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THE MEDICAL LIABILITY CRISIS AND ITS IMPACT ON PATIENT CARE

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BEFORE THE

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THE MEDICAL LIABILITY CRISIS AND ITS IMPACT ON PATIENT CARE

FRIDAY, AUGUST 20, 2004

UNITED STATES SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., at the Huntsman Cancer Institute, Auditorium, 6th Floor, 2000 Circle of Hope, Salt Lake City, Utah, Hon. Orrin Hatch, Chairman of the Committee, presiding.

Present: Senator Hatch.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM THE STATE OF UTAH

Chairman HATCH. Welcome. We are happy to have all of you here in this beautiful facility that is dedicated for the well-being of mankind. This is an important hearing because we are going to consider some of the issues on both sides that make a difference in all of our lives.

Today's hearing will address the medical liability and litigation crisis in our country. It's a scourge that is preventing patients from receiving high quality health care, or in some cases, any care at all, as physicians are driven from practice. This liability crisis not only robs many patients of access to vital medical care, but needlessly raises health care costs for all Americans.

My colleagues and I have worked hard in the Senate to find a remedy for the crisis ravaging our health care system. Most recently, the Senate debated S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act of 2003 and S. 2207, the Pregnancy and Traumatic Care Access Protection Act of 2004.

S. 2061 addressed obstetrical and gynecological care and would hold physicians and insurers accountable for medical expenses in instances where they are clearly wrong. The legislation established a period of 3 years from the date of injury for a person to bring a claim, with exceptions in cases involving minors. The bill also would allow for unlimited awards of economic damages, while placing reasonable caps on non-economic damages, or in other words pain and suffering.

Economic damages are payment of past and future medical expenses and loss of earnings, as well as the cost of having services in the home to assist someone who has been injured or incapacitated from a negligent act. S. 2061 placed no limit on these awards.

Of course, damages meant to compensate for physical and emotional pain and suffering are not quantified. S. 2061 would cap

awards of these damages at $250,000, in addition to economic damages. Very often, jurors award plaintiffs millions of dollars just to punish a defendant, not necessarily to compensate for what is an intangible loss. S. 2061 would also fix contingency fees to ensure that patients with valid claims do not see their rewards siphoned away by attorneys. The bill would allow lawyers to recoup fees to make a profit, but not at the unfair expense of the injured plaintiff.

The bill debated by the Senate this year, S. 2207, was similar to S. 2061 in that it caps non-economic damages at $250,000 but leaves economic damages uncapped. The primary difference between S. 2207 and S. 2061 is that S. 2207 provides relieve to two specialties, OB/GYN and emergency or trauma physicians. It was limited to highlight two of the most high-risk and egregiously affected practice areas in our health care system.

Unfortunately, both bills failed to receive the 60 votes necessary to invoke closure in the Senate earlier this year. We would have had a majority of votes, but in the Senate now on controversial issues you must have a super majority of 60 in order to even debate the matter. Since the House of Representatives approved legislation at the beginning of the 108th Congress, it now appears that the Senate inaction may derail reform and allow this liability crisis to continue unabated.

To me, it is unconscionable that physicians are being driven from practice, and as a result, patients are denied access to quality health care. According to the Utah Medical Association, liability insurance rates for most Utah physicians increased by 55 percent or more in the last 2 years for some specialties. For example, those Utah physicians practicing obstetrics and gynecology have to deliver about 60 babies a year just to cover the standard insurance rate in 2003 at $71,000. 2004 insurance rates are now more than $81,000 for some OB/GYN physicians. A 2003 survey showed that 25 percent of Utah's OB/GYN intend to stop delivering babies within the next 5 years. 25 percent. And medical liability insurance premiums for Utah physicians continue to rise and increase pressures on physicians to restrict their services in our home state of Utah. Premiums rose by 30 percent in 2002, 20 percent in 2003, and a 15 percent increase is expected in 2004.

I am deeply concerned that we are needlessly compromising patient safety and quality health care. We know that only about 4 percent of hospitalizations involve an adverse event and only 1 percent of hospitalizations involve an injury that would be considered negligent by the courts. These numbers have been consistent in large studies done in New York, California, Colorado, and here in Utah. However, equally troubling is that only 2 percent of cases with actual negligent results or actual negligent injuries, excuse me, result in claims. Less than one-fifth of claims filed actually involve a negligent injury. We simply must do something to correct these imbalances.

The problem is particularly acute for women who need obstetrical and gynecologic care because OB/GYN is among the top three specialties with the highest professional liability insurance premiums. The other two are neurosurgery and orthopedic surgery.

Today, there are 36 members of the Utah Neurosurgical Society, and currently there are 27 neurosurgeons practicing in Utah. Not

all of these physicians are willing to cover high risk practice such as emergency rooms and trauma services. According to the American Association of Neurological Surgeons, AANS, Utah is one of 24 states designated as "severe crisis" states based on either a 50 percent increase in professional liability premiums from 2000 to 2002 or an average of neurosurgical professional liability insurance premiums over $100,000 a year. Now, this dubious honor for Utah citizens has affected their access to neurosurgical care.

Studies by both the Utah Medical Association and the Utah Chapter of the American College of Obstetricians and Gynecologists, ACOG, underscore the problem in Utah. Over half, 50.5 percent, of family practitioners in Utah have already given up obstetrical services or have never practiced obstetrics. Of the remaining 49.5 percent who still deliver babies, 32.7 percent say they plan to stop providing obstetrical services within the next decade. These and other changes in practice leave nearly 1500 pregnant Utahns without OB/GYN care. Now that's a tragedy.

An August, 2003 General Accounting Office report concluded that actions taken by health providers as a result of skyrocketing malpractice premiums have contributed to health care access problems. These problems included reduced access to hospital-based services for deliveries, especially in rural areas.

In addition, the report indicates the states that have enacted tort reform laws with caps on non-economic damages have slower growth rates in medical malpractice premiums and claims payments. From 2001 to 2002, the average premiums for medical malpractice insurance increased about 10 percent in states with such caps. In comparison, states with more limited reforms experienced an integration of 29 percent in medical malpractice premiums.

Medical liability litigation directly and dramatically increases health care costs for all Americans. In addition, skyrocketing medical litigation costs indirectly increase health care costs by changing the way doctors practice medicine.

Defensive medicine is defined as medical care that is primarily or solely motivated by fear of malpractice claims and not by the patient's medical condition. According to a survey of 1800 doctors published in the journal, Medical Economics, more than three-quarters of doctors felt they must practice unnecessary defensive medicine. A 1998 study of defensive medicine by Dr. Mark McClellin, currently the head of the Medicare program, showed that medical liability reform, or should I say CMS, his study, his 1998 study showed that medical liability reform had the potential to reduce defensive medicine expenditures by 69 to 124 billion dollars in 2001.

Now, I used to be a medical malpractice defense lawyer. And I have to say that I estimated, when I was practicing, you have to do every possible thing you can to have that in your history, even if you don't think it's really necessary, so that you show that you have done everything, that you've done things way above the average in the community, as well, in order to have any degree of safety. And consequently that's why I estimate there's at least $300 billion a year of unnecessary defensive medicine. And frankly it's a big problem.

The AMA admits to about $70 billion. Listen to the AMA today tell us where their figures are now. If the AMA estimates $70 bil-

lion, you can imagine what it really must be. So it's a big problem and it is costing every American. It is causing our health care system to run out of control. Something has to be done. Something reasonable. Something that still doesn't hurt patients or hurt those who have been grievously injured.

The financial toll of defensive medicine is great, and is especially significant for reform purposes, since it does not produce any health benefits whatsoever. Not only does unnecessary defensive medicine increase costs, it also puts Americans at avoidable risk.

Nearly every test and every treatment has possible side effects. Thus, every unnecessary test, procedure, and treatment potentially puts a patient in unnecessary harm's way. Seventy-six percent of physicians are concerned that malpractice litigation has hurt their ability to provide quality care to patients.

There is plenty that can be done to address this crisis. Last March, the Department of Health and Human Services released a report describing how reasonable reforms in some states have reduced health care costs and you improved access to and quality of care. For example, over the last 2 years, in states with limits of $250,000 to $350,000 on non-economic damages, premiums have increased an average of just 18 percent compared to 45 percent in states without such limits.

California enacted the Medical Injury Compensation Reform Act, also known as MICRA, more than a quarter century ago. MICRA slowed the rate of increase in medical liability premiums dramatically without negatively affecting the quality of health care received by the state's residents. As a result, doctors are not leaving California anymore.

Furthermore—and by the way, they are starting to leave Utah. Furthermore, between 1976 and 2000, premiums increased by 167 percent in California, while they increased 505 percent in the rest of the country. Consequently, Californians were saved billions of dollars in health care costs, and Federal taxpayers were saved billions of dollars in Medicare and Medicaid programs.

Before coming to Congress I litigated several liability cases. I have seen heart-wrenching cases in which mistakes were made. But more often I have seen heart-wrenching cases in which mistakes were not made and doctors were forced to expend valuable time and resources defending themselves against frivolous lawsuits.

A recent Institute of Medicine report, "To Err Is Human," concluded that "the majority of medical errors do not result from individual recklessness or the actions of a particular group. This is not a bad apple problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them."

Now, we need to reform or we need reform to improve the health care systems and processes that allow errors to occur and to better identify when malpractice has not occurred. The reform that I envision would address litigation abuses in order to provide swift and appropriate compensation for malpractice victims, redress for serious problems, and ensure that medical liability costs do not prevent patients from accessing the care that they need. And so I believe

that Congress must move forward with legislation to improve patient safety and reduce medical errors.

Without tort reforms, jurors will continue to award large and often unreasonable sums for pain and suffering. And a sizable portion of those awards will continue to go to the attorney rather than the patient. The end result is that many doctors cannot get insurance and many patients cannot get the care they need, and a small group of lawyers are sometimes unfairly enriched to the detriment of our society. All Americans deserve the access to care, the cost savings, and legal protections that states like California provide their residents. We must begin to address this crisis in our health care system, so Utahns and citizens across the country have continued access to their doctors, and doctors can provide high-quality, cost-effective medical care.

And I might also add there are decent, honorable attorneys who bring suits that are worthy of being brought in this country. And we shouldn't lump all attorneys in a category that they are all out just for the all mighty buck. There are very honorable attorneys in this country and there are suits that deserve to be brought, and I have seen them. But there's a high percentage of malpractice suits that are brought just to see what you can get out of it that are frivolous in nature and really are costing all of us billions and billions of unnecessary dollars.

Finally, I want to thank our witnesses for taking time out of their busy schedules to join us here today. We all look forward to hearing your valuable insights in this ongoing crisis and we have people on both sides of these issues.

I also want to acknowledge some of our friends in the audience that will be submitting written testimony on this important issue, especially Doug Mortensen, who is President of the Utah Trial Lawyers Association. Accompanying Mr. Mortensen are Ed Havas, immediate Past-Present of the Utah Trial Lawyers Association, and Mr. Joel Alred, the President-Elect of the Utah Trial Lawyers Association.

I would like to also acknowledge LaRee Miller, who is the Executive Director of the Utah Citizens Alliance. Ms. Miller is also submitting written testimony for this hearing. All of these testimonies are important to us and will help us to understand this even better than we do today.

Now, that was a fairly lengthy statement, more lengthy than I usually give. But I don't think there's one part that didn't need to be said.

[The prepared statement of Senator Hatch appears as a submission for the record.]

Senator HATCH. On our first panel we have Dr. John Nelson. We're very proud of Dr. Nelson. He is the President of the American Medical Association. Can you imagine? We in Utah have the President of the American Medical Association right here in our state, and he is doing a great job. Dr. Nelson is from Salt Lake City, Utah and has been a practicing obstetrician/gynecologist in this area for many years. We are all so proud of Dr. Nelson and the dedication he has shown for both Utah physicians and physicians across the country. He is a good man, he's an honest man, and he is one who I know very, very well.

Next we have—I think all of our witnesses are honest, by the way. Next we have Dr. George Lee who is representing the American Hospital Association at today's hearing. He is the Vice-President of Medical Affairs for the California Medical Center.

Next we have Dr. Charles Sorenson who is the Executive Vice-president and Chief Operating Officer for Intermountain Health Care. These are all great people. I know them all.

Next we have Dr. Charles Rich, who is a retired neurosurgeon from Salt Lake, and one of the great neurosurgeons. He was also the chief medical officer for the 2002 Olympic games. And we have tremendous respect for him.

Finally we have Dr. Steve Granger, also a great person who is a surgical president, or who is the surgical president at the University of Utah. Or resident, excuse me, at the University of Utah. Did I say "president"? I think I did.

So Steve is a surgical resident at the University of Utah, and we will hear him speak for young people going into the medical and health care field today. And this will be Panel One, and we will produce a second panel later. So we welcome all of you. If you will take your seats at the table, we will go to there.

Let's start with Dr. Nelson, the President of the American Medical Association first. And we can go across the table.

STATEMENT OF JOHN NELSON, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, SALT LAKE CITY, UTAH

Dr. NELSON. Thank you, Mr. Chairman. How delightful it is to be home for both of us.

Chairman HATCH. You've got that right.

Dr. NELSON. For the record, I am John Nelson, practicing obstetrician/gynecologist in Salt Lake, President of the American Medical Association here to tell you that in medicine we are having a crisis. What's a crisis? A crisis is when there is a sudden intensity of symptoms that increase during the course of the disease. We are seeing numerous symptoms today that tells us our system is in a crisis. The symptoms are unmistakable. A young boy in West Virginia, hurt in a football game, who has to be airlifted to another state because there's no neurosurgeon in that state that can see him because of liability concerns, and a helicopter too small to accommodate his mother.

A nurse in Bisbee, Arizona, bypassing the hospital in which she works at night, delivering her baby at the roadside in the middle of the night in the desert, because her hospital stopped delivering babies.

A man killed a few blocks from a Level 1 trauma center because that trauma center had closed 2 days before he was injured, all because of liability concerns.

Chairman HATCH. Pull that microphone closer, Doctor.

Dr. NELSON. Yes, sir.

Chairman HATCH. Can you hear in the back?

Dr. NELSON. We are concerned about efforts to improve patient safety, and quality being stopped because of lawsuit fears. Twenty states are in crisis, up from 12 a couple years ago. And in Utah, a crisis is looming.

Escalating jury awards and the high cost of defending against lawsuits, even meritless claims—I'll let you fix the microphone. It won't be better; it will just be louder.

Escalating jury awards and high costs of defending against these suits, even the smallest ones, are the primary drivers of increasing medical liability insurance premiums. And several studies show that.

So doctors have to do one of the three Rs: We restrict our practice, we relocate, and we retire. Physicians across this country are realizing every day that it simply is not acceptable. There's 100,000 physicians in a grass roots effort trying to do this. But this isn't a doctor problem, really; it is a patient problem. The crisis is becoming a serious problem for patients and the access they might have for care. That's why the AMA has a Patient Action Network with over 180,000 patients around the United States who delivered a half million messages to members of Congress. We will have 300,000 patients by October to do the same.

For the record, you understand this well because you are an attorney. The AMA believes that when an injury is caused by negligence, patients are entitled to prompt and fair compensation including all economic costs; future earnings, lost wages, all medical costs. And when they have these things occur, there is pain and there is suffering, we recognize that, and some money should be paid. We think a quarter of a million dollars is as good a number as any, and a significant amount of dollars because everything else has already been taken care of.

But right now our system is not predictable or fair. You have already suggested many who have claims don't bring them. We have to figure out a way to take care of these unquantifiable damages. The only way studies have suggested to do this is to limit not the issue of whether or not the patient gets paid for the economic part or the non- economic part.

What has happened is we have found by study, that that which predicts the plaintiff being paid is how badly the person has been injured, not the presence of injury.

What that means, Mr. Chairman, is doctors can follow the standards of care and still lose money in a lawsuit. That is simply unconscionable. We thank you for your hard work in this area. We have tried hard with you to work with Senate Bill 11, Patient First Act, which would do exactly as you suggest, to put a reasonable limit of $250,00 on the non-economic damage. This does work in California. We have the data. We can tell you with actuarial data what this will do. The J.O. itself said the rates of medical liability insurance premium growth are slower in those states where there has been this limit than in the states where there are not.

The Agency for Healthcare Research has told us that there are more physicians per capita in states where these terms have been enacted instead of the other ones.

There are many, many more stories. I won't—it would exceed my time and the other colleagues on the panel can answer your question.

The American Medical Association thanks you for your leadership in this area. We are here to tell you we are like the weatherman: There's a storm coming. Mr. Chairman, now is the time to

take care and batten down the hatches or there will not be people delivering babies. There will not be people here taking care of our injured children. Thank you very much for the time this morning

[The prepared statement of Dr. Nelson appears as a submission for the record.]

Chairman HATCH. Thank you, President Nelson. Dr. Lee? We are happy to have you here, Dr. Lee, and appreciate you.

STATEMENT OF GEORGE LEE, M.D., ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, VICE PRESIDENT, MEDICAL AFFAIRS, CALIFORNIA PACIFIC MEDICAL CENTER, SAN FRANCISCO, CALIFORNIA

Dr. LEE. Very pleased to be here. In my current role I'm the Executive Associate to the CEO of California Pacific Medical Center in San Francisco, which is a Sutter Health affiliate. But I have three roles. For twenty years I was the Chairman of the obstetrics department and I practiced obstetrics. For 12 years I have been a full-time hospital administrator. And thirdly, I helped form and have supervised the medical malpractice company that our physicians in San Francisco belong to and have a lot of experience on that side, also.

I'm here today specifically to represent the American Hospital Association's concerns, and the nearly 4700 hospitals and health care system members of which there are about 31,000.

We appreciate the invitation to talk about a serious problem and what we believe is the solution. The problem? How to control a Federal medical liability system that threatens the ability of patients to get the care they need. The solution, Federal reforms modelled after those adopted in California in 1976. These reforms are working. It is not, by any means, a panacea. It doesn't solve all of our justice problems. But it's working extremely well.

The reason it works is that a panel sees the need of all of our constituencies. Our patients receive their settlements and their awards much more quickly than the rest of the country. Our patients receive about 80 percent of the award versus 60 percent in the rest of the country. Our physicians are able to operate in a stable liability system that allows them to practice not only in the urban areas where our major facilities are, but in the rural areas where it is much more difficult to attract physicians.

Our hospitals have the ability now to have more stable cost elements within the liability area so that we can direct more of our resources to other services that we wish to provide. And our rural communities are in a better position to attract physicians, particularly in obstetrics and neurosurgery and emergency room.

Mr. Chairman, the effects of the medical liability crisis are well-known, but the bottom line is that patient care is jeopardized. In many areas physicians are packing up and leaving because they cannot afford the cost of liability premiums. Hospitals and other facilities are closing down or curtailing important services such as emergency rooms and obstetrical departments. Where these kinds of services are still available, not only are liability premiums driving up the cost of care, but defensive medicine, the ordering of extensive tests and other services equally drives up the cost of care.

And here is a very, very telling statistic. After an extensive claims analysis, we can clearly state that there's very little correlation between the presence or absence of medical negligence and the outcome of malpractice litigation.

Several states have enacted medical liability reform bills, but we strongly believe that this growing problem must be dealt with at the national level. The Federal Government pays for nearly half of health care delivered in this country. Standards of care are now national and defensive medicine costs the nation upwards of $100 billion.

The California reforms enacted under the Medical Injury Compensation Reform Act of 1975, that's MICRA, and reflected in the legislation that is now the language in Congress should be adopted nationwide.

I had the privilege to serve on one of the committees that developed the language for MICRA. For more than 25 years MICRA has demonstrated that patients' rights can be protected and at the same time medical liability costs can be controlled. States that have failed in their efforts to control costs are frequently those states that have enacted part of MICRA but not all of MICRA.

The bipartisan Health Efficient, Accessible, Low Cost, Timely Health Care Act has been passed by the House but continues to run up against roadblocks in the Senate. The HEALTH Act contains these following MICRA provisions. It limits the amount a plaintiff can receive for pain and suffering. That's the cap of $250,000. But importantly, all economic losses and all economic costs are paid in full.

It limits the attorney's care of 40 percent of the first $50,000 of the Plaintiff's award, 33 percent of the next, and lowers percentages for higher amounts. This means that patients receive a higher percentage of their awards. In cases where the court decides that the Plaintiff will incur future damages over $50,000, the HEALTH Act allows the award to be paid over time. That's periodic payments.

It establishes a fair rule so that each party is liable solely for its share of damages and not for a share of any others. That's joint and several liability.

Collateral source rule provides that if there are other insurances that will also impact on the ability to provide resources to that patient, they can be taken into account when awards are made.

These kinds of reforms have worked in California. Total awards in California, even with the cap, have kept pace with inflation; in fact, they have exceeded inflation. So the same proportion that we determined was an appropriate proportion in 1976 is what takes place today when awards are made.

The average medical liability insurance premium in California, this is the average across all specialties, is $14,000 a year; less than the nearly $24,000 adjusted for inflation being charged in 1976. It has been a remarkably stable environment in California in that our premiums, although they have gone up to some degree, have remained very constant particularly for the higher specialties.

The average time to settlement is now 1.8 years in California, as compared to two and a half years in other places in the country. As I said before, patients benefit more directly today than the at-

torneys do. And in a $1,000,000 settlement, a patient used to receive about $600,000 of that settlement. Now they receive $800,000. Quicker settlements and a higher percent of awards is what the patient receives under MICRA.

The AHA also supports a uniform statute of limitations and the continued development of successful conflict resolution programs. Non-traditional approaches such as alternative dispute resolution systems can play an important role in reforming the health care liability system.

MICRA-style provisions as embodied in the HEALTH Act won't make a tort system a perfect system, but it will create stability and fairness for patients, physicians, and hospitals.

Again, we appreciate the opportunity to be with you and I'm happy to answer any questions as we move on.

[The prepared statement of Dr. Lee appears as a submission for the record.]

Chairman HATCH. Thank you, very much. It has been very good. Dr. Sorenson? You are handling a major hospital network here, so we look forward to hearing your testimony.

STATEMENT OF CHARLES W. SORENSON, JR., M.D., EXECUTIVE VP/CHIEF OPERATING OFFICER, INTERMOUNTAIN HEALTH CARE, SALT LAKE CITY, UTAH

Dr. SORENSON. Thank you, Mr. Chairman. I'm a urologic surgeon who has practiced in Salt Lake City for the past 22 years, so I'm testifying as a physician and also on behalf of Intermountain Health Care where I serve as Executive Vice-president and Chief Operating Officer. I appreciate the opportunity to offer our perspective on the professional liability insurance crisis and a need for Federal tort reform.

The medical liability crisis is adversely affecting patients in Utah in several ways. First, it contributes to the increase in costs of medical care which is already rising at an alarming rate. As a health care system, we are struggling to keep medical care affordable. This represents a considerable challenge. The cost of pharmaceuticals, medical equipment, and facilities are rapidly increasing. Increasing numbers of uninsured and charity patients, coupled with inadequate Medicare and Medicaid funding, necessitate cost shifting. This further increases costs for those with commercial insurance.

Adding to these expense challenges is a 136 percent increase in malpractice insurance costs over the past 7 years. This is despite the fact that Intermountain Health Care has received national recognition for clinical excellence and has a favorable claims record. We see many dollars expended in the defense of claims that are ultimately judged to have no merit. Clearly we would much rather spend that money on improving patient care or reducing our charges for the patients we serve.

Costs increase even more because of defensive medicine. These additional testing procedures add no useful clinical information and serve only to protect the physician in the case of a subsequent lawsuit. While we have a strong system-wide focus on evidence-based best practices, it is difficult to ask physicians to forego certain procedures they believe might protect them from litigation, even when

such procedures aren't based on objective clinical evidence. The unfortunate fact is that too many medical standards in America have been created by legal precedent rather than by scientific evidence.

Secondly, while increasing costs are worrisome, I have much greater concern about a developing shortage in a number of vital medical specialties. We may reach the tipping point, where doctors are unwilling to care for the types of illnesses and injuries that expose them to unreasonable professional liability risk.

We feel the impact in our emergency rooms and trauma centers. Many doctors are reluctant to take E.R. call in such specialties as trauma surgery, neurosurgery, orthopedic surgery, and plastic surgery. Many have been sued for treating the difficult problems encountered there, even when their peers found the care they provided was consistent with best standards. We worry about who will care for our sickest patients when no physician is willing to assume the professional and financial risk.

We feel the impact in Utah's rural communities where physicians are simply unable to afford the additional liability premiums needed to practice obstetrics or to perform basic surgical procedures. The obstetrical crisis is extending even to our larger communities where a growing number of physicians are giving up obstetrical privileges, leaving expectant mothers with fewer choices.

We are very concerned by predictions of an even greater shortage of critical specialists in the future. America's medical schools and our own at the University of Utah report a dramatic decrease in the number of students pursuing residencies in surgical, obstetrical, and other high risk specialties. Who will be there to care for all of us and our families as patients in the years ahead?

I'd like to now briefly offer two perspectives on potential solutions to the crisis. First, even though Utah has been a relatively progressive state in implementing tort reform, our problems are increasing. National limits on non-economic damages would be especially helpful. While Utah has a cap, it has not yet withstood challenge in the state Supreme Court. Federal laws that are consistent nationwide and able to withstand challenges at the state level would be helpful in correcting perverse incentives in our current tort system.

We recognize the need to fairly compensate injured patient. But liability ought to be based on objective science, not on emotional appeal. For this reason, some form of alternative dispute resolution may be helpful.

In conclusion, number one, the professional liability insurance crisis is adversely affecting the delivery of care in Utah. If changes are not made, Utahns will not have access to critical specialists in time of their greatest need. Second, Federal action on tort reform including limits on non-economic damages is urgently needed.

We definitely agree that injured patients must be fully and fairly compensated. The challenge is to develop a better process for determining such compensation. On behalf of IHC, our volunteer trustees, our clinicians, and the patients we serve, we thank you, Mr. Chairman, for your interest and the opportunity to testify here.

[The prepared statement of Dr. Sorenson appears as a submission for the record.]

Chairman HATCH. Thank you.

Dr. Rich, good to see you. We appreciate all the work you did on the Olympics. You must be enjoying the current Olympics in Athens.

Dr. RICH. They have a very good team.

Chairman HATCH. Our kids have really done well. Can't help but watch them.

STATEMENT OF CHARLES RICH, M.D., SALT LAKE CITY, UTAH

Dr. RICH. Senator Hatch, thank you for the invitation to participate on this panel discussing Utah's professional liability crisis and the need for Federal tort reform legislation.

According to the survey that you mentioned from the American Association of Neurological Surgeons, Utah is one of 24 states that they judged to be a "severe crisis" professional liability state. As a consequence, there is a concern that we are, on behalf of our patients, watching the situation occur where there is no access to us.

There are only 27 neurosurgeons practicing in Utah. That's a smaller number than were here 5 years ago. Some of them cover very liability- intensive Level 1 and Level 2 trauma centers. Others would prefer not to. The University of Utah Health Sciences Center is self-insured. They have excellent neurosurgeons and they operate in a fundamentally different environment than those of us in private practice function.

Chairman HATCH. By "self-insured," what do you mean?

Dr. RICH. The people at the University of Utah Health Sciences self-insure.

Chairman HATCH. Part of their budget?

Dr. RICH. That's right.

Chairman HATCH. So it costs everybody in the state for that self-insurance.

Dr. RICH. But whereas a private- practicing neurosurgeon goes to the market and looks for companies like St. Paul or the Utah Medical Insurance Association, and has to negotiate each year for their own premiums.

