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# NATIONAL CONFERENCE ON MEDICAL MALPRACTICE

(Arlington, Va., March 20, 21, 1975)

PRINTED FOR THE USE OF THE

## SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

## COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

## U.S. HOUSE OF REPRESENTATIVES



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# PREFACE

I was very pleased to be a cosponsor of the National Conference on Medical Malpractice. I believe this meeting was most beneficial and provided an opportunity for the first time, to bring together providers of health care, lawyers, insurance companies, consumers as well as State and Federal representatives to hold in-depth discussions on this critical problem.

Based on the Conference I subsequently developed H.R. 6100, "The Medical Malpractice Claims Settlement Assistance Act," which attempts to deal with the various factors of the problem in a comprehensive way.

The awareness of the medical malpractice issue is the highest its ever been. We are being bombarded daily with information through the media and from affected groups. Yet effective solutions have not been implemented. Doctors are walking out. Health facilities are closing. Casualty companies are leaving the market. The number of suits and amount of awards continue to rise. And finally—the consumer continues to pay for it all. The malpractice insurance premiums ($1 billion annually), the defensive medicine (nearly $7 billion), and both the plaintiff and defense legal costs in seeking recourse through the judicial system.

Most of the States with a serious problem incluuding New York, have passed legislation dealing with medical malpractice. States with an immediate crisis of availability of medical malpractice insurance, for example, authorized joint underwriting or State pools of insurers to assure the availability of insurance. Some appeared to go further than others in facing up to the problem.

But despite these considerable efforts by the States, the results are not uniformly promising. Most State legislation which was enacted, for example, did not deal with the matter of limiting contingency fees, although there is general agreement among experts that this needs to be done. This is true also of collateral benefits, structured payments as opposed to lump-sum payments, and loss prevention or risk control programs. From the reports I have received from the States where crises existed and where legislation has passed, considerable doubt is expressed that the legislation will effectively reduce the number of claims, the size of awards, or the increases in their insurance premiums.

When I introduced the Medical Malpractice Claims Settlement Assistance Act on April 17 I spoke of the need for a strong State solution to the problems of medical malpractice. Both health care providers and medical malpractice insurers have been subject to State laws and regulations, and it appeared to many Members of Congress, the administration, and providers and insurers that State action was the most desirable course to take.

It is the relatively limited response of the States to a problem that is so enormous and growing so rapidly that forces me to the conclusion that the Federal Government must assume a more active role in solutions to medical malpractice. Congress must be mindful too, of the impact that the medical malpractice problem is having on Federal programs such as medicare and medicaid, and the impact it could have on any national health insurance legislation that might be enacted.

In this case, Federal involvement will hopefully mean a solution arrived at with the participation of the States, insurers, providers, and other interested parties. Hopefully the Federal mandate can be limited. But, if a comprehensive response is not forthcoming from the States, the Federal Government must assume ultimate responsibility for seeing to it that effective solutions, both public and private, are achieved in dealing with the medical malpractice crisis.

JAMES F. HASTINGS,
*Member, Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce.*

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We are pleased to join with Representative James F. Hastings in presenting these proceedings of the National Conference on Medical Malpractice, held March 20–21, 1975, at the Sheraton National Motor Inn, Arlington, Va.

This conference convened Members of Congress, physicians, lawyers, State legislators, insurance industry officals, and public interest spokesmen to discuss their respective views on the causes of and possible solutions to the problem of medical malpractice insurance coverage. Nearly 500 participants from all areas of the country took part in what has been described as "one of the most timely, well-balanced and comprehensive programs" addressing itself to the medical liability insurance crisis.

As the organization of physicians in group medical practice, whose interest in quality control has been paramount over the years, the American Group Practice Association was indeed pleased and honored to have the opportunity to cosponsor this conference with Mr. Hastings.

The material we are submitting to you is, in our opinion, the most definitive and current of its kind on this subject. I hope its contents will be useful as a reference source to the committee during its legislative deliberations.

ROBERT W. JAMPLIS, M.D.,
*President,*
*American Group Practice Association.*

## ACKNOWLEDGMENTS

We gratefully acknowledge the thoughtful and concerned guidance we received from the many interested persons in both the public and private sectors.

For assistance given us in identifying specialty area speakers and his own participation, we thank Dr. Robert O. Egeberg, special assistant to the Secretary of HEW for health policy.

For the actual conference organization and arrangements which contributed significantly to the effectiveness of the conference we thank James B. Cobb, executive director; Lawrence S. Hoffheimer, counsel; Betsy M. Goodfellow, director of public relations; and Barbara A. Green, director of educational services of the American Group Practice Association.

For the preparation of the background materials for the conference we gratefully acknowledge the excellent contribution of Mr. Herman Schmidt from the Educational and Public Welfare Division of the Congressional Research Service.

For their assistance in the conference design and format our special appreciation goes to Spencer C. Johnson, administrative assistant; and Jennifer L. Benedict, staff assistant to Representative James F. Hastings.

Our special thanks to all of the conference panelists and speakers, who without their special contribution, the Conference could not have been successful.

JAMES F. HASTINGS,
*Member, House Subcommittee on Health and the Environment.*
ROBERT W. JAMPLIS, M.D.,
*President, American Group Practice Association.*

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## NATIONAL CONFERENCE ON MEDICAL MALPRACTICE

[Held at Sheraton National Motor Inn, Arlington, Va., March 20–21, 1975, Sponsored by Hon. James F. Hastings, U.S. Representative and American Group Practice Association]

The 1975 National Conference on Medical Malpractice brings together representatives from various groups affected by the problem to publicly air their views and to discuss some of the possible solutions that have already been advanced.

Designed as a public forum, the Conference will examine the medical liability insurance crisis from the vantage points of federal and state legislators, public officials, physicians and other health care providers, attorneys, insurers and consumers.

It is hoped that the discussion stimulated by this interaction will result in a greater knowledge of the problem and its many parameters in order to develop a base of information and understanding essential in formulating effective public policy.

*James F. Hastings, U.S. Representative, Thirty-ninth District, New York*

Serving his fourth two-year term in Congress, Representative Hastings has played a leading legislative role in the field of health care, having been a champion of such legislation as the National Cancer Act, the Health Maintenance Organization Act, the Health Programs Extension Act and the National Health Planning and Resources Development Act.

Prime sponsor of the successful 1973 legislation reprieving several major health programs from extinction, the Congressman is known to his Hill colleagues for his far-reaching and innovative attempts to provide Americans with more effective and less costly medical service.

*Robert W. Jamplis, M.D., President, American Group Practice Association*

In addition to the practice of thoracic surgery, Doctor Jamplis is Medical Director of the Palo Alto (California) Medical Clinic and Clinical Professor of Surgery at Stanford. A member of the National Board of Directors of the American Cancer Society, Doctor Jamplis has authored many professional articles and has lectured extensively throughout the U.S. and Europe.

In conjunction with his position as President of the AGPA, Doctor Jamplis has become deeply involved in medical legislative affairs participating in Congressional hearings and delivering the group practice viewpoint in testimony before varous House and Senate committees.

### Conference Program

#### WEDNESDAY, MARCH 19

12:00 noon–10:00 p.m. Assembly Foyer—Registration/Information.

#### THURSDAY, MARCH 20

7:30 a.m. Assembly Foyer—Registration/Information.

8:30 a.m., Commonwealth North Ballroom—Welcome and Introduction to Conference:

James F. Hastings, U.S. Representative, Member, House Subcommittee on Health and the Environment.

Robert W. Jamplis, M.D., President, AGPA, Medical Director, Palo Alto (California) Medical Clinic.

9:30 a.m.—Speaker: Edward M. Kennedy, U.S. Senator, Chairman, Senate Subcommittee on Health.

9:00 a.m.—Availability and Cost of Medical Malpractice Insurance:
Moderator: Senator Edward M. Kennedy.
Discussants:
Warren Cooper, Vice President and Actuary, Chubb & Son Inc.
John E. Linster, Senior Vice President for Governmental Affairs, Employers Insurance of Wausau.
John A. McMahon, President, American Hospital Association.
Malcolm Todd, M.D., President, American Medical Association.
Edward D. Henderson, M.D., Chairman, Professional Service Committee, American Academy of Orthopedic Surgeons.
10:00 a.m. Assembly Foyer—Refreshment Break.
10:30 a.m.—Discussion Continued.
12:15 p.m., Commonwealth South Ballroom—Luncheon—Luncheon Speaker: Paul G. Rogers, U.S. Representative, Chairman, House Subcommittee on Health and the Environment.
1:45 p.m.—Impact on the Health System:
Moderator: Robert W. Jamplis, M.D.
Discussants:
Adrienne A. Astolfi, Director, Hospital and Health Care Sector of the National Commission on Productivity.
Robert E. Cartwright, LL.B., President, The Association of Trial Lawyers of America.
3:00 p.m. Assembly Foyer—Refreshment Break.
3:30 p.m.—Malpractice: State Role:
Moderator: Henry A. Waxman, *U.S. Representative, Member, House Subcommittee on Health and the Environment, Former Chairman, California Select Committee on Medical Malpractice.*
Discussants:
John R. Dunne, *New York State Senator, Chairman, N.Y. State Senate Insurance Committee.*
Tarky Lombardi, Jr., *New York State Senator, Chairman, N.Y. State Senate Health Committee.*
Lester L. Rawls, *Insurance Commissioner of Oregon, Chairman, Committee on Malpractice of the National Association of Insurance Commissioners.*
6:30 p.m. Assembly Foyer—Reception.
7:30 p.m., Commonwealth South Ballroom—Dinner—Dinner Speaker: Dan Rostenkowski, *U.S. Representative, Chairman, Subcommittee on Health of the House Ways and Means Committee.*

FRIDAY, MARCH 21

9:00 a.m., Commonwealth North Ballroom—Alternatives/Remedies:
Moderator: Representative James F. Hastings.
Discussants:
*Risk Control and Patient Education*—Joseph B. Davis, M.D., *Chairman, Insurance Trustees, American Group Practice Association.*
*No Fault Insurance*—Clark C. Havighurst, J.D., *Professor of Law, Duke University.*
*Medical Injury Compensation*—Geoffrey Segar, LL.B., *Medical Liability Defense Attorney, Indianapolis, Indiana.*
*Quality Control*—Henry Simmons, M.D., *Acting Deputy Assistant Secretary for Health, Director, Office of Professional Standards Review Organizations.*
*Arbitration*—David S. Rubsamen, M.D., LL.B., *Editor, Professional Liability Newsletter.*
*Emergency Short Range Approach*—Joseph F. Sadusk, Jr., M.D., *Senior Consultant to The Permanente Medical Group.*
10:30 a.m. Assembly Foyer—Refreshment Break.
10:45 a.m.—Alternatives/Remedies Continued.
12:00 noon, Commonwealth South Ballroom—Luncheon: Luncheon Speaker: Roger O. Egeberg, M.D., *Special Assistant to the Secretary of HEW for Health Policy.*
2:00 p.m.—Adjournment.

# NATIONAL CONFERENCE ON MEDICAL MALPRACTICE

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**THURSDAY, MARCH 20, 1975**

ARLINGTON, VA.

## AVAILABILITY AND COST OF MEDICAL MALPRACTICE INSURANCE

Dr. JAMPLIS. I would like to call this National Conference on Medical Malpractice to order. I am Robert Jamplis, a chest surgeon from the Palo Alto Clinic in Palo Alto, Calif., and president of the American Group Practice Association. I am delighted to welcome all of you and our speakers to this conference here today, which is being cosponsored by the American Group Practice Association and the Honorable James F. Hastings, U.S. Representative in Congress from the 39th District of New York, a Republican and a member of the House Subcommittee on Health and the Environment.

This conference is a culmination of many months of discussion and examination of the malpractice problem. In the course of developing this program, we at the American Group Practice Association discussed this subject in great detail with many people from other national health organizations, Members of Congress, and other government officials. We discovered that although there was a great deal of independent activity and concern over what we think is a real crisis, there was very little sharing of information and viewpoints and virtually no progress toward making any real solutions.

It was really the interest and support of Congressman Hastings that provided the final impetus for convening this conference, because in Congressman Hastings, we found a concerned and sympathetic lawmaker, desirous of exploring the many factors associated with this monstrous problem.

Together, we have tried to assemble a national forum whereby all affected parties may share their ideas not only on the causes but more important, on the possible solutions to this dilemma. The American Group Practice Association is extremely pleased to have Congressman Hastings as a cosponsor and you will hear from the Congressman shortly.

I would like to just take a few moments to outline in my own terms what I think is the problem and why we are all meeting here today. I think I should say at the outset that you will notice that we have called this a conference on medical malpractice, not professional liability. We much prefer the latter term, but we all know that there are also other types of professional liability, on the part of engineers,

architects, accountants, lawyers, so we wanted to be very definite that the public understands what medical malpractice is.

Now let us look briefly at a definition in Webster's Collegiate Dictionary of just what malpractice is. Quote:

> The dereliction from professional duty or a failure to exercise in accepted degree of professional skill, or learning by one rendering professional services which results in injury, loss and damage. 2. An injurious, negligent or improper practice, a malfeasance.

That is the end of the quote.

Now I understand that Black's Law Dictionary is equivalent in medicine to our Stedman's and Dorland's and the definition of malpractice that the lawyers take from their dictionary is as follows, and I quote:

> 1. As applied to physicians and surgeons, this term means generally professional misconduct towards a patient which is considered reprehensible either because immoral in itself or because contrary to law or expressly forbidden by law, and in a more specific sense it means bad, wrong or injudicious treatment of a patient, professionally, and in respect to the particular disease or injury resulting in injury, unnecessary suffering or death to the patient, disregard of established rules or principles, neglect or a malicious or criminal intent.

Now, that sounds pretty bad, and frankly it scared me. But that is the definition and that is what we are going to have to face right now.

Medical malpractice insurance is designed to protect the providers of health services against severe losses which might be occasioned by malpractice claims as well as to compensate the injured patient. Physicians as well as hospitals and other health institutions must have adequate malpractice insurance to provide protection against financial insolvency in the event of some catastrophic malpractice judgment.

In fact, there was a recent court decision which upheld the right of a hospital to require that a physician applying for membership to the staff have adequate malpractice coverage before he could be admitted to the staff and treat his patients there.

I think the critical issues, which have brought us all together, are two. No. 1 is obviously the rapidly skyrocketing cost of the insurance premiums for malpractice. The second, and perhaps even more important, is the increasing unavailability of malpractice insurance for physicians. Compounding this problem is the fact that over the past few years, the number of malpractice insurance underwriters has shrunk to just a handful and these few companies now underwrite fully 90 percent of all of the insurance.

The dramatic increase of the number of claims, combined with the staggering size of the settlements and judgments, particularly in my home State of California, have forced the underwriters to seek ever increasing premiums, or, restrict their business, or they cease providing coverage altogether, which I think is a pretty scary situation. One of the most overriding concerns of physicians and other health care providers is the real threat that they will be unable to purchase malpractice coverage at any price because the underwriters will no longer be willing to offer it.

These actions have already succeeded in forcing some physicians to give up their practices, others to restrict their practices, and some to substantially increase their fees in order to cover the increased malpractice insurance costs.

The threat of possible medical malpractice, and claims that result from alleged malpractice, have created certain other important stresses on the health care system. Physicians, because of their great concern for avoiding malpractice suits, frequently practice what you all know as defensive medicine, ordering additional lab tests, additional X-rays, additional drugs, and so forth. And this practice of defensive medicine has resulted in higher and higher health service costs, and over-utilization of already scarce medical resources.

The fear of medical malpractice charges may also jeopardize the very sacred relationship between the doctor and his patient, so that from the minute a patient enters the doctor's office, he can be viewed as a potential adversary in some future malpractice lawsuit. I think this concerns doctors greatly.

Still another concern about the malpractice problem is that it will discourage physicians from delegating responsibilities and duties to other members of the health care team—the nurse, the physician's assistant, and allied health personnel—who are fully qualified to perform such services, for fear that these ancillary personnel might incur suit against the physician.

We must not lose sight of the fact that we in the United States enjoy, in my estimation, the very best health care in the world and I say that from personal experience the world over. The miraculous achievements of modern medicine and the doctor's image which has been so tremendously improved on TV, is all fine, but it is also leading the public to believe that virtually any condition can be cured by one of the wonder drugs, some fantastic new operation, or some form of medical treatment. In fact, this belief has been held to such a degree that there is almost universal overexpectation by the patient of the possible results. Also, it is almost always true that any drug or indeed any operation or any type of medical treatment modality, however beneficial, is almost always dangerous in proportion to its potential efficacy.

There certainly have been adverse drug reactions and there have been undesirable side effects of surgery or medical treatment, but this per se is not malpractice. In these cases, the patient who has been damaged should be adequately compensated but this compensation should not be of such magnitude or incidence as to disrupt the entire health care delivery system.

Just for a moment, let's take a look at some statistics. We have roughly 300,000 doctors involved in patient care in this country. And these doctors, each one of them, sees approximately 138 patients per week. Now with simple arithmetic, this is approximately 2 billion doctor-patient encounters a year, or to be very conservative, 5 million such encounters occur every day. Now I understand that there are approximately, and this again is on the high side, some 20,000 malpractice claims that are filed each year. Now these are claims, these are not suits that are won or lost but claims, and thereby by another simple arithmetical calculation, you come out with the fact that there is only 1 claim for every 100,000 patient-doctor encounters.

So, from the patient's view at least, the chances are rather small that he will be a party in a malpractice suit. But what we have to be sure is that we do not allow that one sour crabapple to spoil a whole silo of beautiful big, red apples.

Now even the most highly qualified physician can become involved in a malpractice allegation. Not because he is incompetent, but because the practice of medicine is complex and it is becoming ever more complex as the years go by. Human errors in judgment and undesirable results have occurred and will continue to occur, even with the most competent medical practitioners practicing good medicine.

Now we all, and when I say all I mean just that, everyone, the medical professions, the consuming public, the legislators and government officials, the insurance companies, the lawyers, everyone, must recognize that health professionals cannot be expected to be infallible. There must be some protection under the law, for all parties.

The factors surrounding our current malpractice crisis are many and they are varied, and indeed they are so interwoven as to make the situation a veritable maze. And I don't think that any useful purpose will be served by attempting to place the blame on either the doctors or the lawyers or the insurance companies or the patients. All, in my estimation, are inextricably interwoven both in the problem and in the possible solution, so our challenge here today as I see it, and at this conference, is to examine in a constructive forum the component parts of the problem, and to discuss the potential solutions both short and long term, putting them in a proper perspective from which some effective action can be taken.

In other words, let's restore some reason to the system. Let's define the illness, let's make an intelligent diagnosis, let's institute the proper treatment, but for heaven's sakes, let's not throw the baby out with the bath water.

Now I sincerely hope that you will find this conference instructive and more important, that solutions will be forthcoming.

It gives me great pleasure to introduce our conference cosponsor, the Honorable Congressman from New York, James F. Hastings.

Mr. HASTINGS. I thank you Dr. Jamplis, and ladies and gentlemen. I just would like to add my word of welcome as the cosponsor, together with American Group Practice Association for your presence here. It is indicative, I am sure, of the interest and concern that you have and you share with those of us who will be involved in trying to offer some solutions to the problem that faces us.

You will be exposed today, to those people here and in Washington, both the Senate and the House of Representatives, who will be the keys as it relates to legislative approaches, to trying to solve this problem.

I might say that, from my own point of view, I come into this conference not knowing what the Federal role should be, not having predetermined the type of legislation that we should write in response to the problem that we know exists. And that, I guess, would say that the very purpose of this conference is to try to outline to us precisely what the parameters of the problem are, what some of the questions are, and then hopefully answer, after absorbing all of this, to the degree that the Federal Government's role is and will be involved, to try to write that kind of responsive legislation.

There are, as you know, legislative proposals already before the Congress. Senator Kennedy has introduced at least two bills. Senator Nelson, Congresswoman Holt, Congressman Rostenkowski who incidentally will be here as your speaker this evening, and all of those

legislative attempts are being held in somewhat of abeyance at the moment, and I would hope that the results of this conference will then tell to the Congress, in which direction we should proceed in order to respond to this problem.

At this point, I am going to introduce Senator Kennedy, who will address you next. I might say I don't believe there is a man, woman, or child in this country that doesn't know who Senator Kennedy is. I am sure you all do. I want to tell you just a bit and Senator if you don't mind, I believe in very short introductions.

I might say as a member of the Public Health Subcommittee in the House of Representatives, I have had, of course, the opportunity to work with Senator Kennedy in his counterpart role in the Senate, and in matters relating to health. And although the Senator is known for his great and wide and varied interest and concerns in matters relating to this country, the role that I know him in most intimately, is that of a major contributor to health legislation in this country. I can say without any question that of the handful of people who decide public policy as it relates to the delivery of health care in the United States, Senator Kennedy is right on the top of this very list. And Senator, I want to personally thank you for taking your time to accept this invitation to appear here. I know of your interest in the subject and I welcome you and without further ado, Senator Edward M. Kennedy.

Senator KENNEDY. Thank you very much. Dr. Jamplis and the members of our conference group that are here, and the cosponsors of this meeting and Congressman Hastings, I do want to join with all of you in thanking our cosponsors for bringing us all together on a matter that I think is of very considerable importance and consequence to not only the health professions, but to all Americans. And I think this is in the great tradition of our country, I like to believe, where those of us who are in Government and those that are in the practice of medicine have an opportunity to exchange ideas. I will not have the full opportunity to be here during the conference itself, the whole conference, but I want to give the assurance to all of those who are here and participate that I, too, like Congressman Hastings, will very much welcome the deliberations of this conference and the contributions that are made to it.

We are fortunate to have the leadership of Congressman Hastings, as we sit down hour after hour on a variety of different pieces of health legislation, not only on this important measure, but on many of the health care issues. This is where the legislation is really hammered out and the initiative which he has shown today with the American Group Practice Association and others of you is just typical of what is happening.

When I praise a Republican, all hell breaks loose.

It reminds me of my favorite St. Patrick's story where a fellow was walking down the street in Dublin and this fellow comes up and says, stick 'em up. What religion are you? This fellow says, well now I know I am really in trouble. If I say I am a Catholic, he is a Protestant. If I say I am a Protestant, he is a Catholic. So he thought for a little while and he said, I have got the answer. He said, I am Jewish. And the other fellow responded. I am the luckiest Arab in all of Ireland.

Well, I am delighted to have been invited here this morning to this timely conference on medical malpractice. The doctors and hospitals and patients together face the current crisis in medical malpractice insurance. Premiums for malpractice insurance have increased tenfold over the last decade and that is when insurance still exists. The rising number of claims have driven malpractice insurors to attempt to withdraw from the field entirely in some States.

Only the intervention of the States has temporarily restrained them. These developments trigger consequences which threaten the entire structure of our health care system. Doctors are justifiably afraid of the possibility of large plaintiff awards against them in malpractice suits and are threatening in some States to stop practicing unless malpractice insurance coverage is continued.

We cannot allow this to occur. Yet, who can blame the doctors? Malpractice actions can economically destroy a doctor's life and threaten to follow him even into retirement. Doctors cannot be reasonably expected to continue to practice with that sword of Damocles hanging over their heads. The greatest tragedy is that it is often the best doctors, those willing to tackle the toughest cases, who face the highest risk. And it is the patient who will ultimately suffer burdens of the current uncertainties in the field of medical malpractice insurance. It is the patient who would suffer if doctors actually withdrew their services from their communities and in my own State of Massachusetts, surgery at the Springfield hospital may come to a complete stop because anesthesiologists there cannot obtain malpractice insurance. Yet those skilled professionals have not paid a single malpractice claim in the past 10 years.

It is the patient who also is suffering the financial burden of the current crisis in medical practice as well, for the rapidly rising cost of malpractice insurance does not stop at the doctor or the hospital. They are passed straight through to the medical bills that every family must pay.

The Michael Rees Hospital in Chicago, has been hit with a fivefold increase in its malpractice insurance rates in the past year. Last month, they paid over $0.25 million in premiums and those premiums are translated to a $10 average hike in the daily room cost to Michael Reese Hospital patients. It is another example of skyrocketing economics of medical care.

To add insult to injury, the patient, the purported beneficiary of malpractice suits, rarely if ever receives benefits which even approach his costs. Many experts estimate that as little as 16 cents of each premium dollar paid is actually recovered by the injured patient. The rest is consumed by court costs and legal fees and a multiplicity of other charges before reaching settlement.

It is the patient who pays in lost time under the present tort system of resolving malpractice disputes. Almost 15 percent of all malpractice cases and half of all jury cases are still pending 5 years after the initial claim is filed. And it is the patient who also pays the indirect costs of the present system of medical malpractice. Recent opinion surveys report that 50 to 70 percent of physicians polled said they engaged in various forms of defensive medicine. And Dr. Jamplis has pointed this out—the problems with this, and I understand that in a recent survey, two-thirds of our doctors thought that defensive medicine had no effect or lowered the actual quality of health care.

Many analyses of the causes of the malpractice crisis have appeared in professional and lay publication in recent months. The causes are complex. But I believe some of them can be clearly identified. The first, as Dr. Jamplis pointed out, is that the increasing complexity of medicine has made medical malpractice actions more likely. More potent medical techniques have made treatment-related injuries more likely, increased complexity and specialization also has contributed at least in part to the deterioration of the doctor-patient relationship.

The family doctor has been replaced by an amazing array of specialists, each interested in a specific illness rather than in a whole human being. And every patient is reminded of this each time he or she receives a bill from a physician. Jack Jones, M.D., who a generation ago was a friend, personal counselor, and family doctor has become Jack Jones, M.D., a professional corporation and a generation ago, when I was a child, no family would ever have given consideration to suing their doctor, but who would be reluctant to sue a professional corporation, who has charged a high fee and spent a minimum amount of time in examining a left eye or a right elbow. And it would be interesting to know how often those doctors who still spend time getting to know their patients and offering their reassurance and advice in addition to medical treatment are really sued for malpractice.

The tragedy is that they, as much as anyone, are caught up in this whole malpractice crisis.

Second, the insurance industry shares the mantle of blame. According to their own data over one-third of each premium dollar goes for acquisition and production, administration, and general company overhead. And that represents a substantial flow of dollars. When one looks at the rising level of malpractice premiums—and they have drifted from $61 million in 1960 to a highwater mark of an estimated $1 billion, for 1975—even though insurance companies claim that losses incurred have exceeded premium income for every year since 1968. A substantial proportion of those losses represent the insurer's valuation of future potential claims.

Why don't insurers include returns on investment on those huge reserves in their calculation of loss ratios? Attempts by my subcommittee staff to determine just how these estimates are made have as yet been unsuccessful. I hope this point can be clarified in data supplied during this conference and subsequent Senate hearings before my subcommittee.

I would very much like to know why malpractice insurance rates have suddenly doubled and tripled in the past 2 or 3 years, and I believe doctors and patients would like to know the answer as well. It is all too reminiscent of what happened to gas and oil prices during the Arab embargo.

Third, State insurance commissioners have been negligent. They have fiddled while malpractice protection burned. What have they been doing while the situation has been deteriorating so rapidly? I am afraid this is one more example of the impotence and ineffectiveness of State regulatory activities in the health field. The problems of medical malpractice traditionally have been dealt with at the State level, and insurors are regulated by the States, and the health care providers are regulated by the States. But the regulations have been too weak and the oversight too infrequent, and the enforcement in-

visible. The time is overdue for the Federal Government to take a more active role in dealing with the many problems of medical malpractice; to allow the States one by one, to take stopgap holding actions will take far more time than we can afford.

Fourth, attorneys, particularly trial lawyers, must share part of the blame. Doctors and insurors alone cannot be held solely responsible for the development of the present crisis. A major share, over 50 percent of the malpractice premium dollar, goes to plaintiffs and defense attorneys. At an estimated premium volume of almost $1 billion this year, lawyers fees will amount to over $0.5 billion. At a Health Subcommittee hearing 3 years ago, concerning medical malpractice, the representative of the American Trial Lawyers Association vigorously defended the patient's right to litigate. But with those fees, it is no wonder that they see the tort system as the golden goose who laid the golden egg. I suspect we will hear some response on this.

In addition, although the contingent fee system common in the malpractice field does allow patients to obtain competent but high priced attorneys, it discourages the filing of many small but meritorious claims. A recent study showed that 23 percent of all malpractice cases rejected by lawyers were rejected for economic reasons. The potential recovery amount was, in their opinion, too small to warrant taking the case.

I have been told that most lawyers will not accept a malpractice case unless the anticipated verdict is at least $50,000. Once again, the patient ends up shouldering the greatest share of the burden, of our dinosaur-like system of medical malpractice insurance and litigation.

Finally a word on one of the most important parts of the medical malpractice problem. The amount of preventable injuries that are occurring and the effect of malpractice and the way that medical care is delivered in this country, by and large, the care given by doctors in hospitals in America is the best in the world but unfortunately, too many errors still occur. The insurance industry estimates that half of the claims filed for malpractice are meritorious and the secretary's commission on medical malpractice estimated that 1 patient out of every 40 discharged from hospitals suffered injury as a result of negligence.

Based upon this data, the number of negligence related injuries probably far exceeds the number of claims. We as a nation cannot allow a single hospital or a single doctor the luxury of providing substandard care. Unfortunately, we have not been able to reach the point where care throughout the United States is of equally high quality. Any proposed solution to the medical malpractice problem must address the problem of the quality of health care. It must be improved, but that is not a simple task. I think professional standards review organizations, PSRO's are a step in the right direction.

Developing standards of care and monitoring quality against those standards gives health care providers and consumers an essential tool to deal with substandard performance. Monitoring performance, however, is only one way of addressing the quality issue.

We also need to address it by establishing uniform standards of licensure throughout the United States to assure that health care providers are uniformly highly qualified. I understand the problems that doctors face in keeping abreast of all scientific advances in the field of medicine. Many providers of health care are successful in

keeping up with advances in medicine, but many are deficient in this regard. Lack of time can be no excuse however, for practicing substandard medicine. Effective mechanisms to insure that all doctors maintain a high level of proficiency are essential for this purpose.

In the past, many State boards dealing with medical licensure have been lax or have been totally ineffective. Doctors are a national resource. We must have national standards for licensure and a periodic relicensure that will encourage the climate for continuing education.

Although I do not suggest that I have the answers, I have introduced two bills dealing with medical malpractice to the Senate of the United States. And certainly Congressman Hastings, I think, has sounded the right note in his opening remarks about how much all of us look forward to learning from this conference, but I have introduced two pieces of legislation which have been cosponsored by my good friend and colleague, Senator Inouye of Hawaii. These bills represent two very different approaches to solving many of the problems we presently face in the malpractice field.

In both bills, the Federal Government is entering the malpractice insurance business. It will become the insurance agent for the public interest, and an insurance fund will be established within the Department of Health, Education, and Welfare to compensate patients for injuries received from medical care. And the fund would be supported by premiums paid by doctors and other health care providers. S. 215, the first of the two bills introduced, is structured on the premise that persons who receive injuries as a result of medical treatment, or misdiagnosis, regardless of whether fault is involved, should be entitled to certain benefits, including compensation for medical expenses and income loss. Under this no fault system, fault or negligence would need not be established. It is our assumption that victims might prefer no fault route over the traditional tort system. I believe no fault would result in a more rapid processing of claims at a much lower cost; patients could choose, however, and could opt for the traditional court system.

As such S. 215 is written to provide last dollar coverage after the patient has received the benefits of whatever other insurance coverage he has. Obviously the enactment of a comprehensive national health insurance program would greatly reduce the size of awards under the medical injury compensation insurance program, since most of the medically related costs of injury would have already been covered.

The second bill, S. 482, establishes a network in which all claims resulting from medical injury would be subjected to nonbinding arbitration. The arbitration panel which would be made up of both doctors and lawyers, would also decide on the compensation due a patient from the injury. I believe such an arbitration approach would greatly expedite the claims process. While I clearly recognize the need to protect the plaintiff's right to litigate, and the defendant's right to due process, I see absolutely nothing wrong in providing the injured patient with a faster, less costly alternative to litigation in seeking compensation for medically related injuries. In order to insure that the quality of care is maintained, both bills require that professionals who purchase the Federal insurance will have to comply with a minimum set of national standards of licensure and relicensure which would be implemented at the State level.

All physicians must also agree to have their records subject to PSRO review. These bills requiring a confirmation consultation for participating physicians prior to surgery for specific surgical procedures. A recent study in New York City demonstrated that when confirming consultation was sought prior to surgical procedures, the number of operations fell by 25 percent. In addition, all claims would also be reported to the appropriate professional State licensure bodies and to the appropriate PSRO. This feedback to the appropriate agencies will enable him to perform their quality assurance functions and to build a systematic body of knowledge on quality assurance.

I have outlined for you, what I view as the most serious problems with malpractice. The outstanding short term problems are those of availability, cost, and regulation. The long term problems relate to the entire medical care system. We must insure, by statute or by other means, that medical malpractice insurance will continue to be available at reasonable costs to doctors and to hospitals, but we have even a greater responsibility to the public to combine relief from medical malpractice crisis with the maintenance of high quality of our best medical care, and the elimination of poor medical care.

It is not enough to become interested in the problem only when a crisis arises. Bandaid remedies for generalized illnesses do not and cannot work. Any legislative remedies to the current medical malpractice crisis must deal with the causes, not the symptoms of the disease. They must further the treatment of our entire health care delivery system.

The Senate Subcommittee on Health, which I chair, will hold hearings on medical malpractice here in Washington beginning April 8. I hope that what we learn here in the next 2 days will be helpful to our deliberations. I look forward to your debate. I welcome your opinions. I anticipate your criticism and I challenge you to help us find the answers to these problems. Cooperative efforts from doctors, insurors, lawyers, legislators can result in a prompt and permanent solution to the problems we face, a solution which will benefit American medicine and benefit the American people. Thank you.

We will get started with our panel on the availability and the cost of medical malpractice insurance and we want to introduce the various panelists. First of all, on my left and your right, Warren Cooper, the vice president and actuary for Chubb & Son, Inc. He has been with the New York firm of Chubb & Son for 18 years, a member of the American Insurance Association special committee on medical liability. He is chairman of the industry's advisory committee for the NAIC subcommittee on professional liability. He is a member of the Casualty Actuarial Society, the American Academy of Actuaries, and the International Actuarial Association.

Mr. John Linster who is the senior vice president for Government affairs for the Employers Insurance of Wausau, Wis. Mr. Linster, an attorney, has served on the Secretary's Commission on Medical Malpractice. He has been employed with the Employers Insurance of Wausau since 1940. The Employers Insurance of Wausau has been involved in malpractice insurance in New York State for 24 years. Mr. Linster has personally been involved in that program for 21 of the 24 years.

Alex McMahon is president of the American Hospital Association and has served as AHA president since November 1972. He is an attorney, former president of North Carolina Blue Cross and Blue Shield. He served as chairman of North Carolina's first regional health planning agency.

Dr. Coury is a member of the AMA's council on legislation. Former president of the Michigan State Medical Society, 1972–73. He is a—we ought to introduce because some can't see the name tags. So I will ask Mr. Cooper, who is our first—would you stand up, Mr. Cooper. He is the actuary from Chubb & Son. And a New York firm, just so we know who our players are. Mr. Linster, who is from the Employers Assurance in Wausau, Wis. Alex McMahon, who is the president of the American Hospital Association. And Dr. Coury, who is a member of the AMA's council on legislation, former president, as I mentioned, Michigan State Medical Society, 1972–73, and member of the Governor's State health advisory council, State of Michigan. Served on the physicians' advisory council, American Hospital Association, chairman of the medical malpractice committee, Michigan State Medical Society.

Dr. Henderson, who is the chairman, professional services committee of the American Academy of Orthopedic Surgeons, chairman of the department of orthopedic surgery Mayo Clinic. Recently assumed office of the second vice president of the American Academy of Orthopedic Surgeons.

Robert Cartwright, who is president of the Association of Trial Lawyers of America, is a fellow of the International Academy of Trial Lawyers, is past president of the California Trial Lawyers.

Everybody is a president or a vice president around here.

Thomas Vehlin, who is the professional liability risk management officer for St. Paul Fire Marine Insurance Co., St. Paul, is one of the largest underwriters of physicians' liability insurance coverage. They recently announced that they will seek to change from occurrence policies to the claims made approach—we will hear from him in maybe a few moments in the audience. We are going to recognize him right away.

The way we will proceed, we will have each panelist make a brief comment and then we will get the discussion going. We will start off in that order and hear from Mr. Cooper, if he would make a comment, please. Try to keep the comments to 4 or 5 minutes initially, as I am sure we will have a lot of questions.

Mr. COOPER. While sitting up here, I went through the list of registrants and noticed that there was a very minimal representation from our insurance fraternity here. And this perhaps bespeaks of three things. The first is that there are very few of us left in this game.

The second is that those of us who are left are just weary of the whole thing, and third, that this really is not an insurance problem. It is a social problem. We find ourselves in the middle of it, but we do not feel that we caused it and we are not sure that anything really can be done within our particular industry to make the basic changes that have to be effectuated.

This panel is dealing, at least by the name of it, with problems of availability and cost and I thought that it might be wise to review

some of the reasons why there is an availability crunch. The main reason is our inability as insurance people to perceive the price that we really feel should be charged for this line of business, for in our economic scheme, the businesses really operate only effectively only if they can perceive what they should charge. There are perhaps four basic reasons that we feel that we lack this perception.

One is what we call the long tail. This word is a most unfortunate one. It is used in certain contexts which may not pass the censors. At any rate, this particular tail is very long. Basically, if we go back and re-sort losses over a period of time after we have wrapped the whole thing up, we will have paid only around 20 percent of the losses in the first year and maybe 30 percent in the second year, followed by another 30 percent the third and so on out. The payment pattern strings out over a period of 10 years or so before we fully realize the costs that we have charged money for 10 years earlier.

Second, there is very low credibility. Credibility is an actuarial problem dealing with the amount of trust that we put into any rate scheme. My company writes a State group in New Jersey with between 7,000 and 8,000 doctors, and we rate the program as an independent entity. This, as an actuary, makes me a little uneasy, I wouldn't consider making rates for that few automobiles. I would demand several more thousand, maybe a few hundred thousand, in order to be sure of the rates that I was charging, especially if I am going to slice the experience up into various classifications for pricing.

Third, this is catastrophe insurance. It wasn't at one time. It is now, but when we made our rates several years ago, we didn't realize this was to be the case. In California, there have been 26 or so judgments in excess of $1 million, 16 of them have been within the year 1974. In the last 6 months, we have seen one every month. Illinois recently has had four $1 million-plus judgments. Large settlements are even creeping into dental liability. We write, in California, the dental association and have for several years. In 1975, we paid our first award over $100,000 and we didn't pay just one, we paid three, within 1 month.

Fourth, we cannot keep abreast of the trends. We have been making rates, over a period of time, on the occurrence-form basis where consideration of trend are fundamental. Just to give some idea of how unruly trends have been consider one account that we write, where the averages of disposed cases went from $2,800 in 1966 to $16,700 in 1973. In the earlier years when we made the rate schedules, we could not by any chance foresee that we would get an average 20-percent increase per annum in severity.

Frequencies have been equally unpredictable. In another account in which we have taken something of a bath, we started in the early sixties with a constant frequency of 9 percent, that is 9 claims per 100 insured doctors. Looking at these figures, we saw no ready increase in frequencies. But consider what happened. The number of claims immediately went up in the following years, 11, 12, 13, 16, 20, and finally in 1970 21 claims per 100 doctors. St. Paul, I believe, released figures that several years ago they had one claim for every 23 doctors. It is now up to 1 in 10. We are experiencing approximately the same thing. In certain of the high-rated categories such as neurologists we can count on 1 in 4. And again, back in history when we were making the rates that pay today's settlements we couldn't see the scope of such trends.

But there are other problems other than just the perception of price. Smaller companies particularly who are dependent upon reinsurers have found extensive problems in buying reinsurance. The secondary market has receded along with the primary market. We understand that there are very few calls at Lloyds now who are willing to provide coverage to the primary American market.

Further, we are very much afraid that the current publicity that meetings like this are generating plus the coverage in the media—in general the constant public exposure of malpractice problems—are stimulating more cases. We have seen recently a doubling in the frequency of dental claims. A lot of these were not meritorious, but they were made, and I suspect several are due to the publicity. Those of us who stand like myself in front of these microphones are just as guilty of this as anybody else.

Another reason for shrinking markets is our fear of regulatory unfriendliness. Certainly this is not true of all or even many States, but there are a few within the Union where we do not have an understanding, regulatory environment and where our problems, as we perceive them at any rate, are not appreciated by the regulators.

Not unimportant is the fact that in this last year we have had severe surplus problems. Insurance accounting is a very interesting if perplexing thing. Say we had in State A a plan where we thought that our rates were only half what they should be. If our surplus is not big enough to warrant the increase in premiums, we would probably opt to drop that program rather than increase the rates to an adequate level, granted we were able to do that. Our writings, then, might exceed a number which produces a safe ratio to our surplus, and regulators quite properly would show concern for solvency.

With regard to surplus there is one point that I do want to make. There has been, I think, some severe misunderstanding that because of surplus shrinkage and the underwriting losses we sustained in the past year, we are raising rates by way of recoupment. There is no company that I know of who has put into their ratemaking structure any consideration of recouping stockmarket losses, and there is no regulator who would entertain such a filing. It is in strict violation of the rate regulatory laws. Diminished surplus impacts availability, not price.

A new element in the availability picture is an apprehension about the various types of pooling arrangements designed to answer the problems of collapse of market. We fear that there will be subsidies from our industry, either in the form of drain on our surplus or taxes on our other policyholders, which will be related to the amount of our writings. Therefore, we certainly don't want to increase our writings and would rather opt to reduce what we do have.

Just very briefly in finishing, let me explain that there are more than a few companies who do want to remain in the business, but I do take exception with your idea, Senator, that we are only involved because regulators are keeping us so. That is not true. There are many of us who do believe that if structural changes are made in the liability environment, medical professional liability will become a viable part of the private insurance sector once again. And we are working, through various committees in our companies, in our advisory organizations and in our trade organizations, to come up with solutions that will do this. At the American Insurance Association we have

produced a model joint underwriting association bill, which we believe is superior to other types of risk-sharing methods such as State funds, doctors' mutual and—worst of all to us—the facility approach. I will be very glad to expand on these comments in answers to questions, but I think my time must be up by now.

Senator KENNEDY. We are, as every conference runs into time problems. They are very, very interesting, worthwhile comments, but we will try and see if we can—we will leave in—it in the hands of the organizers of the conference when they want to take the various breaks and move onto the other matters, but John Linster now. We will try to keep it to 5 minutes.

Mr. LINSTER. It is good to be here and as Warren says, we meet each other attending conferences on the health malpractice. This is the year of the rabbit for the Chinese and I think for the medical profession, and the insurance industry, this is the year of malpractice.

I want to underline some of the things that Warren Cooper emphasized, that there are many of us who feel that there is a resolve on the part of insurance companies to try and remain in the malpractice insurance business and many of the problems that we face are beyond the control of the insurance companies. And I think we have to recognize that we have a basic problem.

The tremendous delay in the final determination of losses, either by settlement or judgment of the court. In New York, for example, during our 24 years of experience, we found that at the end of 5 years on the average, less than half of our losses in terms of loss dollars had been determined at the end of 5 years. And at the end of 10 years, we still have a very substantial number of cases pending. And this was true, even though we had excellent cooperation from the medical society in a program of reviewing claims and determining liability, and trying to settle cases promptly as we could.

We found, however, that there are delays in the presentation of claims by patients, there are delays in the discovery proceedings in the courts and delay in the trial of cases, matters that are beyond our control. I would also urge, as Dr. Jamplis did, that we consider the various solutions that have been proposed and remember what the British say, that we tend to throw out the baby with the bath water, and when we have a situation that is out of control, we seem to become so enthusiastic about corrective action that we frequently destroy or permanently injure the system that we have set out only to correct.

Now, among the various proposals are forms of Federal reinsurance, compensation plans, State funds, joint underwriting associations, but I want to repeat that these would not come to grips with the basic problem; namely, that the losses are out of control. And whether you have any of these mechanisms or not, you are still going to have a cost problem and I feel as has been mentioned here, I want to again emphasize, as far as this cost is concerned, it is ultimately going to be the patient that pays the cost.

Now—and this I am sure won't come as any surprise to Senator Kennedy—I have confidence that the States can handle this problem. And they are moving in that direction. I want to report, Senator, that in Wisconsin, our legislature has passed a bill which provides for an understanding mechanism to take care of the problem. Our Governor

has indicated that this is only a stopgap measure and that we have to come to grips with needed changes in the substantive law, which is the basic problem.

So my own, old fashioned feeling is that our present reparation system is workable and correctible, as long as we limit it to reasonable goals. If recoveries were limited to actual malpractice, and kept within reasonable and realistic bounds, our chances of preserving the present system at a manageable level of cost would be excellent.

I have a further conviction and confidence that the States confronted by this malpractice liability problem can devise practical and economically feasible solutions as long as they consider not only the interest of those patients or their dependents, who have claims for malpractice, but also the interest of every patient and physician involved in our country's system of health care.

It is the old problem of balancing the problems of the few against the best interests of the many. I have no doubt that the States can strike the reasonable balance that is required and come up with solutions that will advance long range goals and interest of our entire society. I am submitting a paper for the record which I proposed for this conference.

[The document referred to follows:]

PROBLEMS IN THE MALPRACTICE INSURANCE MARKET: STRIKING THE REASONABLE BALANCE

(By John E. Linster, Senior Vice President, Employers Insurance of Wausau, Wausau, Wis.)

The British always say of us in the United States that we tend to throw out the baby with the bath water. When we have a situation that is out of control—or a system afflicted with excesses that make it troublesome—we become so enthusiastic about corrective action that we frequently destroy or permanently injure the system we had set out only to correct.

In a number of states we are confronted by a medical practice insurance crisis. Many solutions—some at the state, some at the national level—have been proposed to cope with it. These range from plans that would compound and expand the problem to solutions that are essentially temporary and tangential: a treatment of the symptoms rather than the causes of the crisis. And for this very reason they may be less innocent and more dangerous than they appear. Instead, our need is for corrective change that will *endure* and will do no permanent harm to a system that has given our citizens the best health care in the world.

First, consider the dimensions of the crisis.

The cost and frequency of malpractice claims are increasing at an unprecedented rate. Many of the awards being granted today by courts and juries are on cases covered under policies that expired five or ten years ago. The liberality displayed by these courts and juries in deciding liability and setting the amount of the judgment could not have been anticipated by even the most pessimistic of actuaries. And malpractice underwriters and actuaries are understandably concerned about whether they are able to predict with any assurance what is likely to happen on the frequency and cost of judgments five to ten years from now.

Consider what has been happening. In one six-month stretch of 1974, multi-million-dollar malpractice verdicts were being handed down in California at the rate of one per month. One award, in 1973, was for $4 million.

It is estimated that nationwide, claims filed are increasing by eight or nine percent each year. Awards made are increasing by thirteen to fourteen percent a year. In 1970 the average claim paid—either by settlement or judgment—was below $5,000. In 1973 it was about $8,000.

Doctors and hospitals are understandably concerned and upset about the galloping inflation in the cost of malpractice insurance but even more concerned about the availability of coverage. The severity of the availability problem

ranges from the temporary lack of a market for a few doctors in some states to the situation in New York where coverage for all the doctors in the Medical Society programs will terminate on June 30 of this year.

