disease.

There are countless walks and races for the cure, although no such cure exists. We fund government research to find out what causes the disease and to develop and promote preventive measures.

Just yesterday, I was driving behind a Pennsylvania vehicle that has a breast cancer awareness license plate.

As stated before, medical malpractice kills some 98,000 Americans, or almost two-and-a-half times as

many as die from breast cancer. Yet, there are no national organizations comparable to Komen that address or even draw attention to the ongoing toll of malpractice.

There are no colored ribbons for medical malpractice awareness, and the most publicized marches -- marches on the issue are directed not at supporting victims and their families but at restricting victims or the survivors' rights. Unlike breast cancer, however, malpractice is completely preventable.

So what we should be focusing our efforts on and what can we do to eliminate or at least sharply reduce the scourge of malpractice?

We should take a page from what works from the wars on drunk driving and breast cancer, and we should stop following policies that have led us away from saving lives.

Allow me to assert some -- some proposals for real reform.

Following the IOM report, the National Quality Forum undertook a research task to improve health care and found 28 different types of health care events that should never occur in a health care setting.

Those never events are designed -- are defined as preventable, serious and unambiguous. Among

the better known are wrong-site surgery, wrong-person surgery, foreign objects left behind during surgery, medication errors, certain stage bed sores, administration of wrong gases, and infliction burns during care.

With this information, eventually members of Leapfrog Group, which is a coalition of large employers who pay health-care benefits to their employees, decided not to reward the occurrence of some of these events by withholding payments. This move was eventually followed by Medicare and our Commonwealth under Medicaid in 2007.

There is still more that can be done. Since a consensus has concluded that these events should never occur, we would urge the legislature to pass a law allowing the presumption of negligence in cases where litigation results from an occurrence of one or more of these never events.

Such a statute would drastically decrease litigation costs, reduce the need for plaintiff's experts and time spent for insurance company attorneys preparing frivolous defenses.

We also need to require the posting of information. When my wife had surgery several months ago in Scranton, as I entered the hospital, there was a

prominent display of the board of directors, complete with studio portraits. Not far away was a list of employees of the month, again prominently displayed.

However, if I wanted to see the hospital's infection or error rate and how the facility's performance compared to other Scranton-area hospitals, there was nothing to be found. That must change.

I lived for several years in California where each restaurant has to display in its window a health department rating for all to see. Our hospitals should do the same, because our loved one's health care is at least as important as buying a Whopper at Burger King. Let's require posting of errors and infection information.

Now, previously Attorney Rieders discussed the issue of medical secrecy, and, as he stated, years ago the legislature granted the medical community the privilege of secrecy during peer review, which is a process employed by hospitals to study circumstances surrounding medical errors.

This was a special privilege and it was upheld by our courts because health care providers promised that allowing hospitals and doctors to police their own would decrease errors and therefore -- thereby lower the cost of health care.

The Patient Safety Authority statistics, as produced by the hospitals themselves for much of the past decade, compale -- compel the unassailable conclusion that patient safety has not improved. Nor can anyone seriously argue that the cost of errors in health care have gone down. In fact, just the opposite occurred.

There is an often cited maxim in the law that when the reason for the law no longer exists the law should no longer exist. It is time to end peer review secrecy and put the interests of harmed patients first in assigning responsibility.

The records of peer review proceedings should be discoverable to patients and/or their families in any medical misadventure regardless of whether it results in litigation.

Furthermore, if peer review finds fault with the provider's actions that resulted in harm, then a heightened standard should apply to any defense report in order to prevent frivolous prolonging of the litigation.

We should also ban secret lawsuit settlements. Some states and federal courts have moved in that direction and several judges in northeastern Pennsylvania have refused to shield malpractice settlements from public scrutiny.

Although it's not part of the law, the

Mcare Fund routinely makes secrecy a condition of its agreeing to pay any part of a settlement and this often delays resolution of the case.

Silencing victims so they cannot tell their stories or depriving patients of valuable information about health care providers serves no legitimate public purpose, and the practice should end.

We also need insurance reform. When the Mcare Act was passed, there was a crisis mentality gripping our Commonwealth. Insurance rates were rising and doctors threatened to leave. Although the number of physicians practicing in our state has never decreased and the insurance cycle has reversed, doctors still fear hikes and complain about rates as well.

Numbers provided by our -- our Insurance Department reveal a startling truth. Since 2003 collection of premiums has well exceeded payouts for malpractice claims and the gap has been widening. For each of the last three years premiums charged by the state's malpractice insurers have exceeded claims paid by roughly $350 million or more.