Chairman HATCH. And St. Paul no longer provides—

Dr. RICH. That's one of the messages here.

Chairman HATCH. I didn't mean to interrupt you.

Dr. RICH. No. That's a very pertinent point.

The issue as it concerns the patients of Utah is the following: That although neurosurgeons are few in number, they are absolutely essential if there is to be available to the Utah public the following services; emergency rooms, tertiary or quaternary care, intensive care units, medical air transport systems, Level 1 and Level 2 trauma services, and for that matter a Utah State Bureau of Emergency Medical Services. Without easy access to neurosurgeons, not one of the above is a viable, functional entity. Our remarkably small number of willing neurosurgeons maintain that vital functional link.

And I want to emphasize that the group with which I'm familiar, you couldn't find a more dedicated, hard-working group of people. There are three neurosurgeons in Ogden who cover McKay Dee, a Level 2 trauma center; five covering LDS Hospital, which is a Level 1 trauma center, taking 1200 severely traumatized patients a year; and then there are three down in Provo covering the Utah Valley

Regional Medical Center. And if you have never done it, don't underestimate what it takes to be on call every third night or every fifth night when the prospect of being up all night is a very likely possibility.

There are three ways that this is affecting patients and the citizens of Utah as far as their access to neurosurgeons is concerned. One of them is early retirement. I cite myself as Exhibit A. When I finished with the Olympics I was 66 and very healthy. I think I know a lot about neurosurgery, but I knew that my premium for that next year would be $82,000 despite the fact that I have never had a payout, to my knowledge, from my insurance carrier. I wasn't willing to spend $82,000 for a reduced level of practice. It simply didn't make any sense.

This year, if I were doing it, my premium would be $93,000 and I submit to you that people in my situation start to make a judgment as to whether any of this makes sense.

When you mentioned St. Paul, this has a direct effect on our coverage. We have a very large referral center here. One of our neurosurgeons who retired this year was insured by St. Paul, and when they went out of business he retired forthwith. And that had the effect of having our neurosurgeons not on call every sixth night, but every fifth night. And I remind you that St. Paul is willing to insure hurricanes and property casualty problems, but they cannot afford, apparently, to engage in the selling of insurance for professional liability.

The other way that this is affecting the access of Utah patients to neurosurgeons is that they are altering their practice. There was a survey done of 563 neurosurgeons nationwide in 2002; 29 percent responded that they were considering retirement, 43 were considering restricting their practices to low-risk surgeries, and 19 were considering moving in response to the liability insurance crisis.

There is a penalty that you pay in terms of your liability premium for doing craniotomies and cranial work. That is a very strange incentive when that's the very service that is needed in these emergency services, and yet those who engage in that—

Chairman HATCH. That's on top of the $91,000?

Dr. RICH. That's part of what they compute. But if you are not doing cranial surgery you pay one, and if you are you are paying a higher amount.

The other way that it is affecting access to the citizens of Utah in neurosurgery care is just the entry level. If you look at surveys which have been done of medical students—keep in mind that neurosurgery requires a six to seven year residency post medical school. And it is a very hard program. There are fewer and fewer people who are medical students applying for the neurosurgery match. That has been documented since 1991, and is particularly true since 1995. And I don't think anybody doubts that it has something to do with the fact that neurosurgery is the most sued surgical sub- specialty and certainly has the most difficulty getting liability insurance.

Four rhetorical questions: If you finished your residency in neurosurgery and were looking for a favorable location in which to practice, would you choose Utah with a severe professional liability crisis? If you were a young neurosurgeon already in Utah and

noted that the fees paid for neurosurgical procedures were higher in Idaho and your professional liability premiums were lower, would it be appropriate to move there?

One of the really capable neurosurgeons that we had in Utah left for Coeur d'Alene, Idaho about 3 years ago, and it's good for them.

In good part a reflection of a litigious atmosphere practice, the number of practicing neurosurgeons in the United States has declined since 1998. By 2002 there were fewer in practice than there had been in 1991. During 2001 alone, 327 board certified neurosurgeons, comprising 10 percent of our National work force, left their practices. Considering the availability of essential services to the public, of more concern is a large proportion of those remaining are in the 50 to 65 year old age group and they have already altered how and where they practice in response to this crisis. And the only remaining option they have is to cease practice altogether.

Senator Hatch, I remind you of the time when my practice partner, Bruce Sorenson, and I sat in your office in April of 1995. As I recall, that very day we discussed tort reform and there had been a vote that day that you were disappointed in. I think you have been our ally, I think you supported us. We are grateful to that. And I think it is important to emphasize that the people you are representing in this are the citizens of the state of Utah. Thank you.

[The prepared statement of Dr. Rich appears as a submission for the record.]

Chairman HATCH. Thank you, so much. We appreciate your forthright testimony.

Dr. Granger, you are one of the younger doctors here. We want to hear what you have to say about your future and what you think about it.

STATEMENT OF STEVE GRANGER, M.D., SURGICAL RESIDENT, UNIVERSITY OF UTAH, SALT LAKE CITY, UTAH

Dr. GRANGER. Thanks for the opportunity to represent medical students and residents in this important hearing.

As you mentioned, I'm in my general surgery residency here at the University of Utah. I chose a career in medicine as an undergraduate because of my interest in the sciences, and a naive desire to help in the healing process. I did not have a personal or family background in health care or law. At the time of this early decision, medical malpractice was little more than a bad commercial to me.

Through 4 years of medical school and 4 years of residency, this naive view of malpractice couldn't have changed more dramatically. Unfortunately I believe most medical students now consider the effects of malpractice when choosing a medical specialty. Students who are particularly adept at surgery or obstetrics are consciously deciding to pursue alternative specialties because they want to avoid the perceived devastating effects of the country's malpractice crisis.

Four years of undergraduate studies followed by 4 years of medical school and then an additional three to 7 years of residency is a significant commitment, and students are unwilling to enter specialties where they perceive they will be thrown to the wolves. A study published in 1998 at the University of North Carolina

showed that perceived malpractice premiums have had a negative impact on medical students choosing specialties in surgery. And I think this influence has only worsened since 1998.

The few of us that do still hold that naive notion that we can practice in these certain specialties have our eyes further opened when we enter residency. As residents, we are protected from almost all the business and insurance aspects of health care. We really have minimal to no exposure with reimbursements, business decisions, and malpractice insurance as residents. We don't act independently and therefore we are protected from lawsuits in residency.

Even in the currently hostile environment of health care, our education continues to focus on the proper care of the patient. Yet despite this protective environment, we see and feel the overpowering influence that medical malpractice has on patient care and leading to practice decisions. Two of the surgical residents that I worked with as an intern, I have a small class of five that get accepted every year into our surgical program, and two of our five my first year clearly stated that they wished to enter alternative nonsurgical specialties and they dropped their surgical training for another specialty. They didn't want to work as hard as surgery demands during residency only to find themselves caught in the middle of a broken system. So they stopped their surgical training and chose alternative specialties.

I remember long conversations with these two residents where they questioned my sanity to stay in a specialty that works as hard only to have more risk. I propose that no businessman or executive would choose to enter an environment where they are guaranteed to have higher risk for guaranteed lower pay.

A survey conducted in 2003 of residents in their final year of training, you should have been excited about the prospects of finally venturing off into their careers showed that one in four of these graduating residents would choose a different vocation altogether if they could start over, and that their predominant concern was related to malpractice.

Physicians have been charged with care of the sick, whether a friend or enemy. Historically, media portrayals such as MASH depicted the physician as a patient advocate, often at great personal or professional costs. Under this environment that we are still trained in today, compassionate quality care of the patient is our highest priority and training.

Interestingly, in June of this year at a national American Medical Association meeting a proposal was made and debated about whether medical treatment should be refused to malpractice lawyers. This seems comical to me and it was widely shunned at the AMA meeting, but it does depict the nature of our current environment. Imagine the new medical student creed: We will care for our patients, friends, enemies, terrorists, but not malpractice lawyers.

That's an interesting statistic, an interesting discussion and it was widely shunned, but it does depict the nature of the environment.

One interesting statistic shows that before 1960, only one of every seven physicians was sued during their careers. However, current estimates indicate that one in seven physicians is sued

every year. For a medical student and a resident, this environment is discouraging.

My training emphasizes competent, compassionate care of the patient. Every interaction of every day is about how I can better care for my patients, often at great personal sacrifice. This is all I'm exposed to as a resident. I don't get exposed to any of the medical liability environment except to see its impact. All I want to do is care for the patient, and that is to spend my professional life caring for the patient. But I fear in the current environment many decisions are made regarding practice based on the impacts of medical liability.

Difficult problems rarely have simple solutions, but I think the difficulty of the solutions shouldn't prohibit aggressive efforts at a multi-faceted solution.

Fortunately, for the physician and patient, medicine can still be about care of the patient, but I fear that under the current medical liability environment this altruism will be more impossible with every passing medical school class.

I appreciate your advocacy for change and hope that we can cause some of these efforts to occur.

[The prepared statement of Dr. Granger appears as a submission for the record.]

Chairman HATCH. Thank you so much. It has been a nice panel and certainly has presented a lot of the problems that exist. I know you have to leave, Dr. Nelson, so I want to start with you first. And that is, in your job as the AMA President, the American Medical Association President, I know you had the opportunity to speak to thousands of physicians across the country. What are these physicians hearing from their patients regarding the medical liability crisis?

Dr. NELSON. We have traveled from border to border and coast to coast. I was in Oregon last week and heard a series of stories of concern. I'm thinking of a young woman in Newcastle, Wyoming who delivered her baby by Caesarean section, was pregnant for the second time. In the eighth month of her pregnancy, the liability premiums increased and the doctors couldn't afford them. She had to go over a hundred miles to another state to deliver their baby elsewhere.

I'm thinking of Dr. Melissa Edwards who all her life wanted to be an obstetrician. At age 15 a caring teacher took her to a hospital, and she became an obstetrician, working her way through on her own from a blue collar family. Board certified. Wonderful doctor. Watched a colleague of hers one night deliver a baby. The colleague did appropriately but a lawsuit, $8 million for cerebral palsy, a disease known to occur in utero and not because of birth trauma, was assessed against this other doctor. And Dr. Edwards quit the practice of obstetrics.

What we are seeing is the doctors are doing the three R's; they are retiring, they are restricting their practice. Lots of doctors are not delivering.

This is only the tip of the iceberg, Senator. Forty-eight percent of medical students tell the American Medical Association where they will practice and what they will practice is dependent on the liability situation. And this year in obstetrics and gynecology, the

best of all specialties, I might add, 68 percent of the residencies did not fill, nearly a third of the residencies did not fill this year.

Bring that home. Last year, in the entire medical school class in the University of Massachusetts, not one doctor went into obstetrics. 2002, the University of Utah, not one of a hundred doctors are going into obstetrics. 2003, two will, but one will not deliver babies. And I don't have the 2004 data. But of the last 200 doctors, only one will deliver babies. This is only the tip of the iceberg. We have to fix this or there will not be people to take care of patients.

Chairman HATCH. In the state of Utah where we have a lot of babies, it seems to me we have have to encourage people to go into obstetrics. But let me ask you this: You have traveled all over the country. How many states allow physicians to practice without—I don't like the word "malpractice," but without medical liability insurance?

Dr. NELSON. It varies from state to state. There are 15 states out of 50 that have a law on the state statutes that suggests that for a physician to practice in a hospital he or she must have professional liability insurance.

The more common circumstance is that the hospital medical staff itself demands it, or the medical station in which they serve. That's the case where I practice at LDS Hospital. We think it is appropriate for our colleagues to be protected so it doesn't negatively affect on patients. But the issue is how much it costs.

There are some very unique schemes. You have to look at Connecticut and what they are doing. You have to look at Pennsylvania. There's a surcharge for a catastrophic fund that doubles the amount of liability insurance. It is so bad there you have to get it from two companies. They will only sell half the policy. Specialists in my specialty in Florida spend $250,000 a year per doctor. Most doctors there are not having liability insurance. If the hospital or the state makes a rule they have to have it, those doctors simply will not practice.

Chairman HATCH. What happens if a doctor doesn't have medical liability insurance?

Dr. NELSON. Of course, if the law or the statute or the hospital says they have to have it and can't practice, they'll lose the patient as well as the doctor.

There are negligent acts. We acknowledge that. When a patient has been injured through the act of negligence on the part of the physician, that patient should be paid promptly, fairly, and completely. We even believe there should be some monies paid, a substantial amount, a quarter of a million dollars for pain and suffering in addition to every other thing that should be paid.

Our concern is that the data tells us, the evidence tells us that that is not the case. What we are seeing is that when a person is badly injured, that is what determines whether there is payout. We actually have cases where the doctor follows the standard of care and there is still payout.

Chairman HATCH. All of you have chatted about this to a degree, but how many physicians have either retired or limited their scope of practice due to medical liability concerns? And how are the patients affected by that? You have all talked about that a little bit here. But is patient access to care more limited as a result of this?

Dr. NELSON. We cannot give you actual numbers. We have one person who is the alliance president in Pennsylvania, he has a white coat ceremony. He goes up on the stage and has a white coat and a name of every doctor in practice in Pennsylvania that year, and we are up to several hundred. The problem is the count isn't accurate.

For example, I have a license in Wyoming which is very difficult to get. I have maintained it. I have not delivered a baby in Wyoming since 1992. I haven't delivered in Salt Lake City since 2003. In both states the opponents of this side would suggest I'm available. But my patients can't count on me in either state. We don't have the data and we need help in getting it. So it's not just the number of doctors; it's what they actually do.

Chairman HATCH. Dr. Nelson, has the AMA seen direct evidence that medical liability premiums have risen more slowly in the states with non-economic damages?

Let's understand. When we are talking about economic damages we are talking about lost wages, medical care, hospital costs, et cetera, et cetera. When we are talking about non-economic damages, basically pain and suffering that a jury is going to have to determine.

Dr. NELSON. Medications, orthotics, prosthetics, hospice care, trauma care. Everything a person would need.

Chairman HATCH. All the bills that can be received are paid by the economic damages.

Dr. NELSON. We can give you three pieces of evidence. Number one, the California circumstance where premiums, on average, have risen three times faster across the country than in California since the enactment of MICRA.

A study by Tillinghast-Towers and Perrin, an actuarial firm, who says the factor for liability premiums to increase, the fact that the liability premiums go up, is due to the fact that there is payoffs that have to do with non-economic damages. Last year the state of Texas passed a state Constitutional amendment in which they limited the losses to $250,000. The largest liability carrier in that state increased those premiums by 12 percent, and seven new carriers are coming into the state of Texas this year that are leaving other states. There's no question. In six states that don't have a crisis all have in common some method to limit non-economic damages. And by the way, I'm sure you know, people in California sue twice as often as the rest of the country. It does not limit their access to court.

Chairman HATCH. You have been a real help here and I appreciate the work you have done for the AMA. And we are proud as fellow Utahns that you head the whole association and we have been privileged to listen to you.

I'm going to have some tough questions in addition for some of you others, but I'm letting him off the hook here.

Dr. NELSON. I'll take a couple, too, Senator.

Chairman HATCH. I knew you would. If you need to leave, go ahead.

When I ask some of these tougher questions, any of you can answer if you care to. Any of you can answer any of these questions that I'm asking. Dr. Lee?

Dr. LEE. I want to make an additional comment that you asked on the long-term impact of when physicians lose their liability insurance what happens to patients, what happens to the system.

Chairman HATCH. Yes.

Dr. LEE. I want to go back to 1976 in California in our rural communities. I happen to have a small ranch in northern California, Mendocino County, a population of about 15,000 people. Prior to 1976, most of the obstetrics was performed by people in general practice. They had a few obstetricians at one central hospital, one central community in that county.

When the crisis of 1976 occurred, most of the general practitioners stopped providing obstetrical practice, and at the present time, patients now have to travel 50 to 75 miles from other parts of the county to get to the one central hospital that will provide obstetrical services.

The impact is not exactly what is happening today. The impact is what will happen over time. When those resources withdraw from a rural county, it takes forever to try to get those resources to go back. Changes—and patterns of practice change. Physicians no longer want to go back into the rural communities because it is difficult to make a living in rural communities. And once the system changes and the physicians leave, getting them back is very difficult, and then the patient no longer has access to the services. That's the longer term impact. And that's what can happen in Utah if this continues on and on. You begin to lose the resources in your rural communities.

Chairman HATCH. Let me ask you this: As head of the American Hospital Association, how many hospitals across the country are paying for their physicians' medical liability insurance or costs? Not even the insurance but—

Dr. LEE. That varies dramatically from state to state. If you take Florida, which has a very serious problem, many of the obstetricians from Florida are either going without insurance or the majority of them are actually now being employed by the hospitals. So the hospital is footing the whole package of providing obstetrical services.

Now, they can do that for a certain amount of time. But at some point in time, there are only certain resources the hospital has. If you direct all those resources to obstetrics, you have to pull back on the other things you have, taking care of other patients who perhaps don't have the same access, financial resources, that the more wealthy blue collar patients have.

Dr. NELSON. So it's a wrong answer to a tough question. There are at least two reasons why hospitals shouldn't do that. Number one, hospitals are already strapped. There are many, many other things of concern to them. They shouldn't have to pay that. And when they do, all that does is shift the costs on their back. It doesn't fix the system. It is just a different way to pay for a system that is broken.

In the state of Oregon the legislature there is paying $10 a year for the next 4 years to subsidize the liability premiums of doctors in rural areas. That's money that could be used for health care that isn't currently being used.

Chairman HATCH. I understand some hospitals are hiring doctors to avoid the medical issues, because the doctors have the insurance.

Dr. SORENSON. I'm not aware of that, Senator. Intermountain Health Care employs about 450 physicians in its physician group and insures those physicians, but the costs of the professional liability insurance is considered in the terms of their practice costs. We try to compensate our physicians according to the market. And so they are affected by the rising costs.

Chairman HATCH. But you have to have medical liability insurance, and the doctors do, too.

Dr. SORENSON. That's correct.

Chairman HATCH. And if there's an unfortunate result and litigation is brought, it is probably brought against both of you, isn't it?

Dr. SORENSON. That is correct.

Chairman HATCH. And you have a whole raft of other—

Dr. SORENSON. Usually the hospital gets drawn into cases because it is perceived as the deep pocket, even when the hospital may have had minimal contact with the patient. And at least in our case, many cases are ultimately dismissed but after very expensive and lengthy litigation.

Chairman HATCH. Let me ask you another question. What would be the consequences to IHC, Intermountain Health Care, or even the state of Utah if we continue to experience the inability to recruit and retain certain specialties such as obstetrics, neurosurgery, or orthopedic surgery? And are we facing that?

Dr. SORENSON. Yes, we are currently facing that, as Dr. Rich indicated. And particularly in those specialties that are most acute; in things like neurosurgery, trauma surgery, orthopedic surgery, plastic surgery. Those things that involve our trauma centers, our emergency room. We are having a hard time because a decreasing number of physicians are unwilling to take calls in that setting. They recognize that there's a high risk of litigation involving these very complicated cases. Even in cases, as I mentioned in my testimony, where the care was according to the best national standards, if there's a bad outcome sometimes judgments are rendered based on the bad outcome alone, not based on whether or not best practices were followed.

Chairman HATCH. That's interesting. What you are saying is the doctor may have practiced the highest standard of medical care, but because this is not an exact science, somebody for some totally unrelated reason or just because they have gone to him in the process, had some condition that was not the fault of the doctors in any way , or that nothing was the fault of the doctors, but the unfortunate result results in litigation. And who knows what the juries will do with those cases because it's much easier to identify with the person who has had the unfortunate result than it is with the doctor or hospital, the health care provider or nurse.

Dr. SORENSON. That's exactly right, Senator Hatch. And that's why we are experiencing the shortages and we predict even greater shortages in those specialties that deal with most difficult patients; patients whose injury or disease has a high risk of a poor outcome, regardless of how good the care is.

Another interesting thing, and Dr. Rich and I were talking about this. If you look at the most respected neurosurgeons in the United States, or trauma surgeons or cardiac surgeons or orthopedic surgeons, every one of them, virtually every one of them has been sued multiple times. These are the physicians that we, as physicians, would go to. And there is not a correlation between bad physicians and the frequency of lawsuit as much as there is a correlation between specialties and how often people are sued.

Chairman HATCH. Dr. Rich, I think you have been eloquent with regard to Utah's problems in retaining or acquiring or enlisting or supporting neurosurgery and neurosurgeons in the state. Are you suggesting that the number of neurosurgeons in Utah will continue to decrease unless we solve this medical liability process? And maybe you might tell us what that means if we don't have access to the neurosurgeons.

Dr. RICH. Well, I think there are two observations—

Chairman HATCH. First of all, I think it's fair to say that neurosurgeons is one of the most specialized, all of these are specialties, but neurosurgery is one where there is much more likelihood of having an unfortunate result that had nothing to do with the ability of the doctor. Am I fair in saying that?

Dr. RICH. Well, in some of the brain tumors, in some cerebrovascular anomalies, in some spine disorders there's a risk inherent in the procedure, known well before the procedure, that it can be done absolutely correctly, seemingly go perfectly well during the procedure, and there can be an unfavorable outcome.

Chairman HATCH. In every case the patient is informed that this could happen.

Dr. RICH. Yes. But believe me, Senator Hatch, I have known from neurosurgeons who just are emotional basket cases when that happens. It is not as though this is something that anyone ever comes to the point where they get used to it.

But the bottom line is that if there isn't some limit, then you are going to have a very fundamental problem. It's not a spigot that you can turn on and off. I didn't finish my neurosurgical residency until I was 35. My son has now gone into neurosurgery and he didn't finish his residency until he was 35 years old. So if you take that long to train people to do this and then we have all heard today that medical students are more and more risk averse and they are responding to the appropriate incentives and they are not going to go into these, as was just said the real alarm is to look down the road and say, is the time going to come when someone who today just assumes that if their mother has had a cerebral hemorrhage and goes to an E.R., they are going to have a two-hour rapid intervention and have done whatever needs to be done? I think anybody who knows the landscape here knows that the numbers don't look good, either in terms of the number of people who are entering that field or the perverse incentives that are taking people who are still well within their capacities to practice that are incentivized to leave practice. So I don't think there's any question that if this isn't addressed that it's going to result in a real man power problem for highly specialized surgical subspecialities.

Chairman HATCH. Especially less and less neurosurgeons in the state of Utah to help with these very serious cases.

Dr. RICH. I think it's inevitable.

Chairman HATCH. It's a matter of great concern to me. You have indicated that you didn't or you really didn't finish your, was it, until you were 35 years of age?

Dr. RICH. That's correct.

Chairman HATCH. That means if you take an average person, at 18 you graduate from high school, 4 years of college at 22, 3 years of medical school. Right?

Dr. RICH. Four years of medical school.

Chairman HATCH. Four years of medical school. That's 26.

Dr. RICH. All neurosurgery residencies are 6 years; some are 7 years.

Chairman HATCH. You have 26 plus six, that's 33.

Dr. RICH. A mission and military service.

Chairman HATCH. I see. But the average neurosurgeon is going to be 32 or 33 before he or she is ready for practice.

Dr. RICH. That's correct.

Chairman HATCH. It not only means that you have to sacrifice from 18 years on up—and I take it during these years of residency, you are not being paid astronomical sums of money.

Dr. RICH. At Johns Hopkins my rent was more than I was being paid.

Chairman HATCH. The point is you sacrifice all the years until you get to the point where you are 32, 33, 35 in your case and your son's case, and then your prospects are limited if there's an unfortunate result so this—

Dr. RICH. That's correct.

Chairman HATCH. And even if you start at 35, you are going to have to pay $91,000 for liability insurance.

Dr. RICH. The UMIA does something I think is very—it lets you work up over 5 years, knowing that you have just barely entered practice. But within 5 years, you are going full bore. And for the guys around here, that's about $100,000.

Chairman HATCH. Doctor, how many of you have left practices or even limited their practices due to medical liability insurance in this particular what you consider to be a crisis?

Dr. RICH. Citing myself as an example, I would be happy to work in a limited environment. But with the overhead that high, one has to make a decision whether you can afford to.

I think the other is the example I gave of a very contributing gentleman willing to cover this very onerous regional trauma center who, when St. Paul went out of business, he went out of business. And when he went out of business we went from an every sixth to an every five night call schedule.

Chairman HATCH. With someone like you who has this experience but wants a limited practice but would like to keep helping people, with someone like you if you wanted to go work, say, in a rural area or some charitable medical group helping the poor, do you have any sense to do that?

Dr. RICH. I think a lot do. The gentleman who went out of practice and is no longer covering the trauma center is in Mongolia on an LDS mission.

Chairman HATCH. I'm talking about within this country. Because if you can't afford the $91,000 of insurance, you are really risking

your home, your family, and everything else that you accumulated over the years.

Dr. RICH. You can stay busy. I'm going to be an examiner for the American Board of Surgery. I still serve on boards and committees.

Chairman HATCH. But that's different from operating on people.

Dr. RICH. Can't afford to do that.

Chairman HATCH. Well, we can't afford to lose people like you. And I know you very, very well and know how competent you are. And, like you say, you have never been sued for medical liability in all the years of practice. And yet you can't afford —you are at the top of your profession. You have a number of years. I know doctors who are doing an awful lot of great work into their seventies. Some even in their eighties. The famous heart physician down there in Houston.

Dr. NELSON. Dubecki?

Chairman HATCH. I know him personally and I watched him perform open heart surgery once. And he is almost a hundred years old and still giving services all over the world. But doctors just can't afford to do it, can't afford the insurance.

Dr. RICH. That's why I agree with the comments being made about it being a broken system. You depend on the incentives being correct, and then you work for the public. And the incentives are bringing about results that do not conform to what benefits them.

Chairman HATCH. Dr. Granger, how many of your colleagues and students, well, students and residents and so forth, have changed their hoped-for specialties because of medical liability concerns?

Dr. GRANGER. I think there's a significant impact on medical students deciding what specialty to practice. Dr. Nelson mentioned even in our own university in 2002, no students chose to go into obstetrics because of the medical liability crisis. And in 2003, I think there were two, but one of them was going to go into gynecological practice and not practice obstetrics. So in 2 years we entered one student into obstetrics. That's a small percentage and there's certainly a greater need there. And then in the surgical training here at the University, we have five residents every year that are chosen to go into surgical specialties.

Chairman HATCH. General surgery.

Dr. GRANGER. And two of the five jumped out after 1 year and changed completely what they were going to do because of the concerns regarding medical liability.

Chairman HATCH. Referring to Dr. Nelson, he talked about how few are going into obstetrics today and they are not even trying medical school. It seems to me we can't afford that.

Dr. NELSON. When I was a resident we had 20 percent of our class going into obstetrics and gynecology. It is such a deep problem. There isn't time to go into it all here today. But I was decrying to one of my Canadian colleagues the day before yesterday in Toronto the issue that we are not even teaching residents by best practice anymore. We are teaching how to protect themselves in case of a liability suit. Seventy-five percent of doctors are saying that the way they practice is affected directly by the concern, the fear of liability.

Chairman HATCH. I estimated about $300 billion, and this was twenty years ago, $300 billion, and this is the testimony of some-

one in the field, of procedures that were unnecessary. We want to practice defensive medicine when it's necessary to do the best you can. But I'm talking about unnecessary defensive medicine. Do you think I'm that far off?

Dr. NELSON. I think you're low.

Chairman HATCH. And that was twenty years ago when I said that.