We are in a crucial time for malpractice insurance. Insurers are, after all, looking back on one of the worst years casualty insurers had ever faced. Soaring losses and the declining equities market combined to put formidable pressures on capacity. Despite this, the insurers continue to try to provide a market for malpractice insurance—although there are areas where the adverse cost trends of the past few years make this extremely difficult. If a way to relieve these trends cannot be devised, the available market of private insurance for medical malpractice in some states for some physicians and surgeons may dry up entirely.

That is what Lawrence Monin—New York's First Deputy Superintendent of Insurance—had in mind when he told the New York State Senate last October: "As dismal as the past may have been, the future may be even bleaker.... The prognosis is that medical malpractice insurance is a race few wish to enter, and one that is almost impossible to handicap. The immediacy and the extent of the problem are clear. How to solve it, however, is less clear."

It is not a time for panic or for hasty and ill-conceived decisions. But it is also not the time for glib statements that since doctors can pass along to patients the costs of malpractice insurance, there really isn't any problem.

The time is fast approaching when some individual doctors or even small groups of doctors in some states will not be able to finance and pass along the cost of their malpractice insurance. An even if they could, we must consider the more important question of whether patients should have to pay the higher price of health care that results from this added cost—not merely the huge premiums for malpractice insurance but also the charges for x-rays, tests, and other precautionary procedures stimulated by the constant threat of malpractice litigation.

In New York the cost of malpractice insurance has increased over 600 percent in the past seven years. For the highest-rated medical classification in New York City, the annual rate recommended by Insurance Services Office is already over $32,000 for $1,000,000/$3,000,000 limits. Since 1969 the rate levels for medical practice coverage are up by over 600 percent in Florida, over 500 percent in Louisiana and Ohio, 496 percent in Pennsylvania, and close to 300 percent in California. If this trend continues, we can expect that a substantial number of doctors will be paying as much as $50,000 to $100,000 a year for adequate malpractice insurance in the not-too-distant future. Some high-risk specialists in Michigan are already paying Lloyd's of London $60,000 a year for insurance protection.

And these will not be doctors with poor records or questionable ability. The doctors paying these rates will be among the most skilled, qualified, and capable of physicians and surgeons.

They will be paying these rates because they are called upon to treat the most difficult and complicated cases—cases where serious disability or death will result if the patient does not receive surgery or medical treatment. But frequently the surgery or medical treatment in such cases involves hazards that may immediately disable the patient or cause death even though the physician and his associates perform with the ultimate in skill.

We are asked many times whether the unfavorable trend in malpractice litigation is caused by a deterioration in the quality of medical care. Everything we see indicates that the quality of care has never been better. With the wonderful advances in medical science, many patients now live who would have died a few years ago. Others who would have been disabled are able to live useful and fulfilling lives because of new medical techniques.

Yes, we *do* see instances of carelessness and malpractice. And the victims of such malpractice should be adequately compensated. There is no quarrel about that.

We are aware, too, that a critical and thorough analysis of meritorious malpractice claims can improve the quality of medical and health care. Our company is one of but many writers of malpractice insurance that have, in cooperation with medical societies, helped implement peer review and case review programs. These programs will undoubtedly be expanded.

There are, however, aspects of the problem which are not within the control of medical societies or insurance carriers. Some of the more important in causing adverse loss experience are:

1. In this age of consumerism, patients who would not have filed a claim or lawsuit against their doctor years ago are now more inclined to do so.

2. Juries and courts are now more likely to render large verdicts and judgments in cases which would have been decided in the past in favor of the doctor. When you analyze some of the decisions you get the impression that the physician was expected to have the physical prowess of Superman, the practical wisdom of someone who has been attending patients for fifty years, and the book-and-literature knowledge of the most recent graduate of the best medical school.

3. Advances in medical science have given surgeons and physicians the option of using procedures and drugs that can perform miracles in terms of prolonging life and preventing crippling disabilities but that can also—in some cases—produce immediate disability or death.

It is unfortunate but true that the most respected, capable, and qualified physicians and surgeons—those having the skill to perform these miracles—are also those most vulnerable to malpractice claims and lawsuits. Because of this their rates are the highest and they are not the best underwriting risk.

In this same group are the most frequent victims of the trend towards liability without fault. They bear the brunt of the trend in some jurisdictions where juries and courts are seeking the best of two worlds—the comfort of financial help regardless of fault available through a no-fault system and the luxury of wealth-producing punitive damages available in a fault system.

An analysis of the decisions in some states illustrates the concepts that underlie this trend. One of the justices in a frequently cited California Supreme Court decision said:

"In the present state of medical knowledge, risks which even the most cautious physician could not have prevented may lead to accidents which even the most expert cannot explain."

But the obvious and terrible results of these accidents exist as bald facts—and the plaintiff usually argues that they speak for themselves. This is the doctrine of *res ipsa loquitur*, and the same judge has said of it, in a decision on a malpractice case:

"The net effect of the doctrine is to shift from plaintiffs to defendants the cost of a certain number of unexplainable accidents in which no meaningful basis exists for finding the defendants at fault."

He defends this shifting of the burden for the unexplainable from the patient to the doctor by suggesting that doing so

"can insure that the burdens of unexplained accidents will not fall primarily upon the helpless but will be borne instead by those best able to spread their cost among all who benefit from the surgical operations in which these misfortunes occur."

In all this the courts are failing to consider the impact that such decisions are having on patients who do not have a malpractice claim but must pay the cost of the awards as they are passed along to patients by doctors and hospitals.

There is also a failure to recognize that because the number of doctors is comparatively small, they are not best able to absorb and diffuse the costs of medical accidents in which no meaningful basis exists for finding the defendant at fault.

The American Medical Association surveys show that at the close of 1971 there were 301 nonfederal doctors providing patient care in Wyoming. In Wisconsin, there were 4,856; in California, 33,010; in New York State, 36,370. In the entire United States, there were 287,248 federal and nonfederal physicians treating patients. If you compare this to the 112 million registered vehicles in the United States, you can see at once it is not a group large enough to disperse easily among its patients the continually soaring costs of malpractice liability.

Another important facet of the problem is the long delay in determining the cost of claims. In New York, even though our company had excellent cooperation from the State Medical Society in reviewing the merits of claims and trying to settle meritorious claims as soon as possible, we found that delay was the rule rather than the exception. Because of delays in the making of claims by patients, in pretrial discovery proceedings, and in the trial of cases, our loss costs were not finally determined in over half our losses in terms of loss dollars at the end of five years. A goodly number of our cases were still open at the end of ten years.

Actuaries have always found it difficult to make rates for malpractice insurance. Some describe it as a "venture into the unkown" because of the difficulties in predicting with any accuracy the frequency and cost of claims. They are also finding it increasingly difficult to predict the cost impact of the trend toward

finding liability regardless of fault in cases involving a severe economc loss caused by death or serious disability.

Among the proposed solutions to the problem are a state or federal reinsurance facility, a state fund, a doctor-operated mutual insurance company, or a joint underwriting association.

Many who propose these solutions lose sight of the fact that we have a problem because losses are out of control. Whether the protection is to be provided in part or completely by a government facility or private insurance will have no effect on losses. The citizens of the United States will have to pay the bill either through taxes or through subsidy of inadequate rates charged by a reinsurance facility.

Let's first look, instead, to the real problem: the losses. Are we—by trying to compensate and overcompensate patients who suffer disability or death regardless of whether there truly was malpractice—victimizing all doctors and all patients?

The plaintiff's bar argues that the threat of a malpractice lawsuit encourages the health care provider to exercise a higher degree of care. Acceptance of that principle does not justify awarding money to patients or their families in cases where there were, in fact, no carelessness on the part of the doctor or the hospital.

Is there any solution to our problems? As Aristotle pointed out 2,300 years ago, if we want to get the right answers, we must first ask the right questions. Among the questions are these:

1. Should there be compulsory arbitration with the right of appeal? Under arbitration, will the patient and the doctor benefit from earlier resolution of their differences? Will the rights of both the patient and the doctor be preserved?

2. Should the severe economic loss resulting from a serious disability or death be financed through the malpractice insurance mechanism in those cases where the true basis for the decision is the feeling on the part of judges and juries that the doctor and his insurance carrier can better afford to bear the loss than the patient and his family?

It is time society considers the impact that a liability-without-fault malpractice system can have on the quality and cost of health care. The most skilled surgeons and anesthesiologists are continually treating patients who are at the extremity of poor health, disease, and severe injury. Many of these patients are going to die or remain seriously disabled. If many of that group are to receive an award based upon the emotional reaction to their fate, there is no method on earth whereby the relatively small number of physicians can finance the costs.

3. Is there a need for change in the substantive law of malpractice—a redefinition of the parameters of liability?

4. Is the doctrine of informed consent being applied in order to hold a physician liable when the patient's disability is severe but there is no evidence of negligence?

5. Is the answer a no-fault system?

Proposals have been made that medically-injured persons be compensated without regard to fault—and give up, in return, their right to sue for negligence. We would expect such a system to be more costly than the present one since it would compensate many patients whom the present system excludes because their injuries are not caused by malpractice.

6. Is the answer a "Patients' Compensation Board" of the sort recently proposed in Indiana? The board would consider each claim and decide whether the patient had been injured through the negligence of a health care provider. If so, they would made an appropriate award based on a schedule of benefits. Here, you will note, the concept of fault or negligence as a basis for recovery would be preserved.

7. Should there be statutory limitations on the amount of recovery? If so, should the limitation be arbitrary monetary limits, or restrictions on general and punitive damages?

8. What changes should be made in the statute of limitations on medical malpractice claims?

9. What kind of limitation should there be on contingent fees?

We can be reasonably sure that the answers would not be the same in every state. In a few states, the problem is extremely serious; in most states, it has not come to that extremity. But the fact that it hasn't does not mean that it can't or won't. Some states who had no problem a year ago are developing one now.

*A reasonable balancing of interests*

The writing of malpractice insurance is becoming an increasingly difficult and hazardous business, one beset by many problems. But I do see a resolve and determination among insurance carriers to do everything possible to maintain a free and competitive market for medical malpractice insurance.

In the states where the coverage is not available in the voluntary market, the insurance industry is cooperating in the development of underwriting mechanisms to provide malpractice coverage. But these are stop-gap solutions; they do not face the problems of soaring losses but merely seek another way to distribute them. In the states where such a way is found, those involved cannot afford to believe they have solved the malpractice liability problem and turn away from it to other concerns.

When we consider the national solutions that have been proposed, I hope we will remember that there seems to be nothing in this problem that will be relieved by centralizing it and creating a system even more costly than the one we have now. "Average" solutions are not generally good remedies for particular or local problems.

There's no question but that some of the problems inherent in the current medical malpractice situation are not within the power of the insurance industry to solve. And—as I said when I began—some of the solutions proposed embody the danger of destroying the system we purport to be correcting.

My own old-fashioned feeling is our present reparations system is workable and correctable—as long as we limit it to reasonable goals. If recoveries were limited to actual malpractice and kept within reasonable and realistic bounds, our chances of preserving the present system at a manageable level of costs would be excellent.

I have a further conviction and confidence that the states confronted by this malpractice liability problem *can* devise practical and economically feasible solutions as long as they consider not only the interests of those patients, or their dependents, who have claims for malpractice, but also the interests of *every* patient and physician involved in our country's system of health care. It is the old problem of balancing the problems of the few aganist the best interests of the many. I have no doubt that the states can strike the reasonable balance that is required and come up with solutions that will advance the long-range goals and interests of our entire society.

Senator KENNEDY. Thank you very much.

Alex McMahon, who is the president of the American Hospital Association.

Mr. JOHN ALEXANDER MCMAHON. Senator Kennedy, fellow panelists, and members of the conference. I would like to approach this from the hospital point of view, dealing very briefly with the problem as hospitals see it, and then suggesting some methods of approaching solutions. The problem of cost you have heard about. From the hospital point of view, it has gone from what used to amount to a few cents per patient day to $3 or $4 per patient day and it is still going up. Why this increase? As we see it and as we have studied it, it is not an increase in negligence. It is not an increase in poor practice. Nor is it "lousy health care," as one constant critic of our health system inaptly or perhaps ineptly described it.

I think there is some overexpectation on the part of patients. There has obviously been a change in the physician-patient relationship as our health system has changed. And finally, the tort system itself with its reward system is part of the problem, along with the increasing willingness to put the loss on the party the jury believes is most able to pay.

But whatever the reason, there is a resultant rapid increase in malpractice insurance cost that now borders on the unacceptable to providers, to insurance carriers, to insurance commissioners, and to the patients as well. And it comes at a time when hospital costs and health costs are under scrutiny as never before.

One final comment on costs. We at AHA have taken a look at malpractice insurance rating practices, and if anything, we have come to the conclusion that the present rates are probably still too low in the light of the increasing number of claims and the increasing cost per claim settled.

Next a word about accessibility of coverage. It is a problem to hospitals as well as to physicians. One carrier has served notice of termination of coverage on the hospitals that it has been covering in 14 States; other carriers have indicated that they intend to give notice of intent to terminate.

This isn't unique nor are the reasons strange, because as I have indicated, the rate structures as we have studied them are inadequate, and therefore, the possibility of termination will continue.

Now a couple of words about solutions. We believe that it is best to approach the present problem by dividing it into two parts. First, there is the need for malpractice insurance for hospitals and doctors whose coverage has been canceled or who cannot obtain coverage when beginning new activity. Second, there is an obvious long-term need to reduce the number and size of malpractice settlements and judgments which are so sharply increasing premiums and causing the withdrawal of carriers from the market.

With respect to the first aspect of the problem, the need for access to coverage, we have joined with doctors and carriers and insurance commissioners at two meetings in HEW to explore voluntary and statutory solutions to assure access. We are pleased with the progress being made in the insurance industry to date in reaching a solution, and we hope they will continue to find ways to provide coverage for all providers at an acceptable premium. The proposal to create a joint underwriting association seems to offer a solution if we can be certain that it will be accepted by legislatures in all of the States.

The AHA itself is developing plans to create a "captive" reinsurance company to provide coverage to hospitals who can't otherwise obtain it. Our posture, in sum, is to continue to work with all interested parties to develop short-term solutions to the access problem.

Finally, let me close by making reference to the second aspect of the problem, the long-term solution. Many explanations have been offered—you have heard them today and you will hear them again—for the rise in the number and amount of malpractice claims. Many suggestions have been made to reduce the rate of increase.

We have studied the situation. We recognized that a solution must be fair to patients as well as providers and carriers. We believe that it will be better to solve the problem at the State rather than the Federal level. But at this point, we have no preferred solutions, believing that any viable solution will have to be acceptable to a substantial portion of interested parties. We intend to participate in discussions—as we have in the past, as we are doing today, and as we will do in the future.

But there are four cautions I would leave with you as we approach the long-term problem. First, long-term solutions must be analyzed with a hard eye on cost. To move away from the fault basis of recovery may escalate costs unacceptably.

Second, long-term solutions must encourage due care on the part of providers. However we change the system, we believe for now that

everyone will benefit if due care by providers is encouraged and rewarded.

Third, long-term solutions must not be accompanied by attempts to impose untried, unproven, or unacceptable changes in our health system. As the Scots are wont to say, Senator Kennedy, things are bad enough in the world without putting water in the whisky.

Fourth, and finally, the long term solutions must not continue to encourage overexpectation by patients. They expect more today than our system can deliver, and they must recognize that there are health problems we cannot solve with all the skills that we can muster today. Thank you very much.

Senator KENNEDY. Dr. Malcolm Todd was unable to be here, but Dr. John Coury, who is a member of the AMA Council on Legislation, is with us.

Dr. JOHN COURY. Thank you, Senator. Dr. Todd does want to send his regrets. It was impossible for him to be relieved of a prior commitment and you have a substitute in me, not as good looking or as versatile as he, but I shall try.

Unfortunately, Bob Jamplis, Senator Kennedy, and Jack Linster and Alex McMahon all stole my speech, so I brought a shorter one along with me. I thought I might give it to you. And I want to express to you the concern, the frustration of organized medicine and practicing physicians in this country. And they are asking the one question: Why is it that we are the only country in the world that has this malpractice problem, particularly when our medicine is equal to, if not better than, all countries in the world. And as you well know and I need not repeat, the lack of availability for new physicians getting into practice.

And put bluntly, ladies and gentlemen, liability insurance premiums today are just too darn expensive for the average doctor, no matter what the public may think of his income. What young doctor in his first year of practice can go out and spend $5,000 or $20,000 for a liability premium? What about the physician who is semi-retired, interested in being productive and of service to his community and who must pay a similar rate?

A few years ago, the National Commission of Medical Malpractice established a study group and after millions of dollars and a voluminous production of paper, the final verdict was, physician, heal thyself. They refused to hear the cry in the dark from the providers of medical care that this was not medicine's problem alone. The minority report in the press of the American Medical Association was ignored until the avalanche was almost at the bottom of the mountain. And now we are in an unnecessary crisis situation.

And speaking of availability, let us not think that availability of insurance alone is the solution to our problem. It is strictly a finger in the dike. If the citizens of this country are to have the highest quality care that doctors can provide, in an atmosphere of trust and reasonable cost, we must obviously change the existing system and improve the climate. To make an uninsurable situation insurable, we must contain costs and redirect dollars in an equitable manner, which is perceived to be fair by all involved parties.

Doctors do want to see the truly injured patient fairly compensated for his injuries. The medical profession does want to see the doctor fairly judged, fairly charged for his premium, and fairly rewarded for

his risk and service. Doctors want both the plaintiff and the defendant lawyers fairly compensated for their services, and while we are talking about fairness, and I think this is important, it should be noted, too, that it is unfair for the system to expect medicine to compensate patients who contribute to their own injury through carelessness, by failing to follow instructions, or poor personal habits. It is also true and fair to mention, and this is important, that no two people are physiologically equal or were they created by God as such, and no two people respond equally to the same form of treatment.

To create this kind of perception of the problem, there must be changes in the present legislative, judicial, and public environment. No longer can providers of medicine be expected to solve society's psychological and socioeconomic problems.

I am shortening this up, and I will go into what I think is important. Our current problem can be resolved if in this country we reemphasize the basic responsibilities of the medical profession, the legal profession, the judiciary, and the public. To improve the climate, medicine must continue to educate our professionals on the matters which tend to lead to malpractice litigation. We must keep abreast of developments in medical education on a regular basis and we must demand adequate performance by our regulatory bodies.

To help insure that enforcement, the State legislatures must provide immunity for physicians serving on peer review boards, sitting in judgment of their fellow professionals. We further believe that the necessary State legislative actions must be carried out, requiring insurance companies to give a regular and full accounting of all malpractice actions brought against their policyholders. This will provide more reasonable and actuarial data on which rates can be determined. There should also be a good samaritan act to protect physicians who are called in to handle emergencies or perhaps treat hospital patients who are not their own. There should also be a requirement of an affidavit of merit when the plaintiff attorney files a claim.

Legislation is also needed to place limitations on contingency fees, much like what has been accomplished in New Jersey. There must be some change in the statute of limitations. There must be some limiting of the guarantee of cure unless there is an assurance in writing. There should be a limitation placed on windfall recoveries and some consideration given to compensating injured patients on a regular as needed basis—perhaps monthly. There must be a ceiling on damages. Why is it that a malpractice damage is so much greater than other damages whether it is in industry or in other accidents?

We feel that there should be an elimination of the injury-speaks-for-itself doctrine—res ipsa loquitor—which in many courts is unfair. An agreement to arbitrate between a patient and the physician should be permissible.

Doctors cannot be expected to continually finance society's ills. We are willing to accept our responsibility. We expect the public, the legal profession, and the judiciary to accept theirs. Availability and reasonable cost of liability insurance can only be achieved if the foregoing remedies are accomplished. Hopefully a concerned public and profession can successfully reach the goal in the very near future so that a health and public welfare catastrophe can be avoided. Thank you.

Senator KENNEDY. Very fine. You saw on your program, we were supposed to break at 10. We have a final two speakers, and if it is all right with the conference, we will hear those and have a coffee break and then begin the discussion right after that. So we will hear from Dr. Henderson, chairman of the Professional Service Committee of the American Academy of Orthopedic Surgeons.

Dr. EDWARD D. HENDERSON. Thank you, Senator Kennedy.

I am here today representing the viewpoint of the so-called high risk specialists, or what is known in insurance circles as class V providers. All physicians and all hospitals are greatly concerned about the present climate, but our particular group of specialties has the greatest concern because we don't see how we can continue to deliver health care to the public at the projected cost of premiums even if malpractice insurance is available to us. In New York City, if the proposed premium rates go into effect on July 1, a neurosurgeon who sees 1,000 patients a year will have to charge each patient, on the initial visit, $45 for his malpractice coverage.

No young surgeon will be able to begin a practice in these particularly high-cost areas unless he was born wealthy or can start practice in a group which has the financial resources to carry him for awhile. Furthermore, if the claims-made policies are the only types of policies available, older physicians will find it difficult to reduce their activities to part-time practice before full retirement. When he does retire, he may have to build up a reserve in the hundreds of thousands of dollars to purchase the insurance which will protect him and his family from the claims which may be made against him after his retirement.

Those of us in the limelight—the neurosurgeons, plastic surgeons, anesthesiologists, obstetricians, thoracic surgeons, and orthopedics—are greatly affected by these factors. Although we are individually, and as a group, extremely concerned about our ability to continue practice under the circumstances, our chief concern is that the people of the United States are the victims of changes in court proceedings and unrealistically high awards which are making the cost of medical care much higher and which are forcing the physicians to consider withholding treatment which may improve the quality of life, but which are not lifesaving.

These are some of the so-called elective procedures which, lumped together, may have been made the object of public suspicion by virtue of unchallenged statements that the people do not need these operations and that the physicians are advising them for economic reasons. There may be such instances, but the vast majority are not. They include such operations as plastic surgery for severe disfigurement of the face or to correct contracting scars in the extremities, grafts of arteries to correct pain in the extremities, operations to correct low back and sciatic pain, and replacement of painful, arthritic joints. None of these procedures is necessary for the preservation of the patient's life.

Many of these operations have a predictable percentage of complications and results unsatisfactory both to the patient and his doctor. Furthermore, as knowledge and technology allow us to bring the benefits of surgery to older patients and those with other health problems, such as smokers and fat people, the predictable incidence of postoperative complications increases. When these complications

occur, the surgeons and anesthesiologists must frequently act rapidly and make decisions which, in retrospect, might have been made differently. The making of such decisions is what we are trained to do and is one of the qualities which characterizes a good surgeon.

If the present malpractice climate continues, if we are able to practice at all, we may have to confine our surgical procedures to the people who are the best risks to avoid complications and to procedures which are standard and easy, thereby greatly reducing the possibility of progress in the surgical fields.

Our friends in anesthesiology are in the same boat with us, partly because there is an inherent risk in putting people to sleep or, in fact. administering a local anesthetic agent in spinal, regional or local blocks. Although the agents used are generally safe, they have a toxicity and not every person reacts the same way to the same drug in the same dose. Furthermore, they are dealing with our old, fat patients who smoke or drink too much. To top it off, they became interested, a few years ago, in dealing with very sick patients and in respiratory care, so they now have important roles in, or are actually delivering, the care in emergency rooms, intensive care facilities and respiratory care areas of the hospitals.

Lastly, our risk is enhanced because the patient and his family can easily see the crooked leg or the ugly scar and he can feel the pain which we have been trying to correct by surgery.

It is difficult to see how there is enough money in the world to take care of for life, in a completely satisfactory manner, everyone who has not obtained what appears to him to be a completely satisfactory result from treatment. If it is truly unfortunate and the physician has contributed to this by some improper or careless act of omission or commission, there is some liability on his part. If the physician habitually practices in an incompetent or careless fashion, there must be a way to remove him from the arena where he is dangerous to the public. On the other hand, the present situation in which the best trained and most conscientious physicians and surgeons must live in fear that a careless word or act by an assistant, a complication retrospectively shown not to have been treated in the optimum manner, or the claim by the patient that he was not fully informed of the risks may result in days or weeks in a courtroom and possible financial disaster for him and his family is intolerable.

Physicians are not, by and large, insensitive or callous. They are trained carefully to make decisions which are hard and are trained not to show their emotions. It has not been recognized generally that being sued by a patient, for whom the physician has developed an attachment and for whom he has done his best, is a devastating occurrence. All of us have seen what it does to our colleagues. Even when they win the trial, they are no longer the incisive, effective, optimistic surgeons which they were before. A court of law may be the workroom for the attorney, but it is the torture chamber for the doctor. Frivolous suits initiated by attorneys are a disaster.

We all hope that a way will be found to acknowledge and compensate reasonably the patient who is truly injured by his physician, but at less cost and without the vindictiveness which really has no place in the 20th century.

We believe that forcing the availability of malpractice insurance is not the answer to the basic problem. There must be some fundamental

change in the mechanisms of handling malpractice claims. It is reported that representatives of the New York Medical Association and the New York Bar Association met on February 21, 1975, and agreed that the alleviation of the situation will depend on some changes in the approach to court procedures. Among them were:

1. A court system of speedier trials, similar to the Federal court method of scheduling.
2. A trial of an arbitration system.
3. Standardization of the informed consent procedure.
4. Making available to the courts a peer specialist group.
5. Reduction of contingency fees.
6. Rejection of the no-fault system as being too expensive.
7. Acceptance of the disclosure of collateral sources in court.
8. Early specification of charges in bills of particulars and exchange of expert reports.
9. Reduction in the statute of limitations.
10. Defined limitation on awards.

We have great concern, enhanced by bills already introduced into the Congress, that the Federal Government's intervention into the medical liability field will result in increased regulations which will further regiment the activities of physicians and reduce the freedom of action which is necessary for the effective practice of medicine.

In our opinion, all of these matters are important, and must be given serious and prompt attention throughout the Nation.

Senator KENNEDY. The final speaker before the break is Mr. Robert Cartwright, president of the Association of Trial Lawyers of America. Mr. Cartwright?

Mr. ROBERT CARTWRIGHT. Thank you, Senator Kennedy. I want you to know that a trial lawyer can't even intelligently introduce himself in 5 minutes, let alone talk on any subject.

And second, that I was not scheduled to be on your program or talk on this particular topic. I was to be on the program that was scheduled for this afternoon and I had a very nice speech prepared about 20 minutes in length, which I have now scrapped.

I was told last night at the cocktail party that I would be on this program, but I am happy to be on this program, particularly since you are the moderator. My wife will be most pleased about that.

Senator KENNEDY. You have 2 minutes left.

Mr. CARTWRIGHT. All right. I have—I do have a nice speech and my address is 160 Sansome Street, San Francisco, Calif. For those of you who are interested in what I was going to say, drop me a line and I will be happy to send you a copy.

Second, and more seriously, we do have, Senator, a very thorough position paper, entitled "A Position of Responsibility," which just came from the printers yesterday. And I am going to give a copy of this to your counsel back here, Larry Hofheimer, to file with the minutes of this proceeding. We have a seven-point program, which is outlined in this position paper, and we think that we have come up with a number of suggestions which will be very helpful in solving the so-called medical malpractice crisis.

Unfortunately, because of your time requirements, I will not be able to discuss those.

I would like to say this. I think experience has proven that tort law, whether in the medical malpractice field or in products liability, avia-

tion, or wherever it is, does serve a tremendous social good. It has a great prophylactic and therapeutic effect in promoting safety and consumer protection.

I have, for example, 500 examples of horror stories that I have brought from our ATLA—American Trial Lawyers Medical Malpractice Exchange—which would boggle your minds, and which would show the tremendous improvements that trial lawyers under the tort system have helped to effect in improving the quality of medical care in this country.

I will just give a few examples. Successful medical negligent cases have caused hospitals and doctors to utilize such safety techniques and procedures as sponge counts, instrument counts, electrical grounding of anesthesia machines, the padding of shoulder bars on operating tables and the avoidance of colorless sterilizing solutions as in spinal anesthesia cases.

I could talk about many cases. Just one very quickly, the *Doctor Nork* case out of Sacramento. This is from my home State. You have probably heard of it. This doctor was incompetent. He had practiced in this hospital for 10 years. He was a drug addict. His colleagues, many of them, turned—closed their eyes and looked the other way. He actually butchered scores of people.

Finally, a trial lawyer through weeks and months of digging under the contingency fee system rooted this out, brought this man to the bar of justice, and a substantial verdict was rendered, not by a jury, but by a trial judge. And the hospital was also held liable for not having picked this up. The nurses' notes would show that after each operation, many operations, the patient would be screaming in excruciating pain, but the doctor's postoperative report would always show that the operation was a tremendous success.

I could go on with dozens of illustrations which demonstrate the social good that is performed by tort law, not only in medical malpractice, but in products liability and all other tort fields. And it is the public interest that we should be concerned with here in this conference today, not what is good for the lawyers, not what is good for the doctors, but what is good for the public.

Now I have in my speech that I had prepared, and in our position paper as I have indicated, many suggestions for solving the insurance premium problem, and I agree with Mr. Linster and a number of the other speakers, that we don't have to throw out the baby with the bath water. I think our American system of justice is a pretty good one, probably the finest that has ever been devised anywhere in the world. It does need some help in this particular area, and there are ways of accomplishing that without destroying the system.

No. 1, I think that doctors cause the malpractice, not the lawyers. Doctors have to become more safety conscious. They have to give more thought to establishing safety techniques and procedures which will eliminate a lot of malpractice cases and in eliminating doctors who are incompetent, and unqualified to practice.

No. 2, lawyers can be most helpful and they are subject to criticism. No question about it. There are a number of suits that shouldn't be brought. In our office, we don't take a malpractice case unless it is carefully screened by a medical-legal consultant, which usually costs us between $200 and $500. I don't think any lawyer should file a mal-

practice case unless it has been carefully screened as to legitimacy and a determination made that it is an ethical and proper lawsuit. Use of screening panels and many other similar devices could cut down on the malpractice cases.

Insurance companies are at fault. I think their rating practices need to be carefully examined. I think that their premiums collected, their payouts, all of their activities, need to be made a matter of public record so that we can know whether or not these claims that they are making are true or false. I have serious questions about whether they are or whether they are not.

We think that there is a malapportionment in the distribution of the insurance premiums. We don't think that the total cost of the insurance premiums is excessive compared to the total medical fees charged. We think there needs to be a redistribution of the premiums and that this will go a long way toward solving the problem.

One possible solution, for example, would be to have the premium based on the gross receipts of the doctor. This would take care of the young doctor, that one of the gentlemen mentioned. It would take care of the retiring doctor, that was also mentioned. There are other such techniques that can be used.

I wish our time permitted greater discussion but I don't want to overstay my 5 minutes, which is already more than up. I thank you for inviting me.

Senator KENNEDY. Thank you very much, Mr. Cartwright. The panel will be back in just a few moments. Before we recess, I do want to say we are glad to have Mr. Cartwright here to speak. It makes me sound like a member of the AMA, listening. That really wasn't the reason he was put on the panel here, but it does—I do think that these—we do have representatives of the different types of interests that we are going to have to consider in any kind of an approach. Obviously, the lawyers and the legal profession, the medical profession, the insurance industries, as well as those that will be participating as your panelists and those of us in Congress.

In listening to the respective panelists this morning, I think all of you can recognize the complexity of the problem that any of us who were attempting to deal with legislation are going to be faced with. You have heard entirely different comments that are reflective, I think, accurately of those that are dealing and coping with this issue, primarily from their perspective, but certainly with the distinguished panelists, they have given an overview. It points up the complexity of the problem that any of us face who are attempting to deal in a responsible way and trying to give a full opportunity for these various viewpoints to express themselves in legislation and to be responsive to those particular interests, in a way that does make sense. And I have listened to the message that we don't want to throw the baby out with the bath water, and each comes down with that different comment, almost as it relates to a particular interest which they have, a particular responsibility.

Obviously, we are going to be challenged to the extent that it is necessary, and I do want to say that I feel as one, that this is a problem of great importance and great consequence, and an area of very considerable need, and one in which our committee in the U.S. Senate wants to act in a responsible way. I think we posed the problem, really,

this morning. Your panelists will develop it and I am sure in this room there is a great deal of expertise that can be enormously useful and helpful in developing and drawing some conclusions toward the end of the conference.

Unfortunately, I will not be here after the break. The Senate is voting on a cloture petition in the tax bill and so if I get back there, I will be able to vote.

Dr. JAMPLIS. I have a few brief announcements. No. 1, there have been some messages for some of you coming in via telephone. The message blackboard or bulletin board is right on the opposite side as you walk out the door right in front of the convention center room. So please check the board as you leave.

Second, for those of you who picked up your packets last night after the official closing of the little table we have there, would you please fill out those registration forms that are in the packet. It is necessary, because of what my third announcement is going to say, and that is this: The entire proceedings of this meeting are being taped. No allegation of Watergate fellows, but it is being taped and it will be typed and it will be distributed to all those who have registered here at the meeting, either before the meeting, at the meeting, so that is why it is necessary that all of the registration cards, those of you who picked up the packets last night, please fill them out.

Finally, there are little green cards upon which we would like you to ask your question and there will be ladies circulating up and down the aisles here, pass them to them and they will be given to the moderator so that as many questions as possible can be directed to the panel members and hopefully answered.

Now before I turn the meeting over to the moderator, I would just like to call on Mr. Thomas Vehlin. Is Mr. Thomas Vehlin in the audience? Mr. Vehlin is coming up here on the left. He is with the St. Paul Fire and Marine Insurance Co. with which I am sure you are all familiar. One of the biggest companies in the professional liability risk insurance business; he is one of the officers. We had asked that one of the officers be present and for some foul-up, we didn't get the message back, but I would like to introduce Mr. Vehlin to you now, for very brief remarks like the other gentlemen. Only we are going to have to give you only about 3 minutes.

Mr. THOMAS VEHLIN. Thank you, Doctor. I will keep it that brief. I can only reiterate the remarks made by my colleagues here today. I think Warren Cooper very well expressed the reason for us going to this claims-made contract. It is a complex subject and as Mr. Cartwright said, something that we certainly can't explain in 3 minutes, but I will give you a quick, thumbnail sketch of what we are talking about.

I will preface this by saying that we have not done this with the thought of greatly expanding our malpractice writings to solve the problem in this country but I think it not naively so that if this concept works as we strongly believe it will, that it will interest other carriers in reentering the field and hopefully open up this market to some degree.

I can also say that our policy form only, which is all that we have filed to date, has been approved in some 23 States. I know some of the regulators that are here today have assured us that once the rates are

filed, which will be in the next week or so, that a contract will be approved and more States will join. We are hopeful that all but one, I believe, are going to approve it.

Claims made is nothing new in the insurance industry at all. There are several other coverages with this long development pattern that have been written on the claims made basis. I think our policy is unique, however, in several respects and very quickly, this being the area—the issue that the premiums do increase over a 5-year period—they graduate up. The beginning premium for any doctor going under this concept will probably be in the area of 40–45 percent of what an adequate claims-made material rate would have been for 1975. The reason we haven't filed this sooner was not until now that we had our 1974 experience in to do it.

The reason of course, that the premium does graduate up and that there is this dropoff initially is the fact that we are only covering acts from the inception date or the retroactive date of the policy and of course, our exposure is limited initially. Claims made will do absolutely nothing to the frequency and severity of these losses. It is only a way for us to price this product. And it will enable us, as has been discussed here to some degree today, to project losses only for a 12-month period, rather than 5 to 10 years as we are having to do now, and as our actuaries have said we can no longer do. This is an impossibility to price this product under the current basis. This is our feeling at least.

We have solved the one prime objection to a claims made contract, in that the ongoing liability or this tail is guaranteed in the policy, guaranteed that we will sell this whether the doctor retires, he leaves us, we leave him or for whatever reason; we have also solved, I think, the two or three objections that have been brought to us by the profession since we have been around explaining this contract. That is in the death situation or when it is an undue burden on a particular doctor, we will sell this tail on one premium price rather than the three endorsement process that we will normally work under.

We are offering a disability or a waiver of premiums for that exposure after a particular health care provider may become disabled, along as a rider to the policy and further, we have, I think, some strong opinion now that the premiums you are paying after retirement will be deductible for that period of time when you were still practicing medicine.

Again, I reiterate that this is not an answer to the problem. A complete answer—but it is a way at least, for St. Paul with some 50,000 doctors insured to stay in the market.

Dr. JAMPLIS. Thank you, Mr. Vehlin. I have to make just one alteration to the comment that I made about sending all of the talks—speeches and tape reports. During the coffee break, apparently somebody borrowed Mr. Cartwright's speech. We hope that whoever it is, they will sneak it back on the table so that when we do get around to mailing out, we want to have a complete packet.

I would like to introduce to you the moderator of this particular panel. We will go on for about an hour and our moderator will be Dr. Phil Caper. Dr. Caper is on Senator Kennedy's professional staff and really he is chief of staff for medical affairs, such as medical malpractice and national health insurance and the like. And Dr. Caper

assures me that everything that is said and all of the input of this meeting will certainly get back to the Senator.

So Phil, you have the floor. The questions, please bring them up and you have about an hour.

Dr. PHIL CAPER. Thank you, Dr. Jamplis. I am pleased to be here. I don't feel entirely out of place, since unlike the Senator, I have been president of a few things. So I feel at home up here with all these presidents.

The format for this discussion will be for me to try to repeat questions which have been sent up here by people in the audience to other specific members of the panel or the panel as a whole. In addition to that, I am going to exercise some prerogatives as moderator and try to ask a few questions of my own. Hopefully, to begin to define a little bit more explicitly some of the basic issues involved in the medical malpractice problem.

I think it is interesting to note, in looking over the list of invitees, that out of six or eight single-spaced typed pages, I counted only three groups which I would have classified as consumer groups. I included the chamber of commerce in those three. I might act a little bit as the devil's advocate here in some of my questioning and try to represent what I think consumers would be interested in knowing about the medical malpractice situation.

I will begin though, by asking some of the questions which have been sent to the podium and I think the first one is for Mr. Cartwright. The question is, how do you feel the contingency fee matter can be modified to provide an equitable arrangement for all parties?

Mr. CARTWRIGHT. Thank you, Phil; first, in answering that question, I want everybody to know that I have never obtained a $1 million verdict against a doctor, a manufacturer, or anybody else whomsoever. I am still waiting and hopeful.

Seriously, the contingency fee issue is a red herring. It has no place in the discussions that we are involved in here today for two simple reasons. No. 1, it has absolutely nothing whatsoever to do with the amount of your malpractice verdicts or settlements. Juries are not permitted to award anything for attorneys' fees. They cannot take the attorneys' fees into consideration, and it is grounds for a mistrial if the attorney even intimates or suggests that anything should be awarded for attorneys' fees. The attorney's fee always comes out of the client's share of the proceeds.

Now second, the contingency fee system is probably the greatest deterrent that there is to prohibit and prevent attorneys from bringing unmeritorious medical malpractice cases or products liability cases or whatever they be, and the reason for that is simple and should be obvious. We have overhead, substantial overhead to pay in our offices. We have to make a living ourselves. When we take on a medical malpractice case, it ordinarily involves a commitment because we have to advance the costs. The patient can't ordinarily afford to do that. We have to advance the out-of-pocket costs to fight the insurance carriers, who generally have unlimited funds; in some cases, these costs run $5,000, $10,000, $15,000, $20,000, or $25,000. I have had them go as high as $40,000 of our own money, plus our time, and our time commitment will run $25,000 to $50,000.

We gamble that. We place it on the line and that is why in our office, in recognition of this, we screen those cases very carefully, because to lose a case is a tremendous economic sacrifice for our office and we don't want to take a medical malpractice case if we think we are going to lose it.

In legal brief, one of your doctors, Dr. Earl F. Rose, professor of pathology at the University of Iowa College of Medicine, stated in headlines that the contingency fee aids the medical profession. It discourages lawyers from taking unmeritorious cases for economic reasons, if for no other.

Suppose that the client could afford, which they can't, in 99 out of 100 cases, and even if they can afford, I can tell you that when a client comes into your office, even if he be one of those rare birds that has the money to pay you a per diem and an hourly rate, he will take the contingency fee every time because he knows that unless you don't do a job, if you don't win that case, you don't get paid. He would rather see you get your third than to agree to pay you whether you win, lose, or draw. I have never yet, in 25 years of practice, had a client say, I would rather pay you on a pier diem—on an hourly rate than go on the contingency fee basis.

In fact, as we said earlier, it is the public interest that we should be concerned with here. And the public has no objection to the contingency fee, the public likes the contingency fee. They will choose it every time.

Four years ago, when this red herring came up in California and I had to testify before our legislative body there, I did a little research. I went to our State bar in California. We try to discipline our lawyers. We have 18 full-time lawyers who do nothing but discipline attorneys—prosecute them when they get out of line, plus a large staff. The largest part of our budget is spent on attorney discipline in California.

There were over 4,000 complaints in that year against attorneys. Only one of them had anything whatsoever to do with the contingency fee. And that one, was found to be unmeritorious.

Finally, the contingency fee used in medical malpractice cases, is nothing different or unusual from the type of arrangement that is used in all tort litigation and in a great deal of your commercial and business type litigation, where large companies are involved. For example, my partner who does securities work, attended a meeting of the securities lawyers. I wish we made these kind of fees in the personal injuries cases. The largest one I know of is the *Niles* case which was a $4 million verdict, and the fee which was approved by the court, the client wanted to pay more—he was so happy, was $1 million.

But now in the commercial cases, they handed out at this seminar a list of your commercial cases. Look at this. These cases make what we are talking about seem peanuts. The *Philadelphia Electric Co.* case, $22 million recovery. The attorney was awarded $5.5 million. About 25 percent.

We have four pages of similar awards. The *New Jersey Gasoline* case is $29 million. Attorney fee recovery, $6 million. The *Grasseau* v. *Gambles Scargmo* cases, $10 million recovery, $1.6 fee. These are commercial cases where the big corporate financial lawyers are involved not the ones who represent the people.

One more. The *City of Philadelphia* v. *American Oil Co.* case, $29 million recovery, fee awarded $6 million.

I think that that should answer that question. Thank you.

Dr. CAPER. There are quite a few questions up here concerning the contingency fee arrangements as I am sure you are not surprised to hear. A figure I have is that about half, on the average, over half of awards in medical malpractice cases end up going to plaintiff and defendant's attorneys. At an estimated claims volume of about $1 billion for the coming year, how can you defend $500 million a year, going into a system which is basically an adversary system? Would you have any objection to offering the patient the opportunity to choose what may work out to be a less costly alternative, such as one of the two proposed in the Kennedy-Inouye bill.

Mr. CARTWRIGHT. I can say this, that if a system could be worked out which would fairly and reasonably compensate the attorney and still be in the public interest, we would not be adverse to it. With reference to the figures that you have mentioned, I have serious question as to whether or not they are valid. I would have to see the facts. I certainly seriously doubt that the plaintiff's attorney is getting anything near the amount of dollars that you just mentioned.

Experience has shown that the amount of fees that the plaintiff's attorney gets is not out of line. There have been two exhaustive studies, or at least one, that have been made on this subject matter. The most exhaustive was the Health, Education, and Welfare study. The Secretary study which was made a year or so ago. A $2 million study as I understand it, which was composed of some 21 distinguished people from all over the United States, only one of whom was a trial lawyer. Only one was a member of our association, and that was Dick Marcus from Cleveland, Ohio.

The ultimate or the upshot of that was, that—and I will quote. These aren't my words. This is from the Commission study, the $2 million study—the people who studied this extensively:

> The Commission believes that most physicians generally place undue emphasis on the influence of the contingency system upon medical malpractice litigation, in that only harm will result from perpetration of the common beliefs about its role in the overall problem. Our study data showed that the contingency systems tend to discourage the acceptance of legally meritorious malpractice cases, involving minor injury and relatively small potential recovery and we view this as a wholly desirable, and fair result of the system.
>
> However, most individuals are also unable to afford legal services in medical malpractice cases on a fixed fee basis,

which is the point I make.

> The net result is the same in both instances. Recovery for injury denied.

And then I will not take the time to read it because of our time limit, but they then go on to point out that from all of the data collected, only about one out of three or one out of four of these cases are won. The attorney doesn't get paid on every case by any means.

The data reveals that the average hourly fee in these cases, after you take your wins and losses for the plaintiff's lawyers, comes to about $65 an hour compared to an average of $50 an hour for defense lawyers. But the plaintiff's lawyers are the ones who take all the gamble.

Now, the argument that the doctors make on the contingency fee is, that it makes it profitable for plaintiff's lawyers to take these cases. Let's think about that. Let's analyze it. If you make it unprofitable for us not to take them, we won't take them and there will be no medical malpractice cases. Now if that is what you want to do, if you want to eliminate medical malpractice cases, if you want to prohibit a lawyer like Ed Friedburg from Sacramento, Calif., who spent months on the *Norr* case, from taking a case like that which was in the public interest, eliminate the contingency fee system. Or, put restrictions on it, like you have done in New Jersey.

Bruce Walkup, one of our great lawyers from California, was asked to take on a products liability case in New Jersey—tremendous commitment and cost and time. He turned it down. He couldn't gamble. He couldn't take a chance to proceed in that case, with the fee limitations that the New Jersey Supreme Court has imposed. Is this in the public interest?

You have to analyze, gentlemen, what you are trying to do. Are you trying to protect the public? Or are you trying to eliminate medical malpractice cases. If that is what you want to do, abolish the contingency fee and you will have no medical malpractice cases, because no lawyer will take them.

Dr. CAPER. I have a question here for Mr. Linster. Why are the malpractice premiums so much less in Canada?

Mr. LINSTER. That is a very good question. When we had the hearings of the malpractice commission, we had a lot of testimony that the reason for it was that they did not have contingency fees in Canada. In fact, I guess we are the only country in the world that has them. I think there is one province in Canada that has them. But I don't think that is the only reason. I think you have a different climate in Canada, so far as the substantive law is concerned and the kind of decisions they hand down. And as I said in my remarks, I think there is a lot that could be done to correct our present system without completely destroying it.

Dr. CAPER. There is a question here. I believe one of the panelists made a comment that a no-fault insurance system would be too expensive. I have a question here, why is a no-fault system too expensive?

Dr. HENDERSON. I made the statement that the group of people representing the New York Bar Association and the New York Medical Association have felt that a no-fault system was too expensive. And I can just guess, but I suspect that it is because there are a number of people who get less than satisfactory results from any kind of medical treatment and if they are going to be compensated for this, this is going to be expensive. It is going to be more expensive than determining fault on the part of a physician and then causing payment to be made.

Dr. CAPER. The statistics on the percentage of awards going to attorneys, was based on an extrapolation from the Secretary's Commission on Medical Malpractice. The Secretary's Commission on Medical Malpractice also estimated only 16 to 17 percent of premiums paid were returned to the injured party as benefits. Would a no-fault system in the context of a national health insurance program which paid on a last dollar basis, be more expensive than the existing system which returns only 17 percent to the injured patient.

Dr. HENDERSON. I just don't have the information to answer that question intelligently.

Mr. CARTWRIGHT. I would like to add a very brief comment. I don't have the figures either, but the HEW report discusses this extensively, and one of the contracts that they let out—they let out contracts—that is in the second thick volume, discusses this. For every malpractice claim—and I don't remember exactly, so these figures may not be exactly right, but for every malpractice claim, there is probably 200 or more, as I recall, medical injuries—people who are injured in hospitals or doctors' offices.

Now if you had a no-fault system and paid everyone of the 200 instead of the 1, and of the one who filed the claim only less than 50 percent of them get paid, you are talking about a phenomenal—an astronomical sum of money, even if you limited the benefits and gave people one two-hundredth of what maybe they are entitled to.

Dr. HENDERSON. May I just comment about that. The gentleman on my left here has some very colorful language. He talked about butchery earlier and now he talks about injury in the doctor's office or in the hospital.

Mr. CARTWRIGHT. I am not talking about negligent injury now—just injury.