Additionally, as was stated before, those insurance carriers have garnered unturn -- untold returns on investments of the monies they have collected and they have in their reserves.

And I have on the last page of my paper, the chart with the actual numbers provided by the Insurance Department of our state.

For instance, you can see in 2006 there was $745 million collected as premiums. Only 372 million paid out.

The following year 700 and -- almost 710 million collected. 369 million paid out.

And for 2008, the last year of statistics, 722 million was collected and only 315 million was paid out. Over 400 million more was kept by the insurance industry.

Under the new National Health Care Reform Act passed in March, health care insurers are compelled to pay out at least 80 percent of premiums towards benefits, rather than enriching executives.

Given the payout-to-collection ratios that exist in Pennsylvania, a similar requirement should be imposed on malpractice insurers. To the extent that the amount in claims paid falls below a certain percentage of premiums collected, the difference should be rebated to doctors and hospitals.

If we allow the insurers to keep, let's say, ten percent of the premium-payout surplus, plus all of their investment income, doesn't seem unreasonable.

It would discourage waste and reward better-run companies, while giving much needed relief to the health care providers.

We also need to revisit the Mcare Act and rebalance the scales of justice. The Mcare Act contains certain one-sided provisions. For instance, a judge is allowed to lower the amount of a verdict if deemed excessive. That's called a remittitur under the law. But he or she may not raise a clearly inadequate verdict -- that's called additur -- without ordering a new and costly trial. The judiciary should be given the power of additur.

There was just a major case decided by our appellate courts that sent a case back for trial because there was an inadequate verdict and now both the insurance defense and the plaintiff are going to have to go through additional costs.

The Act also calls for certification by a plaintiff of procurement of an opinion that the standard of care has been breached. There was an extensive study in 2006 which indicates that far more meritorious cases are lost than nonmeritorious cases won.

Therefore, the certification requirement should also be imposed on a defendant who wishes to deny liability, a defense certificate of merit.

The Act allows for full payment of economic damages, but this is illusory because the victim often loses some or all of those parts of a verdict to subrogation by health insurance carriers. This is just a pass through.

In essence, the health insurer gets a free ride and risks nothing to recover its full loss. This is unfair. To boot, sometimes the health care insurer refuses to adjust its subrogation interest and, thereby frustrates settlements. That raises the cost of litigation.

A victim who recovers a malpractice verdict should get credit in subrogation for the full value of premiums he or she paid to his health insurer. And if an insurer's refusal to sufficiently adjust a lien results in a trial and a verdict lower than the offer, the health insurer should bear the full cost of its -- its refusal to compromise rather than the victim who is just trying to acc -- or be compensated for his losses.

As I stated when I began, real reform is not only necessary, it is long overdue. Each year in our Commonwealth more than 8,600 men, women, and children are either seriously harmed or killed by health care delivery in our hospitals, and that number is probably low because there's widespread underreporting.

It also does not include errors committed in nursing homes, private practices, or other health care settings, although this year we will be getting nursing home numbers.

Be that as it may, the number of patients harmed by serious errors in Pennsylvania in 2008 was more than the combined population of the Borough of Clarks Summit where I live and Newton Township where my children attend school.

It is also the equivalent every year of the population of some geographic areas that may be more familiar to the committee, of Lower Swatara Township, a Collingdale, a Ellwood City, or a Latrobe.

All of this is preventable so long as we stay focused on the real problem. Tort reform is not a solution. It has focused on patients and their rights only to impose restrictions. Real reform will empower our Commonwealth's families through knowledge. Real reform will promote and reward safety first and justly impose accountability. And it will lower physician costs.

Moreover, real reform is the moral and right thing to do. Thank you.

CHAIRMAN CALTAGIRONE: Thank you.

Questions? Will?

REPRESENTATIVE GABIG: Thank you, Mr. Chairman.

And thank you for that testimony. And you gave us a lot of facts and figures and data and arguments and reasonings, et cetera.

I think you were here when I asked my earlier question of a different panel, and what I'm trying to get at, and it's not for the purpose of argumentation. I'm just trying to get some facts.

I've been involved with this issue since I -- since I was first elected in 2000, and it sort of comes back and forth.

MR. FALLK: Sure.

REPRESENTATIVE GABIG: And we're here again. And there's different sides to it.

But what I'm trying to find out is just generally how much money -- you talked -- you used terms like medical errors and negligence and tortfeasors, medical malpractice, et cetera.