Dr. NELSON. Seventy-five percent of doctors said the way they practice is being affected, and they thought 95 percent of their colleagues are being affected.

Chairman HATCH. Let me ask a tough question. In my practice I saw the wrong leg taken off. Clearly negligence. The wrong eye taken out. And I have seen other similar things. How do you solve the problem in those cases where there should be pretty high non-economic awards? Clearly negligent.

Dr. NELSON. Fairly and completely. When something like that happens, a physician is negligent and should be held responsible.

Chairman HATCH. I have seen the wrong kidney taken out. You only have two. You have to have two legs, two eyes. What do we do about that?

One of the problems that I see in the current legislation in Congress is that the $250,000 or $300,000 or $500,000, and I expect it will go up to at least $500,000 in non-economic expenses. But in other words all the non-economic costs including lost wages and so forth can all be reimbursed on the economic damage side. But what do you do about the pain, suffering, inconvenience, and loss of health, life, and so forth?

Dr. NELSON. You pay something for sure.

Chairman HATCH. What do we do?

Dr. NELSON. You pay an amount. We need to fund a system that is fair. If you are my patient and I give you Ampicillin which I have given you before, but this time you have a reaction where your kidney shuts down, your heart stops, you are very injured. Did I make a mistake? No. Was I at fault? No. But what happens is because you are injured you are likely to be compensated. We have to differentiate between those things.

Chairman HATCH. So many could get compensated who never really would get compensated otherwise.

Dr. NELSON. Right. It's an issue of equity. And the equity is people ought to get the money due them when they are injured, for sure. But if there is going to be a system where everything that could go wrong can be compensated, that can't be on the backs of only the physicians.

Chairman HATCH. My question is a little bit different than that. My question is this is a system that should be fair. And the wrong leg is taken off, the wrong eye taken out, the wrong kidney taken out, shouldn't there be an ability to go beyond whatever the cap is? I think there should be a cap. The question is should there be an ability to go beyond that cap in those really egregious negligent cases?

Dr. NELSON. No, there should not be.

Chairman HATCH. You don't think so?

Dr. NELSON. No, sir, I don't. And the reason I don't think there should be is we already allege and assert we are willing to pay

every single farthing for the economic damage, and something for the non-economic part. If there's punitive damage because the person does something willful, that's a punitive issue. That's a criminal issue.

Chairman HATCH. Again, you are talking about punitive damages, and that's more than the cap.

Dr. NELSON. Punitive damages, we have no argument with that. We are talking about the liability only.

Chairman HATCH. Then what you are saying is, if I interpret it correctly, and you correct me if I'm wrong, is that where there's a clear cut gross negligent situation like the wrong leg, wrong eye, where there's a clear gross negligent situation, I wouldn't call it punitive damage, but there could be more damage if they can prove that. Yes? Go ahead.

Dr. LEE. I feel strongly, too, about a fixed cap, and I feel strongly about what I have watched the last 30 years. I stated in my early discussion that we don't have a perfect system. I don't believe we will ever get a perfect system, based on all the variables that are in play. But we have to have a reasonable system, a system that works very well.

Chairman HATCH. For the vast majority of the people. A utilitarian stem.

Dr. LEE. If we take one example out of the millions, we come up with the wrong conclusion. We look at what does public policy have to do for all the people being served? The difficulty with a cap, when you don't have a very fixed cap, the cap is incentive to get cases fixed early, not to go off frivolous cases. If you multiply the financial impact of the cap across the entire process, it's much broader and deeper than just is it $250,000 or $500,000? And I think in California, what we have seen is the ability to resolve cases very, very quickly, half of the time it takes in the rest of the country. An ability to get—

Chairman HATCH. And a more fair basis.

Dr. LEE. An ability to get more of a percentage of the award to the patient on a fast, predictable way. And it's the entire package of the cap plus the other parts of MICRA. If we start to unravel one part of MICRA and then another, you openly get into a new system which hasn't been tried. We have no evidence that it is going to work. And we do have a system right now that has had 30 years of experience that has been very predictable.

Chairman HATCH. And I take it innovative lawyers will find a way around it. If you have a gross negligent provision, lawyers will find a way around that. So that everything is gross negligence.

Dr. NELSON. Our thinking is when there's a hole in the limit, there's no limit.

I would point out this in closing. Seventy percent of lawsuits brought against physicians go away without no payment to anybody. It costs about $40,00 per case to make that happen. Of those that do go to court, 80 percent of the time the jury finds in favor of the physician. That costs about $90,000.

Of those where there's a payout, in addition to the payout, the cost is $328,000 per case. There are 125,000 medical liability cases in court in any given day in this country. There are not that many bad doctors. This system is broken. We hope this will be a great

first step to go to a better system. Your point is one we need to be discussing. What is a better system? A medical court? An administration system? Something like a Workmen's Comp, some other plan. But right now the patient is hemorrhaging. If we don't stop this hemorrhage, there won't be a patient.

Thank you very much.

Chairman HATCH. This has been great. I have had a lot of hearings through the years on issues like this and this has been one of the best panels I have ever seen. And all decent, honorable people who have expressed, I think, the problems as well as they could be expressed. I'm indebted to you, to you taking this time, and I really appreciate it. You have helped a lot of people understand this better. Keep working on it. And we appreciate all of you and we will let you go. Thank you. Appreciate you coming up.

[Recess.]

Chairman HATCH. On our second panel we have Ms. Donna Page of Park City Utah whose bacterial infection was repeatedly misdiagnosed; who was one of the torchbearers for the Salt Lake City 2002 Olympics, and we are grateful to have her here. If she would come, we would appreciate it.

Next we have Ms. Karla Glodowski whose son went into the hospital with a cut fingertip and left the hospital severely disabled. We are very interested in hearing these two witnesses.

And finally we have Mr. Charles Thronson who is representing Utah Trial Lawyers Association, and we are glad to have him here, as well, and look forward to taking this testimony.

Start with you, Ms. Page. Thank you so much.

Ms. PAGE. Thank you.

Chairman HATCH. Look forward to hearing from you. Mr. Thronson, grateful to have you here.

Mr. THRONSON. Thank you, Senator.

Chairman HATCH. And get Karla and her little boy here. We appreciate that.

Ms. Page, we will start with you.

STATEMENT OF DONNA PAGE, PARK CITY, UTAH

Ms. PAGE. Thank you, and I appreciate you listening to my testimony.

In January of 2000, I was an extremely healthy—

Chairman HATCH. Pull that microphone closer, right about there.

Ms. PAGE. I was an extremely happy 63-year-old woman. I had my own successful tax preparation business and many hobbies. My husband and I enjoyed skiing, hiking, tennis, working out with weights, and we also traveled. Loved theater, loved dancing, and had lots of other activities.

Six months before this, I competed in the Honolulu Tinman Triathlon, which consists of a half mile ocean swim, a 25 mile bike ride, and a 6.2 run. I was in very good shape.

Chairman HATCH. That's very impressive.

Ms. PAGE. On February 17, 2000 I didn't fell well, which was very unusual for me because I'm always healthy. I seldom go to the doctor but I am health conscious and will go if I think there is a problem. One lesson I learned from this experience was never let a doctor put you off. If you are sick, make sure you don't let a med-

ical professional minimize the problems. I had a high temperature and went to the clinic. The doctor told me simply to take Tylenol and sent me home.

The next day I was very feverish and felt much worse. My husband took me to a large hospital emergency room in Salt Lake City where I spent the entire day. During the day my fever spiked at over 106 degrees and my blood chemistry deteriorated, which I later learned are clear signs of a major infection. At the end of the day the doctors did nothing and sent me home again with no further instructions.

The third day I was deathly ill and I could hardly walk. I went back to the clinic in Park City and the doctor recommended I take Gas-X and once again sent me home.

Early in the morning of February 20, we went back to the hospital emergency room and exploratory surgery was performed. The doctors came out of the operating room and told my husband to get my family together as I would not survive the day. That began the battle that would change my life.

It turned out I had a Strep A infection that had been misdiagnosed for the last 4 days that was shutting down my body. I spent the next 2 months in a medically induced coma. It was necessary to amputate both my legs below the knee, all the fingers and part of the right hand, and most of the fingers on my left hand. I was very close to death many, many times.

On top of that, as I was finally recovering, a nurse stuck a feeding tube in my lung and filled my lung with feeding solution, causing a respiratory arrest. If I had received medical treatment that I needed when I first went to the emergency room, these horrific things would not have happened to me.

After 4 months, I left the hospital to face the challenges of a very new life. We are not "lawsuit type people," if there is such a thing like that in Utah. I did receive very, very poor medical attention that would change my life forever in awful ways. After much discussion and soul-searching, we decided to file a lawsuit as we knew our financial needs were going to be quite different than our original retirement plans.

A cap of $250,000 would not have come close to solving our problems. We had a lovely home but had to sell it because it had three stories, and that does not work if you don't have legs. Also, remember that insurance companies and even Medicare want to be at least partially repaid if a settlement is received. And lawyers cannot work for free.

This illness used up most of my medical insurance. For once I was lucky to be old and able to apply for Medicare less than a year after leaving the hospital. What if I had been 54 instead of 64? I now have Medicare but I must purchase the most expensive supplement insurance available as my legs, which are replaced every several years, cost $40,000 plus, and the accessories necessary to make them work cost several thousand dollars a year.

There are so many things I need that are not covered by insurance. I need special equipment to turn on lamps, to hold a pencil, and a million little other things. The tax preparation business I had nurtured for 40 years, and the income from it, are a thing of the past. I am blessed with a loving husband who takes wonderful

care of me, however he is almost 9 years older than me and odds are I will outlive him. In many years my illness aged him a lot more than it did me.

I cannot live alone. I'm very independent but there are so many things I just cannot do. Simple things like lifting a pan of water from the stove to the sink, or trying to cut big pieces of meat are beyond my capabilities. There are doors and windows that are more than I can handle. I used to hop on the kitchen counter to reach high cabinets, but that's out of the question now. I don't want to ever be a burden to my children, but if something happens to my husband, this is a real possibility.

After my illness, I applied for long-term care insurance. But to no one's surprise I was uninsurable. The settlement I received in my lawsuit did not make us rich but it will be my long-term care insurance.

Two years ago, after I was misdiagnosed and had to have all my amputations, I was asked to carry the Olympic torch as it come through Park City and that was probably one of the biggest honors in my life. Because I have no fingers left we were able to strap the torch to my palms and that's how I carried it.

I'm a survivor and I'm not a complainer but I seriously doubt that anyone here today actually believes that a $250,000 damage cap is fair compensation for the pain and suffering that I and my entire family have gone through and will go through for the rest of our lives. And I seriously doubt that anyone on the panel, you, Senator Hatch, or the doctors that were here in this audience, would think that a $250,000 cap was fair if they had a wife or child that had to have their legs and fingers amputated and live the rest of their lives that way as a result of medical negligence. Thank you. And if you have any questions, please ask.

[The prepared statement of Ms. Page appears as a submission for the record.]

Chairman HATCH. Thank you. I appreciate you coming, and appreciate you bearing that torch, too.

Ms. PAGE. Thank you.

Chairman HATCH. You're clearly a very good person.

Ms. PAGE. Thank you.

Chairman HATCH. Ms. Glodowski, we want to hear about you and your son.

Mr. THRONSON. Senator Hatch, if you would let me show a short video of Christopher Glodowski which we will now show. This is a before and after video.

[Video played.]

Chairman HATCH. Shall we take your testimony now?

STATEMENT OF CARLA GLODOWSKI, LEHI, UTAH

Ms. GLODOWSKI. Thank you. On July 5, 2002, my 16-month-old son Christopher Karac Glodowski stuck his finger in my older daughter's bike chain. She was unaware that it was there and the tip to first joint was cut off. We rushed him to the hospital and were told that he was a good candidate for replantation and we decided to have the medical team attempt the reattachment.

Chairman HATCH. Would you read just a little bit slower, because you are excited and we can't quite understand as well. I think I can, but I want to make sure everybody can.

Ms. GLODOWSKI. Okay. Due to the lack of professionalism and the inattentiveness of the doctors, my son was allowed to suffer a bronchial spasm to the point of oxygen deprivation. He went into cardiac arrest and had to be revived with chest compressions and finally epinephrine. After this occurred, the medical team chose not to tell me what had happened to my son. They did not give me the choice to end an elective surgery to explore why my healthy son was responding this way. They continued with the surgery, and they took away my right as his parent.

Karac did not come out of the operation with the appropriate responses. He was unable to awaken and could not breathe on his own. He had to be life-flighted to Primary Children's Medical Center and he was subject to a battery of tests to determine why he was responding abnormally. Some of the tests included AIDS, blood tests for genetic disorders, MRIs, and additional surgeries for a muscle and skin biopsy.

The second MRI showed he had suffered a severe anoxic brain injury. His body had gone too long without oxygen. He would never again be normal.

Later as experts were hired and depositions were taken, we finally began to receive the truth about what happened to Karac. He has asthma, which the doctors knew before they operated on him, and he has a more sensitive airway than someone who doesn't. When they intubated, he had a bronchial spasm and it was not treated right away with epinephrine. In fact, this medication was given last. He was allowed to cascade downward until he had a heart rate of 20 and no blood pressure.

An independent handwriting expert had to be hired to prove that Karac's charts were altered to look like he wasn't in distress as long as he was. The charting has two periods in which nothing was charted. Karac was dying and the entire room of medical personnel was allowing it to happen. The very people that swore under oath that patient safety was their primary concern denied having any responsibility.

I have not worked since this happened to my son. My employer was not supportive, and I was forced to quit my job. Due to the fact that I made a majority of our family's income, we began to suffer severe financial difficulty.

On November 10, 2003, we settled our case out of court for an undisclosed amount. I did not want to settle, but due to our situation it was the only way to guarantee that Karac would get the money to care for him for the rest of his life. In settling with the other parties involved, we had to agree not to mention the names of the medical personnel involved or the medical facility where it occurred. In essence, I feel we have to protect them and their identities when they should have protected my son.

And in protecting their names I have learned from their co-workers that they still do not show remorse or acknowledge guilt. In fact, they are stating that my son came into the hospital in the condition he is in now.

I'd like to tell you more about my son, Christopher Karac, and the incomprehensible effect this has had on my family. We call him either Bubba or Karac. My husband named Karac after Robert Plant's son. Robert Plant was a member of the rock group Lead Zeppelin. His son died at the age of 5 of a mysterious virus and Robert Plant co-wrote a song, "All of my Love," as a way of overcoming his grief. This song has now come to mean a lot to myself as well. Although my son is still alive, on July 5, 2002, the medical personnel that operated on him killed the boy he was supposed to grow up to be, and left a hurt and damaged shell.

Prior to July 5, Karac was full of energy. He loved to play catch, interacting with his sisters and eating. He was quick to laugh and smile and was full of life. Now he is quadriplegic, suffers from cortical blindness. He cannot eat normally and must receive his nutrition through a tube in his stomach. He has a baclofen pump implanted under his skin with a catheter threaded into his spinal cord. This mechanism delivers a constant supply of medication to his body to help control muscle contractions. He suffers from high blood pressure, reflux, irritability, and has difficulty sleeping. The quality of Karac's life has been horribly altered. He is committed to a life of pain and frustration.

A few of the things not taken from him are his smile and laugh and his love for his family and music. Ironically, his favorite music is Lead Zeppelin.

This has also had an acute effect on my daughters. My oldest daughter, Kielee, still displays problems with guilt. She wants to know when Karac's finger is going to grow back. She wants to know when he is going to get better and walk and talk. She has moments when she will become thoughtful and when I ask her what is wrong she will cry and tell me that she will never hurt Bubba again. She is unable to separate the accident with the bike and the monstrosity that actually happened to him at the hospital. They are linked together in her mind.

Kiera is five and just learning to read. She was eating a piece of Laffy Taffy in the car and read me the joke. "What has two legs but can't walk?" I thought about it for a moment but did not come up with the answer. Kiera came up with her own answer. She said, "Bubba." I started to cry and could not drive through my tears. I do not know what the true answer was, but hers is forever burned into my mind.

My husband has lost his namesake and his baseball player partner and he has quietly dealt with what has happened to Bubba. He has been forced to continue to work a dead-end job because we have to keep medical insurance. And when he does break down, he tells me that he let Bubba down. He was supposed to protect him and not let anything bad happen to him.

And as for myself, I despise the person who coined the cliche, "Time heals all wounds." I know I will not live long enough to heal. To this day, I still cannot talk about what happened to Bubba without breaking down. The day that Bubba's finger was cut off, I was trimming the rosebushes around our house and I remember thinking that the sheers were sharp and I needed to put them away properly so the kids wouldn't cut themselves. And at that point I

heard Chris yelling. I believe God was trying to tell me something was going to happen, but I didn't listen.

We recently found out we are going to have a new little baby boy in September. This should be an extremely happy time for all of us, but I can't help crying. I keep wondering if this is a way to replace Bubba, and somehow get raising him right this time. It's so hard to be happy when I'm worried all the time. I'm worried about dying before Karac, and having him die before myself, and being physically unfit to care for him. I stress about the girls being emotionally scarred and I'm concerned about spending enough time with them. I do not want them to resent Bubba. It also saddens me to know that every Saturday our family time includes everyone but Bubba. He is left home with a nurse. Our family has been destroyed.

The money we received in this settlement has done nothing to help put our family back together, but it has taken away the financial burden. I have been able to purchase additional therapy equipment for him, receive additional therapies, and it will help assure that Karac will have the best quality of life possible.

I cannot fathom the thought of anyone thinking that putting a cap on the amount awarded to families who have been victimized by malpractice will solve anything. In my eyes, it's an attempt to victimize the innocent even further. My son's life did not come with any dollar sign attached. Although he wasn't important to those who operated on him on July 5, he is important to me and he can't be replaced.

Damage caps only hurt the people who are the most injured. Our claim was not frivolous or a junk lawsuit. The only junk in this case was the quality of medical care Karac received. I want those of you who are voting on this topic to consider how you would vote if this was your son. Should you protect innocent babies like Karac or doctors that lie and alter records? My son had to undergo many additional tests and surgeries because of their deceit.

I would give anything to have my son back. In my eyes the doctors are replaceable. Don't let this happen to your family before you make the correct decision. Make it now. Doctors already have more protection than anyone else. Protect families. Reform insurance companies and hold bad doctors accountable. Do not continue to victimize those who have already lost so much. Make the right and only decision.

[The prepared statement of Ms. Glodowski appears as a submission for the record.]

Chairman HATCH. Thank you. We appreciate you taking time. Appreciate you bringing your son with you. Appreciate very much the pain and suffering you have gone through. Mr. Thronson? We will turn the time over to you.

STATEMENT OF CHARLES THRONSON, UTAH TRIAL LAWYERS ASSOCIATION

Mr. THRONSON. Thank you, Senator Hatch.

As many times as I have seen this, it is still hard for me to watch this video. And as many times as I have talked to Karla, it is still very difficult for me to hear the story again, even though I handled her case.

You just heard the heartbreaking stories of two of my clients. Unfortunately, these families were not alone in their tragedy. I have walls in my office full of photographs of people like Christopher and Donna. Preventable medical errors like those happen far too often in Utah and across the United States. In fact, a new study puts the number of people who die each year in the U.S. from preventable medical errors at 200,000 Americans a year, up from an earlier study by the Institutes of Medicine—not an attorney's group; the Institutes of Medicine—showing upwards of 90,000 dead, making medical mistakes the third leading cause of death in the nation, behind heart disease and cancer. This is the equivalent of two 747 crashes every day in this country. Every day of the year, year in and year out. And that does not include the hundreds of thousands who are injured like Christopher or Donna who are not killed outright.

The real crisis is not medical malpractice litigation. The real problem is medical malpractice. Overworked nurses, exhausted residents, fewer staff per patient, use of paraprofessionals, medication errors, and the list goes on and on.

When we talk about our healthcare system and how to make it better, and we talk about altering our time-tested justice system in which you have been a long-time part of, we would all be well advised to keep these people, these families at the front of our minds. Tell these people that their claims are frivolous and their lawsuits are junk.

I think we can all agree that if something like the catastrophic loss these two patients suffered happened to someone in our families, we would all want full justice and accountability. We would want a fair shake. We would want the specifics of the case to be heard by a jury of people like us. Our citizens, our neighbors, people who pay their taxes and vote. People who put up their flags and send their sons to fight for us. Ordinary people. Entrusted people. We wouldn't want some one-size fits all mandates from the Federal Government, putting a value on the life and suffering of a loved one no matter how shocking the case or horrifying the long-suffering.

Senator it is easy not to question the apocryphal stories of doctors begging on the streets because their malpractice insurance is too high. It's easy to latch onto a few highly publicized cases of justice gone awry, and I'm not denying that there are some cases where that's happened, although those are in the extreme minority. It is easy to accept urban legends as fact. In short, it becomes easy to lose sight of the real facts and the best interest of real people.

I'm going to ask you to consider a few statistics before you think about limiting the rights of those people who have been truly injured. First, contrary to the claims of those seeking what some call tort reforms, there in fact has been no explosion of lawsuits in liability cases generally or in medical malpractice cases specifically. The Department of Justice's Bureau of Justice statistics report the number of tort lawsuits decreased by 31.8 percent between 1992 and 2001. That word is "decreased" by 31.8 percent.

According to the National Center for State Courts, medical malpractice filings per capita decreased by 1 percent between 1998 and 2002 when this alleged crisis supposedly was occurring. And ac-

cording to the National Practitioner Databank, which requires all physicians to report a payment in a medical malpractice case, according to the Databank the number of malpractice payments dropped 7.7 percent from 2001 to 2002. And the Government Accounting Office calculates the total cost of malpractice litigation—that is when the claim is filed, the attorneys' fees, the defense costs, expert witnesses, trial, everything—is substantially less than 2 percent of all health care costs. A proverbial drop in the bucket. This is hardly an explosion or crisis.

Senator I find it interesting that there are no insurance company executives here today. It would be even more interesting to put them under oath like the Senate did with the tobacco executive industries and ask them why, when there is no evidence of a crisis or runaway juries, they increased liability premiums 30 to 60 percent in 1 year. Property and casualty insurance profits last year rose 900 percent. What a fantastic business. As an industry, you can increase premiums as much as you want for essential liability coverage; blame the increases solely on the people who have already been injured or killed, and of course on the attorneys who represent them; have your insureds, the doctors, accept this admittedly phony explanation lock, stock, and barrel; and have Congress and the various state legislatures rush through legislation to fix a problem that never existed in the first place, thereby guaranteeing your profits and hurting the injured people that the insurance you were selling was theoretically designed to help.

The bottom line is—and I have practiced in Utah for almost 30 years. There has never, ever been, in the state of Utah, a verdict in a malpractice case that can, by any stretch of the imagination, be called a runaway or excessive verdict. Ever in the state. And this is the same situation in most states. There are always some exceptions. Like we always say, "Yeah, but that's not Utah." And this is the same story in most states who are facing the same push by the insurance industry and medical lobbying.

The CBO, Congressional Budget Office, has found that recent increases in malpractice premiums are as much linked to market fluctuations and poor investments by insurance companies as they are to payouts and malpractice cases. And claims the doctors are leaving their practices in droves because malpractice premiums have not been substantiated.

You will see in Dr. Nelson's materials, he discusses a physician who has been well publicized in St. George who claims he had to leave his practice delivering babies. That physician has had a number of successful claims brought against him and he could no longer afford the insurance premiums because of his prior claims history. I don't see that to be a crisis, other than perhaps for him.

The Government Accounting Office investigated the situations in five states and reported problems and found mixed evidence. On the one hand, GAO confirmed instances of reduced access to emergency surgery and newborn delivery, albeit in scattered rural areas. On the other hand, it found that many reported reductions in supply by health care providers could not be substantiated or did not widely affect access to health care.

Utah has always had a problem attracting physicians to rural areas. Some cities, for instance, Gunnison, has set up their own

hospital and provided incentives to attract physicians down there. It's always been a concern.

The other issue is Utah medical insurance actively discourages family practice physicians from delivering babies. Why do they do that? Because the claims history for a family practice physician is much worse than board certified OB/GYNs. And I see Karac agrees with me on that point.

Health care providers already have more protections than any other profession in virtually every state of the country. In Utah, and I know you know this well, physicians have a very short statute of limitations in which a claim can be brought; protections on informed consent; a notice of intent requirement; a prelitigation screening process; requirements for qualified expert testimony before a physician can be held liable; and you have to have an expert to even get to a jury or you will be dismissed on summary judgment; caps on attorneys' fees that already exist in Utah, but only plaintiffs' attorneys are capped, not defense counsel. They can charge whatever they want. Not that you did. But they can.

Caps on general damages. We had a damage cap here. It was finally adjusted a couple years ago only for inflation from a $250,000 cap that was enacted in 1986. Cap on judgments against state-run health care facilities; no collateral source rule; and a provision that any judgment against a physician must be paid over time rather than as a lump sum, among other special interest protection.

You have heard about MICRA and the physicians touting what a success MICRA has been. Utah has most of the provisions that MICRA has, including caps on attorneys' fees. The one provision it doesn't have is a sliding scale attorneys' fees. And it is so interesting to me to hear a physician say, "What we really want to do is get more money to the injured people," while at the same time the same physicians are saying, "But we want to cap their damages, of course at 250,000." The real reason they want sliding scale attorneys' fees is to drive out of the practice qualified, experienced attorneys who have represented people in significant cases in the past, to make it economically impossible to continue. Because it is so expensive and so time-consuming to do these medical cases for free.

All of this evidence adds up to the conclusion that our medical liability system is hardly in crisis. The famous Harvard Medical School study of 30,000 patients in New York, 30,000 patient records selected at random, this is Harvard Medical School, has found in reality that in seven cases of actual medical malpractice, only one—for every seven cases, only one claim of medical malpractice litigation was ever filed.

Proposals to limit how much patients can receive as compensation for non-economic damages in cases of medical malpractice will not achieve their stated goal. Proponents of caps on non-economic damages say a Federal limit of $250,000 would stop frivolous lawsuits from being filed. But when a jury sees an error so serious that it justifies giving the victim more than $250,000 aside from lost wages and medical bills, that is, by definition, not a frivolous lawsuit. If your son or daughter ends up in a wheelchair for life because of a medical error, would you want a mandate from the Federal Government deciding what is fair in your case? Most

Americans trust a jury of people like their fellow American citizens to make a better decision concerning specific facts of the case.

Instead of limiting how much patients can be compensated when they suffer tragic losses, we ought to be trying to find ways to make our health care system better so that fewer mistakes are made. Solutions like requiring insurance companies to open their books to the public, and factually justify proposed high premium increases or mandatory reporting of medical errors or penalties for alteration or intentional destruction of medical records like we saw in the Glodowski case, and hospital systems and technology to reduce medical errors would all have far greater benefit to consumers than limiting access to the court system when an injury or death occurs.

And I urge you, as you continue your discussions, and I know you will keep an open mind about improving our health care system. And as you consider proposals to change the way our justice system handles medical negligence claims, I want you to hold on to one thought. Imagine yourself, if you can, and I know how sympathetic you are to this issue, in the shoes of Karla Glodowski or Donna Page. Imagine the pain they and their families have suffered, and ask yourself what is truly fair for catastrophic victims of medical negligence? What is truly best for preventing the errors in the future? And what is truly best not for insurance executives or the medical lobby, but for the long-term health of the people of the United States. Thank you.

[The prepared statement of Mr. Thronson appears as a submission for the record.]