Dr. HENDERSON. Well, we prefer to call this as an unsatisfactory result.

Mr. CARTWRIGHT. All right.

Dr. CAPER. Just one more quick question for Mr. Cartwright. Who is paying the cost of these injuries now, Mr. Cartwright?

Mr. CARTWRIGHT. Well, in most cases, the patient himself or his own carrier or the public, because very few of these cases are won, unfortunately, and this is one of the reasons why we have the crisis here today. Our courts have become acutely aware of the fact that No. 1, the doctors have not properly policed their own profession, and No. 2, they have become increasingly aware of the fact that it is very difficult for the consumer to recover when he is injured as a result of malpractice. This is because of the conspiracy of silence and for other reasons.

For this reason, our courts which have become consumer oriented, not only in medical malpractice but in products liability and all other fields and in the last 10 years, have established rules which has helped the medical care consumer to effect recovery. Such rules are informed consent, a relaxation of the res ipsa loquitor doctrine, abolition of the locality rule, and many other things. So, now we are finding that more of these people are recovering than formerly, and that is one of the reasons why we are here today.

Mr. LINSTER. I assume, Doctor, that your question is really directed at the Kennedy proposal of, as I understand it, a compensation system and a tort system combined, so that the patient would have a choice of collecting either the no-fault benefits or if he felt he had a good liability case, he could go into court and sue for damages as he is today, or as he can today.

The only difficulty with this is that, as I understand the Kennedy bill, the doctors would have to pay the cost of this, which means that, for example, in the total—in the entire United States you have 287,000 physicians. In the State of Wyoming, you have 301 physicians. In Wisconsin, we have less than 5,000. You would be expecting the doctors to pay the cost of results of health care services,

where there is no negligence, as well as taking the risk of the large verdicts that we have been talking about. I just don't see how this would be economically feasible. You just simply do not have a broad enough base here to work with. And just considering this, and I am a lawyer not an actuary, and maybe Warren can comment on this, I would suspect that if your experience rated this, a neurosurgeon and an anesthesiologist in some States might wind up paying $700,000 a year for coverage. Because, obviously for some of our best doctors, there is an incidence of events or occurrences, deaths, serious disabilities, where he has exercised all of his skills and performed his services in a manner which is above reproach, and yet under this proposal, he would be responsible for the compensation-type benefits.

Mr. COOPER. I agree totally with Jack. I think one of the problems we have with many of the bills which have been entered into various legislatures is that no thought has really been given to the pricing of alternatives. There is an expectation that suddenly our files contain more than they do and that we are going to come up with the proper price. The necessary facts are not in our files. We have no way of pricing such no-fault bills. We do know that such systems are going to be more expensive than the current system, and as Jack points out, once this is realized it will be mutually impossible to retreat.

All depends upon what the definition of "medical injury" is and how tight that definition is. It is loose at best in some of the bills we've seen: it means any unexpected result. There have been studies in California that show that in any particular hospital there are probably hundreds, if not thousands, of maloccurrences which never come into the malpractice area.

Dr. CAPER. We have two related questions. One for Mr. McMahon, the other for Dr. Coury. First Mr. McMahon, when you call for preservation of the system of medical care, what do you mean? Fee for service, national health insurance, capitation; are these not factors in the malpractice scene? Any comment on these vis-a-vis malpractice here and in Canada, and a similar question for Dr. Coury. You stated that we are the only country with a malpractice problem today. Do you think there can be any connection with the fact that we are also the only modernized country without a national health insurance or catastrophic health insurance program?

Mr. MCMAHON. Phil, I think this question raises the same kind of questions that we have just been dealing with in connection with the so-called no fault context. When I talked about the preservation of the present system, I was doing it in the context that we had better understand the implications of change before we make the change. Changes are underway, and they are underway in an evolutionary and not a revolutionary sense.

I have some concern that if we try to do too much to change the system, in order to correct, or with the hope that it will correct, the malpractice problem, we may produce unfortunate results for both. I have always thought that the best thing to do in approaching a problem is to analyze that problem very carefully and see how it might be solved, rather than compounding the problem by putting a number of other things in it, and then offering total solutions.

Dr. COURY. The question was with regard to the malpractice situation here, and that we are the only independently practicing physician group in the world. I don't think that has anything to do with it,

because in Canada, this problem did not exist even before they developed their various forms of socialized medicine, Ontario being the last.

If you want to know what I think about what has caused it, I think it is a combination of a few patients, a few lawyers and a few doctors who have brought about the whole problem, plus the judiciary. I feel that the reason we are in this boat in this country is that the laws have been stretched, torn, used for every imaginary, way that they could, supposedly under the guise of due process and civil justice for the individual, to the extent that where it has excluded the large majority of the public and I feel that a great responsibility, and I sit here saying the medical profession has a responsibility. But I do take objection to the fact that it isn't because we haven't policed the profession. The individuals being sued today are the well-trained, and hospitals are rendering excellent care.

I sat on a licensing board for 8 years with regards to physicians and their competence and every time we tried to take an action, we were frustrated by the legal profession, and the attorney general's office. In some instances, when we did suspend a physician's license, he eventually gained it back through the courts.

There is no doubt that this is a complex problem. I don't think eliminating the contingency fee is going to solve it. I think there should be a limit on the contingency fee, and I don't think our problem is the result of socialized medicine in the rest of the world. I think our problem is a result of the present psychological, socio-economic, legal, and judicial environment.

Dr. CAPER. A question for Mr. Cartwright. How can the doctors be successful in controlling their peers when the lawyers and the courts overturn our actions to limit the practice of an incompetent physician? Until he has produced a court-proven malpractice?

Mr. CARTWRIGHT. Well, there have been occasions when the courts have overturned the discipline of a doctor. It is true also with reference to lawyers who we discipline constantly in California, every month. It is true with reference to other professions. However, I do not think the mere fact that you might obtain a reversal in some particular case where you have found a doctor to be incompetent, or unfit, or unqualified to practice, should be used as an excuse or a deterrent to try to discipline these people. I think you should have strong disciplinary boards.

I think there should be laws to protect those who are involved in such proceedings. We do, I believe, now have such laws in California, to protect doctors who sit on disciplinary boards and who do censure or discipline or take away the license of another doctor. I think that the people who are involved in those procedures should be fully and completely protected and that they should have a privilege, just as do those who sit on our similar committees involving lawyers in California.

The fact of the matter is, gentlemen, if you face the issue squarely and honestly, there are very few doctors in this country, in some States practically none, who have had their licenses taken away. Now this is a serious problem. I wish we had time for me to read to you some of the many quotes and findings and statistics which will show that these aren't my words, but the words of independent people.

Let me just take one. The most recent study and that was the Waxman report, which updated the HEW report, and is June 1974, which is a very comprehensive report which considered all of these things that we are talking about. The actions of the county medical societies, the actions of the State boards, and so forth, as to whether or not they were doing the job.

The conclusion on page 55 is—and they discuss all of these various area efforts of the medical profession prior to the conclusion—"It is thus fair to conclude that while there does exist quality control mechanism within the government and the medical establishment, these mechanisms are not sufficiently effective. At the present time, malpractice litigation is clearly"—this is a legislative report, Sacramento legislature. Mr. Waxman is now in the U.S. Congress. "Medical malpractice litigation is clearly the most significant external pressure prompting physicians to practice quality medicine."

Dr. Reed M. Nesbitt, deputy director of the Joint Commission on Accreditation of Hospitals, testified at the Norr trial, that the legal profession has helped the medical profession a great deal by having malpractice litigation and by pointing out several flaws in our system that we are working under.

Dr. CAPER. Thank you, Mr. Cartwright. A question for Mr. Cooper. Please elaborate on your comment that malpractice insurors are wary of hostile State regulators. What other kind are there?

Mr. COOPER. I have a friend sitting over there, Mr. Rawls of Oregon, whom I wouldn't call at all hostile. He is sometimes unpleasant, but not hostile.

We have seen in various jurisdictions a crisis in the malpractice market created by regulators. I think most of you know these cases where rate reviews have been handled in a not particularly swift nor particularly understanding way.

Dr. CAPER. A question, I guess to anyone who wants to tackle it. How can doctors police their profession when the States do not give them—the medical society the authority to do anything about it? And I will add another question of my own to that, what is the relationship between State regulatory legislation which is passed to regulate the medical profession and the lobbying efforts of the medical societies in those States?

Dr. COURY. Of course the answer I would like to see with regards to medicine, since the profession as an organized profession, is always getting the blame for everything that goes on in the profession, and only about half of the physicians in the country belong to organized medicine, I would like to see the profession similar to the way the bar is set up.

That to be relicensed, you would have continuing medical education sanctioned by the medical society and that you must belong to organized medicine. This is the only way. We have a very loose organization so far as organized medicine goes. There is no way of controlling medicine. Most of you here who are physicians know this, other than in your hospitals if you have good audit and good review staffs.

I am convinced that the great percentage do. With regards to State regulatory agencies, in Michigan we have been pleading for years to—we went for reregistration fee and the Government in this State gives

us back 32 percent to run the board. We asked for investigators, we wanted to clean up the profession and get investigators out, but they refused to give it back, give it to the board to operate. Yet, you get kicked in the teeth when you take something away.

Now we have got a new licensing act that after working 5 years on it, the first case they come out with so that we can do some suspension without the final court of appeals, we took away the license of a man—I am off of it now. I resigned after he got the axe—they took away the license of a physician selling script without seeing the patient, and is selling it for hard drugs and speed. Now to me—and the man admitted it—they investigated and what happened, he walks out—his lawyer who is representing him, take it to the court then and the judge gives him back his license.

Now here to me, is where I think the legal profession has to own up to its responsibilities. The State regulatory bodies can only do as much as the legal profession or the judiciary permits them to do.

Dr. CAPER. Here is question—a question for Mr. Cartwright. Can minutes of peer review of medical audit committee be subpenaed if it is suspected they contain evidence that may be relevant in the malpractice action? If so, should they not be granted immunity from such subpena?

Mr. CARTWRIGHT. Well, that would depend on the law in your particular State. In California, we have a law pertaining to certain types of studies that are made by hospital committees, which are privileged and the deliberations of those bodies are privileged. Now, it would—I haven't thought this problem through, but off the top of my head, it would occur to me that if we are serious about wanting to give the doctors or the medical profession teeth to censure, license and discipline their own people, they should be able to do so without fear of retaliation or lawsuits or anything else and they should be able to rest in the assurance that their deliberations, anything they might say, and so forth, are totally privileged, just as are deliberations in a court of law.

For example, a judge, or in an arbitration proceeding, a judge is totally immune as are the attorneys. Oh there may be some kind of exceptions, but there—what is said and done there is totally privileged. Now this encourages the type of action that all of us want. Now if the doctors don't have that sort of protection in some States, they should have it. I might say, Dr. Coury, that I agree completely with your analysis of a good way to proceed. Not that we don't have some bad doctors—lawyers in California. Witness President Nixon just recently, who we forced to resign and some of his cohorts. But we do have what is called an integrated bar. This means that everybody has to belong to that bar association to practice, and they have to pass very tough, stringent examinations. Some of them still get through.

You can be very smart and yet crooked, you know, and pass the bar exam or the medical exam for that matter, or any other exam. And this happens once in a while. But at least that is a good initial step.

Then, we spend the great—a very large percentage of our budget on this activity, this effort. We have a very large staff and you know, you are still going to have incompetent lawyers, you are still going to have some bad lawyers, and so forth. All you can do is do the best you can in that regard. But at least we have the machinery there. We have the mechanism to do it with, and this I think, would be the type of thing

that you could probably use effectively in the medical profession because I can't really believe that if you felt that you were protected as we are, that you would want to see people like Norr and other—talk about tonsilectomies—I could talk about hysterectomies and all kinds of cases. According to one of the people, I think he is here today, there are some 2 million unnecessary operations performed in this country per year.

I can't believe that honest reputable doctors want these kind of doctors to be practicing. It doesn't do you any good, and they probably are a very small minority. Probably 5 percent or 10 percent. I don't know. But you should have the procedure to get rid of those people, and that will help materially, to solve the problem that we are talking about here today.

Mr. JAMPLIS. Phil, as long as I'm not up there I guess I am a member of the panel, and I just wanted to say just a couple of words and ask Mr. Cartwright about it. This—you alluded to it and Dr. Coury—everybody, the fact that even if you police everybody, that it is very often the best doctors, as Mr. Linster said, who would pass all exams, who would be giving the exams that are still being sued. Now, that to me is the crux of here the situation, not—we can get off into what the bar does and others. Now, if, I think that if the patient is damaged, he should be rewarded. But if there is no malpractice involved, maybe the doctor shouldn't be punished.

If there is, he should be punished. But how does one do that and not make instant millionaires out of the paraplegic or the lawyer? That to me, is the crux.

Mr. CARTWRIGHT. There are very few instant millionaire quadraplegics, I can tell you, and very few instant millionaire lawyers. There may be a few, but I am not one of them and most of them that I know—most of my friends aren't. Very few. But to answer our—your question, once you have eliminated or have done the best that you can to police your profession, to get rid of the incompetents, to have relicensing situations, and requirements that you have to continue your study. The whole practice of medicine, I have heard, completely changes every 10 years according to one article that I read. Once you have done those sort of things, then you still are going to have cases where the best doctor in the land commits malpractice. For example, let's take a lawyer—talk about my profession. I have a large office. I have 11 lawyers. A year or two ago, we—what we call in the profession, blew a statute. We have to file our lawsuit within 1 year in California. And if you don't, the client is out. His remedy is to sue the lawyer, because it is malpractice.

Now one of my young men made this mistake. It was our fault. We consider ourselves to be good, reputable honest lawyers. We didn't tell the malpractice carrier, I will fight this. Because we are the best lawyers in California or the United States—we are really not, but—no. We told them, now look. We blew this one. This is one you pay on. We made a mistake. And so if the best doctor in the land truly commits malpractice and cuts off the wrong leg or like one of the examples I have here, takes out the wrong kidney, which I didn't get to—things of this nature—he should face up to his responsibilities too. That is what you have insurance for, and that sort of a case shouldn't be fought.

Now, of course, if the plaintiff is unreasonable and wants more than the case is worth, you many still have to litigate it, but most of the time, if the doctor will admit that he blew this one, if he did, then a reasonable settlement can be worked out, and if he didn't, if he wasn't guilty of malpractice, and you are honest about it, then fight it and you will probably win.

Mr. McMahon. Phil, I wanted to add a word about the first part of the question you put originally to Mr. Cartwright. It has to do with the relationship of utilization review and medical audit to malpractice, because many of us have a very real concern that the complexities of this relationship are not understood.

We are still in the early stages of making utilization review and medical audit work. We are trying to do it in the context of the assurance of quality as well as cost effective care, but the process is in its early stages and we have a lot of hills to get over before we can make it work and count on its effectiveness. One of the things that I had in mind in the third cautionary note that I gave at the end of my first presentation is this: We have a great concern that too much is going to be counted on from obligation review and medical audit. We have long been in favor, in the American Hospital Association, of rigorous and effective in-house review. How that will relate to PSRO's for example, how it will relate to other monitoring devices, we don't yet know. But the cautionary note is, if we were to tie this in at its early stages of development with an attempt to deal with the malpractice problem, we may bog ourselves down. We may forget that medical science is still an art and not a science. We may get so carried away with the application of certain procedures in dealing with certain diagnoses, that we lose sight of the strength that we have in the present physician-patient relationship.

Dr. Caper. Mr. Linster has a question.

Mr. Linster. I have a comment. I couldn't agree more with Mr. Cartwright that a case where the surgeon removes the wrong leg, the patient should be compensated and compensated well. But let me assure you, Mr. Cartwright, that that is not the problem. If we limited malpractice recoveries to cases where it was truly malpractice, I don't think we would be in the difficulty we are in today. Our problem is that with the advances in medical science, your most skilled surgeons and physicians are able to save patients who would have died not too many years ago. Also, many who would have wound up with horrible disabilities and lives that none of us would want to live, are given the benefits of modern procedures.

But with this has come some risks. And risks that are beyond the control of the physician or the surgeon. He can perform with the ultimate skill and yet we have cases where the juries and courts will render substantial verdicts. And I think that is our problem and we have got to come to grips with it. That if we are going to continue to compensate patients on the basis that regardless of whether there was fault on the part of the physician or not we somehow should take care of them, and everyone in this room sitting on a jury would certainly be sympathetic to a patient coming in to the courtroom with—who is a paraplegic or quadraplegic, but I think we have got to broaden our camera view and consider the effect that this is having on all patients, the type of care, the cost of care, the quality of care; the informed consent. The informed consent is getting to the point

where a doctor, when he wants to inject penicillin must—as he is approaching him with the needle, say I have got to warn you now, there is 1 chance in 50,000 that you may be dead, from this injection.

So I think we have got to get this whole system back to sanity and reason.

Dr. CAPER. Fine, thank you. We are going to have to wrap up in just a minute. Iwould like to go through just two more questions. This one is directed to anyone on the panel. I would like to expand that to include anyone in the room who wishes to answer it. What can be done to encourage the news media to give as much publicity to a suit that is dropped or dismissed as they do when a suit is filed?

Mr. CARTWRIGHT. Well, some attorneys get a lot of publicity when suits are won. We don't do that in our office. And I find that reprehensible. And if a case is lost, and the doctor wants publicity, about it, I seriously doubt that he would want that. But even if he lost it, because people would still have a question—but I think that there shouldn't be too much trouble in getting that in the newspaper. The situation is, I know cases I have had, where we have made a settlement, the doctor will say in an obvious case, OK, we will settle the case but will you agree that if I do, that there will be no publicity in the newspapers. In our office at least, we have invariably said of course. We have no desire to hurt you professionally and we will make that a stipulation as part of the settlement and there never is any publicity.

Dr. CAPER. We have many, many questions here which can't be asked. We just don't have time, and many of them are very perceptive and very good questions. I would like to suggest that we, if it is all right with the panelists, that we simply submit those to you in writing and give you an opportunity to respond to them. I am told by the American Group Practice Association Counsel, they can be published in the proceedings. I think that would be a very valuable contribution to this proceeding.

I would also like to convey a message to you, that Senator Kennedy wished expressed just before he left, and that is that he considers this issue to be of great priority, not only because of the short-term problems involved, but also because it addresses some of the more fundamental problems with which he and other members of the Health Subcommittee have been concerned for a number of years. He wanted me to tell you that the committee wants to do something about it and plans to move legislatively in this area, if that seems appropriate.

Finally, I would like to read a question directed to me. Dr. Caper, have you engaged in the private practice of medicine? I am asked this question frequently, and I always like to ask the questioner who is. I guess anonymous in this case, if they have ever drafted Federal legislation. I think each question is about as relevant as the other. I will refrain from commenting on their efforts to practice medicine if they will refrain from my efforts to help draft legislation.

I would like to thank the members of the panel very much. It has been very informative for me and, I know, the members of the audience.

Dr. JAMPLIS. Thank you Phil, before you leave, as I guess chairman of the meeting this morning, I am going to take the prerogative of asking the final question. And it is a very serious question, and I think that I would like Mr. Cooper and Mr. Linster to answer it. I may be very naive but it seems to me that there probably has been no more

actual malpractice. We have also said that the best doctors—that would pass the test, the ones that would get sued, I think that the lawyers have not been maybe overly aggressive in any way, but what bothers me is, and as I understand it, if there were not $4 million, $2 million, $1 million judgments, that the insurance companies would be allowed—not allowed, but would be able to handle the claims.

Certainly, if there was some way that the reinsurer could take on the big ones or maybe also eliminate the big ones entirely, we wouldn't have that much of a crisis, because it is the big suits, as I understand it, that are giving us the trouble. Is that a true statement or not? Mr. Cooper.

Mr. COOPER. Like all truth, it is partial. Our problem as I discussed this morning, was one of what we viewed to be price. In a theoretical economic model we are money funnelers. We take it in one door from many, and we pass it out the other door to a few. Along the line, we give off pieces to ourselves to other intermediaries. If we felt certain that we play this role and come out whole so that our stockholders were protected, we would theoretically be perfectly willing to go along with any system.

However, in the system now—we see large average claims—severities growing anywhere from 10 to 20 percent a year, and a frequency which is going up 10 percent or more a year. At such rates, when they are reflected in our pricing schedules, it doesn't take very long, perhaps 3, 4 or 5 years, to see a doubling of the premium. And within 20 years, we will have premiums that are 700 percent what they are now. We know that we cannot ask for that—or rather, if we ask for the money, we know we won't get it. This is part of the regulatory problem. I talked about States that were hostile. I think that States which are now friendly will become hostile, because they will not be able to approve such increases.

Dr. CAPER. Mr. Linster.

Mr. LINSTER. I would make this comment, that so far as the losses are concerned, and the possibilities of reinsurance, we have to keep in mind, that our basic problem is the losses. And the reinsurance carriers, whether they insure above $100,000, $200,000 or whatever, are going to have to collect a premium that is adequate to take care of those losses. So I am sure the doctors in the audience understand that you don't cure cancer by dividing it into pieces. You don't solve an insurance problem by dividing it up between the primary carrier and the reinsurer. And also, you don't solve the problem by moving it to Washington, and reducing the visibility of the cost of this.

Dr. JAMPLIS. Then how would you put a ceiling on the level. That is the point. Have you any ideas about that? That to me, is the crux. Where do you put the ceiling?

Mr. LINSTER. I think, and I wish we have more time, because this is a very difficult and complicated subject which can't be answered in 1 minute. It seems to me that when we get into the area of the paraplegic for example, that perhaps we have to come up with some system under which that individual will be paid out over a period of years, rather than in a lump sum, and this would reduce the size of verdicts. In other words, frequently a jury, is faced with evidence, conflicting evidence as to how long the paraplegic will live. And what his medical expense is going to be. And understandably, the jury

guesses high. And I guess most people in the room would. They feel that they don't want to come up with a figure that would be too short.

The insurance companies can afford to play the average better than an individual patient, and what would be a better approach, perhaps, is to come up with some modification in our system which would permit the payment of these over a period of years, rather than a lump sum of $1 million, $2 million or $3 million.

Dr. JAMPLIS. Yes, we will go on here. You will all have to eat fast, but I think this is more important. Mr. Cartwright and then Dr. Caper.

Mr. CARTWRIGHT. I just wanted to say that I think that is an excellent suggestion. I don't think it requires, however, any legislative action. In fact, some settlements now are being made on this basis in California. They agree on a certain amount for attorney's fees in the case, and then the patient or the plaintiff is to receive a certain amount over a period of time.

I can tell you, particularly you gentlemen in the insurance industry, because this would apply to any type of tort case, that it is something you should give serious consideration to. In the last two catastrophe cases I have had, one a young vegetable boy, 16 years old, horrible—the doctors did testify that even the defense doctor gave him a reasonably good life expectancy with optimum—that is the magic word—medical care. Our neurosurgeon said that with optimum medical care, his life expectancy is 55 years. He might live 20–25 years.

He died 3 months after the trial. Another case, a horrible burn injury case that I had last year, took—talk about the contingency fee, 3½ months to try, $40,000 in costs, $50,000, $75,000, $100,000 in time, we lost it. But we had been offered a settlement in that case which in hindsight we should have taken. That lady, blind, couldn't talk, had to press a little button to talk, couldn't breathe out of her nose, horribly burned. She died in December.

So consider that.

VOICE. Mr. Cartwright, I think you have made such a great comment on contingency fees; I am a general surgeon. From now on, I am going to propose to all my patients that if this operation is successful, you pay me a percentage of your natural life time's earnings on a yearly basis. You made a great thing. I like it.

Mr. CARTWRIGHT. Doctor, I suggest that you do that and see what the answer of the patient will be, and I think he will say no.

Dr. CAPER. One final question, which I think is an important one, and which I hope is addressed, although I don't expect it to be answered by this Conference. The question was to me. How much will premiums proposed by S. 215 and S. 42, the no-fault and arbitration proposals, cost doctors?

Obviously those questions can't be answered at the present without further refinement of the bill. However, I think a more interesting question is, how can the costs and benefits of the existing medical malpractice system be more equitably distributed among all interested parties, including the patients, and how can the increase in costs be contained? One of the reasons Senator Kennedy introduced two mutually incompatible legislative proposals is because he recognizes the complexity of the problem. That is why there will be hearings held

about the proposals and I hope very much and I know he does, that these basic issues are addressed.

Dr. JAMPLIS. Thank you, Phil. I am delighted that we have had this give and take; as I said, in my opening remarks, it is going to be necessary for all of us sitting here this morning, here this newly formed president's club that I have in front of me, to really—John says, thanks for the promotion. Vice president. At any rate, to be very serious, I am sure that people like we have at this table right now, must sit down and give and take for the benefit of all, because nobody wants—neither Mr. Cartwright, myself, Dr. Courty, anybody, when their wife needs her gall bladder out, or somebody's aorta ruptures, it has got to be taken care of. There has got to be an answer and believe me, those of us who are going to be testifying in Congress in the next few weeks, must reflect what these presidents and what you out there have to say. Because this is a terribly, terribly, vital issue which will be solved, hopefully well, in the next few months.

I do want to thank the presidents, the vice presidents, and everybody else here. Please, Phil, tell Senator Kennedy, we were delighted to have him and please take all of these remarks back. And thank you for moderating.

LUNCHEON SESSION

Mr. HASTINGS. This morning I had the privilege of introducing at the opening of this conference, Senator Kennedy. At that time, I identified him as, in my judgment, one of the five people who are most responsible for the development of health care legislation in the country.

I have the great privilege of introducing to you this noon the man who I consider to be not one of the five, but No. 1 in interest, and in action as it relates to the development of health legislation. Now, I might advise that he is the chairman of the committee of which I am a member which might help explain why I make that kind of an introduction, but I can assure you that in introducing your speaker for this luncheon, that in fact Paul Rogers, Democrat from Florida, is without any question in my mind, the most effective spokesman for the interest of health care and all of the health professions in not only the entire Congress, but in the entire country, and Paul, I say that most sincerely. I want to thank you publicly for agreeing to participate in this conference, and as we proceed after the conference has concluded, and we receive the type of input that we expect from this conference, I look forward to working with you on the development of whatever malpractice legislation we feel may be necessary from the Federal level. It is with a great deal of pride that I introduce to you ladies and gentlemen, the Honorable Paul Rogers from Florida.

Mr. ROGERS. This is what you get when you're introduced by a Republican.

Thank you. Thank you very much, my good friend, Jim Hastings, for your very kind introduction. One does appreciate an introduction from a person who is knowledgeable in the health field, who has participated in writing the laws in the health field as Jim Hastings has, and has been a man of real integrity in trying to bring forth solutions of the many problems we have in this country. Now, he and I are both glad that we're not subject to malpractice suits, I might add. In fact, I would image the whole Congress is. If we were, judging by some of

the remarks the President has been making lately, he might have the Attorney General after us all.

Mr. President, I'm honored to be here at this conference which has been sponsored by AGPA and Jim Hastings, and to see such an excellent turnout. I don't suppose there are many subjects more on the mind of so many people who are involved in health care delivery except perhaps tax relief or the economy. Certainly this is one of the main subjects. I suppose, too, when we look back the classic question of malpractice would appear a pretty simple one. We just wish the solution now were as simple as the problem of medical malpractice, simply to provide an injured patient with a remedy for a fault visited upon him by a physician or others in attendance. Incidentally, I see a few lawyers here, and I might tell you the story I heard at a lawyers' convention just to show you the kind of atmosphere they're building up against all the doctors. They said that this lady went to Texas to a little town. She'd never been there before, so she wanted to know who was a good doctor. She happened to ask the lawyer who was advising her how to get her house and so forth, "Well, who is the best surgeon in town?" He said, "Well, I'd talk to Joe Smith, that is, when he's sober."

She thought about that a moment, you know, and she said "Well, who is the second best surgeon in town?" The lawyer thought a minute and he said, "Well, that's Dr. Joe Smith when he's drunk."

I'm sorry I was not present to hear the panel discussion earlier. But all of us agree that an injured patient has a right of recovery. There's no one that would disagree with that. A wrong should be righted. The events of the past 4 years though, I think, have brought us to a point where this traditional system—arriving at a just conclusion in cases of malpractice—is no longer operative, if you pardon that phrase.

Increased numbers of malpractice suits and some of our really skyrocketing judgments have, of course, caused the insurance carriers to elevate their premiums to astronomical levels. I won't go into all the details; you've heard it time and time again already this morning in your conferences. They make the physicians wince, and claim they have to increase their fees to cover this new cost of doing business. Some are contemplating retirement. I guess the lawyers feel it's a lot of hard work even though we might view it as having its bonanza aspects. When a patient has been harmed and receives compensation, the rest of the physician's patients have to pay and make up for these increased premium charges, and so the entire cost of medical care is going up rapidly.

We have passed legislation within the last 3 years to try to get doctors to go into critically short areas. If the malpractice problem is not handled judiciously, I can see additional problems for getting a spread geographically of physicians in the country, because a young doctor won't be able to pay the high insurance rates when he goes out to start his practice. So this causes added concern in this whole area of medical care and medical service. And of course, as you know, the numbers of malpractice suits and claims have risen rather dramatically. What's the answer?

One must ask, has this come about because medical care is deteriorating, or are patients and lawyers just pursuing more cases than was so,

say 10 years ago. Well, we probably ought to look at this and consider what has happened and what possible solutions we could propose.

The reason the Congress is interested in this problem is twofold.

First, this unusual phenomenon which has developed in this country is changing the practice of medicine in America today, and in doing so, is affecting people by driving up the cost of medical care. Medical malpractice insurance now, it would appear, may no longer be available to some hospitals and doctors, and if the trend continues, this group will be enlarged considerably. The increase in the cost of medical care has led all other segments of our economy for more than 5 years. I don't think that the instance of malpractice suits has played the dominant role by any means. But certainly I think it has been playing a very significant role, because as you know in the past 5 years malpractice claims have more than doubled in frequency, and the size of settlements has skyrocketed.

I'm sure you discussed today some of these awards. In California we have the greatest example of million-dollar suits. I think Jim Hastings told me California has had 26 such awards. Of course, this does make the insurance carrier shudder and the requests for increases in premiums has caused the physician anguish.

To cover themselves further, and this vitally affects cost, the physician has really begun to practice defensive medicine. He's had to. Of course, I might say even before this, we have seen a good bit of that defensive medicine where one enters a hospital and an awful lot of X-days and tests, perhaps in many instances more than what's actually necessary for the particular symptoms. But the patient was given a battery of tests or work up not necessarily because of the best medical treatment, but because the physician felt he had to have a full book of efforts in case of potential malpractice action.

So, the bills have gone up. I expect they've been kept in the hospital a little longer than they needed to be, and I would hazard a guess that they might even have had a few more consultants than were needed, simply because of defensive medicine. It has been estimated that between $5 billion and $10 billion can be attributed to defensive medicine. Now, where's that coming from? It's coming out of the pockets of the people of this country, and that is one reason I think, the malpractice problem in medicine has become of national interest. Formerly, when the problem was stated in terms of what the individual physician is paying, most of the public didn't relate to a $60,000, $70,000, $90,000 salary, and talk of $15,000, $20,000 didn't mean much. But now they understand that the public is having to pay $5 billion to $10 billion in almost direct relationship to what has been brought about from the whole malpractice question and the development of defensive medicine, and this has to be ended. How? Well, I think there will be a number of possible solutions. Hopefully, some will come from this conference.

The PSRO, and I presume you've discussed that some, can be helpful in setting the standards which we accept. I think we're seeing a similar problem develop in the area of immunization. We've had several cases of adverse reactions, suits have been filed, and the drug companies that are making these vaccines are beginning to say it's not worth it. What would be the effect if they were halted altogether? What if they decide to just give up like some of the insurance com-

panies want to give up? If you're only making $30 million out of a whole vaccination market and you're having suits that add up rapidly to a million dollars in verdicts, it won't be long before those people will begin saying, "Well, we don't want to do this." That would have a very adverse effect on preventive medicine in this country.

PSRO's will help, I think, in setting standards. Also, perhaps we can do something with insurance company pools. It is even possible to consider, I think, as we've done in the auto business, assigning them to take so many physicians, so many hospitals. I think possibly that could be worked out. Then, of course, we might even get the lawyers to consider setting forth the distribution of potential awards. Should you build up the verdict for the patient and then present the evidence to the jury, for the amount of work you've done and let there, be two verdicts. For instance, if you go to the jury with a $100,000 case, the attorney might say, "Give him $70,000 and give me $30,000, or give him $50,000 and give me $50,000." That might have some effect on the situation. I am sure the lawyers might let us know what they think of that.

And I can guess.

But are we really accomplishing what the law sets out to do to compensate an injured individual if the attorney in fact receives as much or almost as much as the aggrieved party? That's the question that it boils down to I think. Is that what the law really intends? Is that what the compensation law intends? Is that the equity in the cases? I think this must be studied.

Now, this whole matter will be addressed of course by various proposals in the Congress as Jim Hastings says. He's already beginning to draft some legislation, and we're going to get together. I hope I can be supportive of his efforts. I do think the idea of no-fault is not a very feasible solution because I think you would have a claim for every death or every injury. Possibly we should have a quasi-governmental reinsurance proposal. That's possible. Possibly it should be an outright Government-sponsored insurance program. These are proposals that we ought to look into. Many have introduced legislation to bring forth the various proposals.

I would hope that what we could finally come up with is something at least to give us coverage in the interim period until proper solutions can be worked out. I think we probably need to do something rapidly to meet the emergency. It might be reinsurance for the moment. If the States could handle it, I think we would prefer that. I'm not sure all of them will or can in time.

So, in conclusion, I would say, and join with Jim Hastings in saying, that we will be getting into this matter. We will be holding hearings. We will welcome suggestions, and particularly, Jim, from this conference, I would hope that we would have some very concrete suggestions as to possible solutions for the Congress to explore, and if appropriate, to develop legislation to handle what is truly a national problem. Thank you. It's a pleasure to be here.

Mr. HASTINGS. Thank you very much, Paul. Again, I want to personally thank you for your attendance here today, and your offer of cooperation as we proceed with this problem. Time for reconvening is 1:45. See you later.

AFTERNOON SESSION

## IMPACT ON THE HEALTH SYSTEM

Dr. JAMPLIS. I'd like to reconvene the meeting. May I have your attention, please. This will be a panel discussion of an hour or so on the impact that this malpractice crisis has had on the health system, and we have four experts in the field. Now we thought that after looking at all those presidents this morning, that we would really have a little pulchritude for you this afternoon, so we asked Miss Adrienne Astolfi to be with us and add a little beauty and class and a few other things.

She is, at the moment, director of the hospital and health care sector of the National Commission on Productivity right here in Washington, D.C. She was a former director of research and development of the health services research center in my old town of Chicago. She also served while there as the assistant professor at the Graduate School of Management at Northwestern University. That is that other university upon the North Side.

She has also served as assistant administrator at New York University Medical Center, and Miss Astolfi has been the author of many publications on health care and has been consultant to numerous health organizations and institutions. Miss Astolfi, we are anxiously awaiting your words.

Miss ASTOLFI. Thank you very much, Dr. Jamplis, for that very nice welcome, but if this has any trouble distinguishing me from the other members of the panel, we have a much bigger problem than medical malpractice.

I would like to apologize if I sound a little nasal, but I have an ailment for which the medical profession has not yet been able to find a cure—the common cold. With all the physicians here today I would much rather talk about that subject, but they told me it wasn't on the agenda.

It is a pleasure to join you and be here today, and I would like to thank Dr. Jamplis and Congressman Hastings for inviting me to participate in this program.

As you can see from your program, I am listed under the title "Impact on the Health System." I am going to briefly address that issue in terms of productivity, quality, and the total system. Before I came here today a couple of people asked me how I was going to tie productivity into a conference on medical malpractice. In the event that any of you have the same question, may I point out that one of the major reasons we are here today is because of productivity.

Productivity, as you know, is the output you get for a given degree of input—manpower, materials, and money. It's the efficiency with which goods and services are produced. Increasing productivity, therefore, is getting more output for the same degree of input or getting the same output for less input. Conversely, a decrease in productivity would mean getting the same output for an increased amount of input in terms of manpower, material, or money or less output for the same degree of input. Our present approach to medical malpractice reduces productivity by increasing costs, by the inappropriate use of manpower, and by excessive use of materials and equipment.

I don't think I have to remind any of you today why we must all be concerned with productivity.

For the first time in 25 years, and the second time in 40 years, the average output yielded by an hour of work in the United States declined from 1 calendar year to another. Between 1973 and 1974, productivity fell by 2.7 percent in the economy as a whole.

In President Ford's first major speech after taking office, given at Ohio State University on August 30, 1974, he stated:

> It is my judgment that we must make extraordinary efforts to apply our know-how, our capital, our technology, and our human resources to increase productivity at a faster rate. In a growing economy, everyone, labor, management, and the consumer, wins when productivity expands.

Since that time the President has stressed the need for all Americans to work toward increasing productivity in all sectors of the economy. Most recently in a statement issued by the President on January 14, 1975, he stated:

> Our Nation today faces problems that are unprecedented in this generation. We are being whipsawed by inflation and recession and pressured by powerful foreign economic forces. In these troubled times, it is imperative that labor, management, and government find ways of working together to bolster the strength of the American economy.
>
> At the heart of our problems is the need to improve productivity.

Productivity is practically a new word in the health care vocabulary—it has not been part of the nomenclature of this industry as it has our industrialized community. Recently however, the high cost of health care has forced us to address productivity as it relates to this sector. This attention to productivity has been accentuated by the fact that economists have warned us we are headed toward a service economy, that 6 out of every 10 working Americans are employed in the service sector and that the health care industry as part of this growing service sector, accounts for 7.6 percent of our GNP.

The health care system as you know, is composed of providers and consumers, therefore, when considering the impact of this malpractice problems on the health care system, we must consider it in terms of both groups. Although there is probably little I could say to you this afternoon that you haven't either heard this morning or read about in the extensive literature regarding medical malpractice from the providers point of view which in this issue includes not only physicians and hospitals, but also lawyers and insurers, I would like to summarize for you what we have heard but primarily from the standpoint of trying to understand the point of view of each provider rather than placing the blame on any one group or another as discussions on this issue often does.

## PHYSICIANS

Physicians cite the major problems they face as:

1. The skyrocketing costs of malpractice insurance is forcing some physicians to retire early and new, young physicians to enter other areas rather than open up practice.
2. The system by which malpractice claims are settled is extremely costly to them and subsequently to their patients as rates continue to escalate.
3. They are forced to practice defensive medicine.

4. They fear that in a profession which depends upon the trust and confidence of their patients, medical malpractice is contributing to the erosion of that relationship.

5. The contingent fee system of paying lawyers is an incentive for them to aim for a high settlement from physicians.

HOSPITALS

Hospitals cite the major problems they face as:

1. Hospitals are being severely criticized for their escalating costs and yet the increases in their medical malpractice insurance is forcing those costs up further.

2. The present approach reduces quality of care.

3. The practice of defensive medicine on the part of their physicians forces hospitals to hire more people, purchase more equipment and material and thereby increases their costs.

LAWYERS

Lawyers site the major problems they face as:

1. The contingent fee system is being seriously questioned and yet it allows for the poor as well as the rich to be equally represented.

2. They are being accused of being overly aggressive and suit oriented where medical malpractice claims are concerned.

3. Medical malpractice claims require more of their time than other personal injury claims.

4. Docket delays are significant as is case duration.

INSURERS

Insurers cite the major problems they face as:

1. The inability to predict with reasonable accuracy the number and size of claims that might arise from providers' encounters with patients.

2. The relatively small number of insured providers, and the harmful impact a single very large award can have on reserves and rates.

3. Inflation and its impact on future settlements, and,

4. The concern that courts are increasingly making awards in the case of injuries whether or not negligence has been proven.

The other half of the health care system is composed of consumers. What impact does the present approach to medical malpractice have on them? As a health care professional, as director of the health care sector of the National Commission on Productivity, and as a possible future patient, my most prominent concern and yours should be, and must be, the human dimension of this issue—the consumer or patient.

I am concerned that we have lost the perspective on this issue—that we've forgotten the patient—we must not only bring him back into the picture, but we must make him the primary focus of that picture.

When productivity decreases in any sector of our economy, it is the society that pays either in higher costs, poorer quality product or both, and the medical malpractice issue is no exception.

As the medical malpractice premiums rise for the hospitals, so do its charges to its patients and increases in medical malpractice premiums paid by physicians means an increase in costs to the consumer. It is estimated that the practice of defensive medicine costs this country approximately $7 billion yearly and the cost to each person in the country exceeds $30 per year.

The consumers and providers must both be considered in our efforts to find a solution to this problem and concern for costs and productivity are vital considerations. The most significant issue is quality of care and whatever solution to this malpractice problem we come up with—should and must—insure quality care to every patient—not on the average—but for every patient.

The practice of defensive medicine—defined as medical practices undertaken to avoid a malpractice claim or to provide protection in the event a claim is instituted—increases the possibility of malpractice suits. Defensive medicine may take the form of additional tests and procedures because there is a risk of medical injury involved.

According to a survey by the American Medical Association, 70 percent of the physicians surveyed were ordering additional tests because of concern for medical malpractice. The American College of Surgeons reports that 63 percent of surgeons were ordering X-rays for defensive purposes.

In view of the above, I don't think I have to explain to you the negative effect on quality of patient care that results from our present approach to medical malpractice.

Fundamental reform in the approaches in this country are needed, not more money for malpractice insurance, and whatever reform is adopted it should increase productivity or at a minimum, maintain it, in terms of use of manpower and materials and in terms of costs and it should maintain or improve quality of care.

Let me summarize by reviewing for you the impact of this malpractice dilemma on the total health care system.

What we find when we examine the characteristics of our health care system is a system of care which has made enormous medical and technological advances but which has created expectations from society often beyond the capacity of the system to fulfill, and a system which is more impersonal than that which existed 30 or 40 years ago. Therefore, when a patient experiences an unfavorable outcome of his treatment in this climate, the stage is set for a malpractice claim.

Medical malpractice suits in this climate will continue to grow unless the cycle is broken. As this situation grows so does its negative impact on our whole health care system. The future for our health care system could read something like this—increase in medical malpractice insurance, increase in doctors' fees, increase in hospital charges, inefficient use of medical manpower, and fewer practicing physicians. The picture is bleak, the costs phenomenal, the quality reduced. The picture is worsened when we consider one vital but often overlooked point—the public may be reaching its limit as to what it will pay for medical care. If we have to spend funds doing tests and procedures that aren't necessary, then we are going to have less to spend on necessary medical care or the improvement of that care.

In closing, I would like to present 10 points to you for consideration in addressing the malpractice issue and attempting to find a solution to it:

RECOMMENDATIONS

1. That, any new approach considered for adoption be analyzed carefully in terms of its impact on the total economy and the total health care delivery system so that it does not shift the burden of malpractice costs from one sector of society to another, from one professional group to another or from one part of the health system to another.

2. That any Commission, panel, committee that is established to address the medical malpractice issue have at least one representative from the public—the consumer.

3. That the doctors, lawyers, insurance companies, and policy makers fully analyze the effect on the patient in terms of quality of care and costs, before any new approach to the malpractice issue is adopted.

4. That the primary focus of any new approach to resolving this problem be the patient or consumer.

5. That the significance of the doctor/patient relationship be emphasized to physicians through their respective associations especially among physicians practicing in those States where the largest number of malpractice suits have been filed.

6. That regardless of the approach finally adopted to resolve this dilemma, it does not discourage practicing physicians from continuing to practice or discourage new physicians from serving the public.

7. Additional studies be conducted to address the issue of variation in the number of malpractice suits and the cost of malpractice insurance variation among the individual States. Perhaps we only have problems in a handful of States—are suits significantly on the increase in every State?

8. That the social and cultural forces in our society that have given rise to a more "litigation-oriented" public be identified and examined especially since medical malpractice claims are increasing at an annual rate of 13–14 percent.

9. That studies be conducted to determine if the breakdown in the physician/patient relationship is one of the major reasons for our malpractice crisis. In 1971, a study was performed in which both physicians who had been sued or threatened with suit and those who were not were surveyed as to their perceptions of the cause of medical malpractice suits. Both groups responded that the major cause of medical malpractice suits was the poor communication between the patient and the physician. I suggest we also conduct an up-to-date survey of patients who did sue to obtain their opinions. Have any of the malpractice suits filed been against physicians who were the family physician for 10 or 20 years?

10. If we're looking at the total health system, we should study, analyze, examine the other pieces of it in terms of medical malpractice, such as outpatient clinics, home care programs, and preventive health programs, which are not directly associated with a hospital but in which medical malpractice claims may arise.

The United States is the only country in the world with a medical malpractice crisis. Physicians and hospitals do get sued in other countries and in increasing numbers, but so far not on the scale of U.S. litigation.

In the often irrational search for a reason for this American phenomenon, we have been known to look for a simple scapegoat.

In that search we have targeted physicians, lawyers, insurers, the jury system, and the public as the cause. Not one of these is the sole cause yet all and other, contribute to the crisis situtaion we are faced with today. We cannot, at this point, accurately determine the motivating force that has created this malpractice dilemma. We can only speculate on the possible causes—legal, medical, social, and cultural.

We do know, however, that the present approach to medical malpractice reduces quality, increases costs, and decreases productivity. We change this system for the benefit of all Americans.

Dr. JAMPLIS. Thank you, Miss Astolfi. And if Phil Caper is in the audience, I hope he realizes that the consumer, in my estimation, has been well represented and will be as we go along. And if he is not in the audience, I plan to tell him when I see him.

Our next speaker is, I believe, well known to you: Mr. Eli Bernzweig. He served as executive director of the Secretary of HEW's Commission on Malpractice. Now I think he is better known, at least I know him pretty well as the editor, if you will, of that great big yellow book that is put out on malpractice, affectionally know as the yellow telephone book. It is about that big, and anything about malpractice I can assure you, is in there.

Not all the solutions, I don't believe, but all of the problems. Mr. Bernzweig is an attorney, specializing in the field of malpractice. He was a neighbor of mine in Menlo Park when he was in California, where he was vice president of the Argonaut Insurance Co. And just this week, he was appointed Special Assistant to the Acting Federal Insurance Administrator at the Department of Housing and Urban Development, Mr. Bernzweig.

Mr. BERNZWEIG. Thank you, Dr. Jamplis. In our part of the country, Dr. Jamplis is known as "Super Quack." And affectionately so.

I am very delighted to be here today, back in Washington. I have been chasing the malpractice problem all over the United States. I thought it was in Washington, and then moved to California, but I see it is back here in Washington again. So here is where I am.

I received this speaking assignment just a few days ago, and really didn't get an opportunity to prepare a definitive outline of what I wanted to say. That means that you are going to hear something a little bit better than if I had prepared something.

I welcome the opportunity to be here today, and want to, if I may, make a few observations on things said by earlier speakers. But I will get to that later.

One thing is crystal clear about the present situation: We can no longer expect this problem to go away, or resolve itself. The evidence is all too clear that unless some intelligent steps are taken now, to resolve this problem in a comprehensive way, our entire health care system is going to be even more seriously threatened.

When the HEW Malpractice Commission's report was published 2 years ago, we were not experiencing a crisis in medical malpractice insurance in this country. But then, the Commission never for a moment regarded the insurance issue as the key factor in its delineation of the problem. Nevertheless, to many unsophisticated observers, both in and out of Government, the absence of an insurance availability crisis was deemed sufficient proof of the fact that we were really only dealing with a tempest in a teapot, with the result that after 2 years of

concentrated study by some very intelligent and very dedicated people, and a lot of staff work and a lot of the taxpayers' money, a report which contained many recommendations that would have been profitable for this group today was essentially ignored.