How much money is being paid out in terms of claims or compensation, however you want to define it, to the victims, is the term you used, to the patients that suffer these -- this damage?

How much is being paid out to them and then -- and then in comparison how much is going to

attorneys, plaintiffs' attorneys and defense attorneys both?

That's what I'm trying just to get a figure. Because I just want to use that as a basis for where we need to go.

Do you -- do you have any idea about that?

MR. FALLK: Well, let -- that is both a specific question and I think it's also a philosophical question.

What you have to start out with is, number one, the cost of -- of injury or death. That is a very high cost. It costs the families of this Commonwealth billions of dollars.

It costs -- if you run a small business and you go in the hospital and you're malpracticed and you become disabled, your business goes away. Those kind of costs have really never been -- been calculated. On an individual basis you might be getting your loss of profit back or something like that.

But the gross amount of cost of medical malpractice has never been decided. Now, litigation costs are something different. And we have a system --

REPRESENTATIVE GABIG: All right. Before you move on there, I get the philosophical versus general, I think, distinction.

But you said I think over 8,600 cases and you said that's probably low. Of those 8,600 cases, they're getting compensated with dollars through the -- through the current system that we have.

I understand there are broader things that are hard to measure. How do you measure a life, a leg, et cetera? But don't -- don't we have a general idea, give or take a million dollars here, or whatever, just a broad range how much is being paid out to these 8,600 people?

MR. FALLK: Well, first of all, 8,600 aren't being compensated. What we've found, what we see is there was only 1,500 lawsuits that were filed last year. There were 8,600 events. So there's a -- there's a huge gap.

Most -- most cases of medical malpractice, and there's -- there's some studies that say only one in six, some say one in ten, one in 15, are ever brought. So most families eat -- eat their losses by themselves. That doesn't even get into the legal system.

REPRESENTATIVE GABIG: How many losses did you say?

MR. FALLK: 1,533 last year.

REPRESENTATIVE GABIG: Now, when you say lawsuits, do you mean -- can't cases settle before

there's a lawsuit? They can be compensated or -- or claims can be -- they receive benefits before I would call something a lawsuit.

Are you using lawsuit in a very general term?

MR. FALLK: No. This is a specific term and it's the only thing that the Commonwealth Supreme -- Supreme Court can measure, is the actual filing.

REPRESENTATIVE GABIG: All right. I --

MR. FALLK: I agree -- I agree with you, if I may, that there may be some cases where malpractice occurs and a lawyer will be hired, he sends a letter to the person who commits malpractice, or is alleged to have committed malpractice, and a settlement will -- will -- will be effected.

There is no measure that -- except as was discussed previously within the insurance industry's own statistics, which they're not really willing to be forthcoming about.

REPRESENTATIVE GABIG: So on those 8,600 that you gave -- you gave me -- you gave us that figure --

MR. FALLK: Uh-huh.

REPRESENTATIVE GABIG: -- we don't know or you don't know or no one can tell us how much money is --

is being spent, so to speak, in compensation to those victims?

MR. FALLK: We know this, whether through lawsuit or settlement, and that's the table that I showed in the back of my -- of my presentation, that in the last year that was measured, 2008, insurance companies took in $722 million in premiums and paid $315 million in benefits.

The Mcare Fund additionally paid out 174, roughly a 174 million in benefits.

REPRESENTATIVE GABIG: When you say insurance companies, what are you talking about?

MR. FALLK: Liability companies. The insurance -- the malpractice carriers.

REPRESENTATIVE GABIG: The malpractice, the medical malpractice to the doctors and other health care --

MR. FALLK: Right.

REPRESENTATIVE GABIG: -- are paying -- paid 315 --

MR. FALLK: Million out.

REPRESENTATIVE GABIG: -- million out?

MR. FALLK: Right.

REPRESENTATIVE GABIG: So is that the figure that I've been asking for, do you think, or is

that something --

MR. FALLK: No. There's a -- there's a further adjustment that -- that -- that I think you're asking for, and -- and I appreciate you're trying to clarify this in your mind, because it's very important that everybody be clear.

From that, obviously the victim, if they pursued a malpractice case, has certain costs and they have attorneys' fees. The attorneys work on a -- what's called a contingency fee basis on my side of the -- of the case. On the defense side they usually are on the clock, on an hourly basis.