Chairman HATCH. Thank you. I want to thank all three of you for testifying today. It is important that people hear both sides of these issues, and I have tried to do that. I particularly want to thank you, Ms. Page, and you, Mrs. Glodowski. And of course are appreciative of having you here, Mr. Thronson, because I know the trial lawyers take a lot of abuse, and they give a lot of abuse, too. I have seen it both ways. And as a trial lawyer myself, I know how important some of the work is that is done by plaintiffs' lawyers.

It takes a lot of courage for you folks to be here today and talk about your personal stories. It means a lot to me. And I'm truly grateful that both of you would share these experiences with us for the record. And both of you have my deepest sympathy for what you have gone through, and what you have to go through in the future. And I know this hasn't been easy for either of you to testify, but what you have done is important.

But I would like to pose a question to both of you, and I think it is a question that is a fair one. I have been a strong supporter of placing caps on non-economic damages except, and there's an exception, in the most egregious cases where there's true gross negligence. In my opinion, each of your cases would fit in that egregious category. I don't know all the facts and I can't definitively state that, or categorically state that as totally accurate. But I believe that.

Now, would you think that might be a way of solving this problem as you have heard the medical testimony here today, and I think they make a very good case that we are all losing because the system is out of whack, maybe both ways. But still out of

whack. But if your cases were truly—and I believe them to be—egregious cases, then if I had my way you would be able to get non-economic damages, substantial non-economic damages. Ms. Page?

Ms. PAGE. You know, this issue is so close to my heart that I don't think I could probably give you a really fair answer.

Chairman HATCH. That's fair.

Ms. PAGE. I couldn't ever see a cap.

Chairman HATCH. You would hate to ever see a cap in any way?

Ms. PAGE. That's right.

Chairman HATCH. But you will give some consideration of my attempt or desire to try and solve these problems.

Ms. PAGE. I thought what you said to the doctors was well said, and I saw their backs bristle. They weren't having any part of it.

Chairman HATCH. Keep in mind what they were saying is -and it's true—that if they had a cap situation a lot of people who don't recover today would recover. What I'm saying is, is the reality then in the truly bad cases like yours there would be no cap? Because there is a lot of data out here, a lot of cases brought that shouldn't be brought. There are some that should be brought that aren't brought. And there are some that should be brought that aren't brought where damages should be more than $250,000 or $350,000 or $500,000 or whatever the cap situation would be.

How do you feel about that, Ms. Glodowski? Assuming that you would have a right to recover all the necessary damages that in your case justifies them because it's an egregious case.

Ms. GLODOWSKI. I think that creates a problem, too, because who is going to decide who has been hurt enough to not be capped? And then you have another little grey area where—

Chairman HATCH. The same people who decide it today: The judges and the jurors.

Ms. GLODOWSKI. I personally don't think that—

Chairman HATCH. I'm not trying to put—

Ms. GLODOWSKI. Most of these malpractice cases are not even taken to trial. And then, because of the amount of insurance that these doctors had, we already basically were capped by the amount we could get. Because they were under-insured already. And then they took that as a starting point of what they could offer us and tried to talk us down. And I'm sure if it did go to court and we did get awarded more, they would have taken out bankruptcy and we would have lost anyway. So I don't see how they are going to help anything.

Chairman HATCH. Okay. Mr. Thronson, I respect you and respect the profession. I have been in your shoes. I started out as a defense lawyer. I understood how frightened defense lawyers can be and how difficult the job is. And I wound up doing both plaintiff and defense work. I have to say, I enjoyed the plaintiff's work much more than I enjoyed the defense work and I was remunerated much more. It's easier to—it's not easier to do but it is much more enjoyable in many respects. So I respect many plaintiffs' lawyers.

There's a lot of situations where I think the process is currently under abuse, and you know it and I know it. There are people in our profession who might not rise to the ethical level that you do who would do anything to make money. And I cite a particular area, an analysis done by top radiologists that a high percentage

of these asbestos cases brought by Plaintiffs' lawyers, a high percentage of the medical testimony that was given was fraudulent and false and that's what gives us all a bad reputation.

Let me just ask you this: Your position, as I understand it, is that the too high liability insurance premiums result from price gouging from insurance companies. Now, isn't it also true that here in Utah, many doctors participate in self- insured ways, in self-insurance pools. And we still have a $91,000 premium for a neurosurgeon who has never had a case brought against him, and there are a number in that category, which caused Dr. Rich to retire because at his time and age he didn't want to work full-time but couldn't afford to work or it wasn't worth the incentives to work part-time with that type of a high insurance payment.

So I guess what I'm saying is that even though he hasn't ever had a case brought against him, that didn't cause him to retire earlier. Wanting a higher quality of life probably caused him to retire and so forth. But my point is there's a significant number of Utah doctors who have participated in this self-insurance pool, so it isn't the insurance companies that are going to necessarily cost him the $91,000 price for neurosurgeons.

So what do you say to these doctors who are in this insurance pool, who are like Dr. Rich, and more importantly to the patients or to other doctors who are retiring because they can't afford the premiums? What do we say to them? I would like to see the very best people stay in the profession as long as they can do a good job. And I know Dr. Rich and I know that nobody did a better job.

Mr. THRONSON. Right. Let me address the issue, if I could, about Utah medical insurance, which is the Mutual Company owned and started by physicians, and it insures about 80 percent of physicians in the state of Utah.

They are insured—they provide insurance up to about $300,000 for a claim. And most, as I understand it, most of UMIA's investments are in bonds, they really aren't in the stock market. They are a very conservative company and they have a lot of investments, a lot of money stashed away. But then they go to the market and get reinsurance. And so they buy it from Lloyds of London or some of these AIG, some of these reinsurance companies. And that's where the premium increases come from. It is because UMIA is being charged high prices by these reinsurance companies.

Now, I'm a consumer of medical services. Dr. Nelson delivered three of my children. I don't want people like Dr. Nelson to leave the practice. It seems to me that if there could be some kind of insurance reform which, by the way, nothing happened in insurance rates in California under MICRA until the California legislature adopted insurance reform and forced the insurance companies to identify and justify, just like utilities have to do and others—

Chairman HATCH. Also understand there's a number of insurance companies that won't go to California because they don't think they can make a decent enough profit. So those that were lost in California, some have stayed and some have left.

Mr. THRONSON. That's true. But as we have heard, the insurance situation is relatively stable in California, but primarily in terms of the insurance thing, because the state looks over the books and says, "Okay, this is justified," or, "This isn't."

Now, I don't think it is justified to have a physician like Dr. Rich have to pay $91,000 who has never had a claim against him. Why they charge him that, I don't have any idea. But there are physicians who have had multiple cases against them who probably should pay that.

Chairman HATCH. Well, they charged him that because they presume some day he will have a claim against him because he is a neurosurgeon and there may be more than one claim. And some of the claims, as you and I both know, are frivolous. Some aren't. I certainly think these two cases are not, certainly. But some are. And I have to admit, as somebody who defended some of these cases, I saw cases brought that should never have been brought. And they were brought because the insurance company, where there was insurance, or the doctor, where there wasn't, couldn't afford to take a risk in front of a jury that might run away or might be influenced by emotions that might cause an unfair verdict.

Mr. THRONSON. Well, since you practiced and since that time, Utah has adopted all those short form measures. We have a prelitigation screening panel, we all have the tort reform gamut.

Now, I'm not saying, and I would never say, that there aren't cases that shouldn't be brought. There are cases that shouldn't be brought in every genre of litigation.

One suggestion I have, which I haven't heard before, is I would not be opposed to having a certification process for trial attorneys who practice in medical malpractice. It is so specialized an area that I think that if there was a state requirement here or national requirement to have attorneys who decide to practice in the area, plaintiff and defense, be certified and go through some sort of screening process and scheduling and classroom work, experiential level and so forth. To the extent that there are unskilled practitioners out there, it might solve the problem.

I know what you are talking about with asbestos. It is a problem that there is junk science going on there. But in these cases, even though oftentimes defendants will say, "Well, even in Karla's case they are still denying what happened." It's interesting.

Chairman HATCH. And there's both sides to these cases, too. You take, you know, this attitude that women should have babies by Cesarean because it might prevent cerebral palsy. You know that is junk science and I know it's junk science. And yet millions and millions of dollars have been recovered by some doctors who testified because that's their profession, who come in and say, "That is not junk science." And because they have a medical degree, the courts accept them as experts in the field. Just like these radiologists who are certifying some aspect of asbestosis even though there is not the slightest indication of it. And yet in all of those cases there's been recovery because of false testimony by some of these doctors who testify.

Mr. THRONSON. You are talking about Utah jurors and Kansas jurors and Missouri jurors and North Dakota jurors. If some guy comes in—

Chairman HATCH. I agree with you. I think in Utah we have a much fairer situation. If you go to Madison County, Illinois it's a much different situation.

Mr. THRONSON. Or some place in Alabama. If you get some guy that comes in—

Chairman HATCH. And that's not the only jurisdiction, as you know.

Mr. THRONSON. —with white shoes and sunglasses and says, "This is how this baby got injured," they would be decimated by the highly qualified defense attorneys in town. Bruce Jensen, Elliott Williams, those guys that would come in. The guy would be thrown out of court and run out of town. You have to give some faith, I think, to the jury system to do the right thing.

Chairman HATCH. I did have faith in it. As someone who tried many jury trials, I have faith in it. And certainly in an area like Utah where the people are practical and it's plausible and so forth, and where I think the Bar, by and large, is responsible, like yourself.

I'm just concerned, and I think you should be concerned, that our whole profession gets a black eye because of some of the situations throughout the country where attorneys exploit that and junk science is used. Sometimes it doesn't even rise to the level of junk science. And you know that and I know that. And I guess what I'm saying is that—and I agree, Utah has had a number of reforms with respect to the past. Many were adopted in recent years such as the cap of $400,000, which is adjusted for inflation in Utah, index for inflation. Prelitigation training process, some or all of which you have mentioned.

There's no question, and Dr. Nelson testified that the medical malpractice premiums have risen more slowly in states that have had some measure of tort reform or some measure of this type of reform where states have instituted some measure of non-economic caps and other tort reform measures.

I had problems in this area because when I see an egregious case, a wrong eye, wrong leg, and these two here, let me just say in cases I have personally seen, these cases were not handled by bad physicians. They were terrific physicians who just made mistakes, but they were egregious mistakes. And I don't think a cap of $250,000 or even $400,000 in those cases or these cases is adequate.

On the other hand, you and I both know that you can, through expert testimony, prove an awful lot of damages in the economic phase of it. And good attorneys are going to get reasonable results even with tort reform. What's wrong is we have some who aren't good attorneys, who aren't honest attorneys, who are giving all of us a bad name and doing it just for money. And that's the only thing I'm concerned about. If I had a magic wand and I could wave it and solve all the problems, I would do it. I appreciate any help you can give me in this area.

I personally want to express my sympathy and deep feelings for you two women and your families. It took courage to be here today. I'm personally grateful you are here and took time to be here. Let's work together and see what we can do to resolve the conflicts. I don't think it helps the profession or most people who are injured to have people who—and I kind of agree with your idea about specialties in this field, that people ought to have to qualify, to be people of integrity who do those type of lawsuits. And I think it would

help everybody and the verdicts would be higher, too, in the areas where they are justified. You wanted to say one other thing?

Mr. THRONSON. I just wanted to comment on the cap issue you asked about. I think Karla is right. Most cases, probably 95 percent of my cases settle, and I think that's close to what the average is. But what happens when we get to mediation or some sort of settlement conference is the Defendants say, "Well, look, $250,000," or Donna's case, it was $250,000 at the time. That's all the jury can award you so that's the number, and then we will negotiate down from that. So it becomes a hammer.

Chairman HATCH. Sure.

Mr. THRONSON. I can go in and say in Karla's case or Donna's case, this is an egregious case and they will say, "No, it's not." And so where do we go from there? I mean, I think we would be very willing to continue the dialogue and look at any of those things, but I think you have identified a significant area and that is this one-size-fits-all idea for a cap doesn't fit all people.

Chairman HATCH. Well, I agree with that. And the one-size-fits-all idea does help millions more who will never get help. It may be helpful but it still doesn't justify these type of cases, I have to admit.

Let me just say I have tried to solve these problems like the asbestos problem. We all know that the high percentage of those cases really should never have been brought. They are hurting the whole legal profession and we all know that everybody in society is paying the cost. Settling companies are already bankrupt, and these are the companies where the mesothelioma cases really were, where people are going to die. They get a nickel and a dollar from those cases, and some of the other cases that are brought are just fraudulent, to be honest with you. And some day, I'm worried that some day the whole legal profession, the Plaintiffs' lawyers are going to get sued because of the undignified and unrighteous acts of those who aren't as honest.

In this particular area I have seen very egregious faults on both sides. I have seen attorneys who have brought in doctors who will say anything they want them to say. Not honest doctors. I have seen patients who had bad results where the doctors have done everything they possibly could and get huge verdicts because of some of the fraudulent testimony. But I have also seen folks like these who have not been compensated fairly and I don't like that, either. And I wish I was an oracle and had the ability to solve problems with snapping my finger. I work at it and try to solve it but I need your help and I need the help of the first panel who have been very helpful in many respects. And we will have to keep working on it and see what we can do. But I want it to be right and I want it to be fair.

Let me just close by saying after listening to today's testimony, in my opinion I think we all have the same goal. The system that we all desire is one that leaves no injured person who has really truly been injured without remedy, but at the same time does not have a devastating impact on those who have dedicated their lives in caring for others such as physicians and other health care professionals, and society at large.

There needs to be some appropriate balance and all of us involved in this discussion—patients, physicians, and other health care providers, state officials, members of Congress, members of the legal profession—we need to work together and try and find some balance in these particular areas so that people who deserve compensation really are. People who don't really aren't.

So I want to thank all of our witnesses for traveling here today to present the Committee with compelling and thoughtful testimony. Both panels have been excellent. I believe the medical liability crisis is one that has to be addressed and I believe that we have heard some interesting ideas on how these matters may be addressed.

And before I close this hearing I would just say we will include the written testimony of the Utah Trial Lawyers Association and the Utah Citizens Alliance, and it will be made a part of the record. The hearing record will be kept open for two weeks so the members of the Committee may submit statements, and we will do everything we can to try to resolve these matters in a way that is fair, decent, honorable, and above board.

In that regard, I want to thank every witness who has testified here today. Everyone has done a good job. Everyone has been important. And both sides of this issue have been explained to the degree that we can in this limited hearing. And I will just keep working on and hope that we can do justice in the end, which is what all of us who are honest really hope can be done. And I want to thank every witness for being here. Thanks so much. And with that we are recessed until further notice. Thank you.

[Whereupon, at 12:30 p.m., the Committee was adjourned.]

[Submissions for the record follow.]

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30, August 2004

The United States Senate
Senate Judiciary Committee
Washington, District of Columbia

Re: The Medical Liability Crisis and Its Impact on Patient Care
Field Office Hearing of 08/20/04 – Salt Lake City

Dear Senators:

I attended the 08/20 hearing at the Huntsman Cancer Center chaired by Senator Orrin Hatch.

At the hearing, Senator Hatch proposed a "solution" to those victims of medical malpractice whose injuries resulted from gross negligence. He related that he would advocate legislation that would have a provision that would vacate the Cap on pain and suffering damages when there was particularly egregious malpractice/misconduct. I believe in some limited instances that would be an excellent approach but in most instances it would miss the mark.

Oftentimes, the simplest negligence can cause tremendous pain and suffering. That is, in some situations, gross negligence or even intentional misconduct can cause life-long suffering but suffering that the damage Cap could appropriately cover. But, all too often the simplest mistake will generate injuries that cause excruciating daily pain forever. Unfortunately, the proposed Cap would not provide adequate compensation for such horrific, life-long pain and suffering. Accordingly, I believe the proposed legislation is fatally defective.

Consider that twelve men and women off the streets in Utah, Maryland, Oregon or Texas become a jury and hear malpractice cases on a weekly basis. They swear to be fair to both sides, they swear to be serious and independent to their jury duties. Then, after having heard all the evidence on the injuries and damages, these twelve men and women collectively blessed with twelve life experiences, armed with having experienced some degree of pain in their lives,

possessed of hands-on knowledge in caring for a sickly loved one and touched with an empathy or understanding for the victim's daily suffering, put a price on that daily suffering. With their hundreds of years of life experiences, they collectively argue and then agree to what the twelve believe to be fair and just compensation for the plaintiff-victim's ongoing pain and suffering. That thoughtful, informed evaluation is priceless. That American tradition is sacred.

A Cap deprives all victims of malpractice of having the strangers in their community carefully decide their fate. A Cap deprives the victims of malpractice from having their fate decided by the housewife, the school teacher, the bookkeeper, the auto mechanic, the carpenter, the fork-lift driver, the nurse, the accountant, the truck driver, the secretary, and the produce man, etc. A Cap deprives the victims of medical malpractice from the thoughtful consideration of America's citizen juries.

Thank you, Senators and Senator Hatch for your willingness to listen. Thank you your time, consideration and efforts surrounding this issue which is so vitally important to so many Americans presently and to hundreds of thousands, even millions of Americans in the future. I trust you recognize that damage Caps are not the answer.

I remain,

Very truly yours;

JOHN F. FAY

AUGUST 20, 2004

MEDICAL MALPRACTICE HEARING

BEFORE THE
SENATE COMMITTEE ON THE JUDICIARY

STATEMENT OF
MS. CARLA GLODOWSKI

On July 5th 2002, my sixteen-month-old son, Christopher Karac Glodowski stuck his finger in my eldest daughter's bike chain. She was unaware that it was there, and the tip to the first joint was cut off. We rushed him to the hospital, and were told that he was a good candidate for replantation. We decided to have the medical team attempt reattachment.

Due to the lack of professionalism and inattentiveness of the doctors, my son was allowed to suffer a bronchial spasm to the point of severe oxygen depravation. He went into cardiac arrest and had to be revived with chest compressions and finally epinephrine. After this occurred, the medical team chose not to tell me what had happened to my son. They did not give me the choice to end an elective surgery to explore why my healthy son was responding in this way. They continued with the surgery, and they took away my right as his parent.

Karac did not come out of the operation with the appropriate responses. He was unable to awaken, and could not breathe on his own. He had to be life-flighted to Primary Children's Medical Center. He was subjected to a battery of tests to determine why he was responding abnormally. Some of the tests included aids, blood tests for genetic disorders, MRI and an additional surgery for a muscle and skin biopsy.

The second MRT showed that he had suffered a severe anoxic brain injury. His body had gone too long without oxygen. He would never be normal again!

Later as experts were hired, and depositions were taken, we finally began to receive the truth about what happened to Karac. He has asthma, and has a more sensitive airway than someone who doesn't. When he was intibated he had a bronchial spasm. It was not treated right away with epinephrine. In fact, this medication was given last. He was allowed to cascade downward until he had a heart rate of twenty, and no blood pressure.

An independent hand-writing expert had to be hired to prove that Karac's charts were altered to look like he wasn't in distress as long as he was. The charting has two periods in which nothing was charted. Karac was dying, and the entire room of medical personnel was allowing it to happen. The very people that swore under oath that patient safety was their primary concern denied having any responsibility.

I have not worked since this happened to my son. My employer was not supportive, and I was forced to quit my job. Due to the fact that I made a majority of our family's income, we began to suffer severe financial difficulties. On November tenth 2003, we settled our case out of court for an undisclosed amount. I did not want to settle, but due to our situation it was the only way to guarantee that Karac would get money to care for him for the rest of his life.

In settling with the other parties involved, we had to agree not to mention the names of medical personnel involved or the medical facility where it occurred. In essence, I feel we now have to protect them and their identities when they should have protected my innocent son instead. In protecting their names, I have learned from their co-workers that they still do not show remorse or acknowledge guilt. In fact they are stating that my son came into that hospital in the condition he is in now.

I would like to tell you more about my son Christopher Karac, and the incomprehensible effect this has had on my entire family. We call him either Bubba or Karac. My husband named Karac after Robert Plant's son. Robert Plant was a member of the rock group Led Zeppelin. His son died at the age of five of a mysterious virus. Robert Plant co-wrote the song "All of My Love" as a way to overcome his grief. This song has come to mean a lot to myself as well. Although my son is still alive, on July fifth 2002 the medical personnel that operated on my son killed the boy he was supposed to grow up to be and left a hurt and damaged shell.

Prior to July fifth, Karac was full of energy. He loved to play catch, interacting with his sisters, and eating. He was quick to laugh and smile and was full of life. Now he is quadriplegic, and suffers from cortical blindness. He cannot eat normally and must receive his nutrition through a tube in his stomach. He has a baclofen pump implanted under his skin with a catheter threaded into his spinal cord. This mechanism delivers a constant supply of medication to his body to help control muscle contractions. He also suffers from high blood pressure, reflux, irritability and difficulty sleeping. The quality of Karac's life has been horribly altered. He has been committed to a life of pain and frustration. A few of the things not taken from him are his smile, laugh, his love for his family, and music. Ironically, his favorite music is Led Zeppelin.

This has also had an acute effect on my daughters. My oldest daughter, Kielee, still displays problems with guilt. She wants to know when Karac's finger is going to grow back. She wants to know when he is going to get better and walk and talk. She has moments when she will become thoughtful. When I ask her what is wrong, she'll cry and tell me she will never hurt Bubba again. She is unable to separate the accident with the bike and the monstrosity that actually happened at the hospital. They are linked together in her mind.

Kiera is five, and she is just learning to read. She was eating a piece of Laffy Taffy in the car, and she read me the joke: "What has two legs, but can't walk?" I thought about it for a moment, but did not come up with an answer. Kiera came up with

her own answer and said "Bubba." I started to cry and could not drive through my tears. I do not know what the true answer was, but her answer is forever burned into my mind.

My husband has lost his namesake and his baseball partner. He has quietly dealt with what has happened to Bubba. He has been forced to continue to work in a dead-end job because we have to keep medical insurance. When he does break down, he tells me that he let Bubba down. He was supposed to protect him and not let anything bad happen to him.

As for myself, I despise the person who coined the cliché "time heals all wounds." I know that I will not live long enough to heal. To this day, I still cannot talk about what happened to Bubba without breaking down. The day that Bubba's finger was cut off I was trimming the rose bushes around our house. I remember thinking that the shears were sharp, and I needed to put them away properly so that the kids wouldn't cut themselves. At that point I heard Chris yelling. I believe God was trying to tell me something was going to happen, but I didn't listen.

We recently found out we are going to have a new little boy in September. This should have been an extremely happy time for all of us, but I couldn't help crying. I kept wondering if this was a way to replace Bubba, and somehow get raising him right this time. It is so hard to be happy when I'm worried all the time. I am worried about dying before Karac, having my son die before myself, and being physically unfit to care for him. I stress about the girls being emotionally scarred. I am concerned about not spending enough time with the girls. I do not want them to resent Bubba. It also saddens me to know that every Saturday our family time includes everyone, but Bubba. He is left home with a nurse. Our family has been destroyed.

The money we received in this settlement has done nothing to help put our family back together, but it has taken away the financial burden. I have been able to purchase additional therapy equipment, receive additional therapies, and it will help ensure that Karac will have the best quality of life possible.

I cannot fathom the thought of anyone thinking that putting a cap on the amount awarded to families who have been victimized by malpractice will solve anything. In my eyes it is an attempt to victimize the innocent even further. My son's life did not come with any dollar signs attached. Although he wasn't important to those who operated on him on July fifth, he is important to me, and cannot be replaced.

Damage caps only hurt the people who are the most injured. Our claim was not frivolous or a "junk" lawsuit. The only "junk" in this case was the quality of the medical care Karac received. I want those of you who are voting on this topic to consider how you would vote if this was your son. Should you protect innocent babies like Karac, or doctors that lie and alter records? My son had to undergo many additional tests and surgeries because of their deceit. I would give anything to have my son back. In my eyes the doctors are replaceable. Don't let this happen to your family before you make the correct decision--make it now. Doctors already have more protections than anyone else.

Protect families! Reform insurance companies, and hold bad doctors accountable. Do not continue to victimize those who have already lost so much. Make the right and only decision!

Senate Judiciary Committee
The Medical Liability Crisis and Its Impact on Patient Care

August 20th, 2004 @ HCI Auditorium, 10am-12pm

Steven Granger, MD
Resident Invitee

I am in my 4th year as a resident in General Surgery here at the University of Utah.

I chose a career in medicine as an undergraduate because of my interest in the sciences and a naïve desire to be involved in the healing process. I did not have a personal or family background in healthcare or law. At the time of this early decision, medical malpractice was little more than a bad commercial to me. Through four years of medical school and four years of Residency - this naïve view of malpractice issues could not have changed more dramatically.

Unfortunately, I believe, most medical students now consider the effects of malpractice in choosing a medical specialty. Students who are particularly adept at Surgery or Obstetrics are consciously deciding to pursue an alternative specialty solely because they want to avoid the perceived devastating effects of our countries malpractice crisis. Four years of undergraduate studies, followed by four years of medical school, and then by 3-7 years of residency is a significant commitment and students are unwilling to enter specialties where they perceive they will be thrown to the wolves.

A study published in 1998 out of the University of North Carolina showed that perceived malpractice premiums had a negative relation to medical students choosing a surgical specialty [1]. It is probably safe to say that since 1998 this influence has only grown as medical trainees continue to see no significant realized changes in this system.

The few of us that still hold to the naïve notion that we can practice in these threatened specialties have our eyes further opened when we enter residency. As Residents, we are protected from almost all of the business & insurance aspects of healthcare. We have minimal to no exposure with reimbursements, business decisions, and malpractice insurance. We do not act independently, and therefore we are protected from lawsuits while in residency. Even in the currently hostile environment of healthcare, our education continues to focus on the proper compassionate care of the patient.

Yet, despite this protective environment, we see and feel the overpowering influence that the current medical liability environment has on patient care and our individual practice decisions. Two surgical residents from my small class of five ended their surgical training after one year. They both clearly stated their desire to enter an alternative non-surgical specialty. They did not want to work as hard as surgery demands during residency and beyond, only to find themselves caught in the middle of a broken system. I remember well conversations with these two residents where they questioned my sanity to stay in a specialty that works this hard only to have more risk. (No businessman or executive would choose to enter into an environment that guarantees higher risk for less pay). A survey conducted in 2003 of residents in their final year of training, residents who should be excited about the prospects of finally venturing off on their

careers, showed that 1 in 4 would choose a different vocation altogether if they could start over, and that their predominate concern was related to malpractice. [4]

Residents, upon completion of their training, are choosing subspecialties and practice characteristics that will minimize the pitfalls of medical liability. The effects of the career choices being made now will only worsen the crisis as it relates to access to care. Under the current environment there will continue to be fewer medical students choosing "at risk" specialties and there will be fewer residents already in those specialties who will choose to include in their practice the procedures and patient populations that are higher risk. Adding, to the already described problem of more physicians in high risk fields retiring, dropping aspects of their practice including emergency and on-call services [2], and moving from communities where malpractice insurance is prohibitive.

Physicians have been charged with the care of the sick, whether friend or enemy. Historically, media portrayals such as MASH depicted the physician as a patient advocate, often at great personal or professional costs. It is under this environment that we are still trained today. Compassionate, quality patient care is our highest priority. Interestingly, in June of this year at a national American Medical Association (AMA) meeting a motion was proposed and debated – about whether medical treatment should be refused to malpractice lawyers [3]. This motion seems comical to me and it was widely shunned at the AMA meeting, but it does depict the nature of our current environment. Imagine the new medical student creed - We will care for our patients, friends, enemies, terrorists, but not malpractice lawyers. One interesting statistic compares the number of lawsuits from 1960 to today - "Before 1960, only one of every 7 physicians was sued during their careers. Current estimates indicate that 1 of 7 physicians is sued every year." [4]

From a medical student and resident perspective, this environment is very discouraging. My training emphasizes competent, compassionate care of each patient - every interaction of every day is about how I can better care for my patients, often at great personal sacrifice. This is all that I am exposed too as a resident. This is all that I want to do – that is to spend my professional life caring for patients.