Had even the most noncontroversial of the Commission's recommendations been implemented by the public and the private sectors we would have been considerably ahead of the game at this point. The failure to continue the Commission's pioneer data gathering efforts and the failure of the Government to fund studies dealing with alternative medical injury compensation systems is in my opinion, a real tragedy.

This delay will have far-reaching consequences in the mad rush to develop legislative solutions, given the time constraints we now face.

A reluctance to take affirmative action in the absence of hard data is always understandable, but the Government's failure to act after the data had been gathered and the issues thoroughly identified, is unpardonable. What is the result?

The result is that the very same factors which prompted the creation of the Malpractice Commission in the first place are still plaguing us today, but with greater intensity than ever before. Today, we find physicians and hospitals in unusually vulnerable positions. They work in an atmosphere of tension and alarm approaching near hysteria. The effective delivery of health services cannot help but be disrupted when physicians and hospitals are unable to protect themselves against the catastrophic financial burdens associated with the increasing magnitude of awards in malpractice cases in the present malpractice claims environment.

And as bad as they are, the insurance aspects of the problem tell only part of the story. The increasing numbers of claims are adversely affecting many components of our health care system as a whole. You heard them before, and I am not going to burden you by repeating them. The discussions of defensive medicine, the refusal of physicians to engage in certain types of medical treatment and therapy, and so on.

In sum, these practices describe a threatening environment in which the quality of health care is being seriously compromised.

Health manpower and facilities are being wastefully utilized and unnecessary health care costs are being generated. Neither health care providers, their insurers, the Government, nor the general public is satisfied with this state of affairs.

Now what is behind all of this and what can we do about it? These are the real issues of the day. To begin, I would like to discuss with you what I consider to be a misplaced emphasis in our view of the subject. I believe that one of the critical reasons why we have made so little progress to date in dealing with this problem is our overriding preoccupation with discussing the effects of malpractice claims and litigation, rather than the root causes. It would help immensely if we were to recognize the conceptual differences between actual malpractice and malpractice claims. Malpractice per se, as has been described, is injury resulting from negligent conduct. But malpractice claims are merely allegations that an injury to a patent was caused by negligent conduct.

Now, no one will dispute the fact that malpractice claims have been increasing steadily over the past several years. This statistic was just

given that it is approximately 13 percent, or something like that, each year. But there is absolutely no basis for concluding that all or even the majority of those claims are attributable to negligent medical treatment, although some undoubtedly are, and the number may indeed be growing as we provide more medical care to more people. The important point to note is that most discussions of the medical malpractice problem tend to blur the distinctions between malpractice claims and de facto malpractice. Now, it is impossible to talk intelligently about solutions when the discussants are not talking the same language.

Virtually all malpractice claims arise out of injury or other adverse results suffered by patients in the course of medical or hospital treatment. The injurious result sometimes referred to as iatrogenic injury, or medically induced injury, may or may not be due to the negligence of anyone in the health care hierarchy. The fact remains, however, that out of the billions of units of patient care provided each year, which Dr. Jamplis referred to in his opening remarks, inevitably some give rise to injuries which result in varying degrees of disability and even death.

All physicians are aware of the potential risks of even the most routine medical procedures, and their daily patient care activities involve the making of choices and judgments which attempt to balance these risks against the expected benefits to their patients. Most medical journals contain in each issue at least one article devoted to the adverse effects of drugs or various medical or surgical procedures, and an entire book has been devoted to this subject of iatrogenic injuries attributable to diagnostic and therapeutic procedures.

Every study to date substantiates the conclusion that there are many more such injuries to patients than there are malpractice claims. I refer you to the AMA's 1970 professional liability survey, and to the Malpractice Commission's report. The latter, incidentally, pointed out that fully 30 percent of all malpractice insurance carrier claim files resulted from reports by doctors and hospitals which never materialized as claims asserted by patients. Let me repeat: 30 percent of those claim files were reported by the doctors and hospitals, but no claims were asserted by patients. What this tells me and should tell you, is that we are not looking at a malpractice claims crisis yet. That is a few years ahead of us, when the public begins filing claims at greater and greater rates, catching up with what I consider is a claims filing lag.

While the vast majority of these injuries to patients are not due to negligent conduct, they certainly couldn't be—we are talking about injuries in the range of 2 to 3 million as I recall, but many of them, are preventable. And this, I submit, is where our efforts should be directed, if we ever hope to cope with this serious health system problem. Now second, it should be obvious that any remedy aimed only at reducing the incidence of negligent conduct will prove to be inadequate from the standpoint of protecting the welfare of all health care consumers. Negligence is only one causative factor, and is probably less significant than has been supposed.

I have to digress here and comment for a moment on some of the remarks made by earlier speakers, that if we could only rout out the bad actors in the medical profession, that is going to solve the

malpractice problem. I totally disagree. You could discipline every doctor who should be disciplined and remove him from practice tomorrow, but you are going to have as big a malpractice problem 2 and 3 years from now as though those doctors were still in practice. It makes no difference whatsoever, because the patients aren't suing only because of negligent conduct. They are suing because of injury.

Certainly, then, every effort should be made to reduce the total number of iatrogenic injuries—I don't even want to use the word "malpractice" in this context—thereby reducing not only the potential number of claims based on true negligence, but improving all medical outcomes and the quality of care in general.

Well, this brings us to the problem of compensating injured patients. In our zeal to focus attention on the need for medical injury prevention, we must not overlook the fact that, despite all of our best efforts, patients will continue to suffer harm in the course of treatment, either through negligence or unavoidable accident. Nevertheless, all are casualties of the health care system. Yet many, if not most, presently go uncompensated.

The time has come to recognize the needs of all injured patients for help in obtaining both prompt restorative medical treatment and just compensation for the disabilities they have sustained. The plain and simple fact is that most injured patients are far less concerned with placing blame on the doctors and hospitals they sue than they are in obtaining financial relief for the economic losses they have suffered. And to make matters worse, a growing number of courts and juries are seeing it exactly that way. Thus, we see an inexorable trend toward what has been called the socialization of injury: payment for damages suffered, without regard to the issue of who or whether someone was at fault. Those of you who talk about no-fault medical malpractice as being unworkable do not realize that we are witnessing it in practice today, in the decisions of juries and pretrial settlements under our current system. In effect, we are creeping toward a no-fault malpractice system.

Now, malpractice liability insurance was never intended to cover losses sustained by every patient, but only those losses attributable to negligent conduct. With the erosion of this fundamental principle in the growing number of litigated cases the problem is being compounded enormously. Insurance companies can't possibly predicate intelligent rates where the basis for the rate structure is not negligence, but injury. We don't have that kind of a system yet.

Many trial attorneys firmly believe that malpractice suits coerce doctors into being more careful, but this is a partial truth at best. Although there are probably some doctors who practice better medicine because of their fear of malpractice suits, there are undoubtedly more who practice worse medicine because of this fear. More important, malpractice litigation does not reach the day-to-day problems of medicine very often or very well. The system is an extremely remote and roundabout way of approaching a problem which undoubtedly exists, but which needs a more direct solution.

One of the major defects of the current system, therefore, is its attempt both to regulate the quality of care and to compensate injured persons in one and the same action. Somebody said earlier today that

if the doctor does something wrong, he should be punished. Punishment seems to be something ingrained in our American way of life. Thus, if a doctor does something wrong, we must punish him. But a malpractice suit doesn't really punish him, except, perhaps, indirectly. His insurance carrier is punished first and foremost, and it eventually will result in an increase in his malpractice premium, but that doesn't really punish him. There are better ways of monitoring and controlling the quality of care and I submit we are going to have to deal with those ways as an entirely separate issue. And I think the second and collateral issue is: how do we deal with the subject of compensating all persons who sustain serious and disabling injuries as they go through the health care system, the people who I call the casualties of that system?

I think I have said enough for the moment, and I will be glad to respond to questions later. I do think that we should recognize this dichotomy that I just referred to, and hope that as a result of meetings of this type and the legislative proposals that have been raised, some form of modification will result. And I really am not looking for a total overhaul of anything, but I do think that a modification of our existing way of looking at it, this malpractice phenomenon, is an absolute must. Thank you.

Dr. JAMPLIS. An old ball player. Thank you, Eli. I think that anyone can tell that when one listens to Mr. Bernzweig or reads what he has written, that you are hearing it from the horse's mouth. I don't think there is anybody that knows more about the malpractice problem and some of its solutions than Mr. Bernzweig and I am delighted that you are still in the thick of it here in Washington and maybe will come up with some solutions. Eli is right. I am known hopefully affectionately as he said, as "Super Quack" around home. I also have a parish priest who is a cousin who we call "Super Robe". Ought to be Pope, as a matter of fact. But we have a lot of fun that way.

We are not quite through with all the presidents because our next speaker I see, is a president. He is Jack Mullin. Jack L. Mullin, and he is president of Jack L. Mullin Co. Mr. Mullin tells me that he—his real only claim to fame is that he has been able to survive for 30 years in the insurance industry, and I guess that takes some guts. He is risk manager for the administrating patient injury at the Halifax Hospital and anybody that is at all familiar with insurance—in the insurance field knows that risk management is the magic word. Everybody knows about risk management, and I for one don't know what the devil it means so I hope you are going to tell us.

Now he also feels that has has designed a system for not calling it insurance, but calling it administering for patient injury and he hopes that by this he has restored some of the doctor-patient relationship and hospital patient relationship that has gone by the wayside. Mr. Mullin.

Mr. JACK L. MULLIN. Thank you, Mr. Jamplis, and Mr. Bernzweig, let me shake your hand because I think that your book that I have over there is the finest work of its kind. I endorse everything that others who have taken the time to study it, to examine it, and attempt to put it into practice; in my opinion, it will remain without parallel as the most unfinished and greatest project because so few people understand it and it is too bad, but I did try some 3 years ago and what I am going

to describe to you, many parts of the success of what I have been able to do is based on that very fine work.

Briefly, to tell you who I am, I am almost embarrassed to be identified as a president. I am a very little president. I have eight employees.

I am not in the category of the tremendous weight and talent of this morning and I would be embarrassed to be referred to as an expert. But I would be flattered to be known as a student, and I would enjoy and I particularly enjoy meeting other students of this very critical and complex situation, so that we can hopefully put together what we have studied and I will take Senator Kennedy's challenge this morning—he said he challenges us to do something, and I am very partial to Senator Kennedy. I like him, enjoy the magnetism, the aura he creates, the excitement and the good sense, and I am in complete support of Mr. Kennedy's S–215, with one tremendous exception. That I don't want to see a national post office for medicine created when we can do the same thing within the private structure.

Now 25 years ago, as they said that I am in the insurance business. I an an insurance agent. According to the insurance industry, sometime ago, my terminology was changed from agent to producer. That kind of puts me off in where they are not really responsible for what I do. I am a producer. And this—I don't really know what a producer is except that you go out and sell policies, and who bought them? You bought them, out there in the audience. So when you have heard all about how we are all to blame, yes we—you are. Because when doctors—they use amazingly good sense. When they get together and they build a clinic, they understand what $20 a square foot and so forth means in construction although it is not their business, but amazingly enough, when the Argonaut Insurance Co., for example, the poor Argonaut came to them in my State and offered them something that absolutely could not statistically succeed, they bought it.

What I did, was that I went to them in my producer's status to the industry, to all the good people and they are good people—to the medical association, to the Florida Hospital Association. And I produced my charts, and I am indebted to today, I want to mention, to Dr. Roger Egeberg for being here today, and people like Congressman Hastings who survived my charts and analyses and said my God, if we don't invite him, he will send us up more charts.

I took my charts to them and I prognosed it. I put it into figures. They threw them away. Had I ever had experience in doing this? Yes. When I produced the backup, they didn't like that. All right. So it is easy to talk theory.

So 25 years ago, my hospital came to me because they thought I was a very nice guy, and in the insurance business and I got good deportment marks and they appointed me to be their agent to take care of their insurance, and I was very flattered and I did. And for 15 years I didn't have the slightest idea what I was doing. I didn't know how the hospital operated, I didn't know how the insurance industry operated, and why should I? Every time I sent them a bill, they paid me.

So, I like statistics. I cannot imagine anything more boring than trying to explain an insurance policy, a homeowner's policy, or an automobile policy. It bores me and I dearly love all my customers, don't misunderstand me. But it bores me to distraction. But I love research. I like statistics, and I like to be involved with people and I

like reality, so 10 years ago, I developed a new system entirely. It involved self-insurance. It involved being involved with the patient. It involved recognizing all of the problems in the human qualities that you have to deal with in a hospital. The boards, the executive directors and so forth, and so on. And we put it into practice.

Now I want to carefully say this. My hospital has a board of trustees and I am a stickler for protocol, and they make the policy. And they will speak for the hospital so when I speak to you, I speak to you on the basis of my experience and what I have learned there in my experience in Florida and the research that I have, and then you draw the conclusions as to whether or not he has done is homework well.

In what we did, we went right to the patient and just let me ask for a show of hands if your family, if your wife is in the hospital tonight and something goes wrong, do you want to go through a torturous process of hearing about primary insurance agreements and reinsurance meetings and so forth, or do you want your doctor to do what he thinks is right, in accordance with hospital management.

I think that is what you want. Is that being done? Well, if they tell you it is being done, I won't say they are telling you the truth. I will simply tell you that it doesn't agree with my findings in my research. They are scared to death.

How many hospitals today have a patient grievance mechanism which is outlined in his great work? How many have a full time safety department to take care of the complexities in modern medical society and science? And as the younger doctors come along, they are not like, unfortunately, my age, my peer group. They are sharper. They are technically minded, and from this great technical knowledge and complex science, we are going to have tremendous problems. So what do we do? What I have proposed is that we do—and it sounds like an oversimplification. Let's forget about insurance and all of the reinsurance and actuarial things and so forth, and use the tremendous talents of these gentlemen that I am looking at. Chubb & Son, employers, St. Paul, the man who courageously proposed and I actuarily disagree with your prognosis, but a fine company.

What we must do is use this tremendous talent, but the insurance industry, and I disagree with them, have approached it as they would insure commerce. And if that is what it is, we should stop right now. And we should go over and talk about Penn Central, their problems are just the same as ours. We are not talking about commerce. We are not talking about using the usual rules of torts, but I agree with Mr. Cartwright. What other choice does he have?

If there isn't any such system for immediately taking swiftly, doing what the doctor wants to do for his patient, then he has got to resort to whatever the system is. So I disagree with Mr. Bernsweig that we want to modify it. We have got to take it all and throw it away. OK.

To sum up, let's take S. 215, the work on S. 215 in my opinion is tremendous. I have analyzed every line of it. It is great. Except that S. 215 in the State of Florida, in my prognosis, would cost approximately $15 to operate, per day in a hospital and it would drive the poor doctor absolutely to where he is already so burdened with reports and PSRO's and every kind of administration, he can hardly find time to practice medicine. So what do we do? We take that and we have the Federal Government develop guidelines, and those guidelines,

No 1, should anyone be injured as a result of medical treatment, and I agree with Dr. Jamplis, it is not the bad doctor.

I have been involved in 25 years in over 1,000 incidents. I was counting those the other day, those 1,000 incidents, and I agree with the Kennedy statistics, about 35 to 38 percent actually involved injury. I am proud of the doctors in Florida, but it is the good doctor that is in trouble because there are injuries in the system because of its complexity. You cannot in a 500-bed hospital, for example, discharge 20,000 patients. Senator Kennedy said the ratio is 1 in 40. That is 0.025 percent. That is 400 possible injuries a year. I think we have been doing better than we realized.

The numbers are staggering. So, what we do is we guarantee to everyone in every State, that medical compensation is swift and automatic and unlimited. Who decides? We struggle over definitions of injury. As Mr. Cartwright I am sure is familiar, and the others, what is the definition in workmen's compensation which protects the employer? Can you imagine, we have an OSHA for employees, but we don't have any OSHA for patients.

Hospitals do not have to report their injuries. Doctors don't have to report them. In part of the system I propose, the doctor when he has reasonable knowledge, and the health care provider, must report the injury. Now I cannot imagine any doctor jumping for joy over that, but I simply say to him in all candor and respect, doctor, then what else will you agree to or will you be forced to agree to by Federal Government when the shambles continues, when the wreckage is such that something has got to be done by default. What would this do? This would protect the physicians. And it gives him in the hospital, the decision. So they make an error. And they take care of poor Sam Jones, because maybe they weren't legally responsible, but he was still injured in here in the hospital, where something went wrong.

Is that bad? I don't think so.

Now, let each State decide—each State. Let the State of New York. for example, say well we want this benefit. Fine. Maybe the State of New York will say, well we don't want the Federal Government involved in medical compensation. We will pay it all. I think they would be foolish. because I think it is a social problem. and I think it must be equitably distributed among all the States, and so that all of society pays for what we are talking about which is in my opinion, a fundamental part of the social structure of a civilized country.

So, I proposed that excess of $50,000 to—the Federal Government be involved in medical compensation. but they do not be involved in the economics, other than medical benefits. And that the medical benefits be handled how? We set up patient grievance mechanisms by district, by region, combining hospital and county medical societies and they are people who are trained not insurance adjustors who 1 minute are handling a bicycle theft and a fire in the kitchen or something, and bear in mind it was the Argonot that on this told us they were going to have experts handle claims.

And what happened? So let's train people. If the Federal Government wants to spend money. I think we would be delighted. I think Florida would welcome any Federal funds spent down there. Let's—don't we train police officers through Federal funding. college programs. Let's do it for hospital personnel. Let's help the hospitals.

Let's help them develop safety units. Let's help them develop patient-grievance mechanisms and tie it in with the county medical society. Then who will handle—what do we do about the $1 million made for judgment. In my judgment, most of that I have seen in every State of the so-called legal reforms are excellent.

So what we do is we form a JUA, a joint underwriting authority, and we permit the doctors to insure excess of $5.000 to $10,000 in risk-managed pools, and they get tax credits for it. Is this a Buck Rogers idea? I have researched it and everyone that I have showed that is knowledgeable said that it is great, and as of today, my doctors are still supporting me. I can't say they sent me here, but they still like it in my own hometown, and in my State.

This gives us then—we return to the health care industry—we return to the American health care industry what must be done. We have got to get me the producer and the actuary and everybody else out of the health care system, and return to a business, return to a warm relationship of where the doctor and the patient can once more communicate and remove the harrassment and so forth.

I have fully documented it in charts and so forth and so on, I would be glad to go into it with you, and I am sorry I have taken so long. Thank you.

Dr. JAMPLIS. Thank you very much, Mr. Mullin. I am afraid you won't be down in Florida very much this year. You will be on the circuit from State legislature to State legislature.

Our last speaker on the panel is Dr. Sidney Wolfe. He is director of the Public Citizens Health Research Committee which is a Ralph Nader organization, and I again say that Phil Caper, we may not have the consumers down there, but we have got them up here. And Dr. Wolfe has been the author of many articles. He has a broad, clinical background. He was affiliated with the National Institute of Health for many, many years, and we are enxiously awaiting what you have to say to us.

Dr. WOLFE. Before going into some semiprepared remarks, semiprepared because I too was given somewhat short notice, I would just like to agree wholeheartedly with what Eli told you a while ago. Namely all of the time that was lost between the completion of the "Malpractice Commission Report" and the present time in terms of suggestions, actions, and the like. One of the many studies that is being called for now is to talk to consumers and find out what their viewpoint is. Certainly the more we learn about this the better, but one of the more exciting and compelling pieces of information buried back at the end of the malpractice reporter telephone book, so called, was a very excellent survey of consumers in terms of their information about medical malpractice, what their experiences have been and the like. Many of the findings in there are certainly sensible and should have been acted on a long time ago in terms of causes of malpractice and what perception of the health care system is like.

At the present time, HEW, the agency responsible for causing the Commission to come into being, has certainly done very little. You will hear from Dr. Egeberg tomorrow, who in sort of a semiemergency way was charged a number of months ago with looking into the problem from the standpoint of HEW. Much of the time that the Egeberg task force spent was reviewing the Malpractice Commis-

sion's report which had been lying on the shelves there for the 2 or 3 years in between. I think that is a tragedy and it is just another reflection of HEW or at least the "H" part of HEW's lack of commitment to doing anything about health care, other than in an emergency way.

Just in the past several weeks, we have seen another one of the many crises that keeps popping up as a result of a really poor health care system in this country, namely the fact that the unemployed have no health insurance. HEW's position is, there is really nothing that should be done about that. You can't pass any bill to give health insurance to the unemployed. National health insurance would be nice, but we really can't support that, and so forth, and really, all of these derivative issues, and they really are derivative issues, are not going to be taken care of other than buying 5 months or 10 months until the solution called developing a health care system that is controlled in this country occurs. I don't think there should be a "post office" in Washington either. I think that the most effective kinds of control over any health systems that are nationwide are at a local level. We certainly have not seen any of these kinds of controls coming thus far, though.

According to the increasing reports that one reads in the newspapers or sees on television about the medical malpractice crisis, the main victims are portrayed to be doctors and insurance companies and the main benefactors are alleged to be the lawyers. Patients are occasionally mentioned, but only as potential victims in New York, Florida, California, and other States, if the insurance companies carry out their threats and cut off malpractice insurance and doctors stop practicing. But many skeptics in the health care system would argue that that would have very little effect on mortality or life or anything else, if doctors stopped practicing, but I am not quite as cynical as that. Almost.

If the malpractice crisis were an isolated one with origins to be found as one would believe, in a war on medicine by the legal and insurance industries, the way it is being treated would be more understandable. The current rush of legislative efforts, often promoted by doctors, to regulate lawyers and to regulate the insurance companies might then solve the problem.

I would submit, though, that the primary attention must be directed towards the health care system itself as the real source of the crisis. According to the survey by Peterson, which I referred to, which apparently was done with great difficulty—this is the survey of consumers' attitudes about malpractice, and their own experiences in terms of negative injuries by the health care system, according to this survey, the origins of the dissatisfaction with doctors and hospitals appear to be twofold. First is poor technical quality of health services including diagnosis, treatment, and dangerous deficiencies in hospitals. Admittedly, a lot of these are not due to "negligence" per se, but are related to the complexity of the health care system, but a very large number are due, if not to negligence, to gross overprescribing of drugs, ordering of unnecessary operations and other excesses which people are beginning to find out about.

When surveyed as part of this same HEW study, most consumers didn't believe that this technical incompetence has worsened or improved over the last 20 years. They are probably right, since surveys

in 1952, 1962 and today show about one-fifth surgery to be unnecessary and the other explosions which were familiar in the earlier part of the century, have been replaced by newer forms of operating room hazards, such as the other anesthetic agents which are plaguing operating room personnel in addition to the patients.

What has increased is not the amount of technical incompetence, and I think Eli referred to this. The number of claims has gone up, but the basis for the claims is probably about the same in terms of technical incompetence.

What has increased is the public awareness of the frequently poor technical quality of health care, in that more people are now acquainted with such problems as overprescribing of antibiotics, unnecessary surgery, preventable adverse drug reactions, needless hospital infections and the like. And I agree with Eli and others who state that the important problem is not the inevitable consequences of health care delivery, but the preventable ones, and as we learn more, we find that a larger and larger percentage of deaths in hospitals, adverse incidents to people in hospitals, are preventable.

As if these revelations about deficiencies in doctors and hospitals intruding into the time-honored deification of this ancient profession were not enough to cause outrage and more malpractice suits, there is yet another element of changing public perception which is also important. In this same malpractice commission's survey, most people stated that the quality of the doctor-patient relationship had worsened during the last 20 years. It was felt that this weakened the barriers to sue, previously associated with the more personal nature of this relationship in the past, and paved the way for more willingness to consider malpractice litigation.

Aside from the more apparent attributes of modern medicine, such as increased specialization, the use of penning a prescription to avoid having to talk any more to the patient, and more machines, all of which are very understandably depersonalizing to the patient, there is increased patient perception of the low regard many doctors have for their basic human rights. The concept of informed consent, once limited to circumstances in which human experimentation was involved, now is supposedly a part of all surgical procedures. Most clearly and dramatically seen in the area of surgical sterilization, where hundreds of thousands of women have had hysterectomies and tubal ligations without the most primitive semblance of informed consent, the absence of allowing patients an informed choice is thought by many to be a major contributing factor to the steady flow of unnecessary surgery, misprescribed drugs, and other unchecked therapeutic and diagnostic excesses of American doctors and hospitals. The frequent lack of informed consent, however, is only one aspect of a larger problem impacting on the beleaguered doctor-patient relationship, or provider-patient relationship.

Namely, the lack of flow of information from doctor to patient.

"If he weren't so busy, I would ask him why he is doing this, or what will happen to me as a result of doing this," is thought, if not verbalized by many patients. When patients who are dissatisfied with the medical care they had received were asked why, again, the same survey, approximately four out of five said that it was because the outcome was different from what they had expected.

More than anything I have seen, this finding reflects the state of ignorance which the medical profession had imposed for centuries and continues to impose on the public. Beyond these two major reasons behind the increasing magnitude of malpractice litigation, is of interest to consider what patients think is the result of malpractice litigation. The genesis of the still common misconception, that doctors do an adequate job of policing themselves, derives in part from the notion that the loss of a malpractice suit by a doctor results in loss of his license to practice.

In the same survey again, about half of the people thought that loss of license was in fact the consequence of losing a malpractice suit, but a look at license suspensions, revocations, or any other kind of action by State disciplinary bodies reveals quite a different picture. If you include all such actions, only approximately 1 out of 800 doctors a year nationwide has any kind of notification about deficiencies in his practice by State boards. About half of these are said to be related to drug offenses and also many others are an association with commercial advertising by individual doctors.

Only rarely are disciplinary actions taken against doctors who are found to malpractice or to be engaged in various forms of mispractice.

In terms of its potential capacity for use as a means of improving the quality of care rendered by doctors, the State licensing function is currently another farce. Not only is the licensing function dormant in collecting data on mispracticing or malpracticing physicians after the fact, but it is also failing to serve any preventive function. When provisions for mandatory periodic relicensing of doctors were before Congress, last year, there they were bitterly opposed by organized medicine. Thus, many doctors continue to practice medicine which might have been good 20 years ago, but which is now inadequate because they have insulated themselves from advances in medical knowledge, and haven't had to worry about being called to task for it.

The hospital industry has been no better than their medical colleague or foes, depending upon how you look at it, at surveillance efforts which might improve the quality of hospital care, and thus lessen the malpractice calamity. Since three out of four alleged malpractice incidents occur in the hospital, and 30 percent of hospitals account for all of the claims against hospitals, again findings from the malpractice commission, it would seem that intensive efforts would have been made long ago, by the hospital industry to identify these offending hospitals, determine the nature of the incidence leading to malpractice litigation, and correct the situation, with the help of the public. Whether the quasi-disciplinary body is the JCAH, State hospital licensing boards or more locally, the board of trustees of individual hospitals, they have largely failed along with their medical counterparts to produce and disseminate information that would improve the quality of care. Within the hospital, there is a critical need for truly patient-oriented ombudsmen to help people survive the increasing impersonality of these institutions, which as mentioned previously, is causal for so many malpractice claims.

Interestingly, however, hospitals like medical societies, are also giving serious consideration to self-insurance as their proposed solution to the crisis. I think this is just a displacement and really other than for a few months, is not going to really do anything.

What about this insurance industry? Has it performed an insurance function? Namely, to minimize the risk of losses. Were either organized medicine or the hospital industry to have assumed this responsibility of monitoring the way patients are treated, there would be little need to point the finger at the insurance industry for not performing its function. However, the billion dollar medical malpractice industry is, and has been well aware that neither doctors nor hospitals have found it in their own self-interest to improve the quality of care they deliver, and thus decrease the origins of most malpractice suits, and again by quality we include the quality of the doctor-patient relationship which Mr. Mullin alluded to and works at, I am told, at a hospital level to try and improve, as an important source of decreasing the malpractice problem.

Yet, the insurers have not stepped into this regulatory vacuum. The situation is not unlike one several years ago, having to do with automobile collisions. The auto insurers were facing an escalating number of claims for low speed front and rear end collisions, costing an average of $200 to $300 each for repair. Up to a point, this increase in losses was solved "by merely increasing the premium" much as the current mode of therapy for the medical malpractice crisis. Only when premiums had already been raised significantly and losses were still continuing to rise—with several companies seriously considering an exit from the auto collision insurance business—was a new approach tried. Prevention.

The result was an evolution over a very short period of time, of bumpers which were designed to drastically reduce if not eliminate, the damage from low speed collisions. As long as the insurance carriers can continue their own corporate loss prevention, and maintain satisfactory profits by merely increasing the premiums but not decreasing the losses, they will. When this is no longer feasible, they either pull out of that sector of insurance, or as in the almost unique case with the auto bumpers, they attack the cause of the problem.

In the medical malpractice area, there has been no concerted effort by insurance carriers, either to delineate the source of the losses or implement programs of prevention. I mean at a nationwide level. Certain insurers are beginning to do this.

Only in 1975 has a program been initiated not by the insurance industry, but by HEW, to collect and analyze data for all closed malpractice claims to determine the source of the problems. This is a program that, I am told by Dr. Egeberg, and he may discuss it more with you tomorrow, is about to begin. It simply involves trying to convince all the insurance companies to make available their claims closure data so that you can look at the 16,000 closed cases a year and say how many of them occurred in the hospital and what was the alleged origin of them. Was it default of the doctor, was it default of the nurse, was it inevitable, and so forth. This seemingly comprehensive and easy effort, recommended 3 years ago has not been done yet.

Just as the medical hospital and insurance industries have not found it in their self-interest to improve the performance of providers of health care, neither have the trial attorneys. We can't let the trial attorneys off the hook entirely. Collectively, attorneys could have long ago, compiled information on their malpractice experiences and shared this information with doctors, hospitals, and consumers.

Although the effects of malpractice, measured in terms of poorly treated, injured and killed patients should have been enough to cause the public to demand accountability from the health care system, such has not been the case. Now faced with the recently acquired awareness of yet another layer of effects, there are signs of action. This other layer consists of an estimated $6 billion or more of annual expenditures in the form of $1 billion malpractice premiums and what many people think are more than $5 billion in the so-called defensive medical practices, which by definition are not justified on medical grounds.

The public is now faced with treating this expensive, wasteful and often lethal disease called malpractice. Shall the treatment be symptomatic or shall it get to the heart of the problem? Not surprisingly, virtually all the solutions proposed thus far avoid the central causal problems of poor quality, whether by negligence or error, or poor information, and the deteriorated doctor-patient relationship, and instead try to manipulate symptoms, whether it is self-insurance instead of commercial insurance, no fault, instead of fault, these are symptomatic treatments at best. Or, others favor abolishing the contingency fee system, which would cause even more injustice in a legal system that excludes most poor people at the present time.

In summary, the basic causes of malpractice crisis is the virtual unaccountability of the health care system. Rather than diversionary strategies which in order to buy a few months of time, delay the solutions of the problem, the question should be, do we want to institute systems to insure better quality of care now, or not. No amount of self-insurance instead of commercial insurance, no fault instead of fault, or abolishing contingency fees is going to improve the quality or accountability of the American health care system. Those who would pretend that it will, are deceiving the public. And in closing, I would just like to look at a couple hopeful examples that I think people ought to pay much more serious attention to.

After the Malpractice Commission finished, they still had recommended that a study be done of prepaid health care systems, to look whether or not factors in those kinds of health care delivery systems which one would theoretically argue might decrease the amount of malpractice did in fact do this. They looked at a few. There was very poor data available, mainly because the insurance carriers would not make much of it available. One interesting fact which I think bears thinking about, in the State of Washington, through Aetna Insurance Co., they were able to get data on what the experience was for the bulk of doctors in the State. I think Aetna, at that time, had well over half of the malpractice insurance in the State, and they asked a question, how much it paid out per premium dollar in the State at large, as opposed to the group health cooperative in Puget Sound, the Puget Sound area. As I remember the figures, for every dollar in premiums that were collected for the entire state, approximately $1.50 or so was paid out but for the prepaid Puget Sound, the Group Health Cooperative, it was something like 90¢. This at least was data collected at one time with relatively comparable populations. And I think it bears looking at, because some of the factors that we and others submit are causal to the malpractice crisis; namely, a sense of being excluded from the decisionmaking process. a sense of having no role in what kinds of decisions are made, the absence of grievance procedures, the absence of quality control was built in much more in

many of these prepaid systems than they are in the general health care system.

So I think the push toward more prepaid group practice, particularly with consumer involvement has got to occur. Thank you very much for bearing with me for my 10 or 15 minutes.

Dr. JAMPLIS. Thank you, Dr. Wolfe. I would like to say that we will start the next panel on time at 3:30, but we will not take a half-hour break. We will take a 10- or 12-minute break and go onto some of the questions that you want to ask of this panel and some of the gentlemen in the front row.

First, for Miss Astolfi, can you define the line of separation—in other words, what is defensive medicine and what is prophylactic or health maintenance medicine? What is the difference?

Miss ASTOLFI. I just happen to have a definition handy. Defensive medicine is defined as medical practices undertaken to avoid a malpractice claim or to provide protection in the event a claim is instituted. Does that make it a little more clear?

VOICE. I think it should be added that by definition also, there—they are not justified on medical grounds themselves.

Miss ASTOLFI. This intimates that. This is done to avoid a claim or to avoid being sued later. It is not done for necessary medical care.

VOICE. I asked that question, and I don't think it has really been answered. I wish Mr. Cartwright was here. Let's take a perhaps hypothetical question. In this audience, there are at least five patients that have carcinoma of the colon right now. At least three of those are asymptomatic. Now where does defensive medicine begin and where is prophylactic and health maintenance begin. That is this—the catch. Where in this audience—who has cancer?

Defensive medicine doesn't all originate in the emergency room, any longer, because, if I miss a cancer of the colon that walked into my office, and he sees everybody—another a month later, and it may be symptomatic then, Dr. Cartwright or Mr. Cartwright is delighted to sue me for missing a diagnosis. And that is written into the new no-fault insurance forms or law, or at least the legislation. Misdiagnosis or a bad diagnosis.

Dr. JAMPLIS. Thanks, John. Do you want to respond to that, Miss Astolfi?

Miss ASTOLFI. I just want to say, you have taken it another step further as far as I am concerned, you are including misdiagnosis as a possible place where you could sue the doctor for misdiagnosis. Now to me that is just another step or another level or another problem. What I think all of us here are talking about instead, is the doctor who does the test because he is worried about being sued, rather than it is just a necessary test. If you are in a hospital, I am sure you have been, you have seen this happen. Many physicians will do extra tests and extra procedures, because they are concerned that the patient might sue if they are not very, very, very sure, and that is going to make them more sure.

However, those extra tests and those extra procedures are also endangering the patient's life and the chances of more tests being taken can also mean, I underline can the possibility of more suits because they are retesting the same patient and chances are, something in going to happen that wouldn't already.

So I think what you say is right, but you are talking on another level. That is also a possibility for further lawsuit.

Mr. CARTWRIGHT. Well, unfortunately, during the noon hour, I took all of my papers and left them in the room.

Dr. JAMPLIS. At least they weren't stolen.

Mr. CARTWRIGHT. No. They are still there hopefully.

Dr. JAMPLIS. There is always some waggle there in the left wing, over there. Go ahead.

Mr. CARTWRIGHT. I do have my speech, however, I had anticipated that somebody would probably have asked me that question, and I did have with me this morning a very extensive article from the Duke Law Journal. There was a joint study done at Duke by a medical society and the law school on this whole subject matter of the human cry of doctors that it puts them to the necessity of performing unnecessary tests, and so forth. The conclusion of that report is, that this was another red herring for the most part, that it is a myth that the doctors attempt to perpetrate, but in truth and in fact, it is not a significant factor in medical care.

Under the law, a doctor is only required to perform such tests as good medical care and practice might require and if a doctor does that, he cannot be held liable because if he didn't perform some esoteric test of some kinds, that by some remote figment of the imagination might have discovered something, as a matter of fact, I would say to all of the doctors who are present here and would caution you to be very careful about performing unnecessary tests, because if you do perform unnecessary tests, and an adverse result occurs, you may get sued for malpractice.

And let me give you an example, I had a situation following surgery 3 months postsurgery where I had fluttery feelings in my heart, and my chest and I thought maybe I was having a heart attack, went to the doctor, he gave me a treadmill test; he says oh boy, you have got bizarre findings. Class 3, class 4, stage 3, stage 4, and he says, you need to have an arteriogram. I said, what is that doctor. Well you know, we put some dye in your chest and so forth and look at it. And I said, well how much does it cost—well it is kind of expensive. I said are there any risks? Well, not much worse than driving on the freeway. You can have a stroke, you can have a heart attack, or you can die. I said doctor, I would like to think about this for a while. I got worse and worse as I thought about it and that following weekend, thought I was having a heart attack when I was giving a speech in Hartford, Conn., and was rushed to the hospital. And that doctor, in Hartford, Conn., spent about an hour with me and heard my whole story. He said, well I am 3,000 miles away from San Francisco. That doctor—the trouble with you is, you have cardiac neurosis. There isn't a damn thing wrong with you. Put your pants on and go to the cocktail party tonight. There is no way that you should take that arteriogram. It is dangerous and if that doctor had given it to you and you had been injured, you would have one heck of a malpractice case.

Dr. JAMPLIS. But God help us if you had a heart attack at the cocktail party.

I have two questions for Mr. Bernzweig. There were a lot directed to you, Eli. I have picked out just two. First, why did HEW not take action to implement the recommendations of the Malpractice Com-

mission, and No. 2, did the Malpractice Commission really say that the malpractice problem is solely caused by malpractice, as plaintiff lawyers repeatedly?

Mr. BERNZWEIG. As to the first question, I haven't the faintest idea. And I am not trying to be cute when I say that. All I know is that when I left the Department of HEW, there was a policy decision made that the Department of HEW had done all that it was going to do about the malpractice problem. It funded—well actually Congress funded the study and there was a general feeling that we did all we should do—it is up to the private sector.

That was rather narrow sighted, I think, on the part of the Department, but then that is nothing unusual.

As to the second question, the Malpractice Commission didn't single out any one factor behind the problem. If there had to be a single thing pointed to, one would say that the Commission at least focused on the genesis of malpractice claims and litigation, and that was that most malpractice claims, if not all, begin in a doctor's office and not in a lawyer's office.

Now I know this antagonized the medical community terribly, but it is a fact of life. People go into hospitals and that is where it begins. And unless we keep looking at where it begins, talking as Dr. Wolfe said, talking about the consequential—how to get better insurance, and how to work in improving the legal system, all of that is dealing with the problem after the event, and that is really what I thought that the Commission—how it served a very useful purpose.

Miss ASTOLFI. Dr. Jamplis, can I just address the first question in addition to what you said about HEW, not implementing the results. Not in defense of HEW or any organization, but I think all of us here know that there is a great difference between conducting research and implementation. Very few organizations, associations, whether they are Federal, State, or even individuals get involved in implementation. We do the studies and that is where it stops. It is unfortunate, but it is a fact, and we ought to change this. But it is not just HEW. You look around, it happens all over, and mainly because implementation is a difficult time. It is very difficult and there is very few rewards, in implementing the results of any study or any survey.

Dr. JAMPLIS. Thank you. For Mr. Mullin, specifically what risk management functions do you perform for the hospital in Florida?

Mr. MULLIN. Have we got 3 hours? There are many, as the insurance—there are many descriptions of risk management. Very simply, what I have done is that I think I am fully conversant with finance, cash flow, and how the insurance industry operates and how I think it should operate and what I have done is to remove insurance management from operating any facet of my hospital or telling my hospital when they have an injury or what they should do about it. And I have been the difference between the great help of the insurance industry—and they are wrongfully castigated. They do have terrible problems. They have done their best, but they have been imperfect, so I have taken the protection of the insurance industry, but we insist that hospital management decide when an injury is or is not—the hospital management do what is the right thing to do for the patient, that they did sit down with the doctor instantly, and that they do immediately the right thing for the patient.

Now all I do is develop the schematics, charts that I love, but the hospital runs it. Does that do it?

Dr. JAMPLIS. Jack I want to see some of those charts then some day. Sorry you didn't bring them.

We have two final questions for two of the gentlemen in the front row. First, to Mr. Cooper who, as you remember, is with Chubb & Sons. No. 1—or actually it is all one question, Mr. Cooper. Is there actuarial evidence relative to claims made against one—foreign medical graduates, and two—physicians by age groups within the various specialties which would be useful in drawing conclusions regarding quality and/or relicensure?

Mr. COOPER. To the best of my knowledge, this information has not been gathered. It was in our normal statistical areas. There may very well be individual companies that have gathered it for their own purposes or within certain group contracts where they have looked at it, but there is nothing publicly available to the best of my knowledge.

Dr. JAMPLIS. Would you like to answer that, too?

Mr. BERNZWEIG. The Malpractice Commission data study showed that there was not greater incidence—no greater frequency of claims against foreign medical graduates than against the general population of physicians. Now one could argue that the study wasn't a broad enough study, or an indepth study, but as of 1970, the closed cases did not reveal any statistical disparity.

Mr. COOPER. That was a study that was a one-time study, which was done on a specialized—I presume that the question was addressed to an ongoing collection—data collection thing, now I do not believe such a thing exists.

Dr. JAMPLIS. One final question. And it was addressed to both Mr. Cartwright and Mr. Bernzweig. First, Mr. Cartwright, they are both on PSRO's. The actual question was, what is the trial lawyer's position on the effectiveness of PSRO's to reduce the number of malpractice cases?

Mr. CARTWRIGHT. Well, I don't know that we've had sufficient experience yet for me to comment on that. I think that if we have effective, honest, well-run peer review, that it should be a beneficial and helpful thing. I don't know how else to answer it.

Mr. BERNZWEIG. I have a different viewpoint. I think that the PSRO legislation is probably going to mess up relationships and probably even precipitate the malpractice litigation that would not otherwise be precipitated. Certainly, I don't think it is going to provide the immunity to the physician that the physicians are being told that they are going to get. There are many ramifications to this statutory language, and I dare say it will cause more problems than it will solve.

Dr. JAMPLIS. Thank you. Well, I do also want to adjourn this session. We will take a 10-minute break and we will be back here then in 10 minutes. Thank you.

## MALPRACTICE: STATE ROLE

Dr. JAMPLIS. May I have your attention. This final panel presentation of the afternoon will be on the State's role in malpractice. The moderator will be Congressman Henry Waxman, a fellow Californian recently elected, on the Democratic ticket, to the House of Representatives of the United States. Mr. Waxman is a member of the House Sub-

committee on Hetalth and the Environment, along with Representative Hastings and Representative Paul Rogers.

Prior to his election to Congress, Representative Waxman had served 3 years in the State Assembly of California, and is quite a famous fellow out there, mainly because he was the former chairman of the California Select Committee on Medical Malpractice. Representative Waxman will be your moderator for the panel.

Mr. WAXMAN. Thank you very much for the introduction. I was wondering, when you mentioned my fame, exactly what you were going to identify as the reason for my fame, but I am pleased you referred to the select committee on medical malpractice.

We had in California, a committee which was formed not as a standing committee, but a special committee with representatives from the standing health committee, the insurance committee and the judiciary committee, so we had input from the insurance industry, the legal and the medical profession as well as the input from the different perspectives of looking at the medical malpractice field.

We have prepared an extensive report which many of you might have already seen, and some of our thoughts in California's experience have been prepared and are part of the Congressional Record reprint, which is, I believe in the back of the room.

I am not going to address myself to the problem of malpractice, because now that I am a Congressman I get to be a moderator, and not a participant. It is nevertheless a distinct honor to moderate this panel and to hear what some of the States are doing in response to the medical malpractice crisis.

Our first panelist is a New York State senator. He is the chairman of the New York State Senate Insurance Committee, has been a senator for 10 years, an attorney, representing the Long Island area in New York. He is the author of legislation to create the Joint Underwriting Association for Medical Malpractice Insurance, the bill that has just passed the State senate in New York, and as I understand it, to an uncertain fate in the State assembly in New York. It is my pleasure to introduce to you, Senator John Dunne.

Mr. DUNNE. Thank you, Congressman Waxman, my colleague Senator Lombardi, this has about all the strength of the insurance industry.

Since this portion of our program will deal with the States' role, and in particular I guess we are going to focus on both Oregon and New York State, the discussion might aptly be entitled "In Search of the Golden Fleece," because as students of mythology, we will recall a heroic character named Jason who was the captain of a band of seafarers who were known as the Argonauts, who quest it was to seize the lengendary golden fleece.

Now, as the Argonauts prepare to set sail out of the Port of New York, after a brief but seemingly profitable shore leave, it is uncertain whether they secured the golden fleece but it is for darn sure that they have taken a healthy portion of the hide off the medical profession.

But if we engage in recrimination and the assessment of blame, it will serve no one's purpose, particularly the cause of health care. And so let us consider the state of the art, as it stands today.

New York State is indeed at the brink of a medical care crisis. On July 1, the insurance company which presently insures over 80 percent of the 35,000 physicians engaged in private practice in New York

will stop insuring doctors against medical malpractice claims. This withdrawal from the field will make malpractice insurance virtually unavailable in the State with the prospect that uninsured physicians will refuse to practice medicine, thereby denying to the general public the delivery of adequate, quality medical care.

This same carrier, which also insures a large number of the State's hospitals, recently announced that its hospital malpractice insurance premiums would be raised by an average of 189 percent, effective March 15. Subsequently, a suit was brought on behalf of the hospitals by the state hospital association and last week a court order temporarily stayed the increase.

How did this situation come about? From an insurance standpoint, the answer is simple. In the last several years, the number of medical malpractice claims and the amounts of the settlements have risen at a precipitous rate. According to the New York State Medical Society figures, during the 5-year period from 1968 until 1973, the number of cases settled annually rose by 70 percent, while the total amount paid annually on claims increased by more than 300 percent. In order to compensate for this tremendous loss experience, the principal carriers writing policies for the members of the State medical society have had to raise physician's premiums at approximately 1,000 percent since 1966. Yet even with these substantial rate increases, insurance companies found the writing of such insurance to be an extremely unprofitable businesss.

In mid-1973, almost 2 years ago, the medical malpractice insurance market in New York City was principally shared by Employer's Mutual of Wausau, the Professional Insurance Co. of New York, and several other companies. Because of a long-term agreement it had with New York State Medical Society, Employer's wrote about two-thirds of the physicians, Professional wrote approximately 15 percent, and the various other companies wrote the balance.

The first alarm signals appeared in the fall of 1973 when Professional became insolvent and the State insurance department obtained a court order placing that company in liquidation. On the heels of that collapse, Employer's announced in December of 1973, that it would not renew its contract with the State medical society when it expired in early 1974. But prior to that deadline, Employer's agreed to a limited extension until mid-1974, but made it clear that it would discontinue writing any new policies after that deadline.

It became apparent that a new insurance carrier would have to be found in order to continue professional liability coverage for a majority of the State's physicians. Faced with that possibility, that insurance would not be available in the voluntary market, the State insurance department together with the State medical society, drafted legislation which would have authorized the superintendent of insurance upon his findings, that medical malpractice insurance was not readily available in the voluntary market, to create a joint underwriting association, a JUA, if you will, of all personal liability insurers licensed in New York State, which would be required to provide malpractice insurance coverage to any and all physicians who applied.

The legislation was passed in the Senate, but the need for the JUA was obviated when the State medical society concluded an agreement

with Argonaut. In order to finalize this arrangement however, the medical society agreed to a 93.5-percent premium rate increase, resulting in a new annual premium range of from $339 for a psychiatrist to $14,329 for orthopedic surgeons. And after reading the headlines of the papers today about the award that the jury gave to that poor little lady who was mistreated by a psychiatrist, I have an idea that they might be reviewing the propriety of the right rate they are charging psychiatrists.