My side gets paid for success. If we don't win a case, we get zero. My side also puts skin in the game, so to speak, because what we do is we front the costs that --

REPRESENTATIVE GABIG: I don't -- we're sort of getting towards the end, and I see actually my --

MR. FALLK: Yeah.

REPRESENTATIVE GABIG: My -- my chairman let me, and I appreciate that, and we can talk offline about that. I sort of get that.

And I don't mean to interrupt you.

MR. FALK: Sure.

REPRESENTATIVE GABIG: But the 315, is that

the best estimate we have in terms of how much money is being spent in Pennsylvania to compensate people that are victims of medical malpractice?

Is that a good sort of rough number? And given the -- you know, are you sort --

MR. FALK: I would guess that's the -- that's the only figure. We have that and the Mcare payouts combined.

REPRESENTATIVE GABIG: All right. So then now what we have to figure out is how much money the plaintiff's lawyer -- and you told us the difference, how they get compensated and the defense lawyers get paid.

Do we have a figure for -- for that? Just a rough sort of similar type figure on a statewide basis?

MR. FALLK: No, we don't. We get a -- we would get a percentage, those on my side of the aisle, of -- of -- of what the payout is. The defense --

REPRESENTATIVE GABIG: Is that usually 20 to 30 or 20 to 40? Is that still --

MR. FALLK: It --

REPRESENTATIVE GABIG: I haven't been in the law --

MR. FALLK: It varies. It's a -- it's a contract. It's a matter of contract, and contracts have

to be written in Pennsylvania for contingent fees between the patient and the attorney.

And I'll tell you, I structure mine depending on what has to be done. If -- if I can settle a case before we have to -- I have to go to a certain level, I take less percentage.

REPRESENTATIVE GABIG: Sure.

MR. FALLK: If I have to --

REPRESENTATIVE GABIG: That would be if you have to go all the way through a jury trial.

MR. FALLK: Trial, it's another one. And if the -- if I win and it's appealed and it takes two more years to get a result --

REPRESENTATIVE GABIG: And most of them are going to be settled before that. So I'm just looking for, say, an average on the typical cases of this 315 million.

Does a quarter sound right to you?

MR. FALLK: Some work on a quarter, some a third, some 40 percent. You know, if --

REPRESENTATIVE GABIG: Forty if you get to a jury trial perhaps --

MR. FALLK: Yeah.

REPRESENTATIVE GABIG: -- and -- and then if it settled earlier it would be lower and somewhere in

the middle -- most of them are settled earlier.

And then the defense bar is not cheap either. So they're probably on the hourly basis getting -- costing the system, so to speak, not too much less than that I would imagine. Am I right about that?

MR. FALLK: I --

REPRESENTATIVE GABIG: Even though you --

MR. FALLK: I don't do --

REPRESENTATIVE GABIG: -- structure them different.

MR. FALLK: I don't do the defense. I can't tell you. Their -- remember, my costs are not an add-on to the system. They come out of the plaintiff.

The defense costs also don't come out of the plaintiffs. The insurance company has to pay that.

REPRESENTATIVE GABIG: No, I'm just trying -- I'm trying to get comparative -- compared to how much is actually going to injured people and then comparing how much we're spending on the -- on the legal system to get there.

That's -- some of us think we should be moving to a different type of system.

MR. FALLK: I understand.

REPRESENTATIVE GABIG: And you -- you know about that. It had nothing to do with tort reform. It's

like moving away from the whole idea and compensating directly to the victim, certain cases more of a welfare type of a system.

But I don't want to get into policy. I'm just trying to get those numbers.

So 20 to 40 percent of the 315 and then -- but there's going to be a similar number for the defense side. If you can't give it to us --

MR. FALLK: I can't.

REPRESENTATIVE GABIG: -- I'll have to talk to the defense side. But I appreciate --

MR. FALLK: That's on the defense. And I wouldn't venture or make any assumptions about that.

REPRESENTATIVE GABIG: Those attorneys that you deal with that are on the other side of the fence, the defense attorneys, are some of the highest paid attorneys in the Commonwealth of Pennsylvania, aren't they, by -- by hourly rate?

You know. You go up against some of the toughest attorneys. All right. No, I know. If you're a good plaintiff's lawyer, you have to agree with me that they cost a lot of money on the defense side.

MR. FALLK: They're highly skilled. But I will tell you this, that the insurance industry is trying to rein in that cost. And a lot of them complain about

their hourly rate and they complain about being nickeled and dimed and reviewed by the insurance companies.

REPRESENTATIVE GABIG: Sure. It's over time. But they're not cheap. I know that.