Difficult problems rarely have simple solutions. However, the difficulty of the solution should not prohibit aggressive efforts at a multifaceted solution. It seems likely that tort reform, damage limitations, and insurance reform should all be addressed in a sincere balanced effort at healing a broken system. The far reaching benefits of more accessible and affordable healthcare cannot be overstated.

Fortunately, for the physician and patient, medicine can still be about patient care, but I fear that under the current medical liability environment this altruism will be more impossible with every passing medical school class.

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NEWS RELEASE

ORRIN HATCH

United States Senator for Utah

Statement of Senator Orrin G. Hatch
Senate Judiciary Committee Hearing
On the Medical Liability Crisis
August 20, 2004

Today's hearing will address the medical liability and litigation crisis in our country, a scourge that is preventing patients from receiving high quality health care or, in some cases, any care at all, as physicians are driven from practice. This liability crisis not only robs many patients of access to vital medical care, but needlessly raises health costs for every American.

My colleagues and I have worked hard in the Senate to find a remedy for the crisis ravaging our health care system. Most recently, the Senate debated S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act of 2003 and S. 2207, the Pregnancy and Traumatic Care Access Protection Act of 2004.

S. 2061 addressed obstetrical and gynecological care and would hold physicians and insurers accountable for medical expenses in instances where they are clearly wrong. The legislation established a period of three years from the date of injury for a person to bring a claim, with exceptions in cases involving minors. The bill also would allow for unlimited awards of economic damages, while placing reasonable caps on non-economic damages, or pain and suffering.

Economic damages are payment of past and future medical expenses and loss of earnings, as well as the cost of having services in the home to assist someone who has been injured or incapacitated from a negligent act. S. 2061 placed no limit on these awards.

Of course, damages meant to compensate for physical and emotional pain and suffering are not easily quantified. S. 2061 would cap awards for these damages at $250,000, in addition to economic damages. Very often, juries award plaintiffs millions of dollars just to punish a defendant, not necessarily to compensate for what is an intangible loss. S. 2061 would also fix contingency

fees to ensure that patients with valid claims do not see their awards siphoned away by attorneys. The bill would allow lawyers to recoup fees and make a profit, but not at the unfair expense of the injured plaintiff.

The other bill debated by the Senate this year, S. 2207, was similar to S. 2061 in that it caps non-economic damages at $250,000 but leaves economic damages uncapped. The primary difference between S. 2207 and S. 2061 is that S. 2207 provides relief to two specialties -- OB/GYNs and emergency or trauma physicians. It was limited to highlight two of the most high-risk and egregiously affected practice areas in our health care system.

Unfortunately, both bills failed to receive the 60 votes necessary to invoke cloture in the Senate earlier this year. Since the House of Representatives approved legislation at the beginning of the 108th Congress, it now appears that Senate inaction may derail reform and allow this liability crisis to continue unabated.

To me, it is unconscionable that physicians are being driven from practice, and as a result, patients are denied access to quality health care. According to the Utah Medical Association, liability insurance rates for most Utah physicians increased by 55 percent or more in the last two years for some specialties. For example, those Utah physicians practicing obstetrics and gynecology have to deliver about 60 babies a year just to cover the standard insurance rate in 2003 of $71,000. 2004 insurance rates are now more than $81,000 for some OB/GYN physicians. A 2003 survey showed that 25 percent of Utah's OB-GYNs intend to stop delivering babies within the next five years. And medical liability insurance premiums for Utah physicians continue to rise and increase pressures on physicians to restrict services in Utah. Premiums rose by 30 percent in 2002, 20 percent in 2003, and a 15 percent increase is expected in 2004.

I am deeply concerned that we are needlessly compromising patient safety and quality health care. We know that only about 4 percent of hospitalizations involve an adverse event and only one percent of hospitalizations involve an injury that would be considered negligent in court. These numbers have been consistent in large studies done in New York, California, Colorado and here in Utah. However, equally troubling is that only 2 percent of cases with actual negligent injuries result in claims, and less than one fifth of claims filed actually involve a negligent injury. We simply must do something to correct these imbalances.

The problem is particularly acute for women who need obstetrical and gynecologic care because OB/GYN is among the top three specialties with the

highest professional liability insurance premiums --- the other two are neurosurgery and orthopedic surgery.

Today, there are 36 members of the Utah Neurosurgical Society and currently, there 27 neurosurgeons practicing in Utah. Not all of these physicians are willing to cover high risk practice environment such as emergency rooms and trauma services. According the American Association of Neurological Surgeons (AANS), Utah is one of 24 states designated as "severe crisis" states based on either a 50% increase in professional liability insurance premiums from 2000 to 2002 or an average of neurosurgical professional liability insurance premiums over $100,000. This dubious honor for Utah citizens has affected their access to neurosurgical care.

Studies by both the Utah Medical Association and the Utah Chapter of the American College of Obstetricians and Gynecologists (ACOG) underscore the problem in Utah. Over half, 50.5 percent, of family practitioners in Utah have already given up obstetrical services or never practiced obstetrics. Of the remaining 49.5 percent who still deliver babies, 32.7 percent say they plan to stop providing obstetrical services within the next decade. These and other changes in practice leave nearly 1,500 pregnant Utahns without OB/GYN care.

An August 2003 General Accounting Office report concluded that actions taken by health providers as a result of skyrocketing malpractice premiums have contributed to health care access problems. These problems included reduced access to hospital-based services for deliveries, especially in rural areas.

In addition, the report indicated that states that have enacted tort reform laws with caps on non-economic damages have slower growth rates in medical malpractice premiums and claims payments. From 2001 to 2002, the average premiums for medical malpractice insurance increased about 10 percent in states with such caps. In comparison, states with more limited reforms experienced an increase of 29 percent in medical malpractice premiums.

Medical liability litigation *directly and dramatically* increases health care costs for all Americans. In addition, skyrocketing medical litigation costs *indirectly* increase health care costs by changing the way doctors practice medicine.

Defensive medicine is defined as medical care that is primarily or solely motivated by fear of malpractice claims and not by the patient's medical condition. According to a survey of 1,800 doctors published in the journal, *Medical Economics*,

more than three fourths of doctors felt they must practice defensive medicine. A 1998 study of defensive medicine by Dr. Mark McClellan showed that medical liability reform had the potential to reduce defensive medicine expenditures by 69 to 124 billion dollars in 2001.

The financial toll of defensive medicine is great, and is especially significant for reform purposes, since it does not produce any health benefits. Not only does defensive medicine increase health care costs, it also puts Americans at avoidable risk.

Nearly every test and every treatment has possible side effects. Thus, every unnecessary test, procedure, and treatment potentially puts a patient in harm's way. Seventy-six percent of physicians are concerned that malpractice litigation has hurt their ability to provide quality care to patients.

There is plenty that can be done to address this crisis. Last March, the Department of Health and Human Services released a report describing how reasonable reforms in some states have reduced health care costs and improved access to and quality of care. For example, over the last two years, in states with limits of $250,000 to $350,000 on non-economic damages, premiums have increased at an average of just 18 percent compared to 45 percent in states without such limits.

California enacted the Medical Injury Compensation Reform Act, also known as MICRA, more than a quarter century ago. MICRA slowed the rate of increase in medical liability premiums dramatically without negatively affecting the quality of health care received by the state's residents. As a result, doctors are not leaving California.

Furthermore, between 1976 and 2000, premiums increased by 167 percent in California while they increased 505 percent in the rest of the country. Consequently, Californians were saved billions of dollars in health care costs and federal taxpayers were saved billions of dollars in the Medicare and Medicaid programs.

Before coming to Congress, I litigated several medical liability cases. I have seen heart-wrenching cases in which mistakes were made. But, more often, I have seen heart-wrenching cases in which mistakes were *not* made and doctors were forced to expend valuable time and resources defending themselves against frivolous lawsuits.

A recent Institute of Medicine report, To Err is Human, concluded that "the majority of medical errors do not result from individual recklessness or the actions of a particular group—this is not a 'bad apple' problem. More commonly, errors are caused

by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them."

We need reform to improve the health care systems and processes that allow errors to occur, and to better identify when malpractice has not occurred.

The reform that I envision would address litigation abuses in order to provide swift and appropriate compensation for malpractice victims, redress for serious problems, and to ensure that medical liability costs do not prevent patients from accessing the care they need. And so, I believe that Congress must move forward with legislation to improve patient safety and reduce medical errors.

Without tort reforms, juries will continue to award large and often unreasonable sums for pain and suffering. And a sizable portion of those awards will continue to go to the attorney rather than the patient. The end result is that many doctors cannot get insurance and many patients cannot get the care they need and a small group of lawyers are sometimes unfairly enriched to the detriment of our society. All Americans deserve the access to care, the cost savings and the legal protections that states like California provide their residents. We must begin to address this crisis in our health care system, so Utahns and citizens across the country have continued access to their doctors and doctors can provide high-quality cost-effective medical care.

Finally, I want to thank our witnesses for taking time out of their busy schedules to join us here today. We all look forward to hearing your valuable insights on this ongoing crisis.

I also want to acknowledge some of our friends in the audience who will be submitting written testimony on this important issue, especially Doug Mortenson, who is the President of the Utah Trial Lawyers Association. Accompanying Mr. Mortenson are Mr. Ed Havas, the Immediate Past President of the Utah Trial Lawyers Association; and Mr. Joel Alred, the President-Elect of the Utah Trial Lawyers Association. I also would like to acknowledge Ms. LaRee Miller, who is the Executive Director of the Utah Citizens Alliance. Ms. Miller is also submitting written testimony for this hearing.

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Testimony of Edward B. Havas
Past President of the Utah Trial Lawyers Association

Submitted to the Senate Judiciary Committee regarding the August 20, 2004 Field Hearing "The Medical Liability Crisis and its Impact on Patient Care"

The typical debate over "tort reform" and the "medical liability crisis" pits doctors against lawyers. Doctors understandably bemoan large increases in medical malpractice insurance premiums, incorrectly blaming those increases on trial lawyers. Framing the debate this way misses the true root of the problem, lays blame at the wrong place, engenders animosity and alienation between the professions, and leads to further limits on the rights of seriously injured patients to be treated fairly and compensated for losses from avoidable medical errors.

To really address the increases in malpractice premiums of the magnitude we have seen recently, we must look not to limiting rights of patients but to closer scrutiny and regulation of the insurance industry responsible for this "crisis."

The vast majority of doctors are commendable, hard-working professionals who make great sacrifices and deserve to be handsomely paid for their work -- and they are. These good doctors are understandably protective of other doctors, yet they also agree that patients ought to be properly compensated when a doctor's negligence results in serious injury to a patient. According to an analysis of federal data, 5.4% of doctors are responsible for more than 56% of all malpractice case filings.[i] In fact, eighty-three percent of doctors have never made a medical malpractice payout since the National Practitioners Database was created in 1990.[ii]

Given these facts, we can readily understand why good, reliable doctors would be angered and frustrated by the recent, seemingly arbitrary increases in their malpractice premiums. For that matter, lawyers and other professionals have, like doctors, seen their malpractice premiums go up dramatically in past years, and are equally concerned and frustrated.

Lawsuits are not the cause of premium increases

It is misleading, wrong, and counterproductive to blame medical malpractice liability premium increases on an explosion of lawsuits. Those allegations are simply contradicted by the facts:

- The Department of Justice's Bureau of Justice Statistics reports that the number of tort lawsuits *decreased* by 31.8% between 1992 and 2001.
- According to the National Center for State Courts, medical malpractice filings per capita *decreased* between 1998 and 2002.
- According to the National Practitioner Databank, to which all medical malpractice payments must be reported, the number of malpractice payments *dropped* 7.7% from 2001 to 2002.

- A recent study analyzing medical malpractice payouts over the last 30 years demonstrates that payouts in legal proceedings have tracked medical inflation closely. However, malpractice insurance premiums have fluctuated wildly, moving up and down with the economy, interest rates, and insurance companies' investment returns.[iii]

Given these facts, any objective person would ask: "If lawsuits have decreased and payouts have matched inflation, why have premiums skyrocketed?"

The answer must focus on the insurance industry, a focus that the industry would rather avoid. Questionable business practices, stock market losses, creative accounting, lax underwriting standards, and of course a desire to maximize profits have all contributed to the insurance industry raising malpractice premiums dramatically.

On June 24, 2002 the *Wall Street Journal* detailed some of the questionable business practices that led the insurance industry into difficulty:

> *"Following a cycle that recurs in many parts of the business, a price war [among insurance companies] that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims. Some of these carriers had rushed into malpractice coverage, because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year.* ***'I don't like to hear insurance-company executives say it's the tort [injury-law] system -- it's self-inflicted,'*** *says Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California." (Emphasis added).*

Even the Congressional Budget Office has found that recent increases in malpractice premiums are as much linked to market fluctuations and poor investments by insurance companies as they are to payouts in malpractice cases.[iv]

"Tort reform" is not the solution

With doctors justifiably angered about premium increases, the insurance industry has attempted to shift the blame from itself to trial lawyers and the patients they represent in medical negligence cases. By proposing tort reform and blaming the easy scapegoat of "greedy lawyers," the industry has diverted attention from the real solution: insurance reform. Yet insurance industry representatives have been very careful *not* to say that "tort reform" will bring down malpractice premiums. In fact, an American Insurance Association press release in 2002 claimed: "Insurers never promised that tort reform would achieve specific savings."[v]

Proposals to cap patients' ability to recover in malpractice cases may help maximize insurance industry profits, but they will do nothing to insulate the industry

from its own bad practices and market fluctuations, and likewise will do nothing to bring premiums down and keep them at a reasonably affordable level.

That this is the case is reaffirmed by our past experience. "Tort reforms" have already been implemented and failed to limit premium increases. Here in Utah, we already have many limitations on malpractice lawsuits, and have had for many years (during which time liability premiums have at times gone down enough to lead to rebates to insured doctors, and have at other times soared). Utah has a very short statute of limitations in which to bring a claim, a pre-filing notice of intent requirement, a pre-litigation screening process, requirements for qualified expert testimony to hold a physician liable, caps on attorneys' fees, caps on general damages, caps on judgments against state-run health care facilities, no collateral source rule, presumptions favoring medical providers regarding informed consent, and a provision that judgments against a physician may be paid over time rather than in a lump sum. None of these "reforms" have done anything to prevent malpractice premium increases in Utah, for obvious reasons – they do not address the true cause of those premium increases.

A 1999 study by the Center for Justice and Democracy analyzed insurance premiums in states where tort reforms had passed and found that "[s]tates with little or no tort law restrictions have experienced the same level of insurance rates as those states that enacted severe restrictions on victims' rights."[vi]

The real solution: insurance reform

In California, which many medical industry lobbyists cite as a model for tort reform, limitations on malpractice lawsuits (MICRA) were passed in 1975. However, insurance premiums were not controlled until 1988, when a citizen initiated ballot proposition (Prop. 103) passed, imposing several insurance reform measures. In fact, over the first 13 years of the 1975 MICRA law, *insurance premiums increased 450%.* However, in the three years following the passage of Proposition 103, doctor's malpractice premiums *decreased* by 20%.

California insurers are now subject to Proposition 103's "prior approval" regulatory system, which requires medical malpractice insurers to justify rate increases or decreases to the Department of Insurance, and the commissioner may invalidate an insurers' rate if it is too high or too low.[vii] This system has kept doctor's insurance premiums relatively stable in California while still permitting insurers to make a fair profit, and that has served the state well.

Capping the amount a catastrophically injured patient can recover will not help doctors get affordable insurance rates. Caps would just mean that the most badly injured patients, those who have lost limbs, ended up in wheelchairs for life, had the wrong organ removed, or suffered brain damage will face federally mandated, one-size-fits-all partial justice for their lifelong, unfathomable suffering.

On the other hand, insurance reforms are proven to work. Federal exemption from

anti-competitive oversight should be repealed. The insurance industry's financial practices should be closely scrutinized and exposed to the cathartic light of public awareness. A California-style prior approval system permitting insurers to make fair profits but requiring a sufficient showing to justify premium increases based on *bona fide* need should be implemented. Good doctors should be afforded favorable rates, while bad doctors should face financial disincentives to continue practicing medicine and harming patients through their negligence. Such measures could truly be called "reform," for their beneficial effect would actually achieve the stated goals – making liability insurance available and reasonably affordable.

Senator Hatch, I applaud your and the Committee's efforts to seek a solution to the vexing problem of out-of-control liability insurance premiums. I urge you to consider and attack the ***real*** problem, and not to be distracted by politically expedient, but ultimately ineffectual, rhetoric. Thank you for considering my comments.

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[ii] Analysis of National Practitioner Data Bank data from September 1990 through 2003, by the consumer group Public Citizen.
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Testimony of the
American Hospital Association
before the
Senate Committee on the Judiciary
on
The Medical Liability Crisis and its Impact on Patient Care

August 20, 2004

Mr. Chairman, I am George F. Lee, M.D., executive associate to the CEO at California Pacific Medical Center in San Francisco, an affiliate of Sutter Health. For more than 10 years I have been involved with hospital administration on a full-time basis. I am here today on behalf of the American Hospital Association's (AHA) nearly 4,700 hospital and health care system members, and our more than 31,000 individual members. We are pleased to testify before you concerning the harmful impact that excessive litigation is having on patient access to care, and the need for a national solution to the problem. This issue is of critical importance for hospitals, physicians, patients, and the communities we serve.

BACKGROUND

Mr. Chairman, the effects of the medical liability crisis are well known … and every one of them hurts the ability of many patients to get the care they need in a timely manner. In many areas, physicians are packing up and leaving town because they simply cannot afford the skyrocketing costs of liability premiums. Hospitals and other facilities are closing down or curtailing important services, such as emergency rooms and the delivery of babies. Where these kinds of services are still available, not only are liability premiums driving up the cost of care, but defensive medicine … the ordering of extensive tests and other services to cut down on the potential for a lawsuit should something go wrong … drives up the cost of care.

Mr. Chairman, on any give day, there are more than 125,000 malpractice suits in progress against America's doctors and hospitals. Many of them will lead to awards so high as to make us question how anyone can survive in the health care field. For example, in Texas, where they do everything big, there was a claim of $268 million. Many states see claims of $100 million and more. These kinds of unlimited verdicts have serious consequences. They make it very difficult to afford being able to go to court. They dramatically increase the cost of settling a case. In short, unlimited judgments require unlimited premiums.

And here is a very telling statistic: There is no correlation between the presence or absence of medical negligence and the outcome of malpractice litigation.

A survey that the AHA did of its members earlier this year found that, for the previous two years, more than 20 percent of the hospitals in crisis states (crisis states as identified by the American Medical Association as of March of 2004 include: PA, WV, NV, MS, WA, OR, TX, AR, MO, GA, FL, IL, NC, KY, OH, NY, CT, NJ, WY), had seen their liability premium rates double. Sixty-four percent reported they had been forced to take on more risk by raising their deductibles or self-insuring, for example. More than half reported their community had lost physicians. And 39 percent of hospitals in those states reported having lost specialty coverage for any period during the past 24 months, most of them due to liability concerns. Recently, St. Paul's, one of the largest providers of liability insurance, withdrew from the market, further exacerbating the problem.

An AHA TrendWatch report from 2002, researched by the Lewin Group on behalf of the AHA, documented that health care providers across the nation are becoming increasingly concerned about their ability to find affordable medical liability insurance, and that patient access to care has been undermined. The report suggests that the current crisis is likely to be more complicated than medical liability insurance problems that occurred in the 1970s and 1980s, stating that the factors influencing the wide geographic differences in premiums include the following:

- State regulations
- Characteristics of physician organizations
- Local culture and legal practices
- Differences in the costs of defending claims
- Population size and degree of competition among insurers in the market

The TrendWatch report also stated that the exit of large insurers such as St. Paul's from a market could push premium rates up and make coverage harder to find. "In response," says the report, "physicians may leave for another market and hospitals may need to alter the services they provide."

Indeed, insurers faced heavy losses when declining returns on investment exposed them to expenses that were significantly above premiums collected. In addition, large jury awards, which often set the standard for settlement awards, began to put upward pressure on premiums. Some large insurers became insolvent and no longer offered medical liability insurance. In short, insurance capacity evaporated.

In addition to experiencing serious increases in the cost of health care liability insurance, hospitals are coping with a workforce shortage; private, Medicare, and Medicaid payments that do not cover the cost of providing care; and redoubled disaster preparedness efforts. These additional burdens are threatening hospitals' ability to appropriately staff emergency departments, recruit new physicians to high-risk specialties, deliver babies, and provide other services communities depend on.

In the book "Ghost Soldiers," by Hampton Sides, a veteran of the Battle of Bataan describes how "the defense of Bataan devolved into a brutal war of attrition – a war … of consumption without

replenishment." It is just such a circumstance that confronts our nation's hospitals and physicians. Without intervention by Congress, we could find ourselves unable to address the basic health care needs of our communities. Congress must help hospitals and physicians find a solution to skyrocketing medical liability premiums so that we can continue to provide the right care, at the right time, in the right place; 24 hours a day, seven days a week.

The current medical liability system is a costly and ineffective way of resolving health care liability claims and compensating injured patients.

It is well documented that the United States has the world's most expensive tort system, with tort costs over the past 50 years outpacing growth in the United States' economy by a factor of four. Such growth has not translated into efficiency. According to the General Accounting Office (GAO), 43 percent of insurance defense costs are spent on claims that have no merit. Other studies show that many claims with merit are never filed.

THE NEED FOR A FEDERAL SOLUTION

To cope with the problem, several states have enacted medical liability reform bills. But we strongly believe that the only way to successfully deal with this growing problem is to address it at the national level. The federal government pays for nearly half of the health care delivered in this country. Standards of care are national. And defensive medicine costs our nation more than $100 billion a year.

I would like to specifically focus on the strong need for federal reform that is based on the reforms we implemented in California, which stands as a model for the nation. The AHA believes that the California-style reforms enacted under the Medical Injury Compensation Reform Act (MICRA) of 1975 and reflected in legislation that is languishing in Congress should be adopted at the federal level. I served on one of the committees that developed the language for that law. For more than 25 years, MICRA has demonstrated that patients' rights can be protected at the same time that medical liability costs are reduced.

The goals of MICRA were simple, and they have been met:

- A sustainable insurance system providing full indemnification of actual loss
- More money for injured patients
- Faster settlements
- Preservation of access to medical care without impeding access to courts for truly injured patients
- Society does not incur double costs
- Assures money is available at the time it is needed

The bipartisan Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act, has been passed by the House but continues to run up against a roadblock in the Senate. The HEALTH Act contains MICRA-style provisions that can help make this happen at the national level.

Limits on non-economic damages: The HEALTH Act limits the amount a plaintiff could receive for pain and suffering to $250,000. Such a ceiling on these non-economic damages restores

stability to the insurance market. All economic losses and/or costs are paid in full. Such a cap provides affordable coverage, and ensures that health care providers can buy coverage. It does not affect a plaintiff's ability to be fully compensated for economic damages such as medical expenses or lost wages.

Limits on contingency fees: Under the current health care liability system, patients awarded compensation are often shortchanged. Money that should go toward their long-term care goes instead to their attorneys. This is because, traditionally, attorneys in liability cases are paid through contingency fees, which provide the attorney a percentage of the plaintiff's award. Percentage limitations should be applied to attorneys' fees. The HEALTH Act limits the attorney's share to 40 percent of the first $50,000 of a plaintiff's award, 33.3 percent of the next $50,000, and lower percentages for higher amounts.

Periodic payments: In cases where the court decides that the plaintiff will incur future damages over $50,000, the HEALTH Act allows the award to be paid over time. Periodic payments would allow compensation to be made in intervals rather than a lump sum, permitting settlements to be geared to a plaintiff's needs over the course of his or her life. In addition, because periodic payments can be funded through an annuity, future needs can be fully met at a considerably lower cost to the health care system.

A fair share rule: The "joint and several" rule allows any defendant to be liable for the entire amount of an award, regardless of how small that defendant's share of the fault may be. As a result, the rule generally punishes a co-defendant (or a sole defendant) who is fully insured or has substantial assets – the so-called "deep pocket" defendant. For some providers, this removes any incentive to carry full liability insurance coverage. By establishing a fair share rule in health care lawsuits, each party is liable solely for its share of damages and not for the share of any others. In cases with multiple defendants, the HEALTH Act proposes that defendants can be held liable for only their share of the damages.

Collateral source reform / halt double recovery: In cases where plaintiffs sue for medical expenses and loss of income, the HEALTH Act allows doctors and insurance companies to inform juries if the expenses had already been paid by an insurance company.

The California experience under the MICRA law has proven to be more equitable to the medically injured. While the number of health care liability claims brought by medically injured plaintiffs in California, on a per capita basis, is the same as before MICRA, the compensation actually paid to those medically injured in California is higher after MICRA than before. Total awards in California have kept pace with inflation.

And million-dollar verdicts are down. In California, the number of million-dollar verdicts per 1,000 physicians stands at 1.3 … less than the national average of 1.92. That's a far cry from New York, for instance, where the number is 3.71.

The average medical liability insurance premium in California is now about $14,000 a year … a far cry from the nearly $24,000 a year, adjusted for inflation, being charged in 1976. Another improvement: in California the average time to settlement is now 1.8 years … for states without

caps on non-economic damages, cases go on for almost two and a half years. And patients benefit directly, instead of attorneys. Before MICRA, a patient's portion of a $1 million settlement was about $600,000. Under MICRA, that percentage has jumped to $800,000.

The AHA also supports a uniform statute of limitations in health care liability cases and the continued development of successful conflict resolution programs. Bringing liability claims to court is often inefficient and costly and renders unpredictable results. Nontraditional approaches such as alternative dispute resolution systems can play an important role in reforming the health care liability system.

CONCLUSION

Patients, hospitals and physicians need Congress to enact the HEALTH Act to prevent even more hospitals from being forced to shut down or curtail services, to prevent physicians from doing the same, and to ensure that patients can get the care they need when they need it. Hospitals want to continue providing the type of health care that saves patients' lives and improves their quality of life, but skyrocketing medical liability premiums and awards too often tie their hands.

MICRA-style provisions as embodied in the HEALTH Act won't make the tort system perfect, but they will create stability and fairness for patients, physicians and hospitals.

I appreciate the opportunity to testify before your committee today. The hospital and physician communities look forward to working with you to ensure that important medical liability reforms ... like those in MICRA ... are enacted at the federal level.

August 16, 2004

An Open Letter to:
US Judiciary Committee Chairman, Senator Orrin Hatch
American Medical Association, President Dr. John C. Nelson
United States of America, President George W. Bush

From: Your voice of experience – Victims of Medical Malpractice

Re: Healthcare Liability – Please, No Caps

Dear Leaders of America,

During the last three years, America has been inundated with healthcare liability rhetoric; our nation's physicians have staged walkouts, insurance companies have increased their premiums for everyone and everything, including healthcare liability. Representatives of all sides of the issue have recited statistics – without a viable solution! Restriction of healthcare liability is now a campaign issue for the 2004 election, with lawyers and our civil justice system taking much of the blame. Victims of medical malpractice have been under attack, trivialized as "lottery-winners filing junk lawsuits."