Realizing the impact of this increase in health care costs, the State legislature's select committee on insurance investigated the underlying causes of the growth in medical malpractice claims and the size of awards. Last October, in conjunction with Senator Lombardi's Senate Health Committee, the select committee held a series of public hearings to examine possible solutions, and representatives of all groups appeared and testified. Following the hearing, the committees made prelegislative recommendations.

First, allow the recommendation of settlement made by a special pretrial mediation panel to be admitted in evidence if the case subsequently went to trial.

Present law provides for a panel composed of a judge, a physician, and an attorney, to hear each malpractice case and recommend disposition. The panels have been successful in settling or otherwise disposing of a substantial number of the cases reviewed. If the findings of the panel were of no liability, or for a low award, and could be used as evidence at a future trial, it would provide a stronger deterrent to capricious and expensive court litigation than exists today.

On the other hand, if the case does go to trial, the recommendations of the panel would be of great value to the jury in evaluating the evidence in the case.

Second, require malpractice insurers to file detailed reports on all malpractice claims with the State insurance department.

Much of the testimony given at the hearings concerned the lack of available data on malpractice claims. The unavailability of this data severely limits the determination of whether requested premium increases are truly justified by actuarial experience.

Such reports would contain information regarding the nature of the claim, amount of the reserve set aside in each case, and the amount paid to the claimant after the conclusion of the case.

Third, to mandate that the insurance department approve medical malpractice insurance policies written on a claims made basis.

Unlike other professional liability insurance written in our State, medical malpractice policies are written on an "occurrence" basis, covering all acts committed during the policy period, regardless of when the claim is brought. Underwriters are thereby forced to anticipate claim costs for many years in advance, with which in turn causes them to allocate vast sums in reserves. As inflation continues to erode the value of the dollar, higher premiums are needed to offset the higher reserve requirement, thereby further aggrevating the ill effects of the notorious and vexatious tail.

A claims made policy will permit the underwriter to establish rates based on more predictable data since a policy purchased in 1975 with 1975 dollars will only have to cover claims actually filed in that year. Accordingly, premium rates in the initial year of coverage should be

less than current rates, and subsequent premiums would more accurately reflect the actual exposure during the policy year.

In mid-December of 1974, Argonaut decided to move out. They announced that it would terminate its account with the State medical society effective January 10, 1975, and we found ourselves faced with an insurance crisis. The offer to stay would have been on the basis of trebling the already increased premiums. And the effect of such an increase would mean that doctors would have to pay premiums six times greater than the rate charged just 1 year before.

Although Argonaut did not give a specific actuarial justification for the increase, it was believed that their action was precipitated by a significant decline in their investment portfolio as well as pressures from the California State Insurance Regulators.

Shortly after the announcement was made, the State insurance department intervened by citing Argonaut to show cause why its threatened actions should not be enjoined under the State's Unfair Insurance Practices Act. Meanwhile, the Select Committee on Insurance together with the Senate Health Committee, introduced a bill similar to 1974 JUA proposal, except that this new legislation made the legislative finding that insurance was not readily available in the voluntary market, and required the superintendent to establish a joint underwriting association. The bill also required prior approval by the insurance department of all premiums intended to be charged, a departure from the State's open rating law—or competitive rating law which allows underwriters to charge whatever rates they choose, so long as they file them with the State.

Shortly after the bill was introduced, Argonaut, at the insurance department's request, agreed to withdraw its rate increase demand, but announced its intention to discontinue all existing coverage by July 1 of this year. Because of this decision, the insurance and health committees were more determined than ever to push through their JUA proposal, since it would at least solve the availability problem, not the cost problem.

In early January of this year, a public hearing was held on the proposed legislation. Many voiced strong opposition to the bill on the grounds that it would not go to the heart of the problem; that is, the cost of the insurance, and would merely, in the terms of one witness, perpetuate the present intolerable situation of high premiums.

One insurance spokesman proclaimed that, with the passage of the JUA bill, medical malpractice losses will be borne not by physicians alone but by all who purchase any form of personal injury liability insurance, including tenants, homeowners, and small businessmen.

Many physicians objected to the provision in the bill authorizing the superintendent of insurance to accept policies on a claims made basis. They contended that a claims made policy offers them no protection once they retired or gave up their private practice.

After the hearing, the bill was modified. In order to insure the policyholders of other lines of insurance would not be subsidizing the doctor's premiums, recoupment language was added so that the underwriting association would be entirely self-supporting. In response to the physicians' objections regarding the claims made policy, the bill was modified so that the association must issue both "claims made" and "occurrence" type policies. Doctors would therefore be able to

choose the one more suitable to their own individual needs. In late January, the bill passed the Senate by a 41 to 12 margin.

Meanwhile, the assembly insurance and health committees proposed a bill which would create a new State insurance fund, somewhat like the existing State agency in New York, which writes workmen's compensation insurance. The proposal would give a monopoly to the fund, as the sole source of malpractice insurance and all physicians, hospitals, and other health care providers would be required to carry such insurance.

A similar plan was proposed just yesterday by the Governor, and calls for establishment of a special State fund with the exclusive right to issue malpractice policies for both doctors and hospitals. The draft proposal also includes provisions which would modify the medical tort system in a variety of ways, which I am sure Senator Lombardi no doubt will review with you.

Just one last comment, and that is the subject of arbitration. The implementation of compulsory binding arbitration has special problems in New York State, since our State constitution specifically guarantees the right to trial by jury on the issues of both liability and damages. Since the amendatory process would require at least 3 years for completion, compulsory binding arbitration must be eliminated as a prospective source of immediate relief. The doctors may be more attracted to the comprehensive legislation such as the Governor and Senator Lombardi unveiled yesterday, because it is designed to solve both the availability and the cost problems. I strongly believe, however, that the legislature now has the urgent responsibility of finding the most appropriate vehicle for guaranteeing insurance availability.

Since the joint underwriting association's proposal is designed to accomplish this objective, and only this objective, I consider it to be a more realistic approach, especially in view of the uncertainties surrounding the effects of the cost proposals contained in the Governor's bill as well as the many controversial provisions which are likely to provoke substantial opposition from other groups with records of effective lobbying.

In conclusion, let us remember that while we are dealing with specifics relating to physician liability for medical malpractice, we are principally concerned with the basic health care of all of the people. Accordingly, special interests of insurance companies, doctors, lawyers, and even individual litigants must be secondary to the health considerations of the public at large. A broad, understanding approach, not a narrow selfish impulse, holds the only hope for finding solutions to this crisis. The stakes are too high for us to give a response that is any less. Thank you very much.

Mr. WAXMAN. Thank you, senator, for that report. Our next panelist is a colleague of Senator Dunne's. He is also a New York State Senator. Senator Tarky Lombardi, Jr., has also been a senator for 10 years. He represents an upstate New York district. He is the chairman of the senate health committee and the author of a package of bills dealing with medical malpractice that is now pending before the New York State Legislature. I present to you Senator Lombardi.

Mr. LOMBARDI. Congressman Waxman, Senator Dunne, Commissioner Rawls, and also ladies and gentlemen. First, let me say I am delighted to be with you today. Ever since I have been involved with

the malpractice problem, I find that I have developed an identity problem as well, and it reminds me of a story that when I came back from a similar conference and arrived in my own home community of Syracuse, I called for a cab and got in the taxicab, and asked the driver to take me to my office, and he said, "Say I recognize you." I said, fine. Being tired, I wasn't too conversational, and he said, "Sure your name is Garibaldi." And I should have corrected him, told him no my name was Tarky Lombardi, but I didn't—he kept on talking and so we drove in and during the drive in, there was conversation which I listened to and nodded to, and he told me where I worked, which was wrong again, and so when we got into the downtown area, he went through a red light. A policeman stopped the cab, came over and started to chastise him for going through the light. He looked in the back of the cab and saw me. I recognized the patrolman because we had gone to school together, and so he said, "Hi Tarky, how are you." And I said I am fine. So he says to the cab driver, "Say listen, I am going to let you go today, because you have got an important friend of mine here, but you should be more careful whenever you are driving, especially when you have someone like Senator Lombardi in your cab." So the taximan thanked the patrolman for letting him go, he drove off and for the next two blocks there was total silence. I was very embarrassed. I should have corrected him, and suddenly he eyed me through the rearview mirror and he said to me, "You know something, that stupid cop thought you were a senator."

Well, since I have gotten involved with this malpractice issue, being a Republican Senator from upstate New York, a very conservative area, I find that I have been very much grossly involved with a liberal democratic Governor from the downstate area, and so the identity crisis is beginning to show on me, even more.

But I had a speech prepared and there are copies, in the pressroom. However, I have decided not to give the address as I had prepared it today, because so many of the other speakers have covered much of the material and Senator Dunne gave you such a fine job in terms of the history of where New York State is, in terms of the malpractice problem.

So I think perhaps I will adjust a little bit and tell you about what we are doing in New York State, addressing ourselves to the solution of the problem.

First of all, as additional background, I think you must realize that New York State, where we have approximately 35,000 physicians in the medical society alone perhaps over 40,000 physicians in practice, plus with much of the sophisticated surgery that come from the State that is so densely populated as New York, we certainly do have a crisis—a health crisis when we have a malpractice problem in the magnitude of what is existing today in New York.

In 1964, the total medical society paid out claims for medical liability claims of $2 million. In 1974, with the statistics in on only the first 6 months, the claims that have been settled to date show a trend of claim losses of $2 million per month, so you can see the magnitude in terms of the size of the losses. You know what has happened in terms of the magnitude of the premiums and the threat to the practitioners in our State. Doctors who are perhaps neurosurgeons and orthopedic surgeons will pay under the projected rate increases, as

high as $40,000 to $42,000 for an annual policy under the projected rates of the Argonaut Co., when they asked for their increase.

Hospitals throughout the State have been also notified where their per bed rate could go up to as much as $53 per patient's stay, or $6.73 per patient day. The magnitude in terms of the cost to the delivery system and also the threat to the loss of talented personnel is certainly severe. Realizing this, the State has been working toward, it has come to focus since the rate increases were made public last November, trying to address the question of how we first of all guarantee insurance coverage, and second, what do we do to the system in order to lower the number of claims and at the same time, protect the claimant.

The Governor announced, and we joined with him in the announcement yesterday, of a proposed bill which is a composite bill, or we call it an omnibus bill, which addresses itself not only to the question of the insurance coverage, but also the question of the tort system. First of all, I think Senator Dunne outlined what the JUA proposal is in New York, and I will say right here and now, I support Senator Dunne's proposal and would hope the JUA program could be started in the State of New York.

However, at this point in time, it has been stymied in the assembly. It does not seem that our assembly is going to take favorable action. Time is running out on us, because of the threat that on July 1, there will not be a physician presently with the medical society who will be covered by the current carrier. There is no hope for a replacement carrier unless we do something. We have 23 hospitals at least, that are threatened with the loss of their coverage on June 1 of this year, so we are really under a time bind. The bill that we propose then, seeks to encourage first of all, the private carrier to come in with their own answer to the malpractice problem.

There are two approaches that are presently being encouraged. One would be for the carriers themselves to risk pool under their own plan and come in with an underwriting proposal that would be guaranteed to the superintendent of insurance and the health commissioner that they will meet the need of liability coverage, but they only have until May 30 to do it. And with that time frame, I don't know whether or not that is going to be possible.

In addition, we have the Medical Society of the State of New York, who for years has been perplexed by the problem, suddenly coming forward, saying that they want to create their own medical mutual liability insurance company. They are frantically working on this, and here again, their deadline would have to be with such an institution of a new medical mutual carrier which would be a self-insured-type carrier by the medical society, and which would have to, of necessity include hospitals as well, would have to be implemented by the 30th of May, in order for the private sector to continue in the insurance business in this area.

Under the proposed legislation which the Governor announced and which we joined with him, if nothing is done by the 30th of May, this will trigger a State insurance fund insurance proposal for New York State. Under our present existing State fund, they only write workmen's compensation and New York disability insurance. This would add a third and separate unit to the State fund program, which would

be for medical liability coverage. The rates that have been projected on the basis of the State fund, if they have to do it, are right now at the standard national rating organization rate, less perhaps 25 percent.

Now the reason they have been able to give us a projection of rates is primarily because our State fund does have certain unique features that will make it possible, although there could never be a guarantee on a rate structure, where they could insure the medical profession in our State. Certain things they are requiring under this legislation—one is exclusivity. The fact that the State fund, if it does go into effect, will be the only carrier that would be allowed in the State of New York, to write physicians and hospital coverage. The reason for this is obvious. Primarily it is because they will accept all risks.

So the exclusivity provision under the bill extends the State fund for 6 years; in addition, there is a coinsurance feature in the proposal. Now the coinsurance feature relates to physicians to the extent of 25 percent of the loss—of any loss that he suffers, up to a maximum of $3,000 and to hospitals up to 25 percent of the loss, up to a maximum of $6,000. The coinsurance feature is just a means by which they hope to hold down the loss ratio that might occur under the present system.

In addition, we would give the State insurance fund the ability to settle claims without the consent of the doctor. Now this becomes a very controversial provision of this bill somewhat because most doctors don't want claims settled unless they agree to the settlement, but nonetheless, the experience of many of the carriers has been that the cost of defense sometimes far exceeds the cost of the claim itself. So the state fund would be given that opportunity and that privilege.

At the end of the 6 years, at that point in time, the business would be wide open as to physicians and hospitals, for any carrier to come in, in the event the tort system is changed, which would reduce costs. The question of other professionals, nurses, other allied professionals, dentists, psychiatrists, that business in terms of medical liability insurance is wide open to any carrier who would seek to write it.

Besides the omnibus bill carrying the State insurance fund provision, we also have a provision under professional misconduct and this was part of our discussion in the morning. Importantly, the professional misconduct laws in the State of New York are burdensome, the medical society agrees that there should be a swift and accurate way in which it deals with professional misconduct, and one of the main portions of the bill deals with a new way of treating and disciplining the profession itself.

We also address ourselves to the statute of limitations. The New York State statute of limitations today is 3 years on a malpractice claim. It is unlimited up to the age of infancy, which is 18 years. On a foreign matter or foreign material of New York State, it is 3 years after the date of discovery. All of these seek to compound the ability of the insurance carriers to project their losses itself by reducing the statute of limitations to a 2 year, with a 1 year from date of discovery on foreign matter. This would not necessarily be injurious to the plaintiff, and in fact it could very well help the plaintiff in expediting the prosecution of its cases because of the delays that sometimes do occur through the legal and technical procedures.

So a 2-year with a 1-year foreign matter rule would be the new proposal for the statute of limitations, and under the Governor's bill, he

also proposes in terms of infancy, to set a 10-year end of the totaling of the infancy statute in the State of New York.

We also deal with the question in the Governor's bill of res ipsa loquitur, the doctrine that you heard spoken about this morning. Under this bill, we would discontinue this in terms of medical liability insurance. This will be controversial. It is one that is included in the omnibus package, and I am sure that when the bill is brought for discussion and hearing, that there will be much said on this position, itself.

We also have in the legislation a new procedure for the commencement of malpractice actions, which gives trial preference, advance notice that once a summons is served, it has to be noticed within 30 days and there is an expediting procedure under the bill which is technical and I don't think necessary to go into at this point in time. The question of informed consent, another controversial part of the Governor's package deal, which was introduced, deals with where we take away informed consent as an action, under medical liability except in certain instances, dealing with experimental surgery or nonelective, nonemergency surgery, and one other provision which escapes me for the moment, but the informed consent provision in the event under the legislation, someone does sue uninformed consent, it requires proof by an expert witness in order to make the case, rather than just informed consent on the basis of knowledge between the doctor and the plaintiff himself.

We also built into the legislation, a collateral source rule, meaning that for those damages that are included, that are recoverable, whether they be for medical expenses, lost wages, or whatever you have from any other source, that this information could be used by the jury as an offset against the claim.

Those are the basic provisions of the Governor's bill. Now let me talk to you a moment about the technique that is being used here. In that bill, I described some things that are very attractive to certain people and very unattractive to others. The omnibus approach is the idea of trying to sell the package so that if you do pass the legislation, you take the good with the bad, and you reach the compromise in developing the legislation. I myself expressed concern to our Governor's council that this was not the way to do it, although I am carrying his bill and will do everything possible to see that this legislation passes. So, in addition and as a safeguard, I have introduced a package of nine bills, many of which parallel what the Governor has proposed, but which also have certain additional features that are not in the Governor's bill.

One such bill is dealing with the question of mandatory arbitration. You heard Senator Dunne say that we have a constitution problem in our State. that we cannot develop a compulsory arbitration procedure because of our constitutional guarantee of a right to a jury trial. However, the bill that we are submitting in terms of forcing litigation of malpractice claims through the arbitration procedure is one that would set up a mandatory arbitration procedure with a right to jury trial on all malpractice cases. The purpose of this is simply to have the arbitration procedure, developed as a preliminary and in an effort to weed out the spurious cases, to settle those cases that are within range of settlement, and in the event that each--either party disagrees with

the arbitrator's findings, at that point they would have the right to pursue their case in one of two ways. They can elect a remedy of appealing the arbitration judgment, to the newly formed medical liability board, which would be set up as a commission that would oversee all cases, or else it could appeal to the court system.

Now in addition, on the court system, we have another jury—or another mediation panel that has been established. This was legislation that I introduced for the past 3 years. We finally passed it and then it was implemented last year, which created in the State of New York, in all the judicial districts that we have, a malpractice mediation panel with the court system. It was based on the Stevens panel which was tried in our first appellate division by Judge Stevens successfully, successful to the tune where 30 percent of the cases were disposed of without going to jury trial, and the mediation panels that are now statewide and which are just getting started in New York, find that they are having the same type of result. For example, 43 cases in the past year that were brought in the upstate New York area, 15 have been settled, 10 are in the negotiating stage of being settled, 19 have been noticed for trial, but on this in order to give the judicial panel system additional teeth in terms of what their recommendations are, a new piece of legislation was introduced by Senator Dunne and myself, which would allow the recommendations of this mediation panel to be admitted as evidence to a jury, in the event that the case does go to trial itself.

We feel that would give it more clout and more responsiveness on both parties for the action, allowing either party the opportunity to call in the medical expert that was a member of the panel for cross-examination in the event cross-examination was deemed necessary, if it were a question on the liability issue.

So this, ladies and gentlemen, is to give you a brief summary of the legislation that is being introduced in the State of New York. We are under a real time bomb in New York, in this primarily because if we don't succeed with something, within the next 30 to 60 days, come July 1, we have no guarantee that there is going to be an insurance carrier that is going to be willing to write. We have to get it settled in our State and our legislature is working on it. We hope that we will have success with some or all of these bills, within the next immediate month or two.

Now let me just switch for a moment, because when I was invited to speak here, they asked me what my reflection would be in terms of Federal involvement on the medical malpractice problem. I would like to just say two things. First of all, I am very concerned about a Federal no-fault malpractice liability program. I think it could be devastating because as you know, under the medical liability program, the doctors and the hospitals are the ones that have to carry the insurance. the clients do not. They are an uninsured person that comes in and without having any stake in the rates or the premiums, if you allow them to bring an action for every disappointment that they may receive under a health delivery system, it could be catastrophic in terms of the cost to the taxpayers under the health system. I think we should be very cautious and very hesitant to enter into a no-fault system.

Second, I don't think the Federal Government should be involved. At this point in time, unless they are involved in a way that they might form a joint reinsurance corporation if it is needed by the

private carrier, or except if they are involved, as they were with banking when banks were closing up and we had all the banking problems, and they were uninsurable, and they created the Federal Deposit Insurance System. If that is perhaps something that they should think of in terms of creating a viable insurance mechanism, OK. Let the Federal Government help on a nationwide basis that way. But to get involved in the administration of the court proceedings, to get involved in the tort systems of the individual States, to get involved on a Federal basis when really this problem isn't nationwide, as we might think it is, because many small States are not realizing anything more except a rate problem, I think would be wrong.

Third, I would suggest that if the Federal Government does want to get involved, that they ought to look to something that Eli Bernsweig talked about earlier today. He expressed that medical injury, I express it in terms of medical accident. I think there is a big difference between medical accidents and medical liability, medical malpractice. And by this I mean that if the patient falls out of bed and breaks a hip, he will sue the doctor because he failed to order restraining straps on that patient, and he will be accused of malpractice, when maybe perhaps it is only a medical accident and not medical malpractice.

If a cystoscope broke and there was a case of which I know of a cystoscope broke and a piece of this scope fell into the bladder, and they had to operate in order to remove it, the doctor was accused of malpractice when really it was a medical accident. You could go down the line of the number of medical accidents that occur that really today are not being insured. And why couldn't we develop a system of medical accident insurance that is tagged right onto health insurance, where the individuals themselves or the families themselves are the ones that are carrying the insurance for medical accidents rather than the providers of the service having to be covered under medical liability for malpractice. Because so many things that are accidental are included in the malpractice syndrome.

I think this is something that the Federal Government, if it really wanted to address itself, should get the commercial carriers to try to solve this part of the problem, because with 203 million people in this State, if each family had it tacked on, we could certainly for the $5 premium, get enough money to pay for medical accidents and not overburden the medical malpractice liability problem.

So those are my brief remarks on the Federal involvement and I would hope that we would preserve our State rights and that perhaps they would allow the States the opportunity to solve their problem in this instance on a very, very serious problem that we have. Thank you very, very much.

Mr. WAXMAN. Thank you, senator. Our last panelist is the insurance commissioner of the State of Oregon. He also is chairman of the committee on Malpractice of the National Association of Insurance Commissioners. Prior to that time, he was a practicing attorney. He has been the insurance commissioner for 2½ years. Mr. Lester Rawls. Mr. Rawls.

Mr. RAWLS. You are right, senator, it is just like the insurance industry.

Congressman Waxman, congratulations on your election. He is from that great State which is just below that other great State of Oregon. It is the long one sometimes termed California. Of which Oregonians are very jealous of California's coming through. As you know, we had a Governor for some time who openly said, you can come, spend your money, but don't stay. And as I was going to work a couple years ago, I wanted to tell the Congressman about this, a station wagon with California license plates on it was traveling down through the freeway going north up to Wahington, I suppose, but anyway, it was just loaded to the gunnels. And there was a sign on the back which said. "Oregonians, don't shoot. We are just passing through."

Senator Dunne and Senator Lombardi, it is a pleasure to be on the same stand with you two gentlemen. I think we have heard quite a bit today about the problem that we are facing and the malpractice nationwide and it is a pleasure to see legislators on the State level take cognizance of the problem and do something about it.

Sometimes they are forced to do so because their feet are at the fire, and it may be the problem in New York, but at least the States are being responsive and I say this because I definitely agree with the good Senator from New York, both of them probably, on the basis that the Federal Government at this juncture anyway, has no business in the malpractice situation.

Now let me tell you just a little bit about the NAIC, because it was in Dallas, Tex., when we had a meeting of the medical profession with the D–4 subcommittee of which I am chairman, and the industry task force that one of the physicians said, "You know. this is the first time we knew about insurance commissioners. This is the first time we have ever gotten together with anybody but ourselves, and discussed the problem."

Now the National Association of Insurance Commissioners is the oldest consumer protection agency in the United States. It was begun around 1896, and this organization is made up of the 50 commissioners, plus Puerto Rico, Guam, Virgin Island, and they have, through the many, many years, faced the problems of the insurance industry for the best protection of the insurance buying public. However, I think today that the NAIC, through this medical malpractice crisis, probably faces the worst crisis that it has ever faced in here in those 100 years.

Now in the 1943, there was a case that came down, the *Southeastern Underwriters* case. that said insurance is in interstate commerce. And it should be in the hands of Congress, and Congress said. no, no. It is too hot a potato for us. You have been doing a pretty good job. We are going to give it back to you under the McCarran act. Now slowly but surely, they, the Congress has been trying to wean back in and I say Congressman Waxman, if they want it all, they can just repeal the McCarran act and I am sure there are a lot of States that would say just take, it you can have it.

However. I believe there has got to be one or the other. We can't also have a dual jurisdiction. For one particular reason, and one of my good friends said don't get defensive. but after some of the statements that were made this morning, and the good Senator from Massachusetts said the regulators were invisible, that is what my wife says. She says, "I haven't seen you here for 3 months. You have been chasing

all over the country, so I just wanted to say we haven't been staying at home."

But we have an insurance program, the life insurance, which is termed variable life. Which is kind of based on the up and down of the stock market. So the SEC said, That's in our jurisdiction. We are going to take joint jurisdiction with you on that particular program. That was 2½ years ago, when I first came into the NAIC. Now the regulators, the State regulators, have their regulations ready to go on this particular type of life insurance to be sold to the public. The SEC, to this date, has not yet acted on their portion of it, and it is stalemated. That is the reason why I feel that we have got to have one jurisdiction on the malpractice and not joint.

Now, let me bring you up to date.

The D–4 subcommittee has been out working. We have pulled together many of the facets of the problems of the malpractice situation on a nationwide basis. We have had—we found that there are many, many studies—the study that HEW has done—many studies that have been done individually, which at the present time, are not being used. We are working now so that we can put this into our central office, we can put those on our computer, put them into our data bank, and make some use so that we can come out with some recommendations, we can find out just what is in a closed claim file, what are the problems in malpractice field. We can find out in the claims outstanding, what are the problems. We can find out what the patient's input is to it. The injuries, the programs of that type.

We will have those through the National Association of Insurance Commissioners' jurisdiction over the companies. We are the organization that can require those companies, much to their chagrin, to act and react on those type of things, and we plan on those particular things, and April of this year, we will meet in San Francisco with the group that controls the reporting of financial statements of the companies, and we will be hopeful that they will require the companies on what we call schedule P, to put into that particular article that we receive as commissioners once a year from each and every company, that is doing business in our State, schedule P, the medical premiums, medical malpractice premiums and losses. So at least we start on a base so that eventually we will have something to work from to see just exactly where we are going.

The JUA, as Senate Dunne, Senator Lombardi have talked about in many, many of the States, this particular legislation has been introduced and probably will be passed. The problem we have is the same problem that appears that they have in New York. That the legislators do not recognize the seriousness of this particular problem, whether it be in Iowa, New York, Oregon, or California. We cannot hesitate. These particular JUA's must be passed. They must be given—the commissioners of those States must be given the authority to act when, in the States like mine or the legislators go home in May and don't come back for another 2 years. We cannot sit there on our hands and let the total health program go down the tube because we don't have the legislation.

But the commissioners in those States with the assistance of the medical profession, and I realize many of you are in C–3 categories, cannot act. You cannot act as a body, but you certainly can act as an

individual. You have got to work with your legislators and impress upon them the seriousness of this.

I say this to my good friends in the trial attorneys. This is not a fantasy. This is not a conspiracy by the companies to do away with this. Or to do away with the tort system. It is real, and I suggest that if there are any questions by the trial lawyers, in their minds that this is a conspiracy, we have a vehicle by which we can go about it. We can file an antitrust suit against them, we can depose all these companies and we can see whether or not they are bluffing, but I believe in my own mind and I take exception to Warren Cooper's—he says I am not hostile. I guess I will just have to get meaner than hell with you—with his company in Oregon—but these people are telling the truth. The companies—they are greedy enough that if there was a buck to be made, they would be in there.

We have talked about another thing which I have done. Congressman Waxman can follow this through, there is the problem of the retired doctor on the claims made form and one of the very difficult situations was, what happens when he buys this tail, this tail premium, for 3 years.

In 1974, he is a practicing physician. He buys his malpractice coverage, it goes in as an operating expense, Uncle Sam pays whatever portion he is in, whatever bracket he is in. In 1975, he retires. He doesn't have that income coming in, but he still must buy the tail. He reports it, and the year before he would have the reduction of the amount of tax bracket he was in, as I said.

I went to Congressman Ullman, a good Democrat from Oregon, and his committee—he called together the top people and the Ways and Means tax people. I suggested a plan that we would have, as we have in carryforwards, we would have a carryback. But the retired doctor in that 3 years, would be able to carry back to his previous tax years, the amount of that tail premium.

That was in the morning. By that afternoon, Dr. Woodworth of the House Ways and Means Committee had been in touch with the IRS. The IRS said somewhere in this multitude of many millions of regulations, we must have a place we can put that. However, if we don't, then I was assured by Congressman Ullman's committee—his staff people, that it would be put into legislation, so that we have the National Association of Insurance Commissioners has through that particular thing, I think, solved one of the very major problems we have in a claims made form.

Now I am like so many of the others, that I feel I have a speech, present it. But I know there are a lot of questions that you have. We have covered a lot of ground and there is the old axiom, that the mind can only absorb in ratio to what the posterior can endure, and we have been sitting here a long time so I would like to reflect on the two fellows last night, we came in after dinner, and we were up at the bar, having a drink. And the third doctor came in, he said, "Give me three whiskeys." One right after another he threw them down. drank them, he fell flat on the floor and the other doctor said to the other one, "Well, there is one thing about him, he sure knows when to quit."

I thank Congressman Waxman, again, it has been a pleasure to be here. I would be receptive to any questions we might have. I hope

I haven't been too defensive, but we do feel that the National Association of Insurance Commissioners are on the ball, we have taken cognizance of the real problems and we are hopeful that we can work it out on a State-by-State basis. Thank you.

Mr. WAXMAN. Thank you for your comments. While we are waiting for some of the questions to come forward, I would like to ask a couple questions of Senator Lombardi about the New York proposal. Senator, how would you answer those critics of the legislation that would say that by shortening the statute of limitations, by doing away with informed consent and by eliminating the res ipsa loquitur doctrine, that you are depriving those people who may well be actual victims of malpractice from an opportunity to pursue their claims, yet you would still maintain a medical malpractice system where less than 25 percent of the malpractice premium dollar ever gets into the hands of the person who is a victim of medical malpractice.

Second, how would you answer the attack that would come from those who would say, if the claim may be settled without the consent of the doctor, you will be increasing the medical malpracice problem by increasing the amount of nuisance claims that would be brought against doctors.

Mr. LOMBARDI. Congressman, taking your first question first, on the statute of limitations, we feel that that will not be injurious to the plaintiff himself because most actions are brought really, to the attorney's attention in plenty of time. It is just going to expedite the filing by the law firms of their actions within a 2-year period in order to notice the case is up. This actually could be a benefit to the consumer himself, primarily because of the fact that it would expedite the handling of his case, not only by the fact of the limitation of the statute of limitations, but also because of the new procedural rules on the expeditious handling of actions that are commenced under the new legislation.

With reference to res ipsa loquitur here again the party is not denied anything other than that the doctrine was the thing speaks for itself. It was a question of proving liability. It doesn't mean that you can't bring your lawsuit. It only means that you have to prove your liability, which could be an obvious thing perhaps, but once again this burden of proof, instead of being on the doctor to show that it didn't happen that way, is on the plaintiff to show how it did happen.

On the question of informed consent, we do not outlaw informed consent totally. We abolish it in some parts with certain exceptions, and the exceptions that we include in the legislation are, we allow informed consent for nonemergency surgery, for the use of experimental drugs or diagnostic procedures which necessarily involve the invasion or the destruction of the integrity of the body. And lack of informed consent means the failure of the patient, the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto that any reasonable foreseeable risk or benefit involved as a reasonable medical practitioner under certain circumstances would have disclosed.

Now the purpose of the change in the informed consent rule is then because of the exaggeration that is happening now within the claims of medical liability insurance, where because as someone mentioned today, you don't tell someone that perhaps a penicillin shot could

mean one in a thousand that they might cause death to an individual, that their failure to know that is under the present court jurisdictional interpretation, bringing about malpractice liability claims.

I think this is wrong. That was not the intention nor the purpose of informed consent. We are really redefining it which I think is necessary in order to hold the balance to the cost of not only the insurance but also the cost of the delivery of health care.

Mr. WAXMAN. Thank you. Question to Commissioner Rawls. Do you approve of the claims made form of insurance and has your organization held hearings on this kind of insurance?

Mr. RAWLS. Tentatively, our subcommittee has approved the philosophy of the claims made form. We have had several hearings, if you wish to describe them as such, on the particular form. We will have more. At the present time, it is filed as the gentleman from St. Paul said, I believe it has been approved in some 20 States. However, I want to add a caveat to that approval. In many of those States, it is approved on the basis of either/or. And it puts the Commissioner in a very tight situation, when he has one major company writing business in his State, and says you either approve this or we withdraw.

So I don't want to say that because it has been approved by that many Commissioners, that in and of itself says that they have approved it. I personally feel there are still some areas of concern as to whether or not the physicians are going to be adequately covered, if there is going to be some gaps in the coverage, and though many people say, well, the doctors are sophisticated, they can take care of themselves, the physicians and the hospitals are still a member of the insurance-buying public, and they deserve the same objectivity, the same responsibleness of the Commissioner that anybody else does, and so I think that I would probably say, we are looking at it; we feel that if it can be of assistance in a better rating of the policy and still provide the insurer, the doctors, the hospitals with the same type of coverage, then, of course, it should be approved.

But if there is that chance that it would leave an insured without liability coverage—if I might under this just digress for a half a minute on that, this is much like the automobile insurance. It started out to protect the owner of the automobile. Now we no longer think of it that way. We think of it as what can be done to the injured person. All no fault, as we have all heard, very little is ever said about the protection of the driver's assets as a liability. It has shifted over. Socially. And malpractice, as far as I am concerned, is in that same position. It is no longer really the protection of the assets of the doctor, of the hospital, or whoever it might be. We are concerned with compensating the injured person, so it is a socially accepted or—type of coverage and must be treated as such. When we think of this claims made policy, not only do we have to be concerned with the coverage that we are giving the doctor, we have to be concerned about what happens to the victim who may not be able to be compensated because of the gap in the coverage.

Mr. WAXMAN. Senator Dunne, a question of rights, asking specifically why is the JUA bill stalled in the assembly. What is the opposition to the legislation?

Mr. DUNNE. I think—first let me make the observation that the two houses are controlled by different political parties. But I think more

importantly, there had not been a sense of urgency to which one of the panelists addressed himself. I think it was Commissioner Rawls, in that house, with regard to the deadline that we face, and the second one was that there seem to be very strong resistance from the industry, to write—to be forced as the JUA proposal would provide—forced to write this type of, this line of insurance, which has all here the prospects of red ink, and therefore, our colleagues in here in the assembly were looking for another device.

I will just interject , I don't know an awful lot about the insurance business, but I think the implications of a State insurance fund for the voluntary insurance industry, as far—has far greater and more serious implications for the future of that industry than does a limited proposal to compel those companies to come in and write a very narrow area of insurance against their will.

In New York State, there are tremendous pressures from organized labor and other groups to put more and more insurance coverage into a State insurance fund. I am not ready to make a judgment whether that trend is a good one, but it certainly seems to be inimical to the objectives of a free, profitmaking, voluntary industry.

Mr. WAXMAN. Mr. Rawls, a question from the audience. I don't understand why the insurance companies are considered in a bad light when no one seems to dispute that they have lost money. Would you explain this?

Mr. RAWLS. Well, historically, there are three areas of people who are in the bad light, and you don't change history over, and that is lawyers, doctors, and insurance companies—not necessarily in that order.

I guess I have to answer that by habit. I really feel that also that the companies have lost money. However, we can point the finger and say, you should have done this, you should have done that. That really doesn't speak to the problem that we have now to the future. So I think history is history.

However, I think it is a social problem we have, not only in medical malpractice, but all the way down the line. People are fighting back, striking back at authority. Judgments are coming out in excessive manners all over. Settlements, not only because of the inflationary situation, I think, are in the six figures, even in the small State of Oregon. They have just jumped. Who would ever have thought you would pay $7,000 to $8,000 for a small automobile 2 or 3 years ago. The whole picture, and the whole social-economic situation has changed, and I think that a lot of the judgments that have been made against the companies are not warranted. However, they are well to protect themselves, and I think that what we really have to look at, rather than pointing the finger as I say, is to find an answer to protect the insured public—or the injured public.

Dr. JAMPLIS. We made a quick switch here. The Congressman had to get back on the Hill, so I will take over and substitute for him. I would like another question for Senator Dunne. If enacted, would any costs incurred under 25 percent coinsurance clause be allowable items in determining hospital subsequent reimbursement rate?

Mr. DUNNE. I would suggest that you direct that question to Senator Lombardi, since that is embodied in his proposal and not in the JUA one.

Mr. LOMBARDI. The 25 percent coinsurance feature of the Governor's bill would mean that that would be part of the operating cost of the hospital. And I would think that they would have to make application to the health department, which now establishes a reimbursement rate schedule for the hospitals under the New York cost reimbursement formula, and I think they would have a very good case in terms of making that part of the rate reimbursement feature.

Dr. JAMPLIS. Senator Dunne, you inferred that Argonaut made buckets of money in New York. Why will no other insurer write the amount, even at higher rates than Argonaut.

Mr. DUNNE. It has the appearance that they went in and reaped a tremendous amount of cash for what was rumored to be the design of their apparent holding company to provide significant cash flow. Whether when the final verdict is in, this was a profitable endeavor, I don't know, but many of the people who were questioning the propriety of what occurred in New York State are suggesting, and I certainly would not reject it out of hand, that this was indeed a very short term but profitable visit for them in terms of at least cash flow situation.

Dr. JAMPLIS. Mr. Rawls, what is the leadtime—how long will it take to accumulate data through annual reports, and when—is 1 year's data enough with—would smaller sample demonstrations be more useful?

Mr. RAWLS. Well, it depended upon what area of information they are after. Now the—we can take and will be taking, information from the carriers that are in the business as to the financial condition. That which Senator Dunne is just referring to. We are going to look into that particular portion of it, right away, those companies that are still in the business. However, we have to be very careful when we analyze those figures, because they most likely will show just on the surface, that there is no real problem. But you have to look into the total picture of the reserves, the costs and all the other matters that are there and that really takes about a 5-year projection to get a true picture of how something is right.

However, I think that some of the other statistics that we can run down, we will have a better handle on it. I really don't want to leave this meeting or any of the meetings that we have been in with any thought that because we come up with better statistics on the financial that we are going to show that this thing is going to have a great reduction in premiums. Really, it is . . . we want to stabilize the market. Let the water settle a little bit, and get a better handle on where we are going and what we plan on doing. But because we are going to have this data available, we . . . will not in and of itself reduce premiums or make the market more available in particular areas.

Dr. JAMPLIS. Thank you, Mr. Rawls. To Mr. Cartwright, why have medical liability suits markedly increased in those States where no fault auto liability has been legislated?

Mr. CARTWRIGHT. I suppose to ask the question is to answer it. But I would like to see the statistics on that.

Mr. RAWLS. I don't know where those statistics come from. That is why . . . that is an interesting philosophy and I would like to find out who made it, come up to me afterwards, if they have got some statistics on it, I would like to follow through on his comments. And otherwise, I will follow through anyway about it. Just in going through my mind, I don't think that necessarily is true.

Dr. JAMPLIS. Does anybody from the audience want to use one of those microphones and want to ask the question. Do they know?

VOICE. It is also related to the bout of business in home mortgage. The area where the home mortgage business has gone done to zero, suddenly the malpractice problem seems to be present.

Dr. JAMPLIS. Yes?

VOICE. I don't think that is valid.

Mr. RAWLS. As a lawyer, I agree. We are just as greedy as the insurance company. If we can make a buck, we will go after it.

Again to Mr. Cartwright . . . Would you accept change from jury trial to a judge handling cases?

Mr. CARTWRIGHT. I am happy that somebody asked that question, because there has been a lot of comment here today about astronomical verdicts of juries in this sort of thing. I don't know whether this is true everywhere in the United States, but I suspect it is true almost everywhere, and it certainly is true in California. Not only in the medical malpractice field, but in all fields of tort. Automobile accident cases, products liability, and so forth. It is not the victim, it is then not the plaintiff's lawyer who demands the jury in most cases. It is the defense lawyer, insurance company lawyer. They want a jury rather than a trial judge, in most of those cases, because they know from experience that your chances of winning are better. They have found that they can persuade juries to accept doctrines like contributory negligence, assumption of the risk and other things, that they would not be able to get away with if they were making the same argument to a judge.

I haven't demanded a jury in 25 years of trying these cases. I have really tried an awful lot of them. It is always the defense lawyer. If the judge is a good, competent judge, we have some who aren't, but most of them are, if he is a good competent, experienced judge, I would rather try my case to the judge. It won't take as long to try it, it will be much less expensive, and I have a much better feeling that I will get a verdict that I think would be in line with justice.

Dr. JAMPLIS. Would that be the same for an arbitration board, or would you rather work with a judge?

Mr. CARTWRIGHT. Well, the problem with an arbitration board . . . now in our position paper which we have here, we have suggested that there is a problem in providing coverage for true or meritorious victims of malpractice cases in the small case, and that is because as we mentioned earlier, lawyers are . . . they do have overhead to pay, they do have to make a living, and so forth, and we found that because of the tremendous expense of processing and handling medical malpractice cases, that we can't really economically process a case if it is worth much less than say $20–$25,000. Even with your ⅓ fee. By the time you put in your fee, your time, you can't come out. And so, in a lot of malpractice cases, where maybe the damages are only $5–$10,000 you just have to turn the people down, even though they have a good case.

Now we suggest that type of case be handled by arbitration, because it is faster, it is more economical to process, and we think that that might eliminate that particular problem, but you get into your larger cases where there is a lot of money involved, and serious legal issues involved, and many other legal issues. There are a lot of doctrines that are involved in these cases.

I think it is important to have an experienced judge who is trained, who knows the rules of evidence and where you have all of the protec-

tions provided by the rules of evidence and so forth. You don't have these in arbitration proceedings ordinarily. Anything goes usually in an arbitration hearing. Heresay and so forth. And so when you get into the substantial case, I am not sure that the medical community or the plaintiff's lawyers and the victims would be well served by having those arbitrated. I doubt it and I with this seriously doubt that the defense lawyers would argue to the contrary.

Thank you all very much.

DINNER SESSION

Dr. JAMPLIS. I am particularly pleased to be able to introduce our speaker, Congressman Dan Rostenkowski, not just because he's the Chairman of the Subcommittee on Health of the powerful Ways and Means Committee but mostly because he's an old Chicago boy like I am. We talked at dinner and I told him I was born and raised there, and was at the University of Chicago for 20 years. He said that I was a real slow learner.

I think we're exceptionally lucky tonight to have Congressman Rostenkowski with us. He was first elected to the House in 1958. At that time he was the youngest Member of the 86th Congress. He had been a former member of the House Committee on Interstate and Foreign Commerce. As a member of the 93d Congress, he was on the Joint Study Committee for Budget Control and the sponsor of the resulting legislation which created a new system of congressional budgetary control. At the moment, as you know, he has taken over the chairmanship of the Subcommittee on Health of the Ways and Means Committee; and you know what those fellows on that committee have to say; quite a bit.

Congressman Rostenkowski, we're delighted to have you here tonight.

Mr. ROSTENKOWSKI. Thank you, Dr. Jamplis. I certainly appreciate the fact that Jim invited me and that I can participate with you this evening. I'd like to make an apology to Jim. He just found out that I was one of those that was instrumental in creating the Budget Committee on which he serves. We all make mistakes in a political career.

And I don't mean he made a mistake getting on it but I don't know whether they're going to be able to keep us within the framework of the budget that they're considering for this year.

I think what most impresses me in my new assignment as chairman of the subcommittee is the keen competition that exists in the Congress to work out the problems in the health care area and to see the effort displayed by my colleagues. I introduced legislation with which you're vitally concerned, and believe me I have been thoroughly impressed with the amount of concern. And since I've now delved into it in greater detail, I can understand why.

The problems in the field of medical malpractice have recently been attracting quite a bit of attention. Almost every day, you can read about a new malpractice crisis in the newspaper. On weekends, the Sunday supplement covers the issues in depth. And on Capitol Hill, solve the problem once and for all.

Some people feel that whenever the Congress of the United States takes an interest, the private sector had best watch out. But I disagree.

On this issue, I think that congressional interest is a good sign. It shows that there is a widespread public awareness of a most serious problem, and public awareness can pave the way toward a solution.

What we need to guard against, however, is a rush to adopt any so-called solution developed on the basis of inadequate information. Such an approach will probably leave everything in no better shape than we are currently in and might even introduce new obstacles as severe as the ones which we are trying to escape.

The real need now is for solid information about the problem and for careful exploration of alternative ways of resolving it. This is why I commend my colleague Jim Hastings and the American Group Practice Association for sponsoring this national conference on medical malpractice. It provides interested parties with the opportunity to share information and discuss potential solutions to this multifaceted problem. I appreciate very much the opportunity to speak with you and be part of your effort to find solutions.

At this stage I do feel that the Federal Government can constructively assist in the solution to this problem. The Government can stimulate information gathering and stimulate thoughtful analysis of the problem and the possible solutions. That approach is reflected in a bill that I introduced on the first day of this Congress. It calls for studies of the problems in medical malpractice insurance to be conducted by the National Academy of Science.

My particular interest in the growing crisis of medical malpractice insurance is twofold. First, like all of my colleagues in the Congress, I am particularly concerned with any issue that can have such a significant adverse impact on the people that I am privileged to represent. And in Illinois, here are some of the things that I am told as I return to my district each weekend. In February 47 hospitals in Illinois whose malpractice liability policies were soon to expire received notices of premium increases ranging from 281 to 433 percent. To date these hospitals are not up against the problem of the magnitude that is facing the hospitals in 14 other States where the major malpractice insurer has indicated an intention not to renew at all. But it is an ominous trend.

The number of malpractice suits against physicians is rising dramatically in the Chicago area. In addition, the number of firms writing coverage is down to two; whereas 5-years ago, there were five firms. One year ago no malpractice judgment in Cook County had ever exceeded $250,000. Today the record is 2½ million. Other Congressmen are hearing similar news from their districts. It is no wonder that congressional concern is mounting.

As chairman of the Subcommittee on Health of the House Ways and Means Committee, I'm also concerned with the well being of more than 23 million medicare beneficiaries and with the cost of health care that they receive. Problems in the area of malpractice have most definitely increased medicare costs. Patients ultimately bear the costs of professional liability premiums as well as the unnecessary costs arising from the defensive practice of medicine, that practice which doctors apparently engage in in order to protect themselves against malpractice suits. HEW has estimated these premium and defensive medicine costs at between $3 billion and $7 billion a year. Medicare's share alone is likely to be counted in the hundreds of millions.

In 5 days of hearings beginning March 3, the Subcommittee on Health heard quite a bit of testimony on the problem of medical malpractice. The American Hospital Association told us that in a little over 6 months professional liability premiums had increased as much as 700 percent in some States. Because a major underwriter of malpractice insurance for hosiptals is completely pulling out in some States, the AHA is working on the possibility of their own captive reinsurance company. Dr. Malcolm Todd of the American Medical Association stated that since the professional liablility insurance is becoming unavailable in many States across the country, legislators and insurance commissions have been forced to compel insurance carriers to write such coverage as a condition of doing business within the affected State.

We heard in addition from a number of other professional associations having interests in malpractice problems. These organizations propose a variety of solutions. Many look with some hope toward the possibility that stability may come through the insurance industry's support of a mechanism of a joint underwriting association banding together liability insurers.

In general, proposals we heard in our hearing were not new. They were very similar to the many recommendations included in the report of the Commission on Medical Malpractice. Among them were changes in legal procedures and doctrines that were seen as treating malpractice defendants unfairly, limitations on contingency fees, use of medical/legal screening panels, arbitration, no-fault base compensation schemes, and Federal assistance in such areas as reinsurance.