And thank you very much for your answers and thanks to the chairman that's left, my majority chairman, for sticking with me on that.

Thank you.

CHAIRMAN CALTAGIRONE: Yeah.

MR. TYLER: Real quick. I'll be very brief. I realize we're running out of time on this room.

We keep talking about the amount of money that -- that goes to the attorney and not to the injured person. Is it not true that there are certain -- the attorney doesn't get all that money?

How is that broken down? Obviously there's witnesses, there's costs.

MR. FALLK: Well, there's two things. There's -- there's fees and costs. We're -- we're paid for our skills, our abilities. We take the risk. We're not like -- we're not like the big executives on Wall Street that come in and get a million dollars whether they --

MR. TYLER: Oh, I'm not going there. I

guess let me ask a more specific question, again, because we are running out of time.

What is the average cost of a witness in, let's just say, a medical malpractice claim?

MR. FALLK: If -- if you can get --

MR. TYLER: Yeah, let's talk about a witness. Because we keep talking about 33 percent goes back to the attorney, but from what I'm hearing they could be 40, $50,000 just for the cost of a witness.

MR. FALLK: Just to start out, first of all, you've got to get records. You have to do records review of what happened here. Those cost.

You do a preliminary review. And then you have to call -- and I see some people want $5,000 as a retainer, some want 10, some want more than that, to issue a report, like we to have for a certificate of merit.

Then you get into, as the litigation proceeds, they charge more money because then they're -- they've got to start reviewing depositions, they help you prepare depositions, they go through all -- all of that and all this time the attorney is for -- fronting all this money out there not knowing whether he's going to get it back or not.

And this is what depresses the number of

lawsuits, because attorneys then are much more careful about what they take and much more conservative about what they take and a lot of meritorious cases, as Attorney Haines said, are put aside because the costs are so great that the risks/reward isn't there.

It's a shame on that. Attorney Rieders also talks about that. On the smaller claims, you just can't do a smaller claims case. And something needs -- should be done with regard to that.

But people do have a right for a jury trial. It's an absolute right for a jury trial in the -- in the federal constitution, the Seventh Amendment, and those things are inordinately expensive.

I -- I hope I've -- I've addressed that.

MR. LYON: I think it's fair to say the costs of witnesses can run well into the six figures.

MR. FALLK: Six figures.

MR. LYON: Anywhere from 100,000 to a half a million dollars per --

MR. TYLER: I guess my point out -- I understand I probably didn't ask the question correctly. But my point in all this is is the cost is not just driven up by the lawyers, it's also driven up by --

MR. FALLK: Yeah.

MR. TYLER: -- the expert witnesses and the

fees associated with the trial.

MR. FALLK: Sure. What you have to do for it.

MR. TYLER: Okay. Thank you.

MR. FALLK: All right. I'll just make one other point. There was an earlier question about how can we tell the number of attorneys -- or doctors practicing. Mcare. It's hard to get the numbers from them. I've tried to talk to them.

They'll tell you, no doctor will pay his Mcare premiums unless he's really practicing in Pennsylvania or she's actually practicing. So if you ask them how many -- how many doctors are actually practicing in -- that will give you the closest number that you can ever get as to how many -- how many are here.

Because there's no reason to -- if they're complaining about malpractice rates, why pay it if you're practicing in another state? You would only pay Pennsylvania rates if you're living here.

CHAIRMAN CALTAGIRONE: Good point.

MR. FALLK: And you have to get Mcare. So....

CHAIRMAN CALTAGIRONE: Okay. Thank you, gentlemen.

MR. LYON: Thanks.

CHAIRMAN CALTAGIRONE: Appreciate your testimony.

MR. FALLK: Thank you.

CHAIRMAN CALTAGIRONE: Dr. Shapiro, President and CEO of Pennsylvania Health Care Association. I enjoy watching you with Terry Madonna on Sundays, having my coffee and listening to you. So it's -- it's an honor and privilege to have you here today, sir.

DR. SHAPIRO: Thank you. You must be the only person in America who watches that -- that show.

CHAIRMAN CALTAGIRONE: I think there's a lot of members that watch that show. Terry does a good job.

DR. SHAPIRO: Terry does do a pretty good job. A very good job.

Thank you very much, Mr. Chairman, other members and staff who I know is here and tireless.

My name is Stuart Shapiro, and I'm representing the Pennsylvania Health Care Association and the Center for Assisted Living.