We, as victims of medical malpractice in Utah, were forced to bring lawsuits against negligent doctors or health care institutions because we sustained grievous injury or death due to negligent, substandard medical care. Our cases were neither "junk" nor "frivolous," and none of us won a "lottery." We resent "caps" being placed on non-economic damages. The citizens of Utah have also shown they will not be "forced" into a private, pseudo-legal system such as "forced arbitration" created by our medical community, a system which is nothing more than a blatant no-win situation for victims of medical malpractice. A report released this week by the American Bar Association shows 68% of American citizens still preferred to have their civil cases heard by a jury of their peers.

Senator Orrin Hatch, in a letter dated April 30, 2004 to the Utah Citizens Alliance, thanked us for our support of the passage of the *Unborn Victims of Violence Act.* We cite Senator Hatch: ***"I was proud to support this legislation, and to stand beside President Bush in the White House when he signed it into law on April 1st. This law recognizes that when a pregnant woman is attacked and her unborn child is also injured or killed, there are two victims. That is a matter of biological fact, of common sense, and now of federal law. I will continue to defend the principle that human life is sacred and must be appropriately defended."***

Congress, the AMA, and the American College of obstetricians and Gynecologists (ACOG), have all been outspoken advocates for a nationwide $250,000 cap to compensate a catastrophically-injured child for a life time of pain and suffering. Our question to all of you, "Why do you eagerly support the legal rights of the unborn child, yet as soon as that child is born, you wish to immediately limit the newborn's legal rights for medically catastrophic injuries? The AMA, state medical associations, and the insurance cartel have

spent billions over the last three years to convince lawmakers and the President to place a $250,000 cap on pain and suffering if a person is injured during or after birth. Why are a newborn's legal rights less important after birth than before birth?

Dr. John C. Nelson, President of the American Medical Association, stated in an email to the UCA: ***"Let me repeat that in the instance where negligence is the cause of injury, the AMA supports all economic recovery for the victim. This would include surgical bills, hospital bills, medications, prostheses, future and lost wages, etc. The cap would ONLY apply to the non-economic portion of the award, the so-called "pain and suffering."*** **Dr. Nelson concluded by saying,** ***"And to be absolutely clear, the AMA believes that any physician who is negligent should be punished to the full extent of the law."*** The UCA asks, what is the value of a $250,000 cap if it should become a Federal Law? Would this become the full extent of the law that any physician can be punished for negligence?

In his speech as the new president of the AMA, Dr. Nelson likened the Salt Lake 2002 Olympic theme of 'Lighting the Fire Within" to physicians. He declared, ***"Because I know that all physicians...have within, a fire of compassion, a fire of service to patients. Let our light be the light that illuminates the path ahead, giving our patients hope and human kindness. Let that light shine on us as we work together, rebuilding a health care system that will work fairly and effectively."***

To the AMA and all physicians, we the victims of malpractice plead - don't use the "Fire Within," to torch our backs with Federal Caps of $250,000 for pain and suffering. In many ways, our biggest losses are not the narrowly defined economic cost of our injuries. The worst part of our ordeal is the pain, suffering, heartache, discomfort, and difficulty of living with permanent disability, or surviving the death of a loved one. We are very much aware of the ugliness of medical malpractice because we live with it everyday.

Victims of medical malpractice deserve to have a jury, which has heard all the facts and weighed all the evidence, decide upon the compensation for our losses. Political officials sitting far away in Washington should not make that decision in a one-size-fits-all ruling with a $250,000 cap.

No one appreciates the need to have doctors available to serve in every area of this country more than families like ours who have needed medical care and continue to do so. But placing an arbitrary limit on compensation for devastating losses will not solve the medical malpractice insurance crisis. It will only punish people who are already victims! "We are your voice of experience."

Written by LaRee Miller, Executive Director - Utah Citizens Alliance for Safety & Accountability. In memory of her parents that both died from medical malpractice and in honor of all victims of medical malpractice and their families.

TESTIMONY OF DOUGLAS G. MORTENSEN
PRESIDENT OF THE UTAH TRIAL LAWYERS ASSOCIATION

Submitted to the Senate Judiciary Committee regarding the August 20, 2004 Field Hearing "The Medical Liability Crisis and its Impact on Patient Care"

The proponents of the so-called "tort reform" proposal to cap general damage awards seem not to appreciate the purpose of tort law. That purpose is to prevent injury and to encourage people and corporations in a position to inflict grave harm to be careful.

Many who are asked to weigh-in on the issue seek to steer the debate away from this fundamental purpose. Some try to put the focus on "defensive medicine," despite the fact that multiple studies (including one from the Government Accounting Office) have debunked the claim that defensive medicine, if it exists, has negatively impacted healthcare. Others point to a few cases of justice gone wrong and argue that those rare outliers are the rule rather than the exception. Still others maintain, despite clear evidence from neutral sources to the contrary, that medical lawsuits are increasing and malpractice awards are out of control.

I, too, am tempted by the current debate to focus on facts which may not directly relate to patient safety. For example, I have difficulty not suggesting that a principal issue in the debate ought to be: Who really is hurting the worst? I can't resist the urge to point out to you that on April 13, 2003, *The Deseret Morning News* reported that obstetricians and gynecologists earn more per hour than any other service providers in Utah. The article went on to report that their closest earnings-per-hour competitors, based on data collected by the Utah Department of Workforce Services, are general internists, pediatricians, family/general practitioners and psychiatrists. In a companion article, a Northern Utah obstetrician is reported to have declined to reveal her annual income because "her patients would get mad if they knew how much she makes." A year later (on March 10, 2004), *The Salt Lake Tribune* published an article entitled "Doctors Remain Top Wage-Earners." Based on more recent data compiled by the Utah Department of Workforce Services, this article revealed that obstetricians/gynecologists continue to lead the list of the highest paid (income per hour) workers in Utah. They are followed by surgeons, internists, anesthesiologists, pediatricians, family practice doctors and podiatrists, in that order. Some may find it illuminating that the seven highest paid professionals in our state are physicians and that obstetric specialists are at the very top of that list. Some wonder where the hard data is supporting the contention that obstetricians are "suffering" more than other service providers or that they are less able than lower paid service providers to bear the burden of liability insurance premium increases? Is there really some reason why our justice system needs to be warped to cut them an extra break?

Oregonians are about to vote on damage caps in malpractice actions in that state. The issue has been placed on the November ballot there as Measure 35. Columnist Robert Landauer wrote this in *The Oregonian* on August 24, 2004:

> If money talks, the way the medical community invests its funds gives a high-decibel shout about its priorities. Doctors and their HMO, hospital and insurance company allies have already contributed $4.79 million to support the Measure 35 campaign.
>
> By contrast, they have contributed only $40,000 toward the $400,000 to $600,000 a year that the Oregon Patient Safety Commission estimates it needs for its operations. The commission, founded but not funded by the Legislature, is supposed to develop a medical-injury reporting system that will produce changes that will reduce preventable medical errors.
>
> The difference in spending should make skeptics wonder....

A lot of people are hurting. A lot of people are bearing unfair burdens. Despite what I've reported in the foregoing paragraphs, I'm not sure the focus should be on trying to ascertain who is bearing the heaviest, most unfair burdens.

The real focus in this whole debate, I submit, ought to be this: **Will putting caps on general damage awards produce safer medical care?** The social purpose of tort law, I repeat, is injury prevention. It is only when that purpose fails that the system moves to the secondary purpose - compensation for the injured person. I ask: Will placing caps on that compensation likely lead to safer medicine in this country?

I am currently handling two cases for the families of men who died from subdural hematomas sustained in falls while patients at a local hospital. Their falls occurred on successive evenings. The hospital at which they were patients is owned and operated by a national chain of hospitals. One of the cases will go to trial next March. The man who died was an ICU patient recovering from open heart surgery. His assigned care provider, an LPN, had three other ICU patients to care for besides my clients' husband/father. The nurse was outside on a smoke break when his patient fell. On the evening of the unattended fall, that unit was unquestionably understaffed. This patient did not receive the attention he needed, deserved and paid for. He was a retired, non-wage earner. As you know, a cap on non-economic damages in medical cases already exists in Utah. The hospital sees its risk in this case as relatively small. The cost of going to trial and paying whatever the jury may award for this man's death is much smaller than the cost of arranging for adequate nursing coverage.

For years, efforts have been made to persuade the Utah Legislature to provide more funding for nurse education. The Legislature has not yet made nursing shortage one of its top priorities. How are legislators and hospitals going to be persuaded to see that patients in intensive care units receive the level of care they ought to receive? Will caps on damages and other tort reform measures help or hinder efforts to bring about the needed change?

Tort reformers seem to start with the premise that lawsuits are *ipso facto* a bad thing and that those that bring them are evil. They forget that lawsuits have brought about important, much-needed changes in our country. The Supreme Court's decision in *Brown vs. Board of Education* fifty years ago was the result of a lawsuit. If it weren't for tort lawsuits, children in this country would still be wearing flammable pajamas, tobacco companies would still be denying they concealed terrible facts about the dangers of smoking, and farm machinery which regularly amputated limbs would still lack protective guards.

I repeat: the purpose of our country's tort law is to prevent injury by encouraging those with the duty and power to prevent it to act responsibly. How will limiting what a quadriplegic adult or a brain damaged infant may recover do anything to help prevent future patients from being harmed in the same way? What will capping damages do to encourage hospital administrators, HMOs, physicians and nurses to provide the standard of care they are expected to provide? Before tinkering with our nation's common law, your Committee would do well to ask whether that tinkering is likely to make patients safer in America.

American Medical Association
Physicians dedicated to the health of America

1101 Vermont Avenue, NW
Washington, DC 20005

Statement

of the

American Medical Association

to the

Committee on the Judiciary
United States Senate
Field Hearing, Huntsman Cancer Institute
Salt Lake City, Utah

RE: Impact of Medical Liability Issues on Patient Care

Presented by: John C. Nelson, MD, MPH

August 20, 2004

Division of Legislative Counsel
202 789-7426

Statement

of the

American Medical Association

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Committee on the Judiciary
United States Senate
Field Hearing, Huntsman Cancer Institute, Salt Lake City, Utah

RE: Impact of Medical Liability Issues on Patient Care

Presented by: John C. Nelson, MD, MPH

August 20, 2004

Good morning, Mr. Chairman. My Name is John Nelson, MD, MPH. I am the President of the American Medical Association (AMA) and an obstetrician-gynecologist from Salt Lake City, Utah. On behalf of the physician and medical student members of the AMA, I appreciate the opportunity to appear before you today to discuss how our nation's medical liability litigation system is seriously threatening patients' access to quality health care.

THE CRISIS[1]

What defines a crisis? In medicine, we define a crisis as a sudden intensification of symptoms in the course of a disease. Today, we are seeing numerous symptoms that tell us our nation is facing a crisis because of a broken medical liability system. The symptoms are unmistakable—patients having to leave their state to receive urgent surgical care—pregnant women who cannot find an obstetrician to monitor their pregnancy and deliver their babies—community health centers reducing their services or closing their doors because of liability insurance concerns—efforts to improve patient safety and quality being stifled because of lawsuit fears, just to name a few.

Escalating jury awards and the high cost of defending against lawsuits, even those without merit, are driving medical liability insurance premiums to unprecedented levels. As insurance becomes unaffordable or unavailable, physicians are being forced to relocate, close their practices or drop vital services—all of which seriously impede patient access to care. Emergency departments are losing staff and scaling back certain services, such as trauma units, while some advanced and high-risk procedures (such as neurosurgery) are being postponed because physicians can no longer afford or even find the liability insurance they need to practice. Many young physicians and medical students are opting out of high-risk

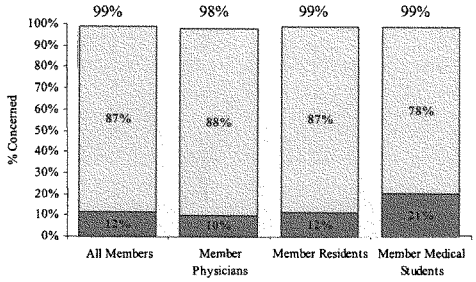
[1] A compendium of facts supporting medical liability reforms and debunking arguments against reforms is available on the AMA Web site at http://www.ama-assn.org/go/mlrnow.

specialties even before their careers begin, while other physicians are choosing to retire from practice altogether.

Mr. Chairman, as you have recognized, the time for action is past due. Physicians across the country are making decisions now, and increasingly patients are wondering, "Will their doctor be there?" We must act now to fix our broken medical liability system. We must bring common sense back to our courtrooms so patients have access to their physicians—whether in emergency rooms, delivery rooms, or operating rooms. This is why the AMA has worked so hard to seek passage of S. 11, the "Patients First Act," which includes reasonable reforms that have been proven effective at keeping medical liability insurance premiums stable, and why we continue to join with numerous other members of a broad-based coalition known as the Health Coalition on Liability and Access (HCLA) to seek passage of critical reform legislation.

As seen in the chart below, an outstanding 99% of AMA members are very or somewhat concerned with the current medical liability environment, with 87% being very concerned.[2]

Concern with the Current Medical Liability Environment:
Physicians, Residents and Medical Students



*Significant at p < .0001 level.

■ Somewhat Concerned □ Very Concerned

Physicians and patients across the country are realizing more and more every day that the current medical liability situation is unacceptable. The AMA has nearly 100,000 physicians who are actively participating in a grassroots network to call attention to the problem and effectuate change. Patients are involved, too. Our Patient Action Network currently has over 180,000 patients advocating for effective reforms by way of over a half million communications to their respective Members of Congress. By mid-October of this year, we estimate that there will be 300,000 patients involved in the effort, and we are on track to exceed that goal.

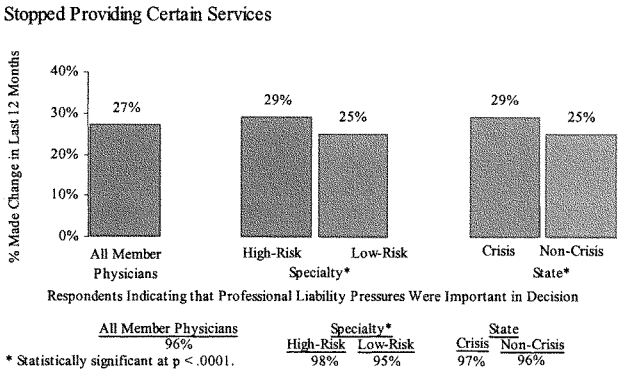
[2] American Medical Association, Division of Market Research and Analysis, May 2004.

ACCESS TO CARE IS AT RISK

The most troubling aspect of the current medical liability litigation system is its impact on patients. Unbridled lawsuits have turned some regions of our country—and in several cases entire states—into risky areas to be sick, because it is so risky to practice medicine.

Throughout 2003 and 2004, the medical liability crisis has not waned. In fact, it is getting worse. Access to health care is now seriously threatened in 20 states, up from 12 states in 2002.[3] In many other states a crisis is looming—a crisis that not only threatens access to quality medical care, but also stifles medical and scientific innovation, inhibits efforts to improve patient safety, discourages new treatments and procedures, heaps billions of dollars in additional costs upon a health care system already strained to the breaking point, and places lives at risk. Virtually every day for the past three years there has been at least one major media story on the plight of American patients and physicians as the liability crisis reaches across the country. A sample of media reports that illustrate the problem faced by patients and physicians is available at http://www.ama-assn.org/go/crisismap.

A recent survey of AMA members shows that physicians in high-risk specialties (29%) are more likely than member physicians in low-risk specialties (25%) to have stopped providing certain services in the last 12 months.[4] Member physicians in crisis states (29%) are more likely than member physicians in non-crisis states (25%) to have stopped providing certain services in the last 12 months.



[3] See attached map of medical liability crisis states.
[4] American Medical Association, Division of Market Research and Analysis, May 2004

A look at several states provides a grim picture of the future of medicine if effective tort reforms are not enacted.

UTAH

- After making the hardest decision of his life, Grant Carter, an obstetrician for 22 years, had to break the bad news to his patients: He was no longer delivering babies. "I consider it the grandest of all medical specialties because you can help women deliver healthy babies. . . . But it became economically unfeasible." His medical liability insurance premiums were about $80,000. Dr. Carter's patients also are greatly affected. "I've been going to Dr. Carter since I was 12 years old because I have endometriosis," said St. George resident Michelle Belcher, 26, who is pregnant with her second child. "To have to go out and find a new doctor after 14 years, I was really upset," she said. "I cried as soon as I got out of the doctor's office." (*Salt Lake Tribune*, April 11, 2004)

- Utah policy makers cannot say they have not been warned. In 2002, The Utah Medical Association said only half the family practitioners surveyed still deliver babies, and nearly one-third of those say they plan to stop practicing obstetrics within the next decade - most within five years. The Utah Chapter of the American College of Obstetricians and Gynecologists said that of 106 chapter members polled, 15 had already stopped practicing obstetrics. Of the remaining 91 doctors, 21 plan to follow suit within five years. "Access to prenatal care will be impaired," said George Delavan, division director with the Utah Department of Health, who also knows of doctors who are getting out because the cost is just too high. (Associated Press, July 12, 2002)

- Many family practice physicians and obstetricians in Utah are dropping obstetrics or planning to retire earlier than planned. At the same time, medical students are largely steering clear of obstetrics, which could create a crisis over the next 10 years. The University of Utah has seen the number of obstetrical-gynecological resident applications decrease from 175 five years ago to 126 this year. The University selects five new residents each year for that specialty. (*Salt Lake Tribune*, April 11, 2004)

- Catherine Wheeler, an obstetrician/gynecologist at Millcreek Women's Center, said rising medical liability premiums are becoming a crisis in Utah, pushing many people out of medicine and discouraging medical students from specializing in high-risk fields such as obstetrics. To pay for her insurance, Wheeler said she has to deliver 60 babies, which typically takes about four months. "We have a lot of doctors who are quitting or moving out of the state," she said. (*Salt Lake Tribune*, March 6, 2004)

FLORIDA

- In Florida, emergency neurosurgery patients are increasingly being transported from Palm Beach County to hospitals in Broward and Miami-Dade counties, and sometimes as far as Tampa and Gainesville. In March, one of those patients, Mildred McRoy,

died six days after being transferred to a hospital in Broward County because no neurosurgeon was available to treat her in Palm Beach County. (*Palm Beach Post*, March 9, 2004)

- Lee Memorial Health System officials announced they were giving the state a required six-month notice to close the trauma center after two neurosurgeons quit, leaving only two to handle 24-hour on-call duty. The center treats more than 1,000 trauma-alert patients a year. Recruitment efforts to bring neurosurgeons to Lee County have been disappointing. "The fact is, three trauma centers in Florida have notified the state that they can't hang on much longer," according to Lee Memorial's government consultant. (*The News-Press*, December 14, 2003)

- 100% of South Florida neurosurgeons have been sued, according to surveys of area physicians. In fact, 31% of physicians also have limited their practice in hospital settings, and physicians in South Florida can expect to be sued 1.44 times in their career. (Floridians for Quality Affordable Healthcare, December 2002)

- At least seven Florida hospitals have closed their obstetrics units due to insurance concerns, and four other hospitals have reduced or limited obstetrics services. In addition, ten hospitals have eliminated, reduced or limited neurological services. (Florida Hospital Association, January 2, 2003)

GEORGIA

- Georgia's ongoing crisis has negatively affected patient access for children, women and families throughout the state:
  - Only seven pediatric neurosurgeons are left in the state.
  - Women in Statesboro often wait between 6 - 9 months for routine mammogram since fewer radiologists are willing to read mammograms.
  - Nine Macon obstetricians have stopped delivering babies or will soon do so.
  - Two of three obstetricians in Eastman have left the state, leaving the remaining obstetrician to deliver nearly 200 babies without backup coverage.

  (Medical Association of Georgia)

- Gainesville obstetrician-gynecologist Linda Harrell, 49, learned in November that her insurance premiums had more than doubled in two years and she's now contemplating retirement. "How can you budget for increases like that?" Harrell asked. "I wanted to retire on my own terms. I didn't want to be run out." (*The Atlanta Journal-Constitution*, February 8, 2004)

- The Athens Women's clinic, which has offered obstetrics services for 35 years, announced May 21 that the state's medical liability crisis was forcing it to no longer deliver babies. It will continue to offer gynecological services. (*Athens Banner-Herald*, May 21, 2004)

- More than two dozen medical liability insurers have left Georgia, according to MAG Mutual, one of the state's remaining carriers. Since 1995, MAG Mutual's average payout in jury awards and settlements has increased from $215,000 a case to $465,300. Last year, it paid claims in 20 cases of more than $1 million. (*Atlanta Journal-Constitution*, February 8, 2004)

ILLINOIS

- One physician relocated from Chicago to Centura Parker Adventist Hospital near Denver after her liability insurance premiums more than doubled, from $75,000 to $170,000. In Colorado, she pays only about $25,000. (*Denver Post*, March 4, 2004)

- Dr. Stephanie Skelly, an obstetrician-gynecologist in Belleville, is considering a move to her home state, Louisiana, where liability costs are about half compared to Illinois. The combined premium for Skelly and her partner, Dr. John Hucker, doubled to $200,000 from $100,000. They took out a loan to pay a one-time $250,000 for tail coverage. "We have to work for free this year," Hucker said. (*St. Louis Post-Dispatch*, October 6, 2002)

- In 2002, non-economic damages comprised 91% of the average total monetary value awarded by a jury. In 1997, it was 67%. (Illinois State Medical Society, Feb. 9, 2004)

- When three obstetrician-gynecologists on staff at Advocate Lutheran General Hospital in Park Ridge learned their 2004 liability insurance premiums would climb from $345,000 to $510,470, they decided to take their practice to Kenosha, Wisconsin, where during their first year their combined insurance will cost $50,018. "This state is like the Titanic," said one of the doctors. "A year ago, we saw the iceberg. Now we've already hit." (*Chicago Tribune*, March 12, 2004)

MASSACHUSETTS

- Cape Cod lost its only board-certified neurosurgeon when Robert Leaver, MD, retired early rather than face insurance premiums that reached $115,000. Dr. Leaver, who said he would have to perform about 100 operations just to pay his insurance bill, had no intention of retiring. (*Cape Cod Times*, October 6, 2003)

- The number of jury awards topping $2 million has quadrupled over five years, according to ProMutual's chairman, Barry M. Manuel, MD, a surgery professor at Boston University. Dr. Manual also said that ProMutual's investments are not behind rising insurance premiums: "In the past 10 years, there's not one year that we've shown a negative return on our investments. It's the severity of awards that's driving this situation." (Associated Press, May 17, 2004)

- A majority of Massachusetts patients believe patients bring too many lawsuits against physicians, and they strongly support reforms advocated by the state medical society. 85 percent of voters said they supported legislation that would assess liability based on

a doctor's or nurse's level of responsibility, and nearly 70 percent favor limiting non-economic damages ("pain and suffering") when economic damages (such as child care costs, lost wages, benefits, etc.) are fully covered. (*Boston Herald*, June 7, 2004)

- Large jury awards and settlements continue to occur in Massachusetts, putting further pressure on the liability system. In 2003, there were jury awards of $3.18 million and $1.8 million. Settlements were reported for $3.75 million and $3.25 million, eight settlements between $2 million and $3 million, and eight settlements between $1 million and $2 million. (*Mass. Lawyers Weekly*, January 19, 2004)

MISSOURI

- St. Anthony's Health Center in Alton will lay off 50 to 75 employees in coming months. William E. Kessler, president and CEO of St. Anthony's, blamed the layoffs on declining revenue associated with increased medical liability insurance premiums and the resulting exodus of doctors from the community. (*St. Louis Post-Dispatch*, June 26, 2004)

- Dr. Al Elbendary, a gynecological oncologist, left a group practice and eliminated a rural outreach clinic because of rising professional liability premiums. "Women with gynecologic cancers in Ste. Genevieve, Carbondale and Chester now have to drive over a hundred miles to see a gynecologic oncologist and receive the care they deserve," said Elbendary. (*St. Louis Post-Dispatch*, October 31, 2002)

- Dr. Scot Pringle, a Cape Girardeau obstetrician, said he has delivered approximately 8,000 babies during his 23 years, and his premiums will likely exceed $85,000 if he continues to practice. "A lot of us have been practicing long enough we are near retirement," Dr. Pringle said. "Frankly, I don't want to put up with this mess anymore." (*Southeast Missourian*, April 26, 2004)

- After obstetrician Jamie Ulbrich's liability insurance carrier stopped doing business in Missouri, the best coverage he and three colleagues at their Marshall clinic could find would have cost them double what they paid in 2003. The four doctors decided they couldn't each afford the $50,000 liability insurance premium, so they decided to stop providing obstetric service and instead work solely as family physicians in 2004. (Associated Press, January 3, 2004)

NEVADA

- The people of Nevada overwhelmingly support comprehensive medical liability reforms. A May 2003 poll conducted by the "Keep Our Doctors In Nevada" initiative found that more than 80 percent of Republicans and Democrats said they would support candidates who supported reforms, including a limit on non-economic damages and trial-lawyer contingency fees. (BestWire, September 15, 2003)

- "I left Nevada because the litigation climate had driven medical liability premiums to astronomical heights," obstetrician-gynecologist Shelby Wilbourn, MD, testified before a Congressional subcommittee. Dr. Wilbourn, whose premiums increased to $108,000, moved to Maine this year and still receives calls from some of the 8,000 patients he saw during his 12 years in Nevada. "Liability isn't about fault or bad practice-it's about hitting a jackpot. Even the best obstetrician-gynecologists have been sued, many more than once." (Associated Press, February 12, 2003)

- Mary Rasar's father died in Las Vegas after the only Level 1 trauma center was forced to [temporarily] close due to skyrocketing medical liability costs. Jim Lawson was injured July 4 in a traffic accident and rather than being rushed to the Level 1 trauma center at nearby University Medical Center, which had been forced to close, Lawson was taken to a hospital that did not have the resources necessary to save his life. He died while physicians tried to stabilize him for airlift to Salt Lake City. (PR Newswire, April 21, 2003)

- The ongoing crisis has caused one of the few remaining liability insurers, American Physicians Assurance, to pull out of Nevada, a move that will leave about 125 doctors looking for new coverage to continue their practices. Dr. Fred Redfern, president of the Nevada Orthopedic Society, said the withdrawal of another insurance carrier should alarm Nevadans. He said APA is his third insurance carrier to decide to leave Nevada because of the high cost of fighting medical liability claims. "This is not a good place to practice medicine. That's the message doctors are getting," he said. (*Las Vegas Review-Journal*, January 29, 2004)

NEW YORK

- Dr. John Cafaro, 45, an obstetrician-gynecologist in Garden City, said some doctors are paying $130,000 for only $1 million worth of protection. "But we are getting sued for $85 and $90 million at a time," he said. "You do the math. Every time I walk into an operating room I put my family's life savings on the line." (*New York Times*, May 25, 2003)

- Of the 13 largest medical negligence lawsuits in the United States in 2002, seven were in New York state, according to the National Law Journal, including a $94 million verdict from a Brooklyn jury. (*Albany Business Review*, March 21, 2003)

- Awards greater than $1 million are three times more frequent in New York than in California, a state that has had reforms since 1975, according to the Insurance Information Institute. (*Poughkeepsie Journal*, April 1, 2003)