It should be obvious that many of the suggestions would involve very major changes in the way we now handle the consequences of medical injuries. I was pleased that many of these who testified recognized, as I do, the danger of simply plunging off in some direction hoping to accomplish a major reform without really knowing where we are going. The American Hospital Association, for example, strongly urged that the Congress not act in a premature manner in response to the malpractice crisis.

I was pleased, too, that so many witnesses indicated support of the two-stage study in my bill, H.R. 1378. There should be a thorough study of all issues in the malpractice area, but there is an immediate need for prompt recommendations that will arrive in time to help us deal with any crisis that may arise in the immediate future. For example, the crisis such as the widespread unavailability of malpractice insurance in one State or region of the country.

Several witnesses cautioned us against assuming that the Federal Government ought to involve itself in a solution to the malpractice problem. I tend to agree. In fact, I start out with the assumption that States, providers of health care, and insurers should find the solution among themselves. But on the other hand, I do not rule out the possibility that there may be a need for a Federal role. I would await the recommendations of the study called for in my bill before drawing any firm conclusions.

Let me say briefly what my bill proposes. The Office of Technology Assessment, a newly created arm of the Congress, would arrange for studies on malpractice insurance problems among physicians and hos-

pitals. The studies would be conducted by the National Academy of Sciences.

Most of you know that the Academy was chartered by Congress in 1863 to be an advisor to the Federal Government. Within the Academy, the Institute of Medicine was chartered in 1970 to enlist distinguished members in medical and other professions, such as the law, for examination of policy matters pertaining to the health of the public. Within this multidisciplinary body, there exists the capacity of marshalling some of the best minds and experts to address the problem of malpractice.

Because a need for quick action may arise, my bill calls for the National Academy to submit a report no later than July 1 of this year. A second report would come later, no later than May 1, 1976. This report would be based on a much more thorough study and would contain recommendations for long-range solutions to the problems in malpractice insurance.

We have not given any direction that would guide in any way the outcome of the deliberations to be conducted by the Academy. As I have already mentioned, I have not made up my mind that Federal actions would be required. My only desire is that Congress and others who may be trying to make decisions should have available to them the best information that can be gathered about the problem and the best advice that expert thought can provide as to alternative courses of action.

Again, I want to thank you for the opportunity to talk with you. You have my best wishes in your study and deliberations aimed at easing the problems in the medical malpractice area.

Thank you very much.

Dr. JAMPLIS. Congressman, we are deeply honored by your presence tonight, and we do hope that the deliberations of this conference will be of some help to you and your committee while you're pondering what we should do about this problem.

I would like to say that the meeting is now adjourned and we will reconvene tomorrow at 9 a.m.

Thank you.

# NATIONAL CONFERENCE ON MEDICAL MALPRACTICE

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**FRIDAY, MARCH 21, 1975**

ARLINGTON, VA.

## ALTERNATIVES AND REMEDIES

Mr. HASTINGS. Being only 17 minutes late, I guess we'll get off and running here this morning.

Before I get onto the introduction of the panel this morning, I'd just like to make a couple of general observations. No. 1, I am extremely pleased as a cosponsor of this conference in the manner in which it's proceeding. I want to personally thank all the panelists who I think have made a tremendous contribution to this conference, the legislators who took their time to come over and chat with you. I might say I'm particularly pleased because these are all voluntary efforts. Those kinds of efforts are leading to the success of this conference. I hope we have a good day today.

The followup from my point of view after this conference is concluded will be an attempt in the next 2 weeks to draft into some legislative form the input that we have received from this conference to develop a legislative proposal that then will be introduced, I believe, by Chairman Rogers and myself. We mentioned at the outset one of the major reasons for this conference is some of us don't know what all the questions are let alone what all the answers are. That's precisely the reason for our getting together here with the American Group Practice Association. So as we conclude the conference today, I can assure you that the input will be valuable to us as we try to develop a legislative approach.

This morning the presentation will be on alternatives and remedies. And I might say that any suggested remedies will have to be in the form of alternatives as we try to reduce those suggestions to a legislative approach. We're not locked into any remedy at this moment.

The panel this morning will consist of Dr. Joseph Davis who will discuss risk control and patient education. Dr. Davis is the chairman of the insurance trustees of the American Group Practice Association, and has been extensively involved in developing insurance programs for group practices for a number of years. The doctor is a general surgeon at the Davis Clinic in Marion, Ind.

Clark Havighurst will discuss no-fault insurance. He's a professor of law at Duke University. Professor Havighurst's interests include antitrust public regulations of business; health law and policy; director of the program on legal issues, health care, Duke University; coauthor of an article, "Medical Adversity Insurance, No-Fault Approach to Medical Malpractice, and Quality Assurance."

Geoffrey Segar will discuss medical injury compensation. Mr. Segar is a medical liability defense attorney from Indianapolis, Ind., involved in the representation of both hospitals and physicians, medical malpractice cases, and direct representation of two Indianapolis hospitals on general hospital matters. He is currently special counsel for the Indiana State Medical Association regarding the drafting and presentation of the Indiana Patient Compensation Act.

Dr. Henry Simmons was originally scheduled to be on the panel this morning. Unfortunately, Dr. Simmons' mother passed away and he was not able to be with us. Replacing him on the panel will be John Ball, doctor and J.D., who will discuss Dr. Simmons' topic, "Quality Control." Dr. Ball is assistant to the Director of Quality Standards Staff Office of Professional Standards Review for the Department of HEW; and in that position, he's been involved in an examination of the legal issues concerning PSRO and the malpractice problem.

David Rubsamen will discuss arbitration. Dr. Rubsamen is an internist and a lawyer. He is editor of the Professional Liability Newsletter, past chairman of the California Medical Association legal liaison committee to the California Bar Association. He is a fellow of the American College of Legal Medicine and currently serves on its board of governors.

Joseph Sadusk, Dr. Sadusk will discuss an emergency short range approach. Dr. Sadusk is senior consultant to the Permanente Medica Group, former president of the California Society of Internal Medicine, served as senior vice president of Warner-Lambert Co. and also served on their board of directors.

And I am to recognize from the floor later on Mr. Melvin Stark, senior vice president in charge of Government affairs of the American Insurance Association, to discuss his association's proposal for a solution.

So with that, gentlemen, in proper order as introduced, I would ask you to proceed. We are in the interest of time, of course, hopeful we can hold down the individual presentations to allow for the interaction with the participants at the conference. So Dr. Davis, if you will.

Dr. Davis. Thank you, Mr. Chairman, ladies and gentlemen. As I listened to the discussion yesterday, I recalled a personal experience with a patient which seemed to outline the problem, perhaps succinctly. I had a lady come in to see me who has a job as a babysitter, and she looks after three young boys during the day while their parents are working. Their ages are 5, 7, and 8. Last summer they were throwing their frisbee around in their front yard and it kept sailing over the fence into the yard of a neighbor.

The neighbor was mowing his lawn on a riding lawnmower, and he got off and threw the frisbee back a couple of times and cautioned the kids, "Don't let it get over here." Finally, it sailed over a third time, and he came over and tossed it back and he said, "Don't let that come over here again. The next time it comes over here, I'm going to run over it with my lawnmower." The babysitter said to the kids, "What are you going to do if he runs over that with a lawnmower?" The 8-year-old said, "I'm going to sue the ——— ———."

I have a feeling that this, general public attitude, perhaps, really puts us where we are in this matter of malpractice.

But we have an approach which I've been asked to outline and I'll attempt to do so as briefly as possible.

When I was a resident surgeon in Philadelphia during my training experience a famous rectal specialist trying to persuade me to become a proctologist told me, "If you say the word 'piles' at a party, 8 out of 10 guests seated for dinner will shift position."

Now the word "malpractice" has gotten to be no less effective as a moving force for medical professionals, as the attendance at this meeting testifies. Most of us here might welcome a surgical procedure, even perhaps as potentially uncomfortable as hemorrhoidectomy, if it would solve the professional liability problem.

I am to talk about risk control, a management technique for approaching the problem of professional liability. This is being presented under the general topic of *alternatives/remedies* with such other topics as arbitration, legislative reform and no-fault insurance.

I am sorry, Mr. Chairman, but I don't believe risk control or quality control can be considered simply as an *alternative* or *remedy*. As we have heard, this complex problem requires substantial remedying. But so far as *our* broad concept of risk control is concerned, it makes little difference whether we legislate, adjudicate, or arbitrate now or in the future. Risk control, as we consider it, is really the better practice of medicine in the best sense, instituted in partnership with the clinic, the insurance carrier and the association with the conviction that good practice is good for the patient, but good practice also will cut the risk of medical misadventures either in the eyes of the patient or of the physician and there should be less professional liability problems.

In 1963, as I can show you in the AGPA publication Group Practice, our association insurance trustees under Dr. Harold Caylor's chairmanship went before the delegates of the association to inform them of a serious problem facing the profession, namely the growing incidents of medical malpractice litigation and all of the implications—we don't claim to have been all that smart. We just had member clinics in California.

We proposed then that studies be undertaken to understand the problems and to help member clinics cope in areas such as California where the problem in its modern form was being recognized. I should say the delegates were substantially unmoved, but we did receive the usual thanks for our report.

Nevertheless, we did request and authorize our insurance administrator, Mr. Charles Stedman, to undertake an investigation of the problem and its causes and to acquaint us with the market for professional liability insurance.

We further requested him to advise us as to the steps multiple-specialty medical clinics as such and an association of such medical clinics might take to protect themselves. The association at that time had no other such membership category.

What we have come to call our risk control program was the result of this study. We give all due credit to Stedman Co. and Mr. Charles Stedman himself for this concept which antedated the relatively recent risk control activity by the St. Paul Co. and is the concept on which the San Diego County, Riverside County, and Oregon State programs and a number of other plans have been based.

There was an article in the National Underwriter for October 27, 1972, by A. John Smither, former chief deputy insurance commissioner of Pennsylvania.

He spoke of the peculiar attitude of the insurance industry and others in considering the patient rather than the physician as the consumer of medical malpractice insurance—I detected this in the discussion that we participated in yesterday and Mr. Rawls referred to it as occurring in the automobile insurance areas as well.

It was particularly interesting, however, to note Mr. Smither's advocacy of a *group* or *collective* underwriting approach to providing malpractice insurance in the manner virtually identical to the approach we had already undertaken.

Differing little from our program, the following were salient features which he referred to in a *Physicians' Medical Malpractice Bill of Rights*: (1) group or association sponsorship; (2) eligibility by membership; (3) Long-term coverage; (4) Adequate limits; (5) Peer review—!!; (6) society involvement in the program administration; (7) malpractice claims prevention and education; and, (8) individual rating.

Our program indeed fits this outline. All of this we include in our risk control program.

For years people in industry have been concerned with establishing loss prevention and educational programs, safety programs or risk control, if you will. Posters about wearing safety goggles, signs to require hardhats, requirement to wear safety shoes, the employment of full-time safety engineers trained in their specialty and the vigorous pursuit of continuous education programs obviously have paid off in terms of money and productivity and are well accepted everywhere as worthwhile.

It all seems pretty corny but indeed it works. It would seem possible that such a "safety campaign" might work in our area of risk as well.

To start such a program is a little bit like following the old recipe for making a rabbit pie. As the recipe said, "First, you catch a rabbit"; so first you need an imaginative insurance company with the resources to provide long-term coverage and with the management insight and skills to provide a truly doctor-oriented program. Our insurance administrator works with the carrier and the association both directly and through the insurance trustees to implement the three-way partnership on which our entire approach is based.

First, clinics eligible for membership in the AGPA are screened by the association's credentials committee and fitness for membership ascertained. This does not include a specific consideration for insurability but ethical standing, specialty makeup, quality of training and numbers of doctors are all matters of concern. In short, membership in the association is not automatic and only quality group practices are admitted to membership.

Once accepted as members, the clinic may apply for professional liability insurance. Representatives of our insurance administrator and of the carrier call upon the applicant and ascertain their professional liability background, frequency of suits, claims or threats, the nature and variety of such, take a look at the facility, personnel, the records, and the community setting. Of prime concern is the relationship to the hospital facility which is used and the quality of this aspect of service.

The carrier is acquainted with all of this data and on the basis of this and all other appropriate consideration provides a premium quote which thus depends upon a variety of factors.

For one thing, the State in which the clinic is located will through its various laws and requirements have an impact upon the premium that can be quoted.

If the carrier and our insurance administrator find all to be satisfactory and the quote is acceptable, the clinic goes on the risk control program, having agreed to abide by the principles outlined.

Now if the company would question the insurability of a member clinic, the matter may be brought to the insurance trustees. The insurance trustees themselves or by means of physician appointees may investigate the professional aspects of the clinic in person in order to ascertain the correct course to follow. We may agree with the company or we may request the company to insure the member clinic. If they are thus considered, the ultimate quote may be with some modification of premium or coverage, but the association can by this device direct that coverage be provided to member clinics. We do, however, have an overriding consideration in making such decisions.

Our premiums go into our own pool for basic coverage up to $100,000 per claim. Seventy-two and one-half percent of the premium dollar goes into this pool and is available for the payment of claims.

All other expenses, including the administrator's commission and the company's expenses, are derived from the remaining portion, 27½ percent of the premium dollar.

There is in addition an umbrella policy providing protection above $100,000 with limits available in multiple millions. This is not a part of the pool, and it is insured as a standard risk.

Again, the pool is our own. It involves only member clinics and it is from the pool that we hope to meet all claims with some excess to generate dividends. Indeed, last year we received our first dividend of 7½ percent for all clinics in the program prior to January 1973. It is early and we must watch, but so far the experience is favorable. It would appear good medicine is better for the patient and better for risk control. Obviously, the insurance trustees cannot capriciously or otherwise jeopardize this pool, so we have substantial interest in selection as to who participates in the program.

A summary of the methodology of our risk control is contained in the elaborate handbook which goes into the hands of each subscribing clinic. I have a copy here.

The objectives are to minimize the possibility of malpractice incidents by utilizing education of physicians, staff, and patient, by peer review and loss prevention programs. A major purpose of these programs is to encourage a professional awareness which will reduce the occurrence of patients injured through malpractice, to identify factors contributing to the occurrence of malpractice, to establish procedure for the handling of alleged malpractice incidents and to provide an environment which will lead to a minimal number of patient or employee injuries.

We also attempt to mitigate the physical and financial damages resulting from occurrences of malpractice by utilizing the combined efforts of specially trained coordinators, Stedman Co. and Insurance Co., a claim review committee composed of physicians from within the individual clinic and experienced, highly qualified defense coun-

sel where required. We require the clinic, among other things, to carry on a medical standards review function aimed at maintaining the professional standards of the clinic through, for example, a random sampling of medical records to determine their adequacy and completeness and by establishing an ongoing educational program aimed at creating an awareness of the causes of malpractice and how to avoid this—at all levels of clinic staffing and employees.

The administrative aspects of clinic practice are important and are beefed up, implementing a program to maintain the clinic physical structures and overseeing the coordination of the credit and collection procedures.

The claims review committee has the responsibility within the clinic to review malpractice incidents and when it finds a case of malpractice it will evaluate the various means for remedial action and will have the obligation to aid the insurance company claims coordinator in obtaining a prompt and just settlement of valid claims.

It will also be the responsibility of the clinic's claims review committee to provide expert witnesses and opinions in an attempt to resist unjustified claims.

One of our key functions—and it is carried out by full-time staff of our insurance administrator—is to monitor these efforts by each clinic. We check to see if they are getting it done. There is an ongoing follow-up program.

I refer again to the risk control program handbook. As you can see, it is a looseleaf style so that additional observations and modifications can be made with minimal difficulty, and it goes into literally every aspect of clinic management. It outlines the manner in which clinic records should be kept. The type of information that should be included in the records and that which should not be included in the record is described. It even coaches physicians in the manner in which they should conduct their daily appointment schedules. There are sample letters, for instance, one that may go to patients who fail to follow up in visits as scheduled where this might have some implication on the quality of care and many others.

The precise manner in which claims should be reviewed is outlined and a standard form is provided. The manner in which employees in the clinic, other than physicians, can participate in loss prevention is outlined and instructional sessions are suggested.

A word about patient education. Patient education starts when the patient enters the clinic seeking medical services. A patient's handbook recommended in our handbook is a prime help in this. We describe one. Our program suggests strongly that a formal educational program directed at patients be established within the clinic. One clinic that has done this is the Lovelace Clinic in Albuquerque, N. Mex. For example, a patient is seen and a diagnosis of diabetes is made. The patient proceeds to the educational section in the clinic staffed by personnel with training to teach the patient about his disease, diet and insulin administration, importance of followup visits, foot care and anticipated complications. Patients are taught how to live the lifestyle dictated by his disease. The family is also taught the necessary techniques to be of best help.

There are audiovisual aids available to help in this approach to care. One such program is sponsored by AGPA and is called CORE com-

munication and health-patient education. A variety of subjects are available for the clinic's use.

Patients can be shown what to expect, for instance, as the result of plastic surgical procedures, say a face lift procedure. Thus fully informed they can sign a consent form intelligently—or faint or run screaming out the door.

Consent forms for all procedures ranging from sterilization down to parent's consent for continuing treatment of a minor are provided in specific form. I might say that these forms are some of the best I have ever seen.

Having participated in this program since its inception and having worked with physicians in our own clinic and in our own community, I can comment that there is much for our fellow physicians to learn about the practice of medicine as it pertains to the question of risk control.

But, we are not simply talking about defensive medicine. If you read through this handbook, you will not see the word used, and I believe you would be impressed with the fact that the suggestions are of a positive nature, that they create a better atmosphere in which to practice medicine and that the patient should be benefited by virtually all of the suggestions.

Again, let me emphasize that risk control—a very broad concept as we conceive of it—is not a defense mechanism. It is a positive approach in partnership with the clinic, the insurance and the association to improve the care of the patient, something which should be undertaken whether there is ever to be another malpractice lawsuit or not.

I will concede that all of this can be done much better and perhaps can be done well only in formally organized, well managed group practices. The solo practitioner, the county medical society and the hospital staff each have limitations when such a program is considered.

It is our conviction, however, that this approach, where it can be done well, can cut down on the threat of malpractice suits in the present atmosphere and will most certainly do so in that new atmosphere which we hopefully look forward to whether it might involve arbitration, legislative reform or judicial modification.

Thank you.

Representative HASTINGS. Thank you, Dr. Davis. Now Clark Havighurst, professor of law at Duke University, will discuss no-fault insurance.

Professor HAVIGHURST. First, the good news. It seems to me that the type of no-fault system that I'm going to talk about—which I call medical adversity insurance, or MAI—is going to solve all the problems that I've heard about at this conference. It can save the legal and administrative costs we've heard referred to and a great deal of doctors' time and anguish. It will reduce the distrust in the doctor-patient relationship. It will remove the stigma, frequently unwarranted, that attaches to malpractice claims. It will eliminate the adversariness of the claims process and the bitterness that accompanies litigation. It will compensate more patients sooner, though not always in the large amounts now achieved. It will improve, in addition, the quality of care. It will obviate a lot of the regulatory intrusions that the medical profession now faces. It will eliminate unproductive defensive medicine. And I think the cost would be manageable.

Now the bad news: It may not work.

But I am very serious about the potential benefits and everything I've said. Even though one has to be careful about offering panaceas to doctors, I do think MAI has great potential and deserves very serious consideration.

I'm also serious about the problems of implementing MAI, and I really am not capable of assessing finally the potential for developing a workable scheme that would, in fact, do all the good things that I suggested were possible. But I think the matter deserves study, and I will propose that the matter be given very serious attention, which would require a great deal of money and extensive professional involvement. That's what I'm proposing as a policy measure at this time.

The MAI idea all began with an academic's concern about how to make the health system perform in the public interest. I tend to be interested in what it takes to make an industry perform effectively in terms of cost, in terms of quality, in terms of consumer satisfaction, and in terms of getting the best we can out of the system at the lowest cost; and what I'm saying here reflects that academic interest. I'm not a tort lawyer, and everything I have had to say about the present malpractice tort system has been critical. The proposal I am speaking of originates from a different set of interests.

When Dr. Laurence Tancredi and I wrote on the subject of medical adversity insurance—Milbank Memorial Fund Quarterly, spring 1973—we ended the paper by saying, "As challenging as MAI has been to us as an academic exercise, we do not offer it as such." That's really my message here today. I'm just about the only academic in the room, I think, and I will try not to be any more academic than I can help; but, nevertheless, this proposal originates with an academic's view of the totality of the problem.

Let me begin by backing off a bit and trying to put the whole no-fault concept into perspective so that I can better explain to you what I think the benefits of pursuing the MAI approach would be.

When physicians hear about the notion of a no-fault compensation system, they tend to be interested. But their interest originates in their expectation that under such a system, they would be relieved not only of all of the psychological burden and trauma of malpractice suits but also of the financial burdens that are involved. Dr. Hoffman in his dissenting statement in the HEW Secretary's Malpractice Commission Report proposed that employers buy insurance against medical injuries for their employees. He suggested, in other words, that the cost ought to be shifted to somebody else, preferably someone who is largely unable to meddle in medical practice. Others have proposed that government meet these obligations out of tax revenue. In the auto field no-fault concepts contemplate that people insure themselves, and some people now propose something similar for medical care, occasionally called patient flight insurance. When entering the hospital you would buy a policy, at a little counter, I suppose, that would protect you against the hazards of entering into the system. The result of such compensation plans would be that the provider, who is in a substantial sense responsible for the quality of care being provided, is nevertheless relieved of the cost of any harms that occur—exonerated, in fact. My point is that the result doesn't necessarily follow from the no-fault concept.

What no-fault means is not irresponsibility, no exoneration, but simply dispensing with the finding of fault in specific cases, which, as we have learned, is an expensive process. But it doesn't follow that liability is also dispensed with. Lawyers would call what I am talking about a system of strict or absolute, meaning that liability follows without regard to fault.

Now, doctors have a hard time accepting the notion of liability without fault. They have come over a period of time to identify malpractice suits with blame for failing in their personal responsibilities. They see a claim as a finger being pointed at them and a charge that they failed in their professional obligations.

But, if you look around, you will find that liability without fault is not so unusual. The workmen's compensation scheme has been around for quite a long time. Fault is not a factor there, and employers are held liable even where the injured employee was himself at fault. In other words, contributory negligence is not defense—employers pay, or their insurance pays, and their premiums go up as a result.

Doctors are familiar, I suppose, with the principle of respondent superior. That lawyers' jargon simply means that employers are responsible for the torts of their servants even though the employer is rarely personally at fault. You undoubtedly also know the principle of the "captain of the ship" as it applies to surgeons. That is another instance of vicarious liability where liability is imposed without regard to personal fault on the part of the party who ends up paying the bill.

But why should doctors pay? Why not the Government or somebody else? I say there's a very good reason, and that is the need to preserve incentives to provide good quality care and to avoid compensable adverse outcomes. These incentives can be preserved even with insurance because the premiums on that insurance can be set in accordance with the provider's experience so that a poor record with respect to outcomes would result in higher premiums. Providers would attempt to avoid bad outcomes, seeing a connection between their premiums and the results they were getting.

Of course, I recognize that doctors are already motivated to avoid bad outcomes, and I anticipate the obvious question: Doesn't all of this assume that doctors are motivated by economic incentives alone? And I say "No." Most of them are of course very responsible. The profession has, I think, a very good record, and I think anyone who looks at the physician objectively can understand the strong desire he must have to do the very best he can for his patients at all times. Nevertheless, I think that there are some, probably a small minority, for whom professional obligations and the sense of professional responsibility are somewhat weaker. These are precisely the people, I suppose, for whom the financial incentives would mean the most, and I would contend that it is desirable to have professional obligations and the financial incentives pulling in the same direction so that they more or less coincide. We could then be sure that we are relying on something more than the trustworthiness of the individual provider.

There's more to say, though, than that. I think doctors probably are not as aware of the outcomes they are achieving as they might be. I think that their sense of professional responsibility goes more to whether they are doing what they were taught or what they think at

any point in time is the best they know how to do. I'm not sure they have the kinds of feedback which help them know whether their results compare favorably with what other professionals are achieving.

Dr. John Williamson's work on outcomes assessment lends some credence to that idea, and I think it would be very helpful if the doctor had the data by which he could compare his experience to that of others as well as the incentive to see if there were ways he could improve his performance. He would then be more attuned to new developments, things that could, in fact, improve his performance, and indeed the entire profession would have reason to concentrate on the many things—frequently nontechnical things like better communication with the patient or better followup—which can improve outcomes, often without significantly increased cost. I think the system could perform substantially better overall if those incentives prevailed.

Recognize that we're not talking merely about reducing negligence. That is a fairly minor consideration compared to the more general problem of avoiding bad outcomes. The negligence standard is really a very minimal one, requiring only that the doctor do what other doctors do. In other words, we're talking about merely complying with a minimum, and that is not all I think we should want to achieve optimally.

On the other hand, an incentive system encourages good performance, the pursuit of good outcomes at all points, and efforts always to improve. I would contrast compliance with the minimum negligence standard with the incentives for good performance overall. Even the best physician would continually, under an incentive system, have a personal interest in improving his outcomes. I think that is something which the system lacks and which we would gain a great deal by restoring.

Thus, I would argue that a no-fault system based on incentives would be much more effective than the fault system in achieving good quality care. Mr. Cartwright's claims yesterday for the quality-promoting benefits of the existing malpractice tort system support only the notion of liability, not the fault element. Eliminating the finding of fault and all the costs that accompany it would be no loss if we could replace it with a system that provides the incentives I'm discussing.

As it is usually discussed, the no-fault concept implies payment for a great deal of harm, for a very large number of injuries. If no-fault is to pay for every bad result, isn't that unrealistic? How are we going to know when we have a medical injury or something that we want to compensate? How are we going to know that the bad result was caused by something that occurred in the course of medical treatment? And, indeed, why should we stop at that point anyway? People who come into the system sick would seem to be equally sympathetic candidates for some form of compensation. In other words, the question is, where do we draw the line as to what should be compensated? Can we avoid taking on an impossible burden?

What I would propose is a very limited approach, something that does not go nearly so far as trying to compensate for all things which might be called iatrogenic disease or medical injuries or all things that somehow are caused by the medical care system. What I would do is start at the other end and identify certain specific results of

therapy which could be declared to be compensable. Then providers would be required to pay for only those things that were on the list of compensable events, other outcomes being left to be handled under the traditional system or some modification thereof. In other words, I would not propose trying to cover everything under MAI. That would be unrealistic. I think this selectivity is the unique feature of MAI compared to other no-fault approaches. Indeed, we began work on MAI only when we realized that it would not be necessary to cover everything but only those things which we decided for affirmative reasons deserved to be compensated because of the desirable incentives to be introduced.

Now how do we decide what's to be compensated? This requires a whole new way of thinking about the compensation process, about liability, and about medical care. Obviously, you should start with the easy things, things that now fall under the doctrine of res ipsa loquitur, for example. One would begin by looking for outcomes which are clearly the events avoidable in almost all cases; in such cases there's good reason not to go through the process of a trial and so on. Classifying those things as compensable would be relatively easy.

Then you might go on and add some things which are avoidable in most cases but which sometimes occur under circumstances where, in fact, the providers have no control. This, I guess, is the trickiest part. We are going to include some results which are clearly unavoidable because they are part of a broader category, of results, some of which are avoidable. Potential quality gains are available from making such events compensable without a specific finding of avoidability in each case. That, I think, is the aspect that is hardest, perhaps, to understand, but it is nevertheless quite central.

The list could be expanded over time as we got more information, as we developed greater confidence in the process, and as we began to understand medical care better and saw opportunities for more quality gains by strengthening incentives.

The criteria for determining whether something should be made compensable would include whether the quality of care could be materially improved by strengthening incentives. Other considerations would include administrative feasibility. Administrative considerations might sometimes require leaving something on the list that was not avoidable in a significant number of cases, because one wanted a system that was complete and in which the incentives were well ordered.

I think many of the problems of making this scheme work are obvious to you, but I should at least acknowledge that I recognize them. One of the problems is the possibility that, by having certain events compensable and others not, the plan would bias in undesirable ways the forms of treatment that doctors choose. Thus, while you might make the possible bad outcomes of surgery compensable, in which case the doctor may be discouraged from performing surgery when in fact he should perform it. And that possible bias, I take it, ought to be avoided wherever we can. For that reason, one would have to do a very careful analysis of every treatment, every disease situation in order to make sure the incentives were being ordered in a desirable way.

Another problem, of course, is that some doctors would reject certain patients because they seem to be more likely to have bad outcomes than other patients. They'd take only easy cases. Now I think that's all right up to a point because some doctors aren't really competent to handle the hard cases and should refer them up the line to somebody else. But that might mean that the best doctors will end up getting the hardest cases and will probably have the poorest results and therefore pay the highest MAI premiums. And that's worrisome.

There are ways of handling this problem which we've talked about in the paper but which I won't go into here. One point would be that the better doctors would charge higher fees, passing their higher costs on to patients. It is a legitimate cost, and the higher prices would serve the function of allocating scarce medical resources, that is, the better doctors, to the harder cases, which is something that we would like to achieve in any event. It may, nevertheless, be necessary to classify doctors in some way for insurance purposes and to subsidize the insurance plan for the high-risk categories in some fashion. I must say that I think this is probably the hardest problem to overcome in making MAI manageable.

The other problems which exist include the difficulty of defining events in ways that make them readily identifiable when they occur so that we can avoid litigation in most cases. I think you can sense better than I can all of the difficulties that would be involved.

Finally, there is the cost problem, which is very complex. If MAI were established on any scale, there would clearly be many more claims than we have now. However, the payments would be smaller because of the schedule of payments that would be provided. Moreover, there should be a very substantial saving in administrative costs under MAI as compared with the fault system.

I would argue that any new dollar costs that would appear under MAI are really not new costs at all. They're costs which are already being borne by patients, and we're simply socializing those costs—sharing them more widely—and the program can therefore be seen, in part, as a plan of social insurance. But unfortunately, even though these are not new costs in any real sense, handling them as we propose would make them look like a new cost of health care, and people would say there's been more inflation in health care costs, even though that would be more appearance than reality. The potential for quality gains might easily justify some of the higher cost in any event, and I would contend that there would almost certainly be a net social gain if all the costs were accurately counted.

I have great sympathy for the doctors' argument, which we have already heard at this meeting. They should not themselves be burdened, as a small segment of the population, with the huge risks which the population at large is necessarily exposed to as a result of the uncertainties involved in medical practice. I couldn't agree more with that concern, and I do not believe that providers need to face the costs of adverse outcomes on a dollar-for-dollar, out-of-pocket basis. As a result, I think it might well be appropriate for the insurance fund to be subsidized either by Government or by some other source. I could discuss other possible sources of subsidies, but Government, I guess, is a good enough candidate for now.

If the subsidies were large enough it might even be possible for the provider who has good experience to pay no premium at all, a zero pre-

mium. Indeed, the subsidy could be large enough so that if he had better than average experience, he could get a bonus at the end of the year. In other words, the premiums under an MAI scheme need not be high. The cost of the program could be borne in other ways without destroying its incentive value, and there's no reason that those costs should be laid on the physicians' shoulders.

Finally, what I would propose is a substantial study of the potential of this scheme. I think the potential benefits are great enough that it deserves careful study with assistance from physicians interested in quality assistance. Only if we determine that MAI is, in fact, not feasible should we turn to other remedies.

Mr. Chairman, I have prepared a memo on implementing medical adversity insurance which I'll submit for the record. It attempts to put the proposal on a more practical footing and should supply the basis for a careful evaluation. It takes the original article and removes some of the little quibbles and things—makes it sound more like a practical proposal than the original publication did.

I make some concessions to practicality from time to time.

But I think things of this sort need to be thought about from the ground up in a conceptual way, and the malpractice problem does have substantial significance in terms of the dynamics of this system and its performance in terms of quality. I would like to see its incentives for better quality preserved, but the very high costs that come with the present system are somehow minimized.

Thank you.

Representative HASTINGS. Thank you very much, professor. First I'd like to say that I like your good news better than your bad news. Second, I'm very much intrigued with the potential for the Congress developing legislation that would try to indicate which are good doctors and which are better doctors.

And if we can't do it, I'm sure the Secretary of HEW would like to have that chore given to him also. Then the other intriguing idea in your presentation which I consider to be a very valuable addition is the question of utilization of general Treasury funds for subsidies. Sitting on the Budget Committee, we're now anticipating a deficit this year of $100 to $120 billion. I can assure you that we get very excited about the possibility of being able to add to that deficit.

I do thank you very much.

Now the doctor's lawyer, Geoffrey Segar, will discuss medical injury compensation.

Mr. SEGAR. Congressman Hastings, members of the panel, ladies, and gentlemen. Physicians, hospitals, and health care providers in Indiana as well as in most other States are indeed in the middle of the same medical malpractice crisis as most everyone has recognized at this conference.

The medical malpractice disease hit Indiana with a tremendous impact about last October when the symptom of the disease, unavailability of liability insurance, became evident. For at least 10 years prior to that time, various groups in Indiana, of course as well as elsewhere, had been attempting to find voluntary solutions to the obvious increasing dilemma of medical health care liability litigation. Review of voluntary arbitration plans, voluntary screening or review panels, and attempting implementation of such programs failed with consistency.

Without attempting to place blame upon any particular group of society, suffice it to say that study indicates that the collective ineptitudes of segments of the medical profession, the legal profession, and the insurance industry combined to defeat any real progress with regard to voluntary programs. Realistically, their individual interests were not and are not today sufficiently compatible to allow the accommodation necessary for meaningful joint effort. To exject those segments of society to really accommodate their different views and interests on any voluntary basis is totally unrealistic.

At about the same time insurance unavailability hit Indiana, the horror stories from around the country with regard to doctors refusing to perform medical procedures involving high risk became common. Stories of patients dying because of neurosurgeons refusing to go to the hospitals and other such war stories became rather commonplace.

Thus, while much time, effort, and talk had occupied joint meetings of the medical, legal, and insurance interests, it became apparent, at least to Indiana doctors and other health care providers, that a legislative attempt had to be made and immediately. Short-term, long-term considerations were no longer realistic. Indeed, the short term had merged in the long term. In fact, a concentrated study which we have undergone in the last 3 months had caused some people to indicate that the solution of the short-term problem of insurance availability and cost may, in fact, be counterproductive from the standpoint of attempting to really solve the underlying problem of the medical malpractice dilemma.

At the outset, it was recognized by those in Indiana that were attempting to find legislative solutions that there, of course, had to be improvement of the quality of patient care; and therefore, separate legislation in the form of an updated Medical Practice Act was introduced in this session of the Indiana Legislature. We were, however, late in 1974, faced with the prospect of a 61-day legislative session and by midsummer of 1975 if something did not happen, we, indeed, would be in worse shape, I believe, than New York from the comments I heard yesterday.

The Indiana Patients Compensation Act was thereupon developed. It is an attempt in the public interest to look at the total parameter of the underlying medical malpractice dilemma and to force an accommodation of the previously mentioned groups in a fashion which they have been unwilling to voluntarily undertake. It has provisions in it which are unpalatable to segments of all interested groups. It is an attempt, however, to solve insofar as possible the total medical health care liability crisis and not just its symptom, the pricing, and unavailability of insurance.

The basic disease of which the symptom of insurance cost and unavailability arises is the effect the total malpractice liability system has had upon the practice of the health care professions. It has resulted, as has been suggested by others at this conference, at doctors looking upon patients as potential law suits with the result that patient care is drastically effected. The current circumstances involved in the professional liability system, indeed as has been suggested, are in the process of destroying the practice of medicine and the total health care provider system in this country. It has effected the human rela-

tionships which exist between the doctor and his patient to the point where the whole medical care delivery system is deteriorating. It was thus determined at the outset, that in attempting to cure the present problem, we would try to resolve not only the symptom, the insurance problem, but also the underlying disease, the total liability system.

We admit that this act is not a panacea. We admit that in its present form it is imperfect. The Indiana Patients Compensation Act in the form which it passed our House of Representatives approximately 10 days ago by a vote of 81 to 16 is not at all in the same form as it was originally proposed. It has been substantially amended, in some fashion in my view for the better and in some fashion for the worse. However, it has taken some accommodation to get where we are today.

It now provides in substance as follows. A patients compensation board is created made up of a total of six members which will be divided into two hearing boards, each made up of a doctor, a lawyer, and a layman. If one of the other health care providers is made a defendant, a representative of that particular profession is substituted for the physician member of the board. The bill, in its present form, covers physicians, hospitals, osteopaths, chiropractors, dentists, optometrists, nurses, podiatrists, and several other health care providers.

A patient has a right to reject the provisions of the act prior to entering into a professional relationship with the health care provider. The fault concept is retained. That is, malpractice, liability based upon negligent practice, still provides the basis of the claim. To me, this is perhaps the most significant difference from any other proposed piece of legislation that I have ever heard discussed. It was designed in this fashion to prevent the almost impossible task of defining or delineating a malpractice claim and when it would otherwise take place as well as to avoid the obvious tremendous cost impact on a no-fault or semi-no-fault system.

The claim is totally removed from the jury system. The board is the sole determinative body from the standpoint of both liability and damages. Our bill now provides in the event of a finding of liability in the first instance an award of up to $100,000 plus attorney's fees of up to 33⅓ percent plus costs would be available as a maximum. This award would be appealable to our higher courts for review.

This would be true in case of all injury or death. This liability would be insured by the private segment of the insurance industry. All awards under that provision of the act would be net to the patient. That is, all costs, attorney's fees, costs of trial would be net in the patient's pocket.

In addition to those amounts provided for above, in the case of a catastrophic injury, an additional amount of up to $200,000 could be awarded. This liability, however, would be funded by fees from the health care providers in the form of something like a self-insured fund. It would provide for maximum contributions, however, so that total contributions would be very limited. As currently proposed, the doctor's portion of that fund would be $100 per physician per year and 5 cents per hospital bed per day to be paid by the hospitals.

We also provide for punitive damages to be awarded in addition to these amounts; and indeed, the last amendment made by our House of Representatives was to provide out of the catastrophic injury fund

lifetime benefits in the event of the inability of the patient to pay his hospital bills or his own maintenance.

The entire bill is self-funded with no obligation on any governmental agency from the standpoint of the cost of its administration. The actual costs of the administration of the act are paid out of the license fees of the health care provider. It also provides by way of backup for a joint underwriting association assigned risk pool. This would provide for coverage as to the basic liability under the act in the event the health care provider was rejected by two professional liability carriers.

This section, however, also provides for a peer review system so that the "really bad doctor" would not be eligible for the assigned risk coverage and be protected by the Patients Compensation Act. The protection of the Patients Compensation Act would be provided to a health care provider only upon his proof of filing of insurance or a surety bond in an amount approved by the board.

It also provides for a shortened statute of limitations. As originally proposed, it was 2 years from the date of the act. It has since been amended so that it is 2 years except in the case of a small child who now has 2 years after he reaches age 5 within which to file a claim.

The principal opposition to this proposal has been from a segment of the legal profession. Their principal objections have been threefold. The elimination of the jury system. The limits or caps provided by the act. And the arbitrary setting of attorneys' fees.

Interestingly enough, the members of our legal profession who represent most of the plaintiffs ultimately concluded after discussion that reasonable limitations in a dollar amount whether under our act or some other form were indeed justified in today's society. That indeed the $1, $3, $4 million award could no longer be justified in the system under which we operate. That sociologically and economically that cost could not be further borne by the segments of society which had to pay such losses.

Therefore, even though they have opposed our bill, they have introduced their own legislation retaining the jury system but indeed with a limitation in their own act of $500,000. This is a long way from any prior discussions with representatives of Mr. Cartwright's group. Not all members of his group I am sure would agree with that, but I think it is a responsible opinion in considering the total problem today.

Even though the proposed Patients Compensation Act eliminates subrogation on all collateral sources, it is interesting that the Blues, the Blue Cross/Blue Shield carriers, have supported the bill. This is largely because of their belief that it will provide a cost limiting factor from the standpoint of the total providing of health care services. And indeed, Congressman Hastings, the total cost picture for providing health care in this country under such a system might well be reduced rather than increased. This is also interesting because we have received unexpected support from segments of labor because of their belief that this system would also substantially reduce or at least limit the total cost factors involved.

The Indiana Patients Compensation Act is presently pending before the Senate Judiciary Committee. If it is not to be voted upon today, it will be voted upon on Monday. The fate of the act will be known in the next 2 weeks.

One aside: the makeup of our Judiciary Committee has 13 members, 10 of whom are lawyers. The fate of the bill is uncertain.

I have to give one aside. One of our opponents who appeared before the Senate hearing Wednesday morning after I testified and before I left for Washington left me so that I was almost breathless, appalled, angry when he stood up and said that the whole matter was contrived, the whole matter was a scheme on behalf of the insurance industry, was a rip-off and that our legislature should do nothing and should go home. I perhaps lost my cool. But it is amazing to me that with such a conference as this going on in the same week that such a conclusion could be reached by anyone of responsibility.

I might say that the reason that we took the bull by the horns is that those of us who were considering what should be done sat in meetings of this kind for over 10 years where they were held in anterooms. If there were three people present, it was a lot. We have had upwards of 5,000 at our committee hearings. We did not have room in the halls of our legislature for the people that were interested. We concluded that if we did not do something, that a room of this size by a year from now, there would be no place in Washington, D.C., large enough to hold the group that might be interested.

The mechanical details and actual figures in the Indiana proposal are not significant. The basic plan, however, we have had studied constitutionally and find that it meets both Federal and State constitutional legal objections. We have been assured that it will provide sufficient predictability that a competitive insurance market would be immediately created in the State of Indiana. The problem of human relationships existing between the patient and the health care provider should be ameliorated.

We believe it will allow the health care professions to return to their fundamental objectives, the best patient care possible. The pallor created by the current malpractice liability crisis should be diminshed so that those objectives could again be met. We believe that a program involving some form of a retention of the fault system and a form of patients' compensation may be an effective State-by-State answer to the current dilemma.

Thank you.

Representative HASTINGS. Thank you very much, Mr. Segar. I might say as one who tends to because of my position legislate from the Federal position, I compliment you greatly for trying to meet this problem back at the State of Indiana. As one who shares the thought that I think primarily we should try to solve this kind of a problem at the State level with the minimum of Federal intervention. I hope it works out that way. With your contribution, it certainly will be most beneficial.

Dr. John Ball now will discuss quality control.

Dr. BALL. Dr. Simmons asked me personally to convey his regret at being unable to attend and wishes to add his thanks as well to Congressman Hastings and to the American Group Practice Association for their sponsorship of this important conference. For my own part, I am pleased to speak for him and to participate in the discussion period.

Representative Hastings, Dr. Jamplis, ladies and gentlemen. Certainly the problems occasioned by the enormous rise in the cost of malpractice insurance constitute a crisis for everyone concerned, for the

consumers of health care as well as for health care professionals and the insurance industry. The malpractice crisis, like any other, demands immediate action. After all, when a river threatens to overflow its banks, you start moving people to higher ground; but when the flood subsides, it is time to figure out what can be done upstream to deal with the problem at its source.

That is, more or less, where we are with respect to malpractice at this time. We have a crisis on our hands that has to be faced now. But over the long term, we are faced with a condition in the American health care system that has to be dealt with on a more fundamental level, at the level of causes rather than effects. When we think about alternatives to and remedies for the malpractice system, we should not limit ourselves to a consideration of ways to make that system more bearable. But we should look seriously at approaches that have the potential at least of drastically reducing the need for malpractice litigation.

Ultimately, a suit alleging malpractice represents about the only way a patient has to exert influence on the outcome of medical care. If he thinks the outcome is improper because a physician or a hospital has somehow acted irresponsibly, he has the option to sue. Knowing that the patient has this option, physicians, hospitals, and other health care providers and institutions, as we all know, arm themselves with malpractice insurance at an increasingly heavy cost that must ultimately be borne by the consumers of health whose taxes, insurance premiums, and out of pocket expenses pay the bill. It seems to me that this is a wholly unsatisfactory way to influence the outcome of health care.

There must be, and I believe there is, a better, more direct, less costly, and more equitable way for health care providers, society, and individual patients to be confident that the outcome of health care will be, to the greatest possible extent, the best that can be achieved. It lies, I think, in organized, formal, mandated efforts whereby physicians will determine standards of quality health care and diligently see to it that those standards are maintained.

By far the most promising of these efforts is the professional standards review program embodied in the social security amendments of 1972. Professional standards review organizations have the potential for reducing malpractice incidents, patient injury based on those incidents, and legal action because of those injuries. In addition, the program is likely to decrease the incidence of defensive medicine; that is, medically unjustified care provided solely to reduce the possibility of a malpractice suit.

These results will flow, in the first case, from the increase in the quality of medical care services that can be expected to occur as review of those services becomes general. That is, as quality of care increases, the number of malpractice suits should decrease.

In the second case, the practice of defensive medicine should decline as physicians gain confidence in PSRO developed norms and standards of care and begin to abandon the overutilization prompted by the fear of suit. The civil immunity provision of the PSRO Act which grants limited immunity from civil liability for health care providers who adhere to PSRO standards and norms will be useful in both regards. As an incentive for physicians to comply with PSRO, it will aid in the review and enhancement of the quality of care; by providing immunity only if the standards are followed, it will clearly indicate that

utilization beyond the standards is unnecessary either from medical or legal viewpoints.

The greatest impact of PSRO on malpractice, however, will be evident in its role in the demise of the malpractice system. Fully operational PSRO's will be more efficient than the malpractice system in controlling and assuring the outcomes of medical care.

PSRO will be an efficient and effective means of control on outcomes of care because it ties the measurement of outcomes to change in those outcomes directly. That is, PSRO will measure outcomes of care and where those outcomes do not comply with developed standards of care, the process leading to the outcome will be changed to effect an increase in the quality of the outcome. The reason for the measurement or review will be to ascertain whether the outcome needs to be improved, and there will be a direct link between measurement, change in process, and outcome. The change in the process will be carried out with the purpose of effecting the change in outcome.

Malpractice as a system of control of quality of outcomes is less efficient because its measurement of outcomes is not tied directly to change in outcomes. That is, it measures outcomes of care to ascertain whether there was compliance with the standard of care, as does PSRO, but not for the purpose of changing the process to improve the outcome. The measurement by malpractice is done to find whether the outcome and its related process were outside the standard of care to the degree that liability will fall on the provider.

Malpractice does not complete the circuit needed to control the quality of outcomes. It does measure outcomes and process, but any change it effects in process is merely fortuitous. And that change in process, if related at all to the original outcome, is tenuously related at best.

PSRO will be a further improvement in outcomes control because the change will occur within the system. PSRO review functions will be carried on by medical care providers with a view to changing the quality of care. The malpractice system, on the other hand, is almost wholly external to the system of care and any increase in the quality of care it effects will be a fortuitous byproduct of that system.

The malpractice system presently exists for two purposes: As control on the outcomes of care, and as a means of compensating injured patients. As PSRO becomes more effective a control on the outcomes of care than is malpractice, the other justification for the malpractice system—that it serves to compensate for injuries—will be subject to a much needed evaluation. Within the environment of quality review and control that PSRO will develop, a rational search for a system of patient compensation more equitable and efficient than malpractice can begin. It is therefore possible in the long term for PSRO to begin the demise of the fault system as a means of outcomes control and patient compensation.

The incidence of professional liability suits is related to but not a function entirely of the quality of medical practice. While the direct effect of PSRO on malpractice will be on those incidents which occur because of the poor quality of care, the general improvement in quality should lead, indirectly, to a decrease in the number of suits based on injury from other causes such as the inherent risk of diagnostic and therapeutic procedures.