I'm going to try to be very brief, summarize my testimony. I was prepared -- prepared to summarize it in about ten minutes. And I'm going to just make a bunch of key points so all of you can move on.

Long-term care in Pennsylvania is very different than the rest of the health care system. And I hope to make that point.

Let me talk a little bit about demographics. To date, 21 percent of Pennsylvania's residents are over age 60. In ten years it's going to be 26 percent. One in four.

We have to have a place where these people are going to receive continuing care when they no longer can be cared for in their home. And we need to keep that in mind as we begin our discussion.

In Pennsylvania there's 725 nursing homes. About 90,000 beds. In Pennsylvania they are about 91 percent occupied, much higher than the national average.

While hospitals and doctors we talked about a lot, in nursing homes 80 percent of the care is paid for by the government. 65 percent by Medicaid, 15 percent by Medicare. Historically about a third of the people enter nursing homes not on Medicare or Medicaid, and by the time they -- they leave, either to go home or they die or they go to another setting, about a third of those have gone onto Medicare. So this is a real driver.

Nursing homes in Pennsylvania lose, according to a national study, almost $14 a day on every

Medicaid individual, and the cost of malpractice insurance and losses -- we're going to talk a little bit about what the impact is on that.

Margins in nursing homes are in the two percent range. Hardly enough. Whether you're for-profit or not-for-profit makes no difference, tough to sustain and continue to make repairs.

Quality is consistent. Quality has improved. Number of provisional licenses have fallen by 50 percent over the last three or four years. Number of complaints have dropped by two-thirds.

All of this data, the stuff that we heard about that's not available anyplace else, is available on the CMS web site and the Department of Health's web site. All is very transparent. Trial lawyers look at it all the time. And all of this data is absolutely available.

While quality of care is improving, by anybody's measure, the number of claims is going up. For example, there were four claims per thousand occupied beds in 1997, and in 2007 that number was 16. A fourfold increase.

To get to a question asked earlier, that means there were about 15 -- 14 to 1,500 claims filed during the last year.

The cost of these claims is going up, and the per diem lost per occupied bed in 2000 -- excuse -- in 1987 was 58 cents. That cost today is $3.57, or was in 2007, and that study is being repeated on 2009 data.

That is -- that means of the Medicaid reimbursement where it used to be .5 percent went to pay claims, now almost 2 percent is going to pay the claims, many of them settled because they're frivolous.

Although, as I indicated a moment ago, the data has improved and shows clearly improved services, the number of claims is going up because plaintiffs' firms are now trolling on television and advertising extensively and they're primarily nationally based firms, not Pennsylvania firms, who have targeted Pennsylvania for nursing home litigation. And they have filed hundreds and hundreds of copycat lawsuits asking for a lot of discovery, looking for lots of information, hiring investigators to go after disgruntled employees, to look to file claims, to break the back of the nursing home industry, which they did in Florida in the past.

As -- some of those same lawyers are advertising around some of the newsmaker shows that we were talking about earlier.

Clearly, we need some reform and we've looked -- we've have proposed, and it's been introduced

by Dan -- Dan Frankel, and well supported, a piece of legislation called apology legislation, which all the other providers talked about.

This is not major reform. This is commonsense reform, and all it does is permits a doctor or a hospital or an employee to simply, without risk, say, I feel badly about the outcome and begin a communication process.

This is very different from what lawyers tell doctors and nurses and nursing home people and hospitals, which is deny and defend. There's a risk group of doctors, about 1,200 in central Pennsylvania, who have implemented this policy and their premiums are now 35 percent below the market.

Where this has been done -- and it's been done in 35 states -- there's some good data. The University of Michigan Health System did this, and their number of claims fell from 262 in 2001 to 83 in 2007.

Similarly, at the University of Chicago, again it drives costs down because it sets up communication. And we hope that the best of the trial lawyers will support some -- some real legislation like this.

There's a couple of other pieces of legislation which I just think I need to set the record

straight. Earlier the trial lawyers talked very clearly about the need to eliminate arbitration agreements, and they called them mandatory. They are far from mandatory. They are voluntary.

CMS has said any nursing home that tries to squeeze somebody who is coming in and force them to sign an agree -- an agreement is going to be penalized. The courts have thrown that out. These are voluntary agreements. They are separated from the admission agreement and they save dollars.

The question of whether there's caps on damages in these voluntary agreements, virtually not at all. So these are voluntary, they are separated, and they go to reduce the cost. In fact, some of them even say that the provider will pay all the costs that relate to them.