- Many young doctors won't specialize in obstetrics. They fear the threat of lawsuits and wince at liability insurance costs, which can be as much as $200,000 per year. Last summer, Manhattan's Elizabeth Seton Childbearing Center, which practiced natural childbirth, had to close when its medical liability insurance premiums rocketed to $2 million. (*New York Daily News*, February 12, 2004)

NORTH CAROLINA

- Dr. David Pagnanelli, a neurosurgeon, said he moved to Hendersonville, North Carolina in 2002 because liability costs were too high in Pennsylvania. But they shot up here too - to nearly $190,000 a year - even though there've been no successful claims against him, he said. Following his insurance carrier's advice, Pagnanelli stopped seeing trauma cases. But neurosurgeons are in short supply in Hendersonville, so his decision means patients with life-threatening head injuries have been transferred to other hospitals. (*Charlotte Observer*, February 11, 2004)

- The annual number of settlements greater than $1 million for medical liability cases has more than tripled between 1993 and 2002 from 6 to 19. (*N.C. Lawyer's Weekly*, April 21, 2003)

- Hospitals in North Carolina have had insurance premiums go up 400 percent to 500 percent in the past three years, the North Carolina Medical Society says. Small, rural hospitals were hit hardest. (*Winston-Salem Journal*, March 9, 2004)

- "If we remain in North Carolina we will likely be forced to make the decision to limit procedures which carry high risks (but also are often life-saving)," said K. Stuart Lee, M.D. of Eastern Neurosurgical and Spine Associates Inc. Dr. Lee's practice saw their medical liability premiums increase 116 percent last year. (*The News and Observer*, January 26, 2003)

OHIO

- Dr. William Hurd, chairman of the department of obstetrics and gynecology at the Wright State University School of Medicine, said the liability crisis already is driving young doctors out of the Dayton area. "In the last two years, not a single one of our (obstetrical-gynecological) residents has set up a practice in Dayton, or even Ohio," Hurd said. (*Dayton Daily News*, August 28, 2002)

- "My wife and I are both physicians and just arrived in Wausau [Wisconsin] in March. We fled the crisis in Ohio after spending our whole careers in that state," said Christopher J. Magiera, a gastroenterologist. Magiera and his wife, Pamela G. Galloway, a general surgeon, gave up their 15-year-old practice when their medical liability premiums that were projected to reach $100,000 apiece. In Wisconsin, they pay a fraction of that. (*Journal Sentinel*, April 20, 2003)

- From 2001-02, Ohio physicians faced medical liability insurance increases ranging from 28 to 60 percent. Ohio ranked among the top five states for premium increases in 2002. General surgeons pay as much as $74,554, and obstetrician-gynecologists pay as much as $152,496. Comparatively, Indiana general surgeons pay between $14,000-$30,000; and obstetrician-gynecologists pay between $20,000-$40,000. (*Medical Liability Monitor,* October 2002)

- Dr. Rebecca Glaser, a popular breast cancer specialist, will retire from surgery on April 1 because of high liability insurance premiums. "I think it's horrifying when we lose a physician who has literally a one-of-a-kind practice," said Donna Buchheit, one of Glaser's breast cancer patients. She continues, "It is literally a life and death issue. The legislature needs to understand that. It is not melodramatic to say that there will be women who die this year because of this. I certainly hope I won't become one of them." (*Dayton Daily News*, February 28, 2004)

PENNSYLVANIA

- In 2000, Philadelphia accounted for 82 percent of the $415 million in medical-liability awards in Pennsylvania, and 14 of the 19 awards that exceeded $5 million, according to the Pennsylvania Trial Lawyers Association. (*The Wall Street Journal*, January 28, 2003)

- More than two out of three medical residents in six medical specialties chose to leave Pennsylvania after completing their training, according to the Philadelphia Daily News, which examined data from the city's major teaching hospitals between 1998-2002. "The resident brain drain is greatest among doctors going into high-risk specialties: ob-gyns, orthopedic surgeons and neurosurgeons. These doctors, not surprisingly, are most likely to be sued for malpractice, and pay some of the highest malpractice insurance premiums." (*Philadelphia Daily News*, May 28, 2003)

- A good example of Pennsylvania's lawsuit culture came in early 2004 when juries returned $15 million and $20 million verdicts on the same day. (Associated Press February 4, 2004)

- According to Grand View Hospital President Stuart Fine, the medical liability crisis is a main reason why patient access problems are occurring throughout the state and "has caused experienced doctors to leave the area, especially neurosurgeons, orthopedic and general surgeons, obstetricians and cardiologists. Few young doctors are coming in to take their place, and the result is a shortage of doctors." (*Morning Call* (Allentown, PA), January 23, 2004)

TEXAS

- David Gray is an emergency medical physician who has been thinking about moving to Colorado for several years to avoid lawsuits in Corpus Christi. His group of 16 emergency room doctors were sued six times in the last 30 days, as lawyers rushed to the courthouse to file cases before [recent] lawsuit caps went into effect. (*Corpus Christi Caller-Times*, September 16, 2003)

- Claims against Texas physicians doubled from approximately 16 per 100 physicians in 1996 to more than 30 in 2000. In the Lower Rio Grande Valley, the number of claims filed is growing at 60 percent a year. (Texas Department of Insurance)

- A pregnant woman showed up in Dr. Lloyd Van Winkle's Castroville office in South Texas, less than 10 minutes from delivery. Her family doctor in Uvalde had recently stopped delivering babies, citing malpractice concerns, and the woman was trying to drive 80 miles to her San Antonio doctor and hospital. (*Fort Worth Star-Telegram*, January 26, 2003)

- Fifty-two percent of all Texas physicians had medical malpractice claims filed against them in 2000, which is about twice the national average. (*The Battalion*, October 28. 2002)

FEDERAL SOLUTION

The medical liability crisis is a growing national problem that requires a national solution. If the crisis was just a matter of physicians obtaining or affording medical liability insurance in one state, we might agree that a national approach would not necessarily be required. However, the problem goes far beyond physicians and other health care professionals and institutions. The medical liability crisis has become a serious problem for patients and their ability to access health care services that would otherwise be available to them, including services provided to Medicare and Medicaid patients.

Also, the premise that it is within the ability of every state to enact legislation to effectively resolve their respective medical liability crisis has been shattered by the fact that many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions that limit reforms. Taking into consideration that studies show the litigation system to be an ineffective, and often unfair, mechanism for resolving medical liability claims, we believe that the time is ripe for a uniform, federal approach to resolving the liability crisis.

Moreover, there is a direct and compelling federal interest in reforming our outmoded medical liability system. According to estimates by the U.S. Department of Health and Human Services (HHS), altogether medical liability adds $70 billion to $126 billion to the cost of health care each year. These are the costs attributed to defensive medicine, which could be significantly reduced by effective medical liability reforms. These costs mean higher health insurance premiums and higher medical costs for all Americans, and especially for the federal government given that one-third of the total health care spending in our country is paid by the Medicare and Medicaid Programs. Further, HHS estimates that excessive medical liability adds $47.5 billion annually to what the federal government pays for Medicare, Medicaid, the State Children's Health Insurance Program, Veterans' Administration health care, health care for federal employees, and other government programs. Recent data from the agency shows that reasonable limits on non-economic damages would reduce the amount of taxpayers' money the federal government spends by up to $50.6 billion per year.

S. 11, A PRACTICAL SOLUTION

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as devastating or worse to patients and their families than injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation. This compensation should include, first and foremost, full payment of all out of pocket "economic" losses. The AMA also believes that patients should receive reasonable compensation for intangible "non-economic" losses such as pain and suffering and, where appropriate, the right to pursue punitive damages.

Unfortunately, our medical liability litigation system is neither fair nor cost effective in making a patient whole. Transformed by high-stakes financial incentives, it has become an increasingly irrational "lottery" driven by open-ended non-economic damage awards. It is also an extremely inefficient mechanism for compensating claimants where court costs and attorney fees often consume a substantial amount of any compensation awarded to injured patients.

To ensure that all patients who have been injured through negligence are fairly compensated, the AMA believes that Congress must pass fair and reasonable reforms to our medical liability litigation system that have proven effective. Toward this end, we strongly support S. 11, the "Patients First Act." The major provisions of S. 11 would benefit patients by:

- Awarding injured patients unlimited economic damages (e.g., past and future medical expenses, loss of past and future earnings, cost of domestic services, etc.);
- Awarding injured patients non-economic damages up to $250,000 (e.g., pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in this bill;
- Awarding injured patients punitive damages up to two times economic damages or $250,000, whichever is greater;
- Establishing a "fair share" rule that allocates damage awards fairly and in proportion to a party's degree of fault; and
- Establishing a sliding-scale for attorneys' contingent fees, therefore maximizing the recovery for patients.

While it is unfortunate that the Senate has been unable to reach the 60 votes necessary to pass a motion to proceed to debate on S. 11, the AMA strongly urges continued efforts to bring about the reforms in S. 11 that have been proven to stabilize the medical liability insurance market in California. Debate on this important issue must continue in order to improve the situation in crisis states and prevent any more states from slipping into crisis mode.

The reforms in S. 11 are not part of some untested theory—they work. The major provisions in S. 11 are based on the successful California law known as MICRA (Medical Injury Compensation Reform Act of 1975). MICRA reforms have been proven to stabilize the medical liability insurance market in California—increasing patient access to care and saving more than $1 billion per year in liability premiums—and have reduced the time it takes to settle a claim by 33 percent. MICRA is also saving California from the current medical liability insurance crisis brewing in many states that do not have similar reforms. In fact, the gap between medical liability insurance rates in California and those in the largest states that do not limit non-economic awards is substantial and growing. Data from the National Association of Insurance Commissioners (NAIC) shows that aggregate premiums in California increased by 245% over the 1976 to 2001 period, while premiums in the rest of the United States increased by 750%.

Studies and expert opinions confirm that MICRA reforms lower costs and improve access. In a study on the effect of reforms, Stanford University researchers Kessler and McClellan concluded that direct reforms, including caps on non-economic damages, reduced the likelihood that a physician will be sued by 2.1 percent. Within three years, premiums in direct reform states declined by 8.4 percent.[5] Another study by Stephen Zuckerman *et al.* looked at several types of reforms and concluded that capping medical liability awards reduced premiums for general surgeons by 13% in the year following enactment of that reform and by 34% over the long term. Premiums for general practitioners and obstetrician-gynecologists were impacted similarly.[6]

When liability insurance premiums are lower, more physicians are able to remain in practice, and the access to quality care is improved. A July 3, 2003, study from the Agency for Healthcare Research and Quality (AHRQ) looked at the distribution of physicians across states with and without caps on non-economic damages since 1970.[7] After adjusting for multiple factors, AHRQ found that by 2000, states with damage caps averaged 12 percent more physicians per capita than states without damage caps.

In a study released in May 2003, the Joint Economic Committee of the U.S. Congress stated: "Some of the key reforms proposed at the federal level, including the cap on pain and suffering damages, have proven successful at producing savings when implemented."[8] The study points to California, praising MICRA as "perhaps the most successful example of reform at the state level," and noting its slower rate of growth in medical liability premiums.[9]

Furthermore, there is strong support for continued efforts to fix our broken medical liability system. A March 2004 poll conducted by HCLA shows that 72 percent of Americans favor a law that would guarantee an injured patient full payment for lost wages and medical expenses

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[5] Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS., 81-106 (1997).
[6] Stephen Zuckerman, Randall R. Bovbjerg & Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167-182 (1990).
[7] FRED HELLINGER & WILLIAM ENCINOSA, U.S. DEP'T OF HEALTH AND HUMAN SERVS., THE IMPACT OF STATE LAWS LIMITING MALPRACTICE AWARDS ON THE GEOGRAPHIC DISTRIBUTION OF PHYSICIANS (2003).
[8] JOINT ECON. COMM., 108TH CONG., LIABILITY FOR MED. MALPRACTICE: ISSUES & EVIDENCE 19 (2003).
[9] *Id.*

but that reasonably limits awards for "pain and suffering" in medical liability cases.[10] These findings are consistent with the results of a Gallup poll released on February 4, 2003, which show that 72 percent of those polled favor a limit on the amount patients can be awarded for "pain and suffering."

CONCLUSION

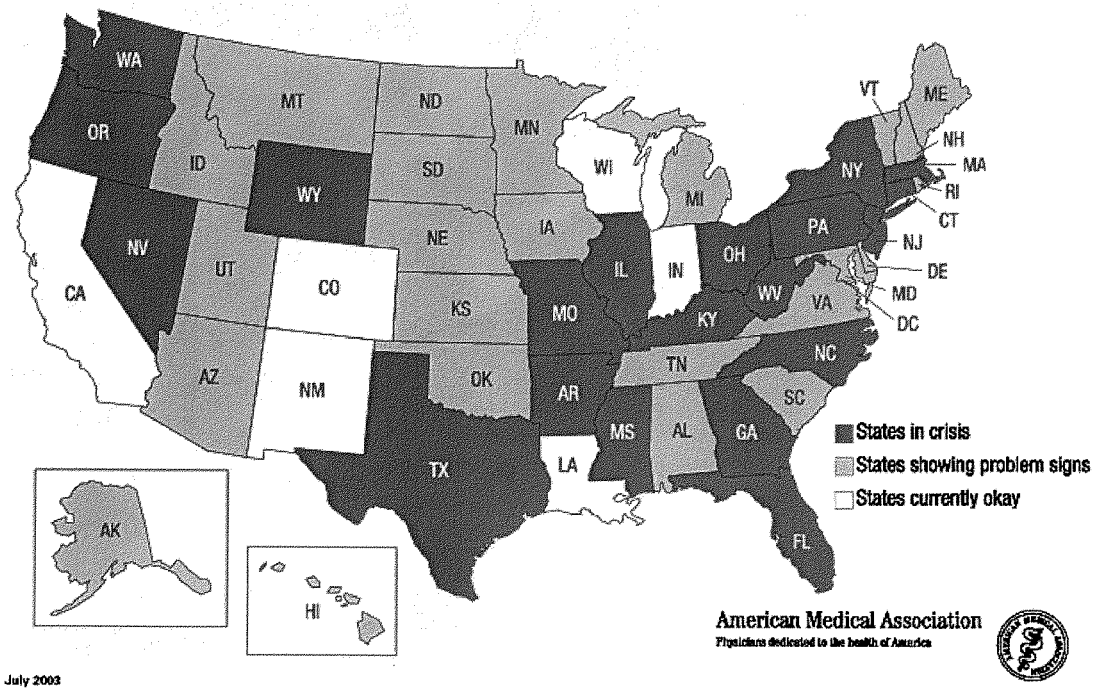
Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an erosion in access to care because their physicians can no longer find or afford liability insurance. The reasonable reforms embodied in S. 11 have brought stability in those states that have enacted similar reforms.

By enacting meaningful medical liability reforms, Congress has the opportunity to increase access to medical services, eliminate much of the need for medical treatment motivated primarily as a precaution against lawsuits, improve the patient-physician relationship, help prevent avoidable patient injury, and curb the single most wasteful use of precious health care dollars—the costs, both financial and emotional, of health care liability litigation. The modest proposals in S. 11 answer these issues head on and would strengthen our health care system.

The AMA appreciates the opportunity to testify on the impact of medical liability issues on patient care and urges Congress to pass legislation, like S. 11, that would bring about meaningful reforms.

[10] Health Coalition on Liability and Access, *More Than Seven-In-Ten (72%) Americans Believe That Health Care Costs Are Rising Because of Medical Liability Lawsuits* (2004), *available at* http://www.hcla.org/polldata/2004-HCLA-Poll.pdf (last visited May 21, 2004).

America's Medical Liability Crisis: A National View



July 2003

AUGUST 20, 2004

STATEMENT OF MS. DONNA PAGE

MEDICAL MALPRACTICE FIELD HEARING
BEFORE THE SENATE COMMITTEE ON THE JUDICIARY

My name is Donna Page. In January 2000, I was an extremely healthy and happy 63-year-old woman. I had my own successful tax preparation business and had many hobbies. My husband and I enjoyed skiing, tennis, hiking, swimming, weight training as well as travel, theater and many other activities. Six months earlier I had completed the Honolulu Tinman Triathlon, which consists of a half-mile ocean swim, 25-mile bike ride and a 6.2 mile run.

On February 17, 2000, I didn't feel well which was very unusual for me. I seldom go to the doctor but I am very health conscious and will go if I think there is a problem. One lesson I learned from this experience was never let a doctor put you off. If you are sick, make sure you don't let a medical professional minimize the problems. I had a high temperature and I went to the clinic. The doctor told me simply to take Tylenol, and sent me home.

The next day, I was very feverish and felt much worse. My husband took me to a large hospital emergency room in Salt Lake City where I spent the entire day. During the day my fever spiked at over 106 degrees and my blood chemistry deteriorated, showing (what I later learned) to be clear signs of a serious infection. At the end of the day the doctors did nothing and sent me home again with no further instructions.

On the third day I was deathly ill, and I could hardly walk. I went back to the clinic in Park City, and the doctor recommended that I take "Gas-X," and once again sent me home.

Early on the morning of February 20, we went back to the hospital emergency room and exploratory surgery was done. The doctors came out of the operating room and told my husband to get the family together as I would not survive the day. That began the battle that would change my life. It turned out I had a Strep A infection that had been misdiagnosed for the last four days that was shutting down my body. I spent most of the next two months in a medically induced coma. It was necessary to amputate both of my legs below the knee, all of the fingers and part of the right hand plus most of the fingers on my left hand. I was very close to death many times. On top of that, as I was finally recovering, a nurse stuck a feeding tube in my lung and filled my lung with feeding solution, causing respiratory arrest. The sad thing is if I had received the medical attention I needed when I first went to the emergency room, these horrific things would not have happened to me. After four months, I left the hospital to face the challenges of a new life.

We are not "lawsuit type" people, if there is such a thing in Utah. I did receive very, very poor medical care that changed my life forever in awful ways. After much discussion and soul searching we decided to file a lawsuit, as we knew our financial needs were going to be quite different than our original retirement plans. A cap of $250,000 would not have come close to solving our problems. We had a lovely home but had to sell it because it had three stories and that doesn't work well for a person without legs. Also remember that insurance companies and even Medicare want to be at least partially repaid if a settlement is received and lawyers cannot work for free.

This illness used up most of my medical insurance. For once I was lucky to be old and was able to apply for Medicare less than a year after leaving the hospital. What if I had been 54 instead of 64? Luckily I now have Medicare but I must purchase the most expensive secondary insurance available as my legs which are replaced every few years are $40,000.00 and the accessories necessary to make them work cost several thousand dollars a year. There are so many things I need that are not even covered by insurance. I need special equipment to turn on lights, hold a pencil and a million other things.

The tax preparation business I had nurtured for forty years, and the income we had received from it, is a thing of the past.

I am blessed with a loving husband who takes wonderful care of me. However he is almost nine years older than me and odds are I will outlive him. In many ways my illness aged him more than me. I cannot live alone. I am very independent but there are so many things that I just cannot do. Simple things such as lifting a pan of water from the stove or cutting a piece of meat are beyond my abilities. There are doors and windows that are just more than I can handle. I used to hop on the kitchen counter to reach high cabinets but that is out of the question. I don't want to ever be a burden to my children but if something happens to my husband, this is a real possibility.

After my illness, I applied for long-term care insurance but to no one's surprise, I was uninsurable. The settlement I received from my lawsuit did not make us rich, but it will be my long-term care insurance.

Two years after I was misdiagnosed and had to have all of my amputations, I was asked to carry the Olympic Torch as it came through Park City. Because I had no fingers left, the Torch was strapped to my palms. I am a survivor and not a complainer, but I seriously doubt that anyone here today actually believes that a $250,000 damage cap is fair compensation for the pain and suffering I and my family have gone through, and will go through for the rest of our lives.

And I seriously doubt that anyone on this panel, you Senator Hatch, or any physician in this audience would think that a $250,000 cap was fair if they had a wife or child that had to have their legs and fingers amputated, and live the rest of their lives that way, as a result of medical negligence.

Thank you, and please let me know if you have any questions.

Testimony before U.S. Congressional Hearing on Tort Reform

J. Charles Rich, MD, Neurological Surgeon
Salt Lake City, Utah
August 20, 2004

Senator Hatch, thank you for the invitation to participate on this panel discussing Utah's professional liability crisis and the need for federal tort reform legislation.

According to an extensive survey by the American Association of Neurological Surgeons (AANS), Utah and twenty-three other states are "severe crisis" professional liability insurance (PLI) states. The criteria: either, a fifty percent increase in PLI premiums between 2000 and 2002 or average neurosurgery PLI premiums over $100,000. That is a truly dubious honor – for Utah citizens.

As one who practiced in Salt Lake City for over thirty years and decided to stop doing so two years ago, my principal concern regarding Utah's "severe" professional liability insurance (PLI) crisis for neurosurgeons is that, as a consequence, patients in this state are losing access to neurosurgical care.

The neurosurgeons, nationally and locally, for whom I have the most admiration and whose surgical services I would insist upon for my own care have been sued, multiple times. An American neurosurgeon can expect, on average, to be sued every eighteen months. The surgical treatment of certain types of brain tumors, cerebrovascular anomalies and spinal disorders is associated with an inherent risk such that everything can be done correctly, proceed optimally during the surgical procedure and, nevertheless, result in an unfavorable outcome. Lawsuits alleging medical negligence are intensely unpleasant, drawn out and vividly remembered. Neurosurgeons will justifiably go to great lengths to avoid medical practice areas associated with demonstrable legal jeopardy. Their behavior is perfectly appropriate considering the harsh disincentives provided by the present litigious medical practice environment.

There are only twenty-seven neurosurgeons practicing in Utah – a smaller number than were present five years ago. Some cover busy, more liability "risk-associated," Level 1 Trauma Center and large Regional Referral Center emergency room hospitals and others cover considerably less busy emergency rooms with the always present option of sending a case to a larger referral center hospital at their discretion. In present circumstances, for obvious reasons, it is increasingly difficult to find neurosurgeons willing to affiliate with the former.

Although few in number, neurosurgeons are absolutely essential if there are to be available to the Utah public the following: emergency rooms, tertiary and quaternary intensive care units, medical air transport systems, Level 1 Trauma Services or, for that matter, a Utah State Bureau of Emergency Medical Services (EMS). Without easy access

to neurological surgeons, not one of the above is a viable, functional entity. A remarkably small number of willing neurosurgeons maintain that vital functional link.

Does the average Utah citizen take for granted that if their son is seriously head-injured in a car rollover that a neurosurgeon will be immediately available to him? Does that citizen just assume that if their mother has experienced a cerebral hemorrhage that, within the brief time-frame essential for intervention, a neurosurgeon will be immediately available to her? As a consequence of Utah's present litigious medical practice milieu and PLI crisis, it is less and less realistic to be comfortable with that assumption. In fact, without the passage of national tort reform legislation that assumption is not warranted at all. Considering the blatant disincentives present in our current litigiously threatening neurosurgical practice environment, there may too few left in practice willing to be available on emergency room coverage rosters.

For neurosurgeons and their patients in Utah, it is a "severe crisis." It has already tangibly affected Utah citizens' access to neurosurgical care in three ways: by neurosurgeons being provided incentives to leave practice; by altering their practice pattern to one less risk-associated; and by diminishing the prospects of attracting neurosurgeons.

Early retirement

After time off to serve as Chief Medical Officer for the 2002 Olympic Games, I was a perfectly healthy sixty-six year old and considered continuing my neurosurgical practice at a reduced level of patient volume and frequency of surgical procedures. I believe that I could have made a valuable contribution. My 2003 Utah Medical Insurance Association (UMIA) annual PLI premium, however, was estimated to be about $82,000. Understand, the UMIA is not making money from anyone. It is non-profit and physician owned.

I could either practice full tilt in order to afford the increasingly high practice overhead or not practice at all. There was no feasible way to slow down. I stopped medical practice altogether. If I were in practice this year, based on close parallels with practice partners, my annual PLI premium would be $93,000 – despite a practice profile such that my insurance carrier never had to make a pay out. The premium is projected to increase again for 2005. That apparent fiscal necessity demonstrates the failure of the extant PLI system.

Last year another Salt Lake neurosurgeon, a medical school classmate and two years younger than I, also abruptly left the practice of neurosurgery. He was scheduled in the regular rotation covering the major referral center, LDS Hospital emergency room. Notified that his annual PLI premium had been doubled (his PLI carrier was one of two companies that decided last year to no longer do business in Utah), he immediately and unexpectedly "retired" leaving a conspicuous void on the rotating coverage roster of that absolutely essential, major referral center emergency room. His place on the roster has yet to be filled. No one is willing to replace him.

Repeated entreaties have been made to three neurosurgeons at Salt Lake suburban hospitals to join our large referral and trauma center emergency room call rotation. How strong is the emergency room coverage aversion? Despite the attraction of access to Intermountain Health Care health plans plus a daily coverage stipend, none are willing to provide that emergency room coverage.

Altering practice patterns

Some neurosurgeons, well trained in cranial surgery, are giving up hospital privileges for cranial surgery and limiting their practice to spine surgery in order to avoid increased risk-associated emergency room coverage. As illustrated in the paragraph above, the number of neurological surgeons willing to provide this emergency coverage under any remunerative arrangements is dwindling with each "crisis" and increase in PLI premiums. One cannot overstate the seriousness of that problem or its implications for the public.

Some higher risk cranial and spine cases previously cared for at suburban hospitals convenient to those population areas are no longer being done locally. They are being sent to a distant referral center.

Trends in the Neurosurgical Workforce in the United States, a recent well-researched paper, one of the authors of which is our own, Bill Couldwell, MD, PhD, Chairman of the Department of Neurological Surgery at the University of Utah Health Sciences Center, comments on the decreasing availability of neurosurgeons.

"One significant contributing factor is the current malpractice crisis in the U.S., which has exerted strain on practitioners of neurosurgery, particularly those in private practice who do not have the benefit of working in a self-insured health delivery system or hospital. Rising malpractice premiums, combined with decreasing reimbursement, have made continued practice in many regions of the country fiscally untenable. In a survey of 563 neurosurgeons nationwide in 2002, 29% responded that they were considering retirement, 43% were considering restricting their practices to low-risk surgeries and 19% were considering moving in response to the liability insurance crisis."

The self-evidently necessary, constructive remedy is to provide relief from the litigiously threatening medical practice environment to which neurosurgeons have appropriately adapted and which ill-serves the general public interest. That requires federal tort reform legislation.

Attracting neurosurgeons

What does the future hold? Responding to these often discussed and well-understood disincentives, U.S. medical student applicants for the neurosurgery residency match began declining in 1991 and have more so since 1995. From a public interest standpoint, that represents a significant problem. Neurosurgery has always been known as an exacting, demanding specialty with a post-medical school residency lasting six to seven years. Since about 1991 it has been increasingly identified as the subspecialty "most

sued" and for which it is most difficult to find professional liability insurance. People respond to incentives – these are persuasive, cautionary and demonstrably effective disincentives.

Had you finished your residency in neurosurgery elsewhere and were looking for a favorable location in which to practice for the long term, would you choose Utah with a "severe" PLI crisis practice environment?

If you are a young neurosurgeon already in Utah and note that the fees paid for given surgical procedures are significantly higher in Idaho and the PLI premiums are significantly lower, would it not be appropriate to move there? About three years ago, one of our most respected, able and well-trained neurosurgeons left Salt Lake for Idaho.

In good part a reflection of a litigious practice atmosphere, the number of practicing neurological surgeons in the U.S. has declined since 1998. By 2002 there were fewer in practice than in 1991. During 2001, three-hundred twenty-seven board certified neurosurgeons, comprising ten percent of our national workforce, left their practices.