The emergence of a malpractice system was probably inevitable and appropriate in the absence of any other effective way to police the outcome of health care and compensate those for whom the outcome was intolerable because of supposed or demonstrated irresponsibility on the part of providers. How well malpractice litigation served these purposes is highly debatable. But what is no longer debatable is that the system is in a state of near collapse and that reasonable and promising alternatives now exist.

With the advent of PSRO, another means of outcomes control is now available. And as PSRO becomes operational nationwide, I believe it will prove to be an efficient and effective system to control the quality of outcomes in medical care. Within the environment of PSRO then, malpractice as an outcomes control will have little reason to exist and its worth as a system of patient compensation can be examined.

Thus, it is within the environment of PSRO that other systems of compensation of the injured patient can be considered and developed—systems both more just and more efficient than malpractice. This is the greatest impact PSRO will have on malpractice. It is, of course, a long-term process and one which will not produce immediate results. In fact, the role of PSRO in effecting a change in patient injury compensation may never be recognized directly. But only with the existence of a working system of control of the quality of outcomes of medical care can the injustices of the malpractice system be righted and alternatives to that system come into existence.

Thank you.

Representative HASTINGS. Thank you, Dr. Ball. I'm delighted we're able to discuss, on behalf of the doctors, a totally noncontroversial subject, that of PSRO.

Before I introduce the next speaker, I would like, as a matter of procedure, to advise that we've had a lot of questions from people about having access to these entire proceedings. And I might advise at this time that we had contemplated and, indeed, will follow through. We're recording the entire proceeding. Those will be printed in a document and everybody who is registered at the conference will be sent a copy. That probably is going to take 1 month to 6 weeks to accomplish, but I can assure everybody that they will have a copy of the entire proceeding made available to them. I might say that document will serve as a basis for the Federal legislative approach, as a matter of fact, on malpractice legislation.

Our next panelist is Dr. Rubsamen who will discuss arbitration.

Dr. RUBSAMEN. Everything we have talked about at this conference, and what we have read in the newspapers for the past several months, cries out for an answer to the question, How do we rationalize the system? Now you've heard from previous speakers about vitally needed reform in the method of paying future medical costs to the injured patient. For example, take the patient in southern California who received a $1,400,000 jury verdict. The jury gave him little over $500,000 for his future medical costs. If he dies in a year, then the heirs experience a windfall. So the structured medical settlement, the payment for future medical costs on a month-by-month basis, is one of the necessary rationalizations of the system.

You've undoubtedly heard about the issue of collateral sources of income. In most jurisdictions, the plaintiff can keep from the jury the

fact that he may have catastrophic health insurance which will pay for his future medical care for the rest of his life. In a severely brain damaged individual, that amount of money can be very large. But the jury doesn't know about it. So the patient has, in essence, a double recovery; one recovery from his insurance company; another recovery from the jury. These collateral sources of income must be exposed in a rational system and the law should bar subrogation. Thus the expense will be spread throughout the insurance system. This is probably the most essential of all reforms if malpractice insurance rates are to be kept within reason.

The contingent fee arrangement is a very sore point. When I speak to lawyer groups especially, I mention a prominent California law office which settled two cases, before trial, last fall, back to back, within 6 weeks of one another. In each of these cases the negligence was quite obvious. The indemnity was $1,200,000 for one and $1,800,000 for the other. That law firm collected between the two cases something over $850,000 as a contingent fee. Does this not describe an irrationality in the system? A preservation of the contingent fee I think is rational but adjusting it so that it will not bring such huge windfalls is also rational.

The contingent fee system, when first conceived, was never intended to give that sort of award to the plaintiff's attorney. The contingent fee system arose in a time when a $50,000 jury verdict or out-of-court settlement was a large award—$100,000 was a huge award. A quarter of a million was enormous. We now are at a point where in the United States we've had something like 35 cases where the award was $1 million or more. In California alone, we've had 18—13 of them within the last 27 months.

Another rationalization of the system is to eliminate the jury; and that's where arbitration, which is my subject, comes in. Within the past 12 to 18 months, an additional motivation for going to arbitration has occurred and I'll mention that after I describe arbitration to you.

Arbitration is provided for by statute and about 32 States in the United States have arbitration statutes, most of them following the outlines of the model arbitration law which itself was modeled after California's statute which goes back 100 years, and has been revised, of course, two or three times since then. The arbitration arrangement is a contractual one. The patient must agree to it; so, obviously, it's best suited to large medical groups. For example, Southern California Kaiser has arbitration contracts with the approximately 900,000 patients it serves.

The arbitration arrangement is an alternative to the court system. It is a true alternative. I'm not talking about screening panel arbitration. I'm not talking about some system where both sides give their stories to a neutral body which merely recommends settlement. Binding arbitration is a complete system. In a few States there is a provision for a trial de novo after the arbitration, but in general the arbitration is the end of the line. There is an appeal if there's been fraud or coercion or duress and so on, but the scope of appeal is sharply limited.

Arbitration proceeds in this manner. The plaintiff goes to a lawyer. In California, which has had by far the biggest arbitration experience in the United States. The lawyer then often goes to the superior court,

not being aware of the arbitration contract, or if he is aware of it, thinking he can get around it. The superior court then directs him to the arbitration forum. At that point, arbitrators are selected. The arbitration contract can provide for one arbitrator, commonly it will provide for three. Each side chooses an arbitrator. They, in turn, have to agree on a neutral arbitrator.

The time limits for selection of the arbitrator, getting to the hearing, and so on are usually set out in the arbitration contract. However, in the experience of California's Ross Loos Medical Group, a clinic with about 130 full-time doctors, it's not uncommon to have these time limits extended a year or 2 years or so before the case is actually arbitrated. But on paper, it is possible to push this arbitration very quickly to a hearing.

In the arbitration hearing itself, the procedure is fascinating. I have been an arbitrator chosen by Ross Loos.

I have so far arbitrated one case. This was a case involving an alleged delay in diagnosis of a bowel cancer. It was a case which certainly would have taken 7 or 8 trial days. In 1 day we cut through all the detritus and got to the issues very quickly. The neutral arbitrator was a retired, very experienced judge, and he kept things going very smoothly. By the end of 1 full day, we had virtually completed the hearing. We were set for one more half day which would have completed the arbitration, and at that point the case was settled.

The arbitration system, it seems to me, has a potential defect which could be a serious one. The parties have to agree on the neutral arbitrator. And experience has shown there can be a lot of pull and haul over that selection. California's statutes and a number of State statutes provide that if there is a logjam on that issue, then the superior court judge will give the parties five names. They must agree on one of the five names, or the superior court judge himself will appoint the neutral arbitrator. I suppose theoretically one could simply agree to the American Arbitration Association providing the arbitrator, and I think for smaller cases that possibly would work. But this is a big problem.

It has led many people to say that if you want to rationalize the system by eliminating the jury, why not go to specialty judges? There is precedent for this in bankruptcy and patent courts where the judge sits without a jury. This approach has the advantage that, being in the public sector, it is not an expense to the plaintiff.

Why eliminate the jury? The question has always been answered by doctors that juries know little if anything about medicine. So their visceral response has been, "We really would do better without a jury." But in practice, in a high malpractice incidence jurisdiction like California where our claims incidence is now approaching 25 percent, the defense has found that more commonly than not the juries seem to benefit the doctors. Nevertheless, I think we're experiencing a change.

This change has been dramatic in the past 12 to 18 months. Let me give you just a couple of minutes of historical background. California's "fully matured experience" proves, I think, that active malpractice litigation is preceded by an occasional plaintiff's jury verdict, involving very obvious malpractice, where there is an error of commission; this is where California was back in the early 1950's. The plaintiff would also occasionally recover where there was some par-

ticularly egregious error of omission. Then more and more errors of commission came into court, more and more verdicts were returned against doctors. But we still didn't find more than a rare plaintiff's verdict involving errors of omission until the middle to late 1960's. These are usually judgmental errors and as the malpractice situation has further evolved in California, we have found that these judgmental errors involve increasingly complex medical issues requiring very refined presentation of medical evidence. In such cases testimony by plaintiff's expert witnesses often involve discussion of some highly esoteric topics relating both to standard of care and causation issues.

If I had the time, I'd discuss two recent cases, one of them was settled for $600,000 and the other went to a jury verdict. The award was $200,000. It involved an inflamatory carcinoma, the most malignant type of breast carcinoma, where the delay in treatment, because of the delay in diagnosis, could not have been more than 7 or 8 weeks.

So, to make a long story short, in the past year to 18 months in California we are seeing an increasing number of cases where, on the negligence issue, juries are applying very high care standards and, in my opinion, dealing with topics which they can't possibly understand. Perhaps equally important, they are dealing with causation issues of extraordinary complexity. This leads me to conclude that when you get to the point in the maturation of malpractice litigation in any jurisdiction where judgmental errors involving complex medical treatment are becoming the topic of litigation, you have a good reason for going to an alternative system of fact determination. So the "rational system" then requires either binding arbitration or specialty courts.

Now this is not a disadvantage to the plaintiff. The final point I would make is this: It seems to me very unfortunate that the consumer-oriented people on the HEW Malpractice Commission in 1972 regarded binding arbitration as somehow a plot on the part of the defense to deprive the plaintiff of his rights. Nothing could be further from the truth. In the majority of jurisdictions today, even with the increased claims incidence throughout the United States, it is still difficult for the plaintiff to win a malpractice action. There are several impediments in his way. In some jurisdictions it is the difficulty in finding expert witnesses for the plaintiff. In other jurisdictions, and especially in rural areas, juries definitely favor doctors. Going to a binding arbitration or specialty court system would put the facts in the hands of a trier or fact who would be more objective. This objectivity would favor the doctor in our California situation, which has gotten so far out of hand, but this same objectivity in determining fact issues would greatly help the plaintiff in jurisdictions where malpractice litigation is in an early stage of development.

If, having rationalized the system, we still find it too expensive, we may have to talk about limiting payment for pain and suffering and limiting total payment to the patient. Certainly in California a legislated limit of $500,000 for personal injury would be greeted with delight by the defense. That's how far we have gone down the road toward a system which I'm afraid soon will not be capable of being financed.

Thank you.

Representative HASTINGS. Thank you, Dr. Rubsamen. I particularly want to thank you. I know the unfortunate experience that you went through to get here—that red-eye special from California. For those of us who were here, it was a little more convenient. I recognize the additional effort on your part. I very much appreciate it. You are in a unique position, I suppose,to gain objectivity being both a doctor and a lawyer. The only question is I don't know whether it's better to be both or neither.

Dr. RUBSAMEN. It's better to be a Congressman.

Representative HASTINGS. We'll debate that sometime, too.

Our next speaker is Dr. Joseph Sadusk who will discuss emergency short-range approaches. We're certainly looking for the short-range answers right now.

Dr. SADUSK. Thank you.

That a major crisis has developed in professional and hospital liability insurance coverage is no longer a matter of speculation. It is a fact and, indeed, is the subject of this conference.

In 1897, the famous William Howard Taft said:

> A physician is not a warrantor of cures. If a failure to cure were held to be evidence, however slight, of negligence on the part of the physician or surgeon causing the bad result, few would be courageous enough to practice the healing art, for they would have to answer financial liability for nearly all the ills that flesh is heir to.

We have now arrived at that point; namely, liability without fault, in many of the judgments awarded against physicians. Not only has the number of cases multiplied beyond all expectation, but so also has the size of settlements paid, and judgments rendered. In 1962, I said to the International Medico-Legal Society: "Settlements and judgements toward and in the six figures are no longer a rarity". I must now say, in 1975, that settlements and judgments toward and in the seven figures are no longer a rarity—certainly as far as California is concerned. Such an escalation in indemnity is almost beyond belief.

The many factors involved in producing malpractice claims lead me to believe that the continuing rise in claims during the 1950's, 1960's, and especially the 1970's will not abate until the present legal and court handling of cases is changed. As far as professional factors are concerned, it may come as a surprise to you that the age and sex of the physician and his or her training and qualifications have relatively little to do with a substantial part of the malpractice hazard as demonstrated in my California studies a number of years ago. This means that we must look also to other factors. Consequently, drastic changes to correct these other basic factors must be immediately instituted through appropriate legislation:

One: The present court system for handling malpractice claims before an unqualified lay jury needs to be replaced by a compulsory arbitration or commission approach, utilizing boards of qualified medical and legal experts. Such boards should have the authority to determine whether or not malpractice was committed and, if it was, set a just and equitable award. By this method, the hearing time should be in days, rather than weeks as is the case with the adversary system trial before a jury. This in itself should substantially lower the cost of defense, and should bring an end to the case in less than a year after the claim is filed.

Two: Awards of substantial size made to a plaintiff should be set up in trust and paid out annually, rather than in a lump sum and, of course, terminated when the claimant recovers or dies, or when there is a change in status of a plaintiff, such as spouse or child.

Three: There should be a reasonable limit set on the level of awards. Awards now being made in seven figures cannot be justified, realizing that they are not taxable. This fact should be explained to the jury.

Four: The statute of limitations should be redefined, setting a realistic period of time after the injury for filing a claim. This will lead to a more accurate actuarial determination of premiums and should solve the "long tail of malpractice insurance" problem which now exists. Certainly, the "claims made" insurance approach now being proposed by some companies is not a solution. Such an approach protects the company but not the doctor who may face financial ruin years after a policy year. Further, it also may not protect the patient.

Five: The present contingency fee for the plaintiff's attorney should be replaced by a fee-for-service or a sliding scale contingency fee. There is absolutely no justification for a contingency fee which takes 30 to 40 percent out of a $100,000 or greater award for an injured patient.

But while it is possible that some or even all of these corrections may be accomplished, let us not delude ourselves into believing that the changes will occur quickly. Assuming that such changes must be legislated at State level, the process may take years.

In the meantime, heavy losses will continue and either the physician or the insurance carrier will have to bear the burden.

The extraordinarily rapid escalation in costs of malpractice insurance over the past 4 years have led to proposals for premium levels that are unrealistic and impractical. The doctor simply cannot absorb under his cost of doing business those proposals for annual premiums as high as $20,000 and even $40,000. And there is no way in which the insurance carrier can absorb such losses if premiums are lower.

This must lead us to the inescapable fact that, during the next several years, neither will doctors be able to afford the cost of premiums calculated on a sound actuarial basis, nor will the insurance industry be able to absorb the losses in defense and indemnity paid out if premiums are offered at a practical level. Clearly, a system must be devised to pick up this probable deficit. We need to maintain the insurance carriers in a financially viable condition.

One of the solutions proposed to date is to pool the assets and losses of carriers at State level. This may be partially effective in that no one insurance company might suffer a severe loss; however, the suggestion that catastrophic losses going beyond the level of the insurance pool should be distributed among other lines of casualty insurance is not practical. And yet we must continue to have malpractice insurance to protect the patient who suffers injury and disability through negligence and at the same time we must protect physicians against financial ruin.

Therefore, it seems to me that this is a matter which should be handled at national level in the public interest during this interim period. I should like to propose that the Federal Government, through appropriate legislation, take the following steps:

One: Declare the field of professional and hospital liability an uninsurable risk, until otherwise redefined at a later date.

Two: Establish under the Department of Health, Education, and Welfare and reporting directly to the Secretary thereof, a Commission on Malpractice Reinsurance to protect the insurance industry against catastrophic losses in much the same manner as has been done for the potentially catastrophic fields of atomic energy explosions and floods. In the public interest, there should be no premiums for such reinsurance.

Three: That such excess risk coverage be effective for a period of not less than 5 years, nor greater than 10 years.

I realize that the private insurance industry and others, including myself, may not look kindly toward Federal Government intervention; however, what I am proposing is a temporary and brief measure in the public interest and one which would be phased out as soon as the basic problems of malpractice are corrected and malpractice losses have stabilized. My proposal could be implemented at State level on a pooling of companies, or it could be developed at national level on an individual company basis. In either case the Government would come in only when losses exceed a specified loss ratio.

Assuming that the average acceptable loss ratio for malpractice insurance is about 0.67, or 67 percent, the Commission would assume losses beyond a loss ratio of 1.00, or 100 percent. At this point, namely, a loss ratio of 1.00, the company would have lost 23 percent, thus giving it an incentive to keep losses at as low a figure as possible. On the other hand, the company would be protected against a catastrophic loss which it otherwise would begin to assume when the loss ratio exceeds 1.00.

And finally, basic to this proposal for interim action is the point that premiums for doctors and hospitals could be set at a practical level after taking into account what an actuarial analysis would ordinarily prescribe.

I hope our panel will give consideration to my proposal, the description of which has been necessarily brief, and will enter into an in-depth discussion on the pros and cons of the plan.

Thank you.

Representative HASTINGS. Thank you very much, Doctor. I can assure you that we will give every consideration to your recommendations. I might suggested a caveat when you suggest the Federal Government and Congress pass legislation that will be temporary in nature. It has been my experience that very seldom do we put a law in the books that ever comes off the books.

I'm going to recognize from the floor now Mr. Melvin Stark. Mr. Stark is a senior vice president in charge of Government affairs for the American Insurance Association who has some suggestions from that industry as it relates to this problem. Mr. Stark is both an attorney and former claims adjuster dealing with malpractice claims for many large insurance corporations. Mr. Stark.

Mr. STARK. Mr. Chairman, ladies, and gentlemen, first of all, I'd like to express my appreciation to you, Congressman, and to your staff for my late request of just a few days ago to appear on your program because I thought we had something to offer that was rather concrete and beyond the field of rhetoric or review or rehash which

has been so much the part of many of these meetings of the past years.

I see around here in the audience a number of people that I've participated with in all the discussions where we thought there was a crisis 6 years ago, 4 years ago, 3 years ago. But the crisis is real now. The crisis is accented. The crisis takes on several dimensions; and I'd like to very briefly tell you what my trade association, the American Insurance Association, is doing to cope with the issue at the present time and how it has broken down its approach to the issue in the interest of trying to bring the solution, both interim and final, about at the earliest possible moment.

We have a standing subcommittee on medical malpractice in our organization that deals with the subject and has dealt with the subject for many years in its more routine and ordinary aspects. We also have created a special subcommittee on medical malpractice which now is about 7 or 8 months old. And the two subcommittees are dealing with this subject on a coordinated basis, short range and long range. Just within the last 10 days or 2 weeks, we have come up with some concrete proposals; and I'd like to tell you about them because we think they're constructive and they offer a way out of a dilemma, short range and long range.

First of all, let me tell you about a proposal that we've constructed in the form of a model bill ready for introduction in all States at the present time that would set up a joint underwriting association, a pool composed not only of writers of professional liability insurance but of all writers of personal injury liability insurance which includes even writers of automobile insurance who have never been in the malpractice field before. This bill recognizes, of course, at the outset that any effort to create a pool made up only of malpractice insurers means that you're going to deal with a very little sum of money in terms of premiums.

Historically, the medical malpractice field has been a narrow field even in its halcyon days of 25 and 35 years ago. There were very few companies who dealt with this subject. And today most of the companies who deal with this subject happen to be members of my trade association. To mention a few major ones, Aetna Life & Casualty, Hartford, and Travelers, St. Paul, are the companies who are keeping the malpractice insurance business going right now to a great extent. I don't mean to exempt or except a number of independent unaffiliated companies on a regional or national basis who are not members of our organization or involved. But the point is that our companies are major national writers, and we have the solution of a joint underwriting association.

What are the very major elements of that bill? First of all, that it had a termination date of 2 years. Second, that it be exclusive in each jurisdiction. That it actually displace and replace the voluntary market completely for that 2-year period. It means that any health care provider, doctor or hospital, will be in a position to get insurance and that the escalating withdrawals from the marketplace of a number of insurers at the present time will be halted immediately.

The bill calls for a readjustment of the rating structure. Obviously, it will not go downward. It will go upward in a number of jurisdictions. In other jurisdictions, it may just be stabilized. It may call for a

new type of rating plan for more equitable distribution of premium among classes. It will call for a contribution by doctors themselves into what we call a stabilization fund so that, for instance, a doctor is paying a $3,000 premium, he will be asked to contribute to a stabilization fund in the nature of an escrow fund that will be handled by this organization under the jurisdiction of the insurance commissioner. He will be asked to contribute one-third of that premium as his personal contribution to this fund. And the reason for it is rather simple and is really a self-damaging statement. The actuaries find themselves unable in the face of what has happened in the last 2, 3, 4 years to cope with the projections necessary to deal with an adequate rate structure. The stabilization fund is an added fund that this bill calls for that the doctor is to put up and in the aggregate can serve as backup should the initial rate itself not be sufficient to take care of this 2-year situation and the rate structure during that time.

It's a bill that's novel. It's a bill that's born of desperation. But it's a bill that has as its tradeoff feature to the medical profession, to all health care providers, the fact that you will be certain to get insurance coverage. That we must give it to you. The price arrived at will be subject to the supervision of the insurance regulator of that State. We will have to make a case out for the price. We will be able, of course, to talk about our problems with the rating structure.

You're all familiar, goodness knows, by this time with the long tail. You know that in the nature of the loss development feature that only half of the losses show up within the first 5 years. This has all been documented. The rest of the losses show up some time later, whether it's 5, 10, or 15 years later. This is a problem that we find so difficult to cope with even with the crystal balls that the actuaries have to use sometimes.

So we have a problem facing us, and we've proposed this as an interim solution, not a long-term solution. It's one of the three facets of our big problem right now; one, availability; two, price; and three, reform.

Let me come to the second part of this particular bill. The bill also calls for in another section the establishment of a medical malpractice study commission in that State, a group to be appointed to sit down, to come up with some answers. Those answers would not necessarily be binding, but they would be a point of departure for legislative action. We hope to proceed on a State-by-State basis, but we do not rule out the possibility that the only way to cope with this crisis may have to be on a Federal basis. We have, however, taken no position in favor of Federal legislation at this stage.

Our executives will be testifying at the future hearings next month and will make our position more clear on this particular point.

In terms of the third facet I spoke of, that long-range solution. We talked about no fault. We talked about a restructuring of the entire situation. We've talked about many different new ways of compensating the victim of the medical mishap. We've used many words and many semantic exercises in trying to describe this issue and avoid the term "negligence." I don't know whether we ever can.

But I'm convinced standing here, as many of you are convinced, that we cannot continue under the present system of compensating victims of medical mishaps. It won't fly. It's going to be too costly.

So our long-range objective, hopefully within the next 2, 3 years at the outside, is with the help of a multidiscipinary force working in our own industry, working with doctors, working with lawyers, working with governmental officials and public advocates to come up with some new approach to this whole method of compensating the victim of the medical mishap.

We happen to be the primary and most outspoken and vigorous advocate of no-fault in the automobile insurance field. We originated it in the insurance industry. But we recognize that no-fault as no-fault in this field can't exactly be handled in the same way. That's why I found some of the remarks of the previous speakers to be rather interesting in terms of the perimeters of a situation to treat medical mishaps that can't exactly go quite as far as auto no-fault.

The first thing that comes to my mind based on my own pragmatic experience is the field, based on my heavy involvement in the automobile no-fault issue is the fact that I don't know whether we can put any number on no-fault in the medical mishap field. To me, it's a blue sky item. You just can't cost it; and it may be, literally, an uninsurable venture. It may be, literally, the sort of thing that only Government can be the last insurer for or the insurer of last resort.

This, in brief, is the message I wanted to bring to you. We have, of course, in mind the same sort of things that come to your minds, the need for taking steps in the civil procedures and the negligence field. Something has to be done about discovery. Something has to be done about the statute of limitations. Something has to be done about the contingent fee. Something has to be done about collateral source rule. Something has to be done about the capping situation which Mr. Segar spoke very eloquently about as part of the Indiana bill.

The Maryland bill in principle is much the same. We've been very interested in the novel approaches those bills have taken because in effect a medical malpractice commission approach is something that we're dealing with right now on a preliminary basis as a possible long-range approach to this issue. That may prove to be the most practical and the most sensible way to deal with this issue to avoid the blue sky numbers, to avoid the total runaway situation that we're faced with presently.

In conclusion, our companies have made the vital decision that they'd like to stay in the marketplace. They don't want to turn this over to Government. They are against State funds. They're for joint underwriting associations. They recognize the joint underwriting association bills and reinsurance facility bills have been introduced in certain States that are not compatible with the bill that we have here as a model.

This bill, incidentally, will be widely distributed within the next week or two by our regional offices to all governmental authorities in many of the States in addition to the distribution that's going to take place here among your leadership.

But we are willing to reconcile these other measures whose principles are basically the same as ours with ours. But we want to call attention to the fact that a joint underwriting association or a reinsurance facility for health care providers has to have a certain exception, a certain cutout area, that doesn't exist in the field of automobile insurance where we subsidize those who are in the involuntary marketplace.

We don't think there should be a subsidy for health care providers. We think health care providers are in a very good position to take care of this situation because of their economic status. So we will fight in every State efforts to subsidize doctors and health care providers in any joint underwriting facility.

We hope that the States will accept the stabilization fund. This is a novel approach. It makes the doctor, it makes the health care provider, a part of the action.

In terms of this facility, it is exclusive with respect to the practitioner. By the practitioner, I define it from doctor down to the nurse level. It is not, however, the exclusive facility in terms of the hospital. It will be a backup facility for the hospital. There will still be a voluntary market, we believe, for the hospital; but for those hospitals unable to secure their coverage in the voluntary marketplace, there will be this particular JUA available to hospitals, too, at an appropriate price.

This is essentially what we have to offer. I think it's of value because it's documented, it's been synthesized in terms of a general overview of what the American Insurance Association as a trade association has come up with. There's a model bill available that our staff in seven regional offices will promptly begin working with at the State level. And we hope that when this is brought to your own attention, you will find in it enough value, enough palatability, enough in the way of an interim solution, at least, while we work on the long-range solution to the problem that it will be a method of dealing with this immediate, recognizable crisis of availability.

That is No. 1 right now . . . availability. We want to be sure that you have insurance coverage. Hence the construction of a joint underwriting association as a pooling facility to deal with the issue of coverage, to deal with the problem of public involvement, to deal with the problem of the doctor being able to practice without fear, and to deal with the manner of controlling to some extent, at least at the outset, the possible rise in the price of patient cost and in the very nebulous but very real issue of defensive medicine practice. All of this has impact in these areas and we hope that in our fashion, working together with many of you, making you understand the issue better as the weeks pass, that we will be able to pass a number of these bills this year while legislatures are still in session and alleviate the current immediate crisis of availability.

Thank you very much for your time.

Representative HASTINGS. I thank you very much, Mr. Stark. Your contribution is well recognized.

We're going to have a brief time for some questions and I would appreciate it if we could keep the answers as brief as possible to allow the consideration of as many questions as possible.

The first question is for Dr. Ball. You are concerned with PSRO's which are designed to review the quality and appropriateness of health services provided to persons covered under the Social Security Act. I wonder if you might describe the relationship you might see as possible and effective between PSRO's, licensing boards, and organizations collecting information of medical malpractice incidents as a way of improving the quality of medical services. What problems and conflicts do you see relative to any possible relationships that have been or might be proposed?

Dr. BALL. Presently, what the legislation is designed to do is as the question states, to review the quality and appropriateness of certain health services, those to the beneficiaries of Federal funds in inpatient facilities. And there is nothing in the legislation, which is what those of us administering the program have to go by, that would mandate the sharing of the information on outcomes of care by the PSRO with the State licensing boards. The possibility clearly exists as a possibility. It is not now in the legislation, however.

The question, though, does point out that there is a relationship between the various portions of care; that is, the outcome of care, the process of care, and the input of care—the input of care in this case being the license. The question itself does indicate that there is a possibility for that sharing to take place. I don't know of any particular proposal that goes to that at this time, however.

The Kennedy-Inouye bills, S. 215 and S. 482, do mandate that a person who would go into the no-fault insurance program must allow his services to be reviewed by the PSRO, not only his inpatient services but also his outpatient services, and also have his qualifications come under a national system of licensure . . . not national licensure but national standards of licensure. His system therefore, has proposed that there be some interrelationship between PSRO and the licensure process.

Clearly there are problems in this area, but at the present time the legislation does not mandate that the program do this.

Representative HASTINGS. Thank you. I might say that for those questions we will not have time to answer; we will distribute them to the panelists and those questions will be answered in the final report that will be printed.

Dr. Rubsamen, the question. In addition to legal rules and doctrines, how can the present court system be modified to make the claims process fairer, cheaper, and more beneficial to the injured patient? And I might add to that, quicker.

Dr. RUBSAMEN. Any system which goes to a very sophisticated trier of fact will do that. If you have specialty judges who are experienced in this field, if the—although I feel very ambivalent about this. Many plaintiff's attorneys say, "Why not have textbook evidence admissible so that in those jurisdictions where there is difficulty in finding an expert, the textbook will substitute for that?" And to the response that you can find anything in textbooks, they would say, "Well, go to a certain set of textbooks which are approved." Then anything in addition to that that you'd introduce, the judge would have to permit. As I say, I feel ambivalent about it. But the rational system is a system which benefits the patient both from a standpoint of speed and fairness, I do believe.

Representative HASTINGS. Thank you. Mr. Segar, did the local and State medical societies have an input into the Indiana legislative proposal and how much support was given by those societies? It sounds like a loaded question to me.

Mr. SEGAR. And the answer is yes and tremendous.

Representative HASTINGS. I get more respect for Indiana all the time.

Dr. Ball, have you had any evidence that PSRO has, in fact, improved the malpractice situation? If not, would it be better to wait

until PSRO's prove themselves before tying them into the malpractice problem?

Dr. BALL. There is, of course, no evidence at this time that PSRO's have affected the malpractice situation simply because there are no operational PSRO's. We're still in the phase of having conditional PSRO's and planning PSRO's.

As far as waiting until comment is made on the potential effect of PSRO on malpractice, I think that what I tried to make clear in the presentation is that PSRO has the potential, the possibility, for creating an environment in which alternatives to malpractice may be considered. Certainly no promises are made that PSRO is the solution or sole solution to the malpractice problem.

Representative HASTINGS. I thank you. Dr. Davis, have you witnessed in your trustee role any attempt to approach viable alternatives to current malpractice insurance coverage through a larger international organization such as Lloyds of London?

Dr. DAVIS. The answer to that would be no; I'm not aware of any such international effort.

I am glad to get the microphone because there was a very important story that came to us in regards to risk control. Larry Hoffheimer who most of you have met I think as counsel for the AGPA was having a physical examination in a doctor's office. Not a member clinic, I might add. But this is a prime example I think of the awareness of risk control. They had him on a treadmill and he was galloping along at a pretty good speed. He had gotten his heart beat up to around 160 and he was beginning to puff and pant a bit. Out of the corner of his eye, he noticed that the nurse was holding up a piece of paper so that the doctor who was conducting the study could see it. He glanced over his shoulder to see what it was; and the note said, "He's a lawyer."

Representative HASTINGS. Thank you. Dr. Sadusk, why should the Federal Government subsidize the failures and inadequacies of the insurance industry? Your proposal simply guarantees insurers against loss which more than likely will be based on the insurers figures. The Federal Government is going to assume the risk, and it is they and not insurers who should keep any profits, which, should they exist, could be rebated to the providers. Comment, please.

Dr. SADUSK. There are many facets to this question but let me attempt to answer it simply. First, I don't believe our present situation is the fault of the insurance people. I believe they've done as good a job as they can. Second, I pointed out that the Government would only come in temporarily and the bill can specify what date such Government coverage is phased out just as in the case with atomic energy explosion coverage which goes out in 1977. Such coverage began in 1954. But I see no one else to cover the tremendous bill that doctors are going to have to pay for the next several years. And I don't believe it's fair to make the doctor pick up the tab in the public interest. I can think of no other person to carry out this subsidy for several to 5 years other than the Government. I might also add that, with the exception of the fact that the Government certainly should look over insurance figures if a company reaches a high loss ratio for verification, I don't believe the Government should monitor malpractice programs.

Representative HASTINGS. Dr. Rubsamen.

Dr. RUBSAMEN. I wanted to comment that part of a rational system extending the logic may well to turn out to be doctor-owned insurance companies. To add just a word perhaps in support of the obvious bias of the questioner, there is good reason to believe that it is not just the claims incidence and severity which caused a malpractice crisis in coverage in the fall of 1974 coincident with the lowest point in the market in some time. It's a rather technical point but it's a very important one. I do have some copies of my newsletter, perhaps not enough to go around. I wrote a special issue covering some of these aspects and I touched on that. I'll leave them here if some of you want to read it. But it's rather more complex than just the matter of the obviously increasing claims incidence and severity. That's true; but I think this other factor may be very, very important.

Representative HASTINGS. Thank you. Professor Havighurst, is retaining the issue of negligence in determining awards for medical injuries an important and effective means of retaining accountability and does the threat of malpractice improve the quality of health care?

Professor HAVIGHURST. Well, I don't think anybody knows if the threat of malpractice is of very great value in that regard. There's some reason, I think, that it has some value. But if doctors think of the law of malpractice as being rather random in its incidences . . . . that is being sort of like lightning strikes here or there but nobody knows when or why or how or can't explain it, I would suppose then they wouldn't regard it as all that substantial a factor in their decisionmaking. Moreover, I don't think they understand the law of malpractice very well. The defensive medicine notion suggests that. They do things that the law doesn't necessarily require that they do.

I guess I would say on balance that yes, I suppose that the net effect is probably beneficial. To do away with it by substituting a no fault system paid for by some other source would, I think, be dangerous. We would lose the incentive values that the present system has. Even though I don't think those values are great or moreover I think they could be greatly improved, I would like to retain the notion of provider payment for the insurance coverage that's provided.

Representative HASTINGS. A question to Mr. Stark. Isn't the stabilization fund a subsidy by the doctors for the insurance industry?

Mr. STARK. No, let me explain that because I didn't explain it very well at all. The premium that the company would collect from the doctor, the heath care provider, would be put into the company's reserves to be held for the payment of losses in aggregate whereas the money in the stabilization fund would be held separately. The money in the stabilization fund would be called for only in the event the premium was insufficient to take care of the losses. And the investment income from the stabilization fund would remain with that stabilization fund and would always be for the benefit of the doctors, not for the benefit of the insurance companies. In total, the novel proposition that we offer here of this contributory arrangement is that we don't regard it as a profit venture in that 2-year test span. We see it completely as a nonprofit program. We don't expect to make any profit out of it and we don't expect to ask the kinds of premium increases that would indicate profit for the insurers. One time contribution per premium . . . . in other words, per year.

I'm reminded that all investment income from the reserves plus the investment income from the stabilization fund will flow to the stabilization fund, even the investment income from the reserves in the hands of the insurance company.

Representative HASTINGS. One final question and this one is open to anybody who cares to comment——

Mr. STARK. Investment losses, too.

Representative HASTINGS. One final question. This one anybody is free to comment on. Would anyone care to comment on the effect patient access to medical records will have on the number of malpractice claims?

Mr. SEGAR. Free access to medical records which automatically then become available to plaintiff's counsel will, of course, make the bringing of law suits more possible and increase frequency. One of the things that Mr. Ball and his group ought to consider in connection with the implementation of standards in PSRO's is that our experience has been like with standards established by the Joint Commission on Hospital Accreditation, that once standards are established, they are ready material for the plaintiff's lawyers in proceeding against anyone who does not meet those standards or, in fact, might even disagree with the standards. One of the problems in PSRO's if the records are readily available, is going to be whether that information is going to be a source for the very alert—and I'm sorry that Bob left—but the very alert, competent, increasing ability of the plaintiff's lawyers who are bringing these lawsuits. And the direct answer which was not as good as my last one is "Yes."

Representative HASTINGS. Does anybody else care to comment on that question?

Dr. BALL. I feel a bit compelled to comment when the question is raised as it has been in a number of locations that the standards, norms, and criteria of the PSRO may be used against physicians and may, because of that, increase the incidence of malpractice litigation. We don't know whether that will be the case or not. There's not been enough experience yet certainly for us to know whether that will be the case.

I think first of all, there is a threshold problem. In some States it may be that the standards may not be able to be introduced in evidence, being only general guidelines of care and not specific to the particular case. In the second instance, the guidelines or standards of care are only screening guidelines; that is, at a low level and not guidelines as to what the standard of practice should be. There is a difference between screening guidelines and guidelines as to the standard of practice. There is therefore a threshold problem whether they will be introduced into evidence.

Even if introduced into evidence, however, the standards will act as only one piece of evidence of what the standard of care in general would be. Other pieces of evidence would come in. And I think that the civil immunity provision of the PSRO Act tends to limit usefulness for plaintiff's counsel of the standards that the PSRO puts forth.

Representative HASTINGS. Thank you. Dr. Sadusk.

Dr. SADUSK. I'd just like to make one brief comment and this relates to Dr. Ball's remarks. While the PSRO reviews may be based on so-called guidelines, my experience as a medical director for the FDA

back in the middle 1960's would be quite different. We started out with the package insert as a flexible guideline but any defense attorney who appears in court now knows how that package insert is interpreted as a directive. And if the doctor begins to depart from that package insert, he can be clobbered. I've seen it again and again.

Dr. BALL. I'm sorry, but my final statement for clarification would be that the legislation specifically addresses the subject of the usefulness of the guide lines as far as a particular case goes. Both the legislative history and the legislation would say that the physicians may use the guidelines as a defense in the case in which he follows the guidelines but that no presumption is raised against him in the case in which he does not follow the guidelines. This is an important distinguishing feature between PSRO guidelines and drug package inserts.

Representative HASTINGS. Thank you. I know we could get into a discussion of PSRO's if we wanted to.

Dr. Ball, it becomes obvious that you know something about the Federal processes, don't you?

That's not a putdown, Dr. Ball, believe me.

I think probably at this point we'll consider adjourning. We're almost on time which is interesting in itself. I want to make a couple of brief announcements that one, there's a supplemental list of registrants available at the front desk, the registration desk. And that a news release from Senator Nelson who has introduced a malpractice bill as of today is available also.

And I want to take this opportunity to make a couple of comments. It may be my last shot at you before you leave. Don't forget to stay for lunch. Dr. Egeberg, of course, is the luncheon speaker.

A couple of problems have been pointed out to me that I think bear further investigation. One I think was most interesting. A doctor from Detroit this morning left a copy of a newspaper where the stories indicate that doctors who have been treating the indigent, the poor, for nothing are now being forced out of that kind of treatment because malpractice claims are increasing. And I think it is a matter that needs some attention.

The Secretary of the Army, Bo Callaway, a good friend of mine, pointed out that military doctors are being sued by members of the military whom they treat. They don't sue the Army, they sue the individual doctor. A military doctor, unless he's been in private practice, most generally doesn't have malpractice coverage.

It's another unique experience that we're seeing in this whole confusing area of malpractice. I might say too you ought to crank into your thinking, all of you, the impact and effect of national health insurance and what kind of a system of national health insurance we may finally adopt. And it is suggested that before this session of Congress, I don't believe this year, but this session of Congress, particularly with a presidential year coming on us in 1976, there will be certain people interested in passing a system of national health insurance. There are certain kinds of systems which have been advocated which would put the Federal Government in the total role of delivering health care and paying for it. This question of malpractice may become a moot question. I hope it doesn't move in that direction, but it's certainly something that you certainly ought to inject into

your thinking in anticipation of the solutions to the problems of malpractice.

I want to thank the members of the panel today. Your expertise and high quality speaks for itself. I won't try to elaborate on that. And I want to thank you people who have come and attended these various forums of the conference. The high quality of yourselves lends itself to the success of this conference.

Thank you very much and now we'll adjourn for lunch.

AFTERNOON SESSION

Dr. JAMPLIS. Dr. Roger O. Egeberg is, I am sure, very familiar to practically everyone in the audience.

Our guest today has the curriculm vitae so long that it's even hard to condense. He was dean at USC. He followed that very shortly by becoming Assistant Secretary for Health in HEW. As he only knows too well, in those two jobs, the half life is something less than that of uranium. So he quickly moved on after doing an absolutely superb job to becoming the Special Assistant to the Secretary for HEW, and a White House Assistant. He, probably more than anyone else, is involved in the malpractice scene. He runs all over the country testifying on our behalf in the malpractice field and, believe me, he has picked up the cudgel for us.

Dr. Egeberg, we are anxiously awaiting your words.

Dr. ROGER O. EGEBERG. Didn't mean to put coffee on your seat. [Laughter]

Anything to draw antagonism. Congressman Hastings, Dr. Jamplis, could use other names. Friends, I hope. I had to give a talk in Montreal yesterday morning, and I managed to go far enough to say, "Je ne parle pas francais." They laughed so damn hard, I couldn't even get over the English.

To sum up might take much longer than any of you want to stay around here, but I am optimistic enough to think that I could review a few things, and perhaps to a degree fill in on what you have heard. I'd like to talk about my optimism. I guess most of you know my nationality, and you know that people in Europe, at least, are supposed to have certain national characteristics. The Dutch are supposed to be pretty stubborn. The French are supposed to be you know, what and the Swedes, or the Scandanavians, are supposed to be optimistic and dumb, and it comes in handy a lot of times.

There was this plane coming across the Atlantic, and after it had passed that mystical point of no return, one of the engines blew up, just disappeared. The pilot came on the loudspeaker and said, "I'm sure you all noticed what happened to the No. 1 port engine. However, I want to reassure you that it won't disturb us in our flight to Kennedy. We'll get there, but we'll probably be delayed about an hour and a half." And people had just gotten relaxed when another engine went off, and the pilot came on and he said, "Now, wasn't that lucky. That was the No. 1 starboard engine that just went off, and puts us in perfect balance, and we'll get to Kennedy beautifully, but probably add another hour and a half to our trip." And the Sun started to set, and just about the time it got dark, there was this big flare and another engine went out. The pilot came on, and he sounded perhaps a little more hysterical, and he said, "We're going to have to seek a lower

level, but at a lower level we'll get to Kennedy, but it will add some more time to our trip." Whereupon this guy in the back part of the economy section scratched his head and he said, "Ola, I been tinking, if dat odder engine goes out, we going to be up here all night."

Perhaps both of those qualities implied in that statement apply to me, and therefore I will do a little talking.

What has HEW done about this problem? Well, when I was Assistant Secretary, they had a crisis in Hawaii which was settled by accepting a much higher premium, but at that time we thought maybe we were going to have to do something about it, and we did then create a malpractice commission, and Secretary Richardson and I picked what we thought was a very good commission, and sent it in, but we got the word from the then White House Committee on commissions that that wasn't the way you did it. You sent in 40 names and they picked the 16 or 17 they thought should be on it. We thought of 40 people that we would be delighted to see on it, but while we had had a balanced commission, the one they gave us had 10 lawyers and 14 doctors, and 2 of them were also lawyers. With lawyers the doctors are at a disadvantage at 1 to 1, so when they found themselves 4 to 10, they really felt miffed, and came out with somewhat of a different report, at least their exceptions made up thirty pages. The report had a lot of very good information in it which had not been brought together in one place before, but it did say that malpractice is not federal business, and it also said that there was no crisis. They didn't see one coming. All right, if there was no crisis and we had said, "Well, it may not be federal business, but let's do something about it." I wonder how many people we could have gotten to listen to us. It wasn't easy to get people aroused at that particular time.

My feeling is that the time has come to get something done about the malpractice situation, and it had not come a couple of years ago. Now, the issue, as I'm sure you've been told many times, is certainly complex and it is a State problem, and the only excuse we can give for coming into it is that we have patients in all the States, and should it get to an impasse in any one State where there was no insurance available, and the doctors couldn't practice, it would be our business. Also, it's becoming our business in a gradual way in inhibiting doctors from practicing in certain areas, and in making older people as they start to retire, retire suddenly rather than gradually. I know of three, no, it's now four or five friends, who had intended to gradually taper off their practice over a period of 5 or 6 years. They would have been happier, and I'm sure their patients would have been happier, but they stopped on the anniversary of their malpractice insurance. In Michigan, I don't know that young doctors can get insurance now. At least this was true a few weeks ago.

There is one other reason that I think will become increasingly important and probably increasingly apparent, and that is the cost. The premiums for the hospitals and the doctors at the present time are supposed to be in the neighborhood of a billion dollars, give or take a hundred million.

That is only part of the cost, and it's one that's apt to double. I heard on good authority the other day that Michael Reese was asked to pay a malpractice premium that would be around $10 a day a bed. This happens to the good hospitals, because they're the ones that are taking care of the difficult cases. They can't just say, "Well, you know, if

this fellow dies it won't appear anywhere, but if we mess it up, it will." So they accept these hazardous and difficult cases, and that is the penalty that they pay. If that's the premium now, one can expect it to be double that in another year or so. As you probably have heard, defensive medicine is entering the picture, and I don't know what kind of figures you were exposed to, but we've been trying to get a good insight into what defensive medicine might be costing, and there are people who look at it differently. There are people who have been studying it for about 2 or 3 years, and they have come up with criteria by which they judge it: the number of negative skull films, or the number of x-rays taken which were an inferior substitute for the doctors own judgment. This figure, as you may have been told, ranges from somewhere around $1 or $2 billion a year to $7 billion a year. Now there are others who go way beyond the 7 up to 18 and 19. But let's say that it's $4 billion a year, average it down there. When you add that to the premiums, you've got more money than we have for our whole health budget.

Our health budget doesn't cover medicaid and medicare, but it covers the National Institutes of Health, the Food and Drug Administration, the CDC, the Alcohol, Drug Abuse and Mental Health, Administration Health Resources, Administration and Health Services Administration. All of those administrations put together, the total public health service is costing us probably less right at the present moment than malpractice. So from that point of view, purely as a financial affair, it does become the Federal Government's concern.

All right. We are concerned. Now, what did we do? About 8 months ago, Charlie Edwards, who was then the Assistant Secretary for Health, and Secretary Weinberger decided it was time to do something about it, and asked me if I would sort of become the focus. So I went out, packed a bag and called on a lot of doctors. I called on a lot of insurers, including walking halfway to Wausau when the plane couldn't make it one night. I guess it was a bus trip, wasn't it? But we called on insurance commissioners, and we began to get some picture of the size of the problem, and then we had a meeting, and we though the people who needed the most moral support were the doctors, so we had them alone at first. But we had a very objective group of doctors, and they had seen the situation rather broadly, and felt there were three things that should be done. One, we should find some way to seeing to it that malpractice coverage would continue to be available. Two, we should get some facts, and apparently there are very few facts; and three, we should see what might be possible to do about changing the manner of pursuing a claim. And those are the three things that we have been after ever since.

So, we had a meeting with the insurance companies, underwriters, I guess, that cover 90 percent of malpractice insurance, eight companies, and with the insurance commissioners in the more affected States, and some of their representatives like Rawls, head of their malpractice committee, who just sneaked out of here, because he thinks he's heard what I'm going to say before.

And with them we had a small portion of that same group of doctors. Two things came out. One, they said this was the first time that they had all been brought together to discuss this at a reasonably

high level, and that, I suppose, is a frequent occurrence: and the second one was, this isn't your—the Federal Government's business; it's States business; we will handle it but don't go too far away. Now, we had that feeling ever since. Don't go too far away, but remember that you're stepping on our territory. Well, they were going to have a meeting in Dallas of the D–4 committee which Lester Rawls headed which was the committee having to do with malpractice, and they had asked a group under Warren Cooper from the insurance industry to come down and act as their adviser. And at that meeting a proposal was brought out much along the lines that Mr. Stark told you about just before lunch, and we also heard them say that they would get some of the information which we thought we needed. I may as well tell you what that is at this point.