So we're hopeful that that piece of legislation will move this year.

We're opposed to several of the pieces of legislation that have moved out of this committee earlier in -- in April or -- or March and, frankly, we hope that they -- they don't move this year, because all of them are going to raise the cost. Nursing homes are barely able to stay in business today. Their margins, as I've talked about, are tiny and all these bills are going to

do is raise the costs, and it's going to lead to problems for those on Medicaid getting care. 65 percent of the residents.

We're hearing this, and we're especially hearing this -- we've heard stories in -- in your -- in your hometown of Reading where hospitals are having trouble discharging people on Medicaid to nursing homes because they can't afford to stay in business and keep taking all the Medicaid individuals. And part of what they're fearing is litigation.

I've tried to be brief. My testimony is longer.

And let me just say that excessive litigation and damages result in higher consumer prices, decreased availability of services, and especially Medicare.

I hope my testimony has been helpful. I hope I haven't been too long, and I'm glad to answer any questions.

CHAIRMAN CALTAGIRONE: Thank --

DR. SHAPIRO: Thanks.

CHAIRMAN CALTAGIRONE: Thank you, doctor. Let me just reassure you, and all the other testifiers, that members that weren't here, we will make sure, and we always do, that every one of them gets a copy of all the

testimony that has been presented here.

And Andy Sandusky, Pennsylvania Academy of Family Physicians, by the way, has also submitted and for the record we will make that part of the official record.

Questions from counsel? Go ahead.

MR. TYLER: With your permission, Mr. Chairman, I see a lot of people wanting to offer rebuttal commentary to some of the things that have been said. With your permission, could we keep the record open for one additional week, Mr. Chairman, for additional comments?

CHAIRMAN CALTAGIRONE: Certainly. I have no problem with that. I have never shut anybody down or shut anybody out.

But I've probably -- I don't know if you're going to be on this Sunday, but I have -- I have enjoyed watching you and your commentaries with Terry.

DR. SHAPIRO: Nice.

CHAIRMAN CALTAGIRONE: And you speak to a lot of the direct issues we're facing. I want to thank you for your testimony.

I want to thank everybody that participated. We'll adjourn the hearing.

DR. SHAPIRO: Thank you.

CHAIRMAN CALTAGIRONE: Thank you, doctor.

(The following are written remarks submitted for the record.)

(The following are written remarks submitted by Madalyn Schaefgen, M.D., President of the Pennsylvania Academy of Family Physicians:)

Dear Representative Caltagirone:

On behalf of the over 4,800 members of the Pennsylvania Academy of Family Physicians (PAFP), I write in response to the House Judiciary's Committee hearing on medical liability issues in the Commonwealth.

First, the PAFP would like to reiterate its support for Act 13 and the work of the General Assembly by enacting reform measures to medical professional liability laws. The PAFP believes that this work, taken together with the subsequent civil procedural rule changes of our State Supreme Court, have favorably impacted the cost of medical professional liability insurance in the Commonwealth. However, there is still work to be done in order for the Commonwealth to realize a more predictable and stable liability environment when pricing these premiums. These additional measures for medical liability reform include:

Repeal of Joint and Several Liability;

Apology Rule;

Caps on Non-Economic Damages;

Collateral Source Rule;

Periodic Payment of Future Medicals;

Expert Witness Qualifications; and

Ethical Standards for Expert Witnesses.

In the PAFP's opinion, one of the worst avenues the Commonwealth could take is to go backwards from Act 13. Unfortunately, this counterintuitive approach is what we believe is behind some of the bills that were recently moved in the Judiciary Committee. Those bills the PAFP opposed include:

House Bills 1095 and 2202 that would expand the types of damages that can be recovered and the persons who can sue to recover them;

House Bill 1444 that would permit a jury to hear closing arguments on the amount of damages, both economic and noneconomic, in civil cases;

And House Bill 2123 that would prohibit the use pre-treatment arbitration agreements.

Legislation in these types and forms will push the medical professional liability system backwards, increase costs, increase litigation, and even stifle innovative approaches as alternatives to trial.

On behalf of PAFP, I again thank you for this opportunity to provide our written testimony to the

House Judiciary Committee on these important matters.

Sincerely,

Madalyn Schaefgen, M.D., PAFP President.

(This concludes the written remarks submitted by Madalyn Schaefgen, M.D., President of the Pennsylvania Academy of Family Physicians.)