Considering the availability of essential services to the public, of even more concern is that a large proportion of those remaining are in the fifty to sixty-five year old age group and have already altered how and where they practice in response to this PLI crisis. Their only remaining option is to cease practice altogether.

Do our Utah neurosurgeons, facing a "severe" PLI crisis, have any reason whatsoever to be optimistic about an improvement in their practice environment? No. Are they going to insist on national tort reform legislation? Yes. Is the Utah public sufficiently aware of how vulnerable they are if that does not occur? No.

Conclusion

Considering access of patients to critically important neurosurgical care in a highly litigious environment, consider the following. The Emergency Medical Treatment and Active Labor Law (EMTALA) legislation requires that one accept a patient in transfer when on-call for the hospital emergency room. In my more than thirty-year practice experience, fielding telephone calls during the middle of the night from emergency rooms spanning three states was common. The last year of practice I was served with subpoenas for two depositions by opposing attorneys concerning two lawsuits that had been instituted alleging malpractice in cases I had apparently discussed on the phone with emergency room physicians.

Our UMIA legal counsel asked a reasonable question. In our litigious environment, was it prudent behavior for me to answer phone calls from emergency rooms all over Utah, Wyoming and Idaho, giving expert neurosurgical advice regarding diagnosis and treatment? My behavior was judged not to have been medico-legally prudent. It was too "risk-associated." Presently, the neurosurgeons in my practice environment do not accept any calls from outside hospital emergency rooms, on advice of legal counsel. Does the

current "severe" PLI crisis interfere with the average Utah citizens' access to excellent and timely neurosurgical care? The answer is yes, directly, in many ways and every single day.

We are fortunate to have John Nelson, MD as a local colleague and American Medical Association (AMA) president. Succinctly, the AMA case is that if there are inflationary considerations regarding so-called economic damages to injured patients, fine. Where some vestige of reason has to prevail and reform has to occur is with the apparently limitless non-economic damages – concerning which, arguments about inflation are not cogent. No one feels worse than neurosurgeons who have been involved with bad outcomes. It puts some right out of business emotionally. Frankly, some are never the same. There is a bottom line, however. Unless there is prompt national legislative reform of the present system, some neurosurgical services in Utah will become increasingly and noticeably difficult to access.

Senator Hatch, in April 1995 you graciously gave me the opportunity to sit with you in your Washington, D.C. office and discuss tort reform. I was the soon-to-become president of the spokes-organization for America's neurological surgeons, the American Association of Neurological Surgeons (AANS). We agreed that if that issue were not then addressed in the U. S. Senate there would be inevitable patient access consequences. To your credit, you worked for tort reform legislation in the mid-nineties. Here we are nine years later with a much worse PLI crisis in Utah and twenty-three other states. Nationally, neurosurgery continues to lose far more board-certified surgeons each year than would be expected from normal attrition. We all understand why.

Neurosurgeons have been coerced into a high-stakes, prohibitively risky game. The ante necessary to just stay in that game continues to soar higher and higher. All over the country, they are making this reply, colloquially, "The stakes are too high and risky for me. I'm no longer in. I fold. I'll leave whatever I have on the table, but … I'm done. You all go on without me."

Each year more neurosurgeons walk away from the present counter-productive, contrary-to-the-public-interest and failed medical-legal-insurance system. That represents the irretrievable loss of a national workforce crucially important if we are to have functioning ERs, ICUs, medical air transports and trauma services. Without neurosurgeons, those services are non-functional.

I repeat for emphasis, every Utah citizen can only hope that a superbly trained neurosurgeon will always be immediately accessible through the emergency room when their own son is seriously head-injured in an auto accident and when their own mother has a hemorrhagic stroke and needs surgical intervention promptly, within two hours. Unless there is meaningful federal tort reform, that immediate neurosurgical access will likely not be available. Under the present glaring disincentives in Utah, there won't be enough willing neurosurgeons around to provide it.

We appreciate your concern and willingness to act as a facilitator on this issue. The general public needs your help in achieving federal tort reform legislation – and the sooner the better.

Thank you.

Senate Committee on the Judiciary

"The Medical Liability Crisis and its Impact on Patient Care"

Huntsman Cancer Institute, August 20, 2004

Testimony of Charles W. Sorenson, Jr., MD
Executive Vice President and Chief Operating Officer
Intermountain Health Care, Salt Lake City, Utah

Senate Committee on the Judiciary
"The Medical Liability Crisis and its Impact on Patient Care"

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Intermountain Health Care, Salt Lake City, Utah
August 20, 2004

Thank you for the opportunity to testify today. My name is Charles W. Sorenson, Jr., MD, and I'm a urologic surgeon who has practiced in Salt Lake City for the past 22 years. I'm testifying on behalf of Intermountain Health Care ("IHC"), a not-for-profit integrated health care system serving the state of Utah and the surrounding Intermountain region. I serve as IHC's executive vice president and chief operating officer. Our organization includes 21 hospitals. While the majority of the 3,300 physicians who practice in our hospitals are independent practitioners, approximately 450 are employed by IHC's Physician Division. IHC also has a Health Plans division that offers four different types of managed care plans serving about 450,000 members. IHC is governed by some 300 local citizens who serve as unpaid, volunteer trustees. Our mission is to provide excellent health care to the residents of the communities we serve and to do so at the lowest possible cost. We take this responsibility very seriously, and we have received national recognition as an integrated delivery system that has demonstrated leadership in patient safety and continuous quality improvement initiatives.

I am testifying today on behalf of our trustees, our employees, and the patients we serve. In my testimony, I would like to offer the perspective of our regional health care system on the medical malpractice insurance crisis and on the need for federal tort reform.

First, let me describe to you the dimensions of the medical malpractice insurance crisis as we experience it here in Utah. In its assessment of the crisis in various states, the American Medical Association has characterized Utah as an at-risk state; that is, a state that has not yet encountered the full dimensions of the crisis but a state that is showing problem signs indicating an impending crisis. IHC fully agrees with this assessment, and we are already seeing the negative impact of the crisis on patient care. Moreover, our experience is typical of the experience of other hospitals and health care organizations in our state. Like all Utah providers, we are currently experiencing the following symptoms of the emerging crisis:

1. **Physician shortages and recruitment problems.** We find it increasingly difficult to recruit physicians to practice in our hospitals in critical specialties such as neurosurgery, neurology, orthopedic surgery, trauma surgery, and cardiology. Physicians have become increasingly reluctant to take emergency call in the emergency rooms of our designated trauma centers. There is a significant amount of uncompensated care provided by both the physicians and the hospitals in these emergency rooms. This fact alone is a challenge for many physicians. The fact that these complicated trauma and emergency cases also bring with them an increased risk of malpractice claims makes the situation completely unattractive

to many physicians. Some doctors ask the hospital to pay them to take call in the ER, despite the fact that hospitals likewise receive no funding from insurance companies or government for these patients. As some physicians relinquish hospital privileges to avoid ER duty, the burden increases on those who remain on staff. It is an unsustainable spiral.

Obstetrics is an area of major concern. As a growing number of physicians cease delivering babies, our patients are left with fewer and fewer options. The problem is evident in urban as well as in rural communities. For example, at our hospital in American Fork, seven family practice physicians have recently relinquished their OB privileges, citing as reasons the rising cost of malpractice insurance, the risks of litigation, and the inconvenience of late night call. We know of numerous other physicians in Utah who have made the same decision, adversely affecting patients in the Salt Lake Valley, Cache Valley, St. George, and other communities.

2. **The training of new specialists.** We are very concerned by trends reported by medical schools around the country, including the University of Utah, that indicate a dramatic decrease in the number of students who are pursuing residencies in surgical and other high-risk specialties such as those mentioned previously. Clearly these are very demanding professions, requiring long years of postgraduate training and many interruptions of personal and family time in order to care for emergency patients at every hour of the day, every day of the year. These facts alone are significant detractors for many students. But others who would enjoy the challenge and rewards of these intense specialties turn to other fields when they come to understand that they would be exposed to a very high risk of malpractice litigation—even when practicing at an exemplary level. They are very aware that, in these specialties, even the best of the best are repeatedly dragged into expensive, time-consuming, and emotionally wrenching litigation.

3. **Escalating health care costs because of defensive medicine.** This phenomenon has been widely recognized in the medical literature for years, and it is not going away. At IHC we have made significant strides in helping physicians understand best clinical practices as recognized by evidence-based clinical trials and national specialty groups. It is impossible, however, for clinicians to ignore the reality of the medical liability environment in which they practice, and far too many diagnostic studies are ordered or interventions performed not because they make the best sense clinically, but because they might protect the physician in case of a later lawsuit. Many commentators have recognized that the United States has higher health costs per capita than many other countries with a comparable standard of living. How much of this difference is due to the unique tort laws we have in the United States, which often frighten physicians into over-evaluating and over-treating their patients?

4. **Escalating legal expenses.** IHC's litigation expenses have gone up by more than 300 percent in the last 10 years, even though our clinical quality is demonstrably excellent, our risk management program has been recognized as one of the best in the nation, and medical malpractice claims against us are extremely rare. (Fewer than one-hundredth of one percent of our 6 million annual patient encounters result in a malpractice claim, and virtually all of these claims are resolved out of court.) Yet we incur costs to defend ourselves even when we are ultimately dismissed as parties to lawsuits due to lack of cause. It has become customary and routine to name hospitals in malpractice lawsuits brought against physicians, regardless of the facts of the case, simply because hospitals are viewed as having "deep pockets." IHC's experience is typical of most hospitals in this respect. We are greatly troubled by these escalating legal expenses—much of which are incurred to defend ourselves against claims that are ultimately judged to have no merit. Obviously, we would much rather spend that money on improving patient care or on reducing our charges to the patients we serve.

5. **Escalating malpractice insurance expenses.** IHC provides malpractice insurance to its employed physicians and to its hospitals, clinics, and other facilities. In order to provide this insurance in the most cost-effective way, we self-insure up to a certain level of coverage. We benchmark our costs in this area against other excellent organizations, and continually strive to control these costs. Yet despite these efforts and a favorable claims record, our malpractice insurance expenses have increased by 136% in the last seven years, driving up costs to payors and diverting resources from patient care.

So IHC and other organizations in Utah are already experiencing serious symptoms of the medical malpractice insurance crisis. It is adversely affecting patient care in our state in terms of decreased availability of certain key physician specialties, increased costs of liability insurance and legal work, and increased costs of defensive medicine.

Now I'd like to address two analyses of the crisis that are frequently made by opponents of reform efforts.

The first allegation is that the medical malpractice insurance crisis is largely due to widespread incompetence in the practice of medicine. In our experience, this allegation is absolutely inconsistent with the facts. As I previously noted, our organization has been widely recognized not only for the excellence of its care and medical outcomes but also for our pioneering efforts to systematically improve patient safety and to raise the standards of clinical excellence.

IHC has focused on clinical quality for years. We have been fortunate to have leaders within our organization like Dr. Brent James, our vice president of Medical Research at IHC and executive director of the IHC Institute for Health Care Delivery Research. Dr. James has an international reputation in the application of continuous quality improvement techniques to the field of health care. Through the IHC Institute, he has helped train thousands of physicians, nurses, and other clinicians in the use of clinical

quality improvement techniques. Dr. James also serves on the Institute of Medicine's National Roundtable on Healthcare Quality and its Committee on Quality of Healthcare in America. He was a member of the IOM committee that produced the two landmark reports on patient safety: *To Err Is Human* (1999) and *Crossing the Quality Chasm* (2001).

The work of Dr. James and of many other clinical leaders is reflected in IHC's six clinical programs and our system-wide Patient Safety Initiatives. These programs create annual goals for clinical quality improvement in areas such as Cardiovascular Services, Cancer Services, Women and Newborns Services, Primary Care, Behavioral Health, and Intensive Medicine. Our programs have resulted in medical outcomes that rank among the best in the nation. We recognize that we still have much work to do, and we will not feel satisfied until every patient receives best care in every encounter. But much has been accomplished, and my point is that even though IHC has one of the most impressive records of clinical excellence and patient safety in the nation, we, like other medical institutions, are still experiencing the damaging effects of the malpractice insurance crisis.

A second allegation often made by opponents of reform is that the precipitous rise in medical malpractice insurance rates is due to profit-seeking by insurance companies. The allegation is that the rates have been increased artificially to cover declines in investment income. This allegation, too, is inconsistent with the facts in Utah, where the insurance companies that provide most of the medical malpractice insurance are efficiently managed and not-for-profit.

Roughly 4,300 physicians practice in Utah, and most of these physicians obtain their malpractice insurance through the Utah Medical Insurance Association (UMIA), a not-for-profit company affiliated with the Utah Medical Association (UMA). Most of the physicians not insured through UMIA are employed by one of the state's two major not-for-profit systems, the University of Utah Hospitals and Clinics or IHC. Both of these organizations self-insure for malpractice claims. UMIA, the University of Utah Medical Center, and IHC all seek to provide malpractice insurance at the lowest possible rates. Yet even in Utah, malpractice insurance premiums are skyrocketing at rates of 20% to 60%—or higher—annually. For example, average premiums for Utah ob/gyns have increased 94% in last four years, from $42,000 in 2000 to $81,628 in 2004. [*Source:* Utah Medical Insurance Association.]

The problem of escalating premiums is especially acute for physicians in rural Utah, who have fewer patients among whom to spread the increasing cost of malpractice insurance. It is making it especially difficult for family physicians in rural areas to deliver babies. We are very concerned that unless significant changes are made, some communities in Utah will be without obstetrical coverage due to the malpractice insurance crisis.

Thus, neither of these two allegations regarding the causes of the malpractice insurance crisis is consistent with the facts or with the experience here in Utah.

Now I'd like to offer our perspective on possible solutions to the crisis:

1. **Tort reform.** Even though Utah has been one of the most progressive states in the U.S. in implementing tort reform legislation, we nevertheless continue to experience the ill effects of the malpractice insurance crisis. For example, over the years, the Utah legislature has supported the following concepts and approaches with respect to resolving medical malpractice disputes:
   - **Prelitigation panels.** These hearings provide opportunities to resolve differences and work through issues prior to going to court. In Utah, prelitigation panels are required by state law as a step in the court litigation process.
   - **Collateral source doctrine.** If plaintiffs have already received compensation from other sources, that is taken into account in awarding damages.
   - **Comparative negligence doctrine.** If a plaintiff is found to be more than 51% liable for damage incurred—that is, is mostly responsible for his or her injury—then the plaintiff is not permitted to recover damages from other parties.
   - **Statute of limitations on malpractice claims.** Plaintiffs must file claims within two years of the event or of becoming aware of damage. (Minors have until age of majority to file claims.)
   - **Structured settlements policy.** This policy ensures settlement money is available to the plaintiffs as needed over time and protects against "windfall" awards that might be squandered.
   - **Caps on non-economic damages (e.g., "pain and suffering").** These caps have been in place in Utah for many years, but several factors have reduced their effectiveness. Several years ago the caps were indexed to economic indicators, and currently the cap is about $410,000. This is significantly higher than the cap on non-economic damages in California. Furthermore, Utah's cap has not yet withstood challenge in the state's Supreme Court. If it is ruled unconstitutional in a current case before the court, many predict that professional liability rates in Utah will rise dramatically, further reducing access to critical health care services in our state.

   We believe that **federal laws that are consistent nationwide and able to withstand challenges at the state level would be helpful in correcting abuses and perverse incentives in our current tort system.** Consistently applied national limits on non-economic damages would be especially helpful.

2. **Alternative dispute resolution ("ADR") methods such as mediation and arbitration may have the potential to slow the increase in malpractice expenses, but will be difficult to implement widely.** Such methods will likely only be effective if a critical mass of patients agrees to use them. Unfortunately, IHC's experience suggests achieving a critical mass may not be possible on a

voluntary basis and that mandating the use of ADR methods is extremely unpopular.

In 2003, at the urging of the Utah Medical Association and most Utah physicians, IHC supported state legislation allowing physicians, as a condition of provision of non-emergency medical care, to require their patients to agree to use arbitration to resolve medical malpractice disputes. Evidence suggested that arbitration was faster, less expensive, and just as equitable as the traditional court litigation process. The Utah legislature enacted such a law, and a large percentage of Utah's independent physicians began using mandatory arbitration in their practices. At the urging of its employed physicians, IHC's board approved the use of mandatory arbitration agreements in some of our Physician Division clinics in late 2003. We did not believe this would significantly decrease our medical liability costs, but we did believe that it would decrease the lengthy time required to resolve disputes through the courts, decrease the percentage of dollars wasted in an adversarial legal system, and increase the dollars available to compensate victims of medical error. Considerable public resistance developed, however, to the concept that physicians could refuse to care for patients who did not sign arbitration agreements, and the 2004 legislature revised the law. IHC's Physician Division clinics now encourage—but do not require—patients to agree to resolve any disputes through arbitration.

In summation, may I offer these concluding thoughts:

1. **The medical malpractice insurance crisis in our nation is real and is already adversely affecting the delivery of care in Utah and other states.** Growing numbers of patients are finding their access to care limited.

2. **The primary cause of the crisis is that traditional tort litigation is a clumsy, expensive, and often inequitable instrument for the resolution of complex medical malpractice cases.** In our current system, limited financial resources are too often consumed by the legal process rather than used to compensate injured patients.

3. **The allegations that the crisis is primarily due to incompetent medical practitioners or to profit-seeking insurance companies are not supported by evidence.**

4. **Federal limits on non-economic damages are a promising method to address the medical malpractice insurance crisis.** Alternative dispute resolution processes such as arbitration may also have potential to mitigate the problem and should be encouraged on a voluntary basis, but in our experience, efforts to mandate such ADR processes have been extremely unpopular with the public.

5. **Providing medical care is an extremely complex undertaking in which each patient is, to some degree, unique and each procedure is a "customized" procedure.** In any field of human endeavor, some error is inevitable. Even in the best medical institutions, medical error will occur, and we all agree that patients who have been injured should be fairly compensated. The challenge is to develop an optimal process for making such compensation, and to reduce the huge number of dollars wasted in an inefficient tort system and in the practice of "defensive medicine."

IHC believes our traditional system of court litigation can be improved and that medical liability reform is sound public policy. On behalf of our volunteer trustees, our employees, and the patients we serve, I thank the committee for the opportunity to provide input on this important topic.

Respectfully submitted,

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Testimony of Charles Thronson
Field Hearing of the Senate Judiciary Committee
August 20, 2004

You've just heard the heart-breaking stories of two of my clients. Unfortunately, these families are not alone in their tragedy. I have two walls in my office full of photographs of people like Christopher and Donna. Preventable medical errors like these happen far too often in Utah and across the United States. In fact, a new study puts the number of people who die each year in the US from preventable medical errors at 200,000 Americans per year, up from an earlier study showing upwards of 90,000 dead – making medical mistakes the third-leading cause of death in the nation, behind heart disease and cancer.[i] This is the equivalent of two 747 crashes every day in this country, every day of the year, year in and year out. And that doesn't include the hundreds of thousands who are injured, like Christopher and Donna, who are not killed outright.

When we talk about our healthcare system and how to make it better – and when we talk about altering our time-tested justice system – we would all be well advised to keep these people, these families at the front of our minds. Tell these people that their claims are frivolous, and that their lawsuits are "junk."

I think we can all agree that if something like the catastrophic loss that these two patients suffered happened to someone in our own families, we would all want full justice and accountability. We would want a fair shake. We would want the specifics of the case to be heard by a jury of people like us, our citizens, our neighbors. People who pay their taxes and vote. People who put up their flags and send their sons to fight for us. Ordinary people. Trusted people. And, we wouldn't want some one-size-fits-all mandate from the Federal government putting a value on the life and suffering of a loved one, no matter how shocking the case, no matter how horrifying and long the suffering.

However, when we treat the issue like an abstraction that could never happen to someone we love, it's easier to lose sight of what's important. It's easier to buy into the arguments of insurance industry lobbyists seeking to maximize corporate profits. It's easy not to question apocryphal stories of doctors begging on the streets because their malpractice insurance is too high. It's easy to latch onto a few highly publicized cases of justice gone awry. It is easy to accept "urban legends" as fact. In short, it becomes easy to lose sight of the real facts and the best interests of real people.

I ask you to consider a few facts before you think about limiting the rights of truly injured patients to pursue justice and receive fair compensation for their losses.

First, contrary to the claims of those seeking what some call "tort reform," there has been no explosion of lawsuits, in liability cases generally or in medical malpractice cases specifically. The Department of Justice's Bureau of Justice Statistics reports that the number of tort lawsuits decreased by 31.8% between 1992 and 2001. According to the National Center for State Courts, medical malpractice filings per capita decreased by

1% between 1998 and 2002. And, according to the National Practitioner Databank, to which all medical malpractice payments must be reported, the number of malpractice payments dropped 7.7% from 2001 to 2002. And, to top it all off, the Government Accountability Office calculates that total costs of malpractice litigation account for less than 2% of all healthcare costs – a proverbial drop in the bucket.[ii] Even a huge decrease in malpractice costs would have only a minute impact on overall healthcare costs for the consumer.

These statistics hardly add up to an "explosion" or a "crisis," particularly when you consider that we have no evidence that medical mistakes haven't substantially increased with the increasing demands on our healthcare system over the last decade. Mention was made in the testimony of AMA President, Dr. John Nelson, of a physician in Southern Utah who finally had to quit delivering babies because he "could not afford his liability insurance coverage." In reality, it appears that the physician in question has had a number of successful malpractice lawsuits against him, which doubtless explains to a large degree his professional liability insurance premium increases.

It is interesting that there are no insurance company executives here today. It would be even more interesting to put them under oath like the tobacco industry executives, and ask them why, when there is no evidence of a "crisis," or "runaway juries" they increased liability premiums 30-60% in one year. What a fantastic business: As an industry you can increase premiums as much as you want for essential liability coverage, blame the increases solely on the people who have already been injured or killed and on the attorneys who represent them, have your insureds, the doctors, accept this admittedly phony explanation lock, stock and barrel, and have Congress and the various state legislatures rush through legislation to "fix" a problem that never existed in the first place, thereby guaranteeing your profits and shafting the injured people that the insurance you are selling was theoretically designed to help.

Much has been made by the medical and insurance lobby about the "success" of the MICRA tort "reform" system in California. Liability insurance rate increases have been lower in California than in some other states. However, this was not the case even after MICRA was passed by the California Legislature, until the California Legislature later passed meaningful insurance reform. In addition, California adopted a "sliding scale" attorneys fee schedule, which made representing victims of medical malpractice so uneconomical that the experienced and knowledgeable legal practitioners in this area left the field to do other kinds of work, making it difficult for many people injured by medical malpractice to find competent legal counsel because it is so expensive and time consuming to analyze, file and prosecute effectively a medical negligence case. Of course, there was no comparable fee limitation or cap on defense counsel.

The bottom line is that there has never, ever, in the history of the state of Utah, been a medical malpractice verdict that could by any stretch of the imagination be called a "runaway" verdict, yet that is not what doctors or patients or the public is being told. And this is the same story in the vast majority of states who are facing this same push by the insurance industry and medical lobby.

The Congressional Budget Office has found that recent increases in malpractice premiums are as much linked to market fluctuations and poor investments by insurance companies as they are to payouts in malpractice cases.[iii] And claims that doctors are leaving their practices in droves because of malpractice premiums have not been substantiated. The Government Accountability Office "investigated the situations in five states with reported access problems and found mixed evidence. On the one hand, GAO confirmed instances of reduced access to emergency surgery and newborn delivery, albeit 'in scattered, often rural, areas where providers identified other long-standing factors that affect the availability of services.' On the other hand, it found that many reported reductions in supply by health care providers could not be substantiated or 'did not widely affect access to healthcare.'"[iv] Furthermore, the GAO has found that the U.S. physician population increased 26 percent, which was twice the rate of total population growth, between 1991 and 2001.[v]

The medical lobby argues that there are fewer medical residents who are going into fields that are perceived to be "high risk" for litigation, such as obstetrics. While it is certainly true that a mistake by an obstetrician during a delivery, that leads to catastrophic brain damage in a newborn baby can result in an expensive settlement, the obstetricians I have talked with overwhelmingly attribute the problem of attracting residents to the field more to long hours and extremely low insurance reimbursements, such as $900 total in Utah for nine months of prenatal care and the delivery.

And health care providers already have more protections than any other profession in virtually every state in the country. In Utah, physicians have a very short statute of limitations in which a claim can be brought, protections on informed consent, a notice of intent requirement, a pre-litigation screening process, requirements for qualified expert testimony before a physician can be held liable, caps on attorneys' fees (but only plaintiffs' attorneys—defense attorneys can charge whatever they want), caps on general damages, caps on judgments against state-run health care facilities, no collateral source rule, and a provision that any judgment against a physician must be paid over time, rather than as a lump sum, among other special interest protections that nobody else has.

All of this evidence adds up to the conclusion that our medical liability system is hardly in a crisis. In fact, the problem may be the opposite. According to the Congressional Budget Office, our current medical liability system may not prevent enough errors because healthcare providers are "generally not exposed to the financial cost of their own malpractice" and because "very few medical injuries ever become the subject of a tort claim."[vi] The famous Harvard Medical School study of 30,000 patient records found that in only one of seven cases of actual malpractice causing injury or death is any claim filed.

Proposals to limit how much patients can receive as compensation for non-economic damages in cases of medical malpractice will not achieve their purported goals. Proponents of such "caps" on non-economic damages say a federal limit of $250,000 would stop "frivolous" lawsuits from being filed. But when a jury sees an error so

serious that it justifies giving the victim more than $250,000, aside from lost wages and medical bills, that is, by definition, not a frivolous lawsuit. If your son or daughter ends up in a wheelchair for life because of a medical error, would you want a one-size-fits-all mandate from the federal government deciding what is fair in your case? Most Americans trust a jury of people like their fellow American citizens to make a better decision, considering the specific facts of a case, far more than inflexible government mandates.

Instead of limiting how much patients can be compensated when they've suffered tragic losses, we ought to be trying to find ways to make our healthcare system better so fewer mistakes are made. Solutions like requiring insurance companies to open their books to the public and factually justify proposed high premium increases, mandatory reporting of medical errors, penalties for alteration or intentional destruction of medical records, and hospital systems and technology to reduce medical errors would all have far greater benefit to consumers than limiting access to the court system when an injury or death occurs.

As you continue your discussions about improving our healthcare system and as you consider proposals to change the way our justice system handles medical malpractice claims, I urge you to hold on to one thought. Imagine yourself in the shoes of Karla Glodowski or Donna Page. Imagine the pain they and their families have suffered. And ask yourself: What is truly fair for the catastrophic victims of medical negligence? What is truly best for preventing these errors in the future? And, what is truly best, not for the insurance executives or the medical lobby, but for the long-term health of the people of the United States?

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[i] Patient Safety in American Hospitals, HealthGrades, July 2004.
[ii] Limiting Tort Liability for Medical Malpractice, Congressional Budget Office, January 8, 2004.
[iii] Limiting Tort Liability for Medical Malpractice, Congressional Budget Office, January 8, 2004.
[iv] Medical Malpractice: Implications of Rising Premiums on Access to Health Care, General Accounting Office, August 2003
[v] PHYSICIAN WORKFORCE: Physician Supply Increased in Metropolitan and Nonmetropolitan Areas but Geographic Disparities Persisted, General Accounting Office, October 2003.
[vi] Limiting Tort Liability for Medical Malpractice, Congressional Budget Office, January 8, 2004.