We don't know the size of the universe of incidents, or injuries as they call them. We know that in the last year about 18,000 cases were closed in the malpractice insurance industry. We would like to know some of the medical facts about those cases that were closed. Chubb & Son thought that would be a good idea and asked Don Harper Mills to work out a questionnaire which could be answered. The best way I can explain this is that if you saw the résumé of a case that was closed, it would probably say, "Hematoma, $3,500; so much from surplus; so much from reserve." I don't know, but mostly financial information. We'd like to know was this some innocent woman walking down the aisle when an orderly came tearing around the corner with a gurney, and knocked her down. We'd like to know where the hematoma was. We'd like to know whether she rolled out of bed because she wasn't used to such a narrow bed as she got in the hospital. We'd like to know whether they thought she might roll out of bed, so they put siderails up, so she could fall farther and have a bigger hematoma. We'd like to know whether she came in confused and should have been put in restraints. You know, you're damned if you do on that, and damned if you don't. If you handcuff them to the bed, somebody will come in and say you're cruel and inhuman and all the rest, but if you don't handcuff them, the higher the siderails, the more danger, and the only thing I can think of is putting the mattresses on the floor, but that gets the nurses' backs, then you have more trouble on that score. Anyhow, I would like to know whether she was sedated and sedated perhaps too much so that she became confused.

You can see how all of those sort of put the blame in different places and make the incident a little different. If we can get that kind of information, we feel we will find groupings of incidents statistically supported that will give a lot of oomph to the case presentations the insurance companies have been putting out. As I gather it, and as I've seen, the insurance companies and medical associations will send out, "This is a story about Mrs. Zilch and her physician, Dr. Gefiltefish." And they'll tell of an incident leading to a suit but the doctor reading it will be sure it would never happen to him, and therefore he won't read it too far. Right now, I understand, the most frequent single cause of incidents that occur in internists offices are falls. If the internists knew that, I am sure they would tackle that problem and drive the incidence down to zero.

Well, that is one of the things that we hope to get. The next thing is how many things happen in hospitals? Did anybody talk about

that? I didn't think so. I have a few spies and agents here, so I've got some idea what we're talking about.

Virgil Slee, of the Commission on Professional & Hospital Activities in Michigan, who gets the reports of discharges—16 million discharges a year—can get some insight as to how many incidents occur. He estimates 6 million. Now, how many of those are utterly innocent that you should expect to have happen to you if you walk through the door of any building? How many of them are carelessness? How many of them are gross callousness? We would like to know. I have a feeling that he's in the ballpark, because I've visited a number of hospitals that have improved their own safety campaigns, and I've asked them "When you started to do this, how many incidents or injuries did you find you had a year, how many mistakes." And the figures they've given me when I extrapolated them to the hospital population or discharges in the country, come out in the neighborhood of 3 million. So, I would say it's the ballpark. We'd like to know what they are. We think that there are a tremendous number that are just things that people should have to accept.

The newspapers have given a lot of false ideas that if you go to a doctor you walk out the other door completely cured, and it isn't true, particularly if you're in some of the newer areas. We've got to try to do something about that.

We finally got up the courage to have the lawyers in. We thought we'd have the ones who were perhaps defense or bar association representatives first. I guess I did that, because I didn't want to have too much discussion at one time, and I'm trying to get myself ready for the next meeting which I hope will come soon when we have the trial lawyers in. We've been trying to get the opinions and the feelings of the people who have been interested in these problems, so that we could see what we might do or what we might encourage States to do. It would be obvious that a purpose of a meeting such as this would be to make sure that more people are made aware of the complexity of this problem. It is complex because of a lot of emotionalism too, but its many facets need to be known by the public, and I'm glad to say that I just was shown a cartoon today which makes the fourth cartoon I've seen on malpractice, and this should be an indication that the problem is getting noticed. But we've got to broaden that base to get the people who pay the bill to be interested in what is happening, and it can't be solved by one group, and it certainly can't be solved by a group that thinks all the blame is on another group.

There are other doctors who have been sued and successfully for something that was not malpractice. In the eyes of most physicians, these are the only doctors they can see. They don't really face the issues of those who have committed malpractice.

Now the trial lawyers go far enough to call us butchers, and I'm just waiting for somebody to say it when I'm in the room, but I do resent that which shows their intensity of feeling. The insurance companies having a lot of money at stake are a little more discreet but you know damn well what they think of both of us.

And you can read between the lines. So we are in the middle of violent areas of feeling. We must get those areas, those groups talking together and cooperating. Now, I think it's very important for anybody who's here to try to spread the fact that this is a problem that

needs solving, and it needs solving by business groups. It needs solving by any group interested in an expensive problem in its own community, and an unjust problem. The estimates are that only about 16 to 22 percent of the premiums come to the patient who may have been injured. If however, you add the defensive medicine in there at the average figure, why it becomes somewhere around 4 or 5 percent of the money spent on malpractice or trying to defend against it, gets to the patient. We should be able to do something a little bit more efficient than that, and I'm sure that you have heard enough of the various suggestions for solution which will be tried out. We hope that anything will be tried out on a smaller sample before it's done all over the country. I'm also glad to hear that the consensus was that no-fault might turn out to be a pig in a poke that we couldn't afford. We don't know what the universe is, as I said, so we better be careful about saying that anybody can have at it without anybody being blamed.

Now, what are we doing specifically? Well, we're glad and I hope we're right that the insurance companies are going to give us this added information on claims closure. We have found money to evaluate and analyze it, and we'll make it public to anybody. I heard that Mr. Rawls said that they would be able to get it on computers, and—that is, the insurance commissioners would—that would be a great help. We are going after the question of what could be done about finding out what happens in a hospital. This is a difficult one. We don't know whether to ask for volunteers to see what they did wrong that day, or whether to go to somebody, a sort of ombudsman in a hospital, to get some concept of the situations they found when they started a campaign to cut down injuries. There is a man here associated with a hospital in Daytona Beach where they've got a man on the surgical service, a man on the medical service and a man among the employees, and they're not looked on as spies. They're looked on as friends, and if anything smells a little bit wrong they hear about it, and they bring it up to somebody who can decide whether it is something they should do something about, and if it is, they bring the patient's family in and the doctor, a hospital representative, the patients' family—they discuss it, and they take care of it as well as they can at that point. This appears to reduce the claims markedly.

We can find out we should be able to learn from such a program and others what the incident situation was before they started. This, we shall do. We shall get this information, and with the cooperation of the insurance companies, we shall get and interpret the information on the claims closures. And then we shall get State by State, when we see what they can pass, what might be a workable compromise on what can be done about the four or five very difficult problems that exist in the tort.

You could have binding arbitration. You could have committees that look at the problem before it gets to tort. I think, no matter what you do, somebody who feels there has been outrageous malpractice will sue, but there are a number of major or minor claims that could probably be settled. We have talked with the Commission on Uniform State Laws, and they would like some statistics before they get into this problem. By then, I think there may well be enough pilot proj-

ects in various States so that maybe from them, other States can get what they need.

Well, prevention of injuries is certainly something we're all going to have to go after. I think that one assumes, if one is a doctor, that there aren't so many; the insurance companies estimate that in 40 percent of the cases coming to court the doctors were guilty of malpractice. In the others, often bigger claims they don't think so.

So, I would just like to say that I'm relieved at the feelings that I've gathered here about no-fault, and I'm glad to see that most of you feel that the Federal Government should stay out of it at least for the present. I would like to say that I think the crises are still ahead of us. Now, the people talk about the sound actuarial premium. I would suppose that would depend on what kind of a night's sleep that poor actuary had. My guess would be that the sound actuarial premium was probably what Argonaut was asking New York for instance, when they found out they were in trouble. What's going to happen when the New York doctors find out what the sound actuaries believe?

Is insurance unavailable if some doctors have to pay $50,000 a year for it, and if they cannot pass it through to medicare and medicaid patients, which they can't for about 2 years.

Well, I think for a postprandial discussion, that's adequate.

I am grateful, very grateful, to both of you who made this conference possible, and I think it has been one of the most useful things that's happened since this problem reached Federal proportions, and I thank you all very much.

Dr. JAMPLIS. We're grateful to you, Dr. Egeberg, for not only being here with us today at lunch, but for the fact that you are out there on the white charger representing us so well.

I want to say very much that I am indebted to Congressman Jim Hastings for joining with all of us in the American Group Practice Association in putting on this conference and both the Congressman and I would be remiss if we did not acknowledge our sincere thanks to our two staffs for doing such a fine job. Jim Cobb, who is executive director of the American Group Practice Association, and also Spencer Johnson, who is Congressman Hastings' right-hand man, for really putting this whole thing together and working out all the details. I know I learned a lot and I hope you have.

Now, I said at the very beginning of this meeting yesterday morning in my opening remarks that this, I hope, would be an instructive meeting and that action would come out of it. There have been a lot of meetings over the last year or two as have been alluded to by Dr. Egeberg. I hope that this meeting has not just been instructive, but that action will come out of it. Congressman Hastings and his staff and I and my staff, along with the governmental relations committee and the political action committee of the American Group Practice Association are meeting, not next week and not tomorrow, but today, exactly 5 minutes after we adjourn this meeting, to ponder the deliberations of this conference, to draft a position paper and hopefully to begin writing some legislation. I thank you all for being here with us, and I hope you've enjoyed it. The meeting is adjourned.

# APPENDIXES

## APPENDIX A

[Excerpt from the Congressional Record, Apr. 17, 1975]

### H.R. 6100, Medical Malpractice Claims Settlement Assistance Act

The Speaker pro tempore. Under a previous order of the House, the gentleman from New York (Mr. Hastings) is recognized for 30 minutes.

Mr. Hastings. Mr. Speaker, the achievement of equal access to quality care at a reasonable cost for all of our citizens has been a priority of this Congress. Recently the problem of medical malpractice has seriously threatened the attainment of this goal. Therefore, today I am introducing H.R. 6100, the Medical Malpractice Claims Settlement Assistance Act.

In 1960, the Secretary's Medical Malpractice Commission estimated the cost of professional liability coverage at $60 million. In 1970, the figure was approximately $300 million. We do not know precisely what the figure is today, but some estimates are as high as a billion dollars or more.

Between 1960 and 1970, malpractice insurance premiums for dentists rose 115 percent; for hospitals, 262 percent; for physicians other than surgeons, 540.8 percent; and for surgeons, 949.2 percent. Available evidence since 1970 shows malpractice insurance rates continuing to climb. In early 1974, physicians in New York State had to pay 93.5 percent more for their malpractice insurance than for the previous rating period. The insurer in that State recently proposed an additional increase of almost 200 percent, raising the rates for some specialists as high as $45,000. As a result of objections by the State Insurance Commissioner to the proposed increase, the insurer announced it would not renew policies or write new business after July 1 of this year.

Hospitals too are experiencing extraordinary increases with rates doubling, tripling, and sometimes increasing as much as 700 percent.

Argonaut Insurance Co., the major hospital malpractice insurer, has recently announced it will no longer cover hospitals in at least 14 States.

The availability and cost of medical malpractice insurance has reached emergency proportions in many States because of dramatically increased claims and skyrocketing award levels. Factors contributing to the availability and cost situation include: Increased technology and complexity of medicine, rising patient expectations, strained patient-provider relationships, expanded use of the judicial system as an alternative for provider accountability, and the lengthy time span between the adverse medical occurrence and the settlement of a malpractice claim.

This is resulting in tremendous pressure on a medical system that is already strained to capacity because of rapid technological developments, increasing patient demand and increased Government intervention.

A serious question has arisen as to whether or not medical malpractice is becoming an uninsurable risk. Inability to predict the ratio of expected claims against premiums to anticipate loss experience is being likened to the risk of natural disasters. Providers, viewing every patient contract as a possible medical injury claim are practicing defensive medicine—ordering extra and often unnecessary tests, procedures, and consultations as protection against a malpractice claim—at a cost of billions of dollars a year to the Nation's consumers who in the end must pay for it all—the medical care—including defensive medicine—the cost of the providers' malpractice insurance as reflected in fees, and the cost of any necessary legal action.

Despite skyrocketing medical malpractice insurance costs, only a small portion of medical malpractice premiums actually goes to the injured patient or his legal representative. The amount of each premium dollar actually awarded

to the patient or his legal representative may range from 16 to 38 cents, depending upon which estimate is accepted. The remainder goes to lawyers for the plaintiff and the defendant, and for costs and profits of insurers. Settlements are seldom prompt; the average time for cases heard by a jury is 5 years. It takes over 10 years to settle all alleged medical malpractice incidents occurring in any 1 year.

An unanswered question is the extent of medical injuries caused by the negligence of health care providers which do not result in malpractice claims. One study, again commissioned by the Secretary's Commission on Medical Malpractice, found that of 23,750 discharges from two hospitals studied, 517 patients had received medical injuries during treatment which were caused by negligence. The investigators found that only 31 malpractice claims would be filed during the year in which the study was made. Since there were only 12,600 claims asserted in 1970 throughout the Nation, and over 30 million hospital admissions a year—according to the National Center for Health Statistics—it appears that malpractice claims are instituted in only a small fraction of cases where medical injuries through negligence have occurred.

Both the Congress and the administration have responded to the medical malpractice crisis. Legislation has been introduced in both the Senate and the House proposing various alternatives to the medical malpractice problem.

DHEW Secretary Caspar Weinberger, noting that a number of carriers were threatening to pull out of certain States urged that insurance companies "take no precipitous action which would deny coverage to physicians." He requested that insurance companies consider the formation of consortiums in order to spread the risk among insurers. To expedite such action, he has convened several meetings of insurance representatives, providers, insurance commissioners, and the trial lawyers. On February 26, the American Insurance Association approved the establishment of joint underwriting associations in States where there were problems, and has prepared draft State legislation for this purpose.

State legislatures have also been extremely active. According to the American Medical Association, over 200 bills dealing with the medical malpractice problem have been introduced this year in our State legislatures, proposing a wide variety of solutions.

I was fortunate recently, through the cooperation and participation of individual Members of Congress, to convene a National Conference on Medical Malpractice. This conference cosponsored with the American Group Practice Association—representing about 14,000 physicians and dentists of various specialties practicing in group settings—drew together expert representation from the key interest groups as well as State and Federal Government.

During the 2-day forum the medical professional liability insurance was examined from every perspective—the provider's, the insurer's, the patient's, and the lawyer's. State and Federal intervention was discussed, including reinsurance, joint underwriting, no-fault compensation, arbitration, and quality control and licensure standards.

While many possible approaches were debated, there was no apparent consensus on a Federal role. Actually, a strong State solution was preferred, meaning that each State can best, depending on the severity of the problem and the uniqueness of its own medical/legal complex, determine the necessary course of action.

Those affected by the medical malpractice insurance crisis want to be certain that the Federal Government, especially the Congress, is acutely aware of their problem, although they are extremely cautious about broad Federal intervention. The prevailing attitude seems to be "do not get involved, but do not go too far away."

The Congress, while recognizing the need for caution in this complex area, must at the same time act responsibly to avert the eventuality of a nationwide medical malpractice insurance crisis, and to assure the availability of reasonably priced quality medical care.

The Medical Malpractice Claims Settlement Assistance Act attempts to respond to the medical malpractice crisis by offering reinsurance to all claims over $200,000 to assure the continued availability of coverage for health care providers. I view this as a temporary solution, with the full expectation that the medical malpractice problem will be solved by the cooperative efforts of the States and the health care providers. In return for this Federal action, States and providers would be required to take certain actions which I consider essential to deal effectively with the medical malpractice problem. These steps are described below in the bill summary.

At the same time, I recognize that we must continue to look for more permanent and equitable solutions. The bill would provide for grants to conduct research and demonstrations to: First, examine such critical issues as the impact of some form of national health insurance on medical malpractice and vice versa, the implications of a no-fault medical injury compensation system and the impact of medical malpractice on Federal health programs; second, to field test certain promising approaches; and third, to conduct demonstrations which might potentially have broader national application.

This bill would enable us to move swiftly, yet judiciously, to undertake a temporary program to systematically deal with the current medical malpractice crisis, while at the same time initiating effort to deal with long range problems. As all of us who have become involved in this complex process know, there is no readily apparent solution which we can turn to with great confidence. At the same time, I think that the Medical Malpractice Claims Settlement Assistance Act does prescribe both reasonable short term solutions and an instrument for determining responsible and effective long-term public policy.

As I mentioned previously, I have been privileged to work with the American Group Practice Association and draw upon their expertise and experience. About 20 percent of the Nation's physicians, of various specialities, practice in a group setting.

In addition to participation in the National Conference on Medical Malpractice, I have had the opportunity to discuss in great detail the effects of medical malpractice on physician groups and their patients. This dialog has been essential in assessing the parameters of a Federal response to the malpractice dilemma.

I would like to include in the RECORD a letter from the American Group Practice Association outlining principles for Federal medical malpractice legislation and indicating their support for this bill:

AMERICAN GROUP PRACTICE ASSOCIATION,
*Alexandria, Va., April 15, 1975.*

Hon. JAMES F. HASTINGS,
*U.S. House of Representatives,*
*Washington, D.C.*

DEAR MR. HASTINGS: Let me again express my sincere appreciation for your cooperation in the joint sponsorship of the National Conference on Medical Malpractice with the American Group Practice Association (AGPA). We were honored to have worked so closely with you and your staff.

The AGPA Board of Trustees has studied the problem of medical malpractice and has developed certain principles which we believe any federal legislation should embody. For your consideration I am herewith transmitting them to you.

The need for medical malpractice legislation to deal with the growing cost and unavailability of medical malpractice insurance must be dealt with in a swift and practical manner. Recognizing that this problem is primarily one for the several states to resolve, the AGPA see only a limited federal role. Because time is running out, a uniform and timely response is needed and we therefore hesitantly recommend federal emergency intervention.

It is recognized that malpractice premiums are skyrocketing, not because of the increasing negligence of physicians, but because of the current mechanism used to resolve malpractice disputes between patients and providers occasioned by medical accidents. We further recognize that the large claims and resulting judgments are the primary reasons for malpractice premium increases; and that administrative costs, particularly attorneys' fees, are a large part of the problem.

FEDERAL REINSURANCE POOL

We therefore recommend the creation of a federal reinsurance pool, similar to the Federal Deposit Insurance Corporation, used by banks, established by medical provider contributions to cover awards in excess of $200,000. This pool would provide what is now known as "umbrella coverage"; providers would continue to purchase malpractice coverage from commercial carriers up to $200,000.

In order to be eligible for the reinsurance pool, states would have to enact certain enabling legislation meeting certain specific federal guidelines; then all providers in the states would begin to reduce their basic coverage and pay into the federal pool.

The guidelines promulgated by the federal government as a condition to membership in the federal malpractice reinsurance pool should contain the following basic features.

STATE MEDICAL INJURY ARBITRATION BOARD

Each state should create, by statute, a medical injury arbitration board which would hear all injury disputes resulting from the provision of health care services. The board should be composed of an equal number of lawyers, both plaintiff and defense, appointed by the appropriate bar associations; physicians, appointed by the appropriate medical society; and laymen knowledgeable in the health field, appointed by the Governor. Administrative expenses for the operation of the board should be paid by the litigants with general revenues providing deficit expenditures.

ARBITRATION AS A MEANS OF RESOLVING DISPUTES

The states should enact a medical injury arbitration law with provision for mandatory entry into the system. Appeal, of course, into the judicial system would be provided for. All findings of the board shall be admissable into evidence upon any appeal therefrom. No awards shall be considered when fault is not established.

AWARDS

All awards based upon future amortized losses in income and earning power, etc., should be paid out on an annuity basis rather than lump sum. Medical expenses and other immediate losses would be paid on a lump sum basis. This would eliminate windfalls going to heirs in the event of the unexpected and premature death of the patient.

All awards shall be public and the amount going to the patient should not contain attorneys' fees. All attorneys' fees and costs should be separately stated for public scrutiny.

ATTORNEY'S FEES

When the attorney and patient enter into a contingency fee arrangement, such fees shall be computed on a sliding scale, similar to that employed in the State of New Jersey, with a reasonable upper limit cap.

STATUTES OF LIMITATIONS

The statutes of limitations for all malpractice claims shall be one year from the discovery of defined foreign bodies, two years after the date of all other medical injuries, with a maximum of no more than four years.

PHYSICIAN CONTRIBUTION

Provider contribution to the federal medical insurance fund shall be based directly on the malpractice premiums for the basic coverage so that contributions will be based directly upon risk.

QUALITY CONTROL

The private provider sector must take greater initiatives in developing their own risk control programs. We believe that the states should provide a mechanism for approving acceptable risk control initiatives such as those exhibited by hospitals and group practices who have instituted highly comprehensive peer review and quality assurance systems. Those groups and hospitals who have not, and those non-group providers, should meet risk control guidelines set forth by the appropriate medical society. All hospital risk control programs must have medical staff approval.

STATISTICS COMPILATION

The states should be empowered to collect statistics on all compensable medical injury incidents, whether such awards were the result of arbitration or voluntary settlement. This mechanism is needed in order to improve the quality of health care delivery as well as to reduce the incidence of injury.

Similarly, much more information as to insurance company costs and payouts in the malpractice field needs to be developed in order to assure an appropriate reduction in premiums.

The federal government should establish a national clearinghouse for the collection, analysis and dissemination of this data.

Having received a draft of your "Medical Malpractice Claims Settlement Assistance Act" and having reviewed it carefully, the American Group Practice

Association supports it as a reasonable and adequate response to the increasingly serious problem of obtaining medical malpractice insurance.

Again, many thanks for your interest.

Sincerely yours,

ROBERT W. JAMPLIS, M.D.,
*President.*

BILL SUMMARY

The Medical Malpractice Claims Settlement Assistance Act would utilize a temporary program of voluntary reinsurance over the amount of $200,000 to assure the continued availability of coverage for those States who would qualify. The Secretary is authorized to conduct certain studies, collect certain data and information, and undertake pilot programs.

In order to qualify, States would have to establish programs of arbitration. Although all medical malpractice claims would be required to be arbitrated before seeking judicial recourse, the arbitration would be nonbinding, but the decision would be admissible as evidence in any court action.

Scheduling of attorney's contingent fees would be required that would reduce the percentage of fee as the size of the award increased.

The State would be required to limit the statute of limitation to 2 years from the time of an alleged medical malpractice occurrence for an adult. For minors less than 6 years of age, an action may be brought at any time until he reaches the age of 8.

States would be required to establish statewide patient grievance mechanisms so that consumers can register concerns relating to individual medical professionals. The statistical data on all such incidents must be reported quarterly to the Secretary of HEW.

States would be required to regulate the computation of demands, which requires that awards shall be reduced by payments for the same purpose from other sources such as insurance, or governmental employment, or service benefit programs.

They would be required to establish rules which would require that arbitration panels would, where appropriate, award periodic rather than lump-sum payments on behalf of injured patients.

All health care institutions and facilities that receive medicaid payments would be required to establish risk control programs to act as patient grievance mechanisms to directly intercede in actual or potential medical malpractice situations.

The program undertaken by individual institutions or groups of institutions, is intended to prevent medical malpractice injury incidents, alleviate patient grievances that could lead to a malpractice claim, and, where necessary, bring about equitable settlements in the early stages of such incidents.

In addition, education programs would be required for staffs and patients alike so that all will be aware of its existence and function. Statistical data on medical injury incidents must be maintained and reported quarterly to the Secretary of HEW.

A section-by-section analysis of the act follows:

SECTION-BY-SECTION ANALYSIS OF THE MEDICAL MALPRACTICE CLAIMS SETTLEMENT ASSISTANCE ACT

Section 1(a) states that the title of this Act is the Medical Malpractice Claims Settlement Assistance Act.

Secion 1(b) states that the findings of the Congress that medical malpractice threatens the delivery of economical, quality care to all Americans, and that the magnitude and urgency of the problem necessitates limited Federal intervention. Such intervention is required to assure the continued availability of medical malpractice insurance within the States where emergency situations exist and to develop the data and information base to formulate long-range alternatives to deal with this crisis.

TITLE I—FEDERAL AUTHORITY

GENERAL AUTHORITY

*Part A—Medical Malpractice Reinsurance Program*

Section 101(a)(1) provides that the Secretary of Health, Education, and Welfare, through an indentifiable administrative unit within the Department, may

take such actions as may be necessary to make reinsurance available to medical malpractice insurers wthin a qualified State for the part of medical malpractice claims which exceed $200,000.

Section 101(a)(2) describes the conditions which a State must meet in order to be qualified under the Act as: a program for the arbitration of medical malpractice claims; regulation of attorneys' fees in connection with such claims, has enacted a statute of limitations on civil actions for damages for medical malpractice, and regulates the computation of damages awarded in such actions and; adopting and enforcing a system for the receipt, investigation and evaluation of patient grievances of physicians practicing outside of health care facilities.

Section 101(b) provides that reinsurance shall be made available pursuant to contract, agreement, or any other arrangement, in exchange for payment of a premium, fee, or other charge sufficient to meet the costs of such reinsurance.

### Payment of claims

Section 102 provides that the Secretary shall establish methods by which approved claims covered by reinsurance shall be adjusted and paid for.

### Use of facilities and services

Section 103 provides that the Secretary of Health, Education, and Welfare may use insurers, insurance agents, brokers, and insurance adjustment organizations as fiscal agents of the United States and use officers and employees of any executive agency of the Federal government to carry out the purposes of this Act. The use of Federal officers and employees would be on a reimbursement basis.

Section 104(a) provides the authority for the Secretary to bring action against insurers to recover unpaid premiums lawfully payable by the insurer for reinsurance under this Act.

Section 104(b) provides that no action may be brought unless the action is brought within five years from the date the right to bring action accrued. Exceptions to the five year limitation are provided in the Act.

### Reports and audits

Section 105(a) outlines the reports required to be submitted to the Secretary by insurers and any pool of insurers participating in the reinsurance program authorized under this Act.

Section 105(b) provides that the Secretary and the Comptroller General of the United States or their representatives shall have access to any records of the insurer or any pool of insurers which are pertinent to the reinsurance provided under this Act. Any audits shall be conducted, to the maximum extent feasible, in cooperation with the State insurance authority.

## *Part B—Studies and Data*

Section 110(a) provides that the Secretary shall conduct certain studies related to medical malpractice to: determine the costs of medical malpractice claims in all federally supported health care programs; explore alternative methods of classifying individual medical practitioners and institutions for medical malpractice insurance ratemaking purposes; study and recommend methods of minimizing the cost of litigation including the contingency fee system; study the possible establishment of national licensure and standards of practice and the effects of licensing standards on the incidence of malpractice and; study the impact of national health insurance on medical malpractice awards and on systems of compensating persons injured by medical malpractice.

Section 110(b) provides that the Secretary shall collect and analyze data on medical malpractice claims by type of injured involved, the type of facility in which the malpractice occurred, the type of health professionals involved and in any other form the Secretary considers appropriate. The Secretary shall establish appropriate controls to prevent the disclosure of the identities of patients and health care professionals. He shall issue quarterly reports on the activities undertaken under this section.

Section 110(c) provides that the Secretary may make grants or contracts to support Statewide projects, including pilot programs, to develop injury prevention programs and to study and evaluate new and alternative approaches to settle medical malpractice claims.

TITLE II—STATE PROGRAMS

*Part A—Arbitration*

Section 201 provides that, for purposes of Part A of Title I of this Act, a State shall be considered to have met the standards for arbitration of medical malpractice claims if it meets or exceeds the standards established under Sections 202 through 212 of this Act. This Section also describes program requirements both to meet and exceed the prescribed standards.

Section 202 requires that any civil action arising from a claim for damages on account of an alleged medical malpractice incident shall be first submitted to arbitration for resolution before it may be instituted in a court of the State. Court actions must be accompanied by a copy of the decision rendered by the arbitration panel regarding the medical malpractice claim.

Initiation of Arbitration

Section 203 prescribes the procedures to be followed in submitting a medical malpractice claim to arbitration.

Section 204(a) provides that the Courts shall appoint the arbitration panel to conduct the arbitration.

Section 204(b) prescribes the make-up of the arbitration panel to be appointed by the court: consisting of a chairman, equal numbers of attorneys and members of the health profession and a member of the general public who is not an attorney or a member of a health profession.

Section 204(c) provides that the parties to arbitration shall be permitted to excuse panel members for cause and by the exercise of preemptory challenges.

Hearing Procedures

Section 205 prescribes the procedures to be followed by the arbitration panel in conducting arbitration hearings.

Decision of the Arbitration Panel

Section 206(a) provides that the arbitration panel will submit findings of fact, a recommendation, and a statement of the basis for such a recommendation. The panel shall, where appropriate, provide payment on a periodic rather than a lump-sum basis.

Section 206(b) provides that the arbitration panel members shall sign the decision, except any panel member may file a written report concurring in or dissenting from the panel's decision.

Section 206(c) provides that the parties to the arbitration shall receive copies of the panel's decision and a copy shall be filed with the court in which the petition for arbitration was filed, pursuant to section 203.

Laws Governing Decision of Arbitration Panel

Section 207(a) provides that except as provided in subsection (b), the decision of the arbitration panel shall be in accordance with the law of the State as applicable to civil actions for medical malpractice.

Section 207(b) provides that no party shall be required to produce expert testimony during the proceedings and that the panel may consider the absence of such expert testimony, along with other relevant factors and evidence, in determining if the applicable burden of proof has been sustained.

Proceeding Subsequent to Decision of Arbitration Panel

Section 208(a) requires that the parties to the arbitration shall file with the appropriate court, as prescribed under section 203, a statement of acceptance or rejection of the decision of the arbitration panel. If the parties accept the decision, the decision shall be binding on them.

Section 208(b) provides that if any party rejects the decision of the arbitration panel, the plaintiff may institute a civil action in the court prescribed under section 203.

### Arbitration Panel Decision as Evidence at Trial

Section 209 provides that the decision of the arbitration panel may be admissible as evidence in any subsequent civil action, subject to review by the court as to its admissability.

### Effects on Statute of Limitations

Section 210 provides that the filing date of a petition for arbitration pursuant to Section 203 shall be considered the date of institution of a civil action for purposes of the applicable statute of limitations.

### Reporting of Arbitration Decisions

Section 211(a) provides that decisions of the arbitration panels shall be compiled and published on a regular basis.

Section 211(b) provides that decisions of the arbitration panels shall be reported to the State agency and the Professional Standards Review Organization designated for the area.

Section 211(c) provides that all decisions rendered by arbitration panels shall be reported to the Secretary.

### Agreement for Binding Arbitration

Section 212 provides that nothing in this part shall be construed to impose any limitation on the right of any person to enter into an agreement to arbitrate a dispute or to be bound by the decision of the arbitration.

## *Part B—Attorneys' fees, statutes of limitations and computation of awards*

### Attorneys' Fees

Section 221(a) provides that the States shall establish rules, either by court rules or statute, to enforce a schedule on attorney contingent fees in connection with awards to claimants for medical malpractice.

Section 221(b)(1) states that fees shall be sufficient to provide reasonable compensation to the claimant's attorney.

Section 221(b)(2) states that fees shall be expressed as a percentage of the net amount recovered in a successful claim and the percentage shall decrease as the amount of recovery increases. Net amount is defined as the amount of the award remaining after disbursements made in connection with the prosecution of the claim.

Section 221(c) provides that contingent fee agreements between claimants and their attorneys must be in writing and filed with the appropriate court as prescribed under section 203. Such agreements shall be confidential and shall be examined only for the purpose of determining if they are in compliance with the fee rate schedule established pursuant to this section.

### Statute of Limitations

Section 222 states that for purposes of qualifying under Part A of Title I, the State shall by statute provide that no action, whether in contract or tort, may be brought in a court of the State against a health care provider or entity for damages on account of alleged medical malpractice unless the action is brought within two years from the date of the alleged medical malpractice, except that a minor who has not attained the age of six years, may, with respect to medical malpractice alleged to have occurred before the minor attains such age, bring an action at any time before he attains the age of eight.

### Computation of Awards

Section 223 provides that an award for damages in a civil action brought for personal injury resulting from medical malpractice may not include losses, replaced or indemnified by insurance or governmental employment or service benefit programs or from any other source except the assets of the plaintiff or of the members of the plaintiff's immediate family.

*Part C—Patient Grievance Mechanisms*

Patient Grievance Mechanisms Applicable to Health Care Facilities

Section 225(a) provides that in order for States to be eligible for payments pursuant to Title XIX of the Social Security Act, they must establish patient grievance mechanisms applicable to all health care entities within their State within 180 days after the enactment of this Act. Such mechanisms must be in accord with regulations to be prescribed by the Secretary.

Section 225(b)(1) states that grievance mechanisms shall be established by all health care entities in the State and that such mechanisms can be developed and applied jointly by more than one health care entity.

Section 225(b)(2) The Patient Grievance Mechanism is used to consider and resolve grievances of patients relating to medical care received, reaching equitable malpractice settlements, determining procedures and situations that lead to medical injury and to provide for the education of facility staff and patients.

Section 225(b)(3) provides that the patient grievance mechanism shall be required to make quarterly reports to the State and Secretary on the grievances received by the mechanism, the disposition of such grievances and the medical malpractice claims arising out of such grievances. Information in the reports respecting grievances shall be classified on the basis of the type of injury, facility, and health care personnel involved and on such other bases as the Secretary may prescribe.

Patient Grievance Mechanisms Applicable to Individual Practitioners

Section 226 provides that for purposes of qualifying under Part A of Title I, that the State shall designate an authority to adopt and enforce a patient grievance mechanism to (1) receive and consider grievances of patients in non-institutional settings, and (2) assist in the equitable settlement of any claims arising out of such grievances. The mechanism would be required to submit quarterly reports to the State and Secretary for the same purposes and with the same classifications outlined in Section 225(b)(3).

[H.R. 6100, 94th Cong., 1st sess.]

A BILL To assist in the settlement of medical malpractice claims through a Federal program of reinsurance and through voluntary arbitration under State laws, and for other purposes

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

SHORT TITLE; FINDINGS

SECTION 1. (a) This Act may be cited as the "Medical Malpractice Claims Settlement Assistance Act".

(b) The Congress makes the following findings:

(1) The Congress finds that the achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.

(2) The achievement of this goal is being seriously threatened by the uncertain future availability and cost of medical malpractice insurance because of dramatically increased medical malpractice insurance premiums due to rapidly rising claims and award levels.

(3) Several interacting factors affect this situation:

(A) Rapid technological advances which have increased the scope and complexity of medicine.

(B) Resulting impersonalization and alienation of the provider-patient relationship.

(C) Rising patient expectations.

(D) Expanded utilization of the judicial system by consumers and lawyers as an alternative for provider accountability.

(4) Lack of sufficient reliable information as to the sources and number of events that potentially or actually lead to medical malpractice events and subsequent claims hamper effective solution determination.

(5) The practice of defensive medicine (the ordering of additional tests, procedures, and consultations as a defense against malpractice claims) is estimated at nearly $7,000,000,000 annually.

(6) These and other considerations indicate the necessity of limited Federal intervention to assure the continued necessity of limited Federal intervention to assure the continued availability of medical malpractice insurance within States during emergency situations and to develop the data and information base to formulate long-range alternatives to this crisis.

## TITLE I—FEDERAL AUTHORITY

### PART A—MEDICAL MALPRACTICE REINSURANCE PROGRAM

#### GENERAL AUTHORITY

SEC. 101. (a) (1) The Secretary of Health, Education, and Welfare (hereinafter in this Act referred to as the "Secretary") may, through an identifiable administrative unit within the Department, take such action as may be necessary to make available, in accordance with this part and subject to such regulations as the Secretary may prescribe, to insurance companies and other insurers and pools of insurance companies and other insurers reinsurance against the part of claims brought by any of their insureds and arising out of medical malpractice within a qualified State which exceed $200,000.

(2) For purposes of paragraph (1), the term "qualified State" means a State—

(A) which has a State program for arbitration of medical malpractice claims which program is in accordance with part A of title II of this Act;

(B) which, as prescribed by part B of such title, regulates attorneys' fees in connection with such claims, has enacted a statute of limitations on civil actions for damages for medical malpractice, and regulates the computation of damages awarded in such actions; and

(C) which, in accordance with section 226, has adopted and enforces a system for the receipt, investigation, and evaluation of grievances of patients of practitioners arising out of medical care received outside of a health care facility.

(b) Reinsurance under subsection (a) shall be made available pursuant to contract, agreement, or any other arrangement, in consideration of such payment of a premium, fee, or other charge as the Secretary finds necessary to cover anticipated claims and other costs of providing such reinsurance.

#### PAYMENT OF CLAIMS

SEC. 102. The Secretary shall establish the general method or methods by which proved and approved claims which are covered by reinsurance made available under this part may be adjusted and paid for.

#### USE OF EXISTING FACILITIES AND SERVICES

SEC. 103. In carrying out his responsibilities under this part, the Secretary may use—

(1) insurance companies and other insurers, insurance agents and brokers, and insurance adjustment organizations, as fiscal agents of the United States; and

(2) officers and employees of any executive agency (as defined in section 105 of title 5, United States Code) as the Secretary and the head of any such agency may from time to time agree upon, on a reimbursement or other basis.

#### RECOVERY OF PREMIUMS

SEC. 104. (*a*) The Secretary, in a suit brought in the appropriate United States district court, shall be entitled to recover from any insurer the amount of any unpaid premiums lawfully payable by such insurer to the Secretary.

(b) No action or proceeding shall be brought for the recovery of any premium due to the Secretary for reinsurance, or for the recovery of any premium paid to the Secretary in excess of the amount due to him, unless such action or proceeding shall have been brought within five years after the right accrued for which the claim is made, except that, where the insurer has made or filed with

the secretary a false or fraudulent annual statement, or other document with the intent to evade, in whole or in part, the payment of premiums, the claim shall not be deemed to have accrued until its discovery by the Secretary.

REPORTS AND AUDITS

SEC. 105. (a) As a condition to the receipt of reinsurance under this part, each insurer and pool of insurers which is reinsured under this part shall file with the Secretary—

(1) a copy of each annual statement (and any amendments to it) filed with the insurance authority of the State in which reinsurance under this part is effective; and

(2) information respecting (A) actual claims asserted by patients (or their legal representatives) against insureds of the insurers, (B) reports of adverse medical incidents filed by the insureds, and (C) any other matter pertaining to medical malpractice insurance as the Secretary may determine is necessary for the effective administration of the reinsurance authorized by this part.

(b) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purposes of investigation, audit, an examination to any books, documents, papers, and records of any insurer or pool reinsured under this part that are pertinent to reinsurance provided under this part. Such audit shall be conducted to the maximum extent feasible in cooperation with State insurance authorities.

## PART B—STUDIES AND DATA

STUDIES AND DATA

SEC. 110. (a) The Secretary shall—

(1) conduct a comprehensive study to determine the direct and indirect costs of medical malpractice claims, including litigation arising out of such claims, in all federally supported health care programs;

(2) explore alternative methods of classifying individual medical practitioners and institutions for medical malpractice insurance ratemaking purposes;

(3) study and recommend methods of minimizing the cost of litigation, including the contingency fee system;

(4) study (A) the establishment of uniform national procedures for examining and licensing health professionals and the establishment of uniform standards of practice, and (B) the effect of varying standards for the licensing of health professionals on the incidence of medical malpractice; and

(5) study the impact of national health insurance on medical malpractice awards and on the system or systems of compensating persons injured by medical malpractice.

(b) The Secretary shall collect and analyze data on medical malpractice claims. In analyzing such data classifications shall be made on the basis of the type of injury involved, the type facility in which the malpractice occurred, and the type of health professional involved and on such other basis as the Secretary determines appropriate. The Secretary shall by regulation establish appropriate controls on data collected so as to prevent the disclosure of the identities of patients and health care providers. The Secretary shall issue quarterly public reports of activities undertaken under the subsection.

(c) The Secretary may, by grant or contract and on such conditions as the Secretary determines appropriate, support statewide projects, including pilot programs, for—

(1) the development of intensified medical injury prevention programs for public and private health care facilities; and

(2) studying and evaluating new and alternative methods of settling medical malpractice claims, including no-fault insurance and compensation plans, prelitigation screening programs, arbitration programs, and mediation of disputes.

# TITLE II—STATE PROGRAMS

## PART A—ARBITRATION

### GENERAL

SEC. 201. For purposes of part A of title I of this Act, a State program for arbitration of medical malpractice claims is in accordance with this part if it meets or exceeds all of the standards for arbitration of such claims prescribed by sections 202 through 212. A State program "meets" the standards only if the substance of the State program requirements is the same as or the equivalent of the corresponding requirements of the standards. A State program "exceeds" the standards only if it includes requirements which are the same as or equivalent to the corresponding requirements of the standards, and imposes additional requirements which are reasonably designed to encourage the arbitration of medical malpractice claims without unduly limiting the rights of any parties, and which are not inconsistent with the standards.

### SUBMISSION OF MEDICAL MALPRACTICE CLAIMS TO ARBITRATION

SEC. 202. Any civil action arising from a claim for damages on account of alleged medical malpractice on the part of any health professional or health care institution may be instituted in a court of the State only after there has been an arbitration of the claim which forms the basis for such action, in accordance with this part, and no complaint in any such action may be filed in any court unless there has first been filed in such court a copy of the decision with respect to such claim rendered by an arbitration panel pursuant to section 206.

### INITIATION OF ARBITRATION

SEC. 203. An arbitration under this part of any claim shall be initiated by filing a petition requesting such arbitration with any court having jurisdiction to hear a civil action based upon such claim. The court shall inform the health professional or health care institution against which the claim is made of the filing of such petition.

### APPOINTMENT OF ARBITRATION PANEL

SEC. 204. (a) Upon petition for arbitration under section 203, the court shall appoint an arbitration panel to conduct an arbitration.

(b) An arbitration panel shall be composed of a chairman, equal numbers of (1) attorneys and (2) members of the health profession of those professionals against whom the claim is being made, and a member of the general public who is not an attorney or a member of a health profession.

(c) Parties to the arbitration shall be permitted to excuse panel members for cause and by the exercise of peremptory challenges.

### HEARING PROCEDURES

SEC. 205. (a) Before hearing any testimony the members of the arbitration panel shall be sworn to hear the claim and render a decision faithfully and fairly by an officer authorized to administer an oath.

(b) The arbitration panel shall appoint a time and place for the hearing and notify the parties by means adequate to assure their presence. The panel may adjourn or postpone the hearing. The panel shall preside at the hearing and shall exercise all powers relating to the conduct of the hearing. The court in which the petition for arbitration was filed pursuant to section 203, upon application, may direct the panel to proceed promptly with the hearing.

(c) The testimony of the witnesses shall be given under oath. Members of the arbitration panel, once sworn, shall have the power to administer oaths.

(d) The parties are entitled to be heard, to present evidence and to cross-examine witnesses, but rules of evidence need not be observed. The arbitration panel may proceed with the hearing and render a decision upon the evidence produced, notwithstanding the failure of a party duly notified to appear.

(e) The arbitration panel may issue or cause to be issued subpenas for the attendance of witnesses and for the production of books, records, documents, and other evidence. Subpenas so issued shall be served, and upon application to the court, in which the petition for arbitration was filed, pursuant to section 203, by a party or the arbitration panel, enforced, in the manner provided by law for

the service and enforcement of subpenas in a civil action. All provisions of law compelling a person under subpena to testify are applicable.

(f) On application of a party and for use as evidence, the arbitration panel may permit a deposition to be taken, in the manner and upon the terms designated by the panel, of a witness who cannot be subpenaed or is unable to attend the hearing.

(g) A party has the right to be represented by an attorney and may claim such right at any time as to any part of the arbitration which has not taken place.

DECISION OF ARBITRATION PANEL

SEC. 206. (a) The arbitration panel shall render a decision which shall consist of findings of fact, a recommendation, and a statement of the basis for such recommendation. The recommendation shall relate to both liability and damages. The panel shall, where appropriate, provide for the payment of awards on a periodic rather than a lump sum basis.

(b) The decision shall be signed by all members of the arbitration panel, except that any member of such panel may write a concurring or dissenting opinion giving his reasons therefor.

(c) The parties to the arbitration shall receive copies of the panel's decision and a copy shall be filed with the court in which the petition for arbitration was filed, pursuant to section 203.

LAW GOVERNING DECISION OF ARBITRATION PANEL

SEC. 207. (a) Except as provided in subsection (b), the decision of the arbitration panel shall be in accordance with the law of the State as applicable to civil actions for medical malpractice.

(b) No party to an arbitration under this part shall be required to produce expert testimony as a prerequisite to a decision in his favor. The arbitration panel may consider the absence of such testimony along with other relevant factors and evidence, in determining whether the applicable burden of proof has been sustained.

PROCEEDINGS SUBSEQUENT TO DECISION OF ARBITRATION PANEL

SEC. 208. (a) The parties to an arbitration shall file with the court (in which the petition for arbitration was filed pursuant to section 203) a statement of acceptance or rejection of the decision of the arbitration panel. If the parties accept such decision, it shall be binding upon them.

(b) In the event that any party rejects the decision of the arbitration panel, the claimant may institute a civil action for damages on account of alleged medical malpractice. Such an action shall be instituted in the court in which the petition for arbitration was filed, pursuant to section 203.

ARBITRATION PANEL DECISION AS EVIDENCE AT TRIAL

SEC. 209. The decision of an arbitration panel with respect to a claim rendered in accordance with this part shall be admissible as evidence in any subsequent trial of a civil action for alleged medical malpractice arising out of such claim if the court conducts a review of the decision and any other relevant information submitted by the parties and concludes that—

(1) the findings of fact, included in such decision, are not clearly erroneous,

(2) the decision is in accordance with the applicable law, and

(3) the required procedures were followed in conducting the hearing and rendering the decision.

EFFECT ON STATUTE OF LIMITATIONS

SEC. 210. The date of filing of a petition for arbitration pursuant to section 203 shall be considered the date of institution of a civil action for purposes of the applicable statute of limitations.

REPORTING OF ARBITRATION DECISIONS

SEC. 211. (a) Decisions rendered by arbitration panels pursuant to this part shall be compiled and published on a regular basis.

(b) Decisions rendered by arbitration panels pursuant to this part with respect to claims made against any health professional shall be reported to the State agency and to the Professional Standards Review Organization designated under section 1152 of the Social Security Act for the area in which such professional practices his profession.

(c) All decisions rendered by arbitration panels pursuant to this part shall be reported to the Secretary.

### AGREEMENT FOR BINDING ARBITRATION

SEC. 212. Nothing in this part shall be construed to impose any limitation on the right of any person to enter into an agreement to arbitrate a dispute or to be bound by the decision of the arbitrators.

## PART B—ATTORNEYS' FEES, STATUTES OF LIMITATIONS, AND COMPUTATION OF AWARDS

### ATTORNEYS' FEES

SEC. 221. (a) For purposes of qualifying under part A of title I, a State shall establish by statute or court rule and appropriately enforce a schedule of maximum contingent fee rates which may be charged or accepted by attorneys for services performed in connection with claims for damages on account of alleged medical malpractice.

(b)(1) The fee rates shall be established so as to provide reasonable compensation for the services performed by an attorney in connection with such claims.

(2)(A) The fee rates, which shall be expressed as a percentage of the net amount recovered in a successful settlement or prosecution of such claims, shall decrease as the amount of recovery increases.

(B) As used in this paragraph "net amount recovered" means the amount actually recovered less disbursements made in connection with prosecution of the claim.

(c)(1) Any attorney who charges or accepts a contingent fee for services performed in connection with a claim for damages on account of alleged medical malpractice shall reduce to writing the agreement or other arrangement whereby such fee was paid and shall provide to his client and file with the court in which a petition for arbitration of civil action respecting such claim was filed a copy of such agreement or other arrangement.

(2) All such agreements or other arrangements filed with a court pursuant to paragraph (1) shall be confidential and shall be made available for inspection only for the purpose of determining compliance with the fee rate schedule established pursuant to this section.

### STATUTE OF LIMITATIONS

SEC. 222. For purposes of