(The following are written remarks submitted by Mr. George Goliash:)

In January 2008, eight years after a construction accident that damaged my left knee, I had a total knee replacement at Evangelical Hospital, Lewisburg, PA. Within ten days I was in the ER in excruciating pain. At that time it was determined that I had a staph infection around the knee replacement that was obtained during the initial surgery.

January 22, 2008, left knee replacement, Evangelical Hospital, Lewisburg, PA;

February 2, 2008, returned to Evangelical ER. Surgery to clean out wound; cultured for infection (I & D);

February 6, 2008, third surgery (I & D) to clean out wound, prosthesis also cleaned thoroughly;

May 27, 2008, fourth surgery (I & D), Evangelical Hospital;

September 9, 2008, surgery to remove knee

and put in a spacer;

December 30, 2008, surgery, Evangelical Hospital, second knee replacement;

January 20, 2009, surgery, Evan - I & D;

February 6, 2009, surgery, Evan - I & D;

February 11, 2009, surgery, Evan - I & D;

November 12, 2009, left leg amputated above knee;

As noted, over the next several months, I went through repeated operations to clean out the knee with the hopes that the knee replacement would not have to be removed. In spite of them, in September of 2008, a spacer was placed in my left leg and in December of 2008 a second knee replacement was performed. Between the surgeries and the stays in homes to administer IV antibiotics, I was away from home for approximately 15 of the 24 months between January 2008 and January 2010.

February 14 - March 25, 2008, Manor Care South, Williamsport, PA;

April 16-26, 2008, Darway Nursing Home, Forksville, PA;

May 30 - July, 2008, Darway Nursing Home, Forksville, PA;

September - October 2008, Roseview Nursing Home, Williamsport, PA;

February 13 - March 20, 2009, Roseview Nursing Home, Williamsport, PA;

November 17 - 21, 2009, Roseview Nursing Home, Williamsport, PA;

December 4 - 30, 2009, Select Specialties Hospital, Danville, PA;

December 30, 2009 - January 21, 2010, Roseview Nursing Home, Williamsport, PA;

Unfortunately, in November of 2009 there was no chance to save the leg because of the affect of the infection on the tissue in my knee and bone. The staph infection was the instigator of this whole medical nightmare but it wasn't the end.

Because of so many surgeries, I have endured kidney failure, heart issues including atrial fibrillation and heart attack, and pneumonia. The pneumonia was so serious that I ended up in Hershey for four weeks and a long-term acute care facility in Danville for another four weeks. I was discharged from a nursing care facility in late January of this year and am only now beginning to deal with the amputation which is a life-changing condition.

Additionally, I have cataracts that are the result of too much oxygen while on a ventilator and had to have my teeth pulled because the fillings all fell out

while on antibiotics.

February 7, 2008, sent to Evangelical ICU with A-fib;

February 28, 2008, ambulance attendant fell on George's knee replacement when transporting for visit to Dr. Cole, taken to Williamsport;

March 25, 2008, George fell at Manor Care breaking his picc line; transported to Williamsport ER;

April 8, 2008, George taken to Williamsport ER with chest pains, admitted to hospital;

October 30, 2009, Evangelical ER - admitted for infection;

November 21, 2009; George transferred to Hershey Medical Center ER for fever; admitted;

November 27, 2009, George put in ICU with breathing difficulties; on bipap machine;

November 28, 2009, George sedated and put on ventilator because of pneumonia;

May 3 and 17, 2010, scheduled for cataract surgery for both eyes;

May 2010, teeth extracted.

I have been a contractor and carpenter for 30 years. My livelihood and identity are gone. Because I was in and out of the hospital for so much of the time since the initial knee replacement, I have not been able

to submit all the documentation regarding the circumstances of my case to an attorney in a timely manner and therefore the statute of limitations has run out. I have no legal recourse.

It took two years to establish that I was legitimately "disabled" and I now have an income of $645 per month. And because of all the red tape and inconsistent information from Social Security, I am still working to get my retroactive disability payments. This is not the life I had hoped I would end up with nor is it the way I would choose. My skills and abilities that I have worked a lifetime obtaining are of very little use now without the ability to use both legs.

Staph infections can and does have debilitating effects on those who are exposed to it. I would sincerely request that you take this topic seriously and hold the medical communities accountable.

George M. Goliash.

(This concludes the written remarks submitted by George M. Goliash.)

(This concludes the written remarks submitted for the records.)

(The proceedings were concluded at 12:50 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the within proceedings and that this is a correct transcript of the same.

_____
Brenda S. Hamilton, RPR
Reporter - Notary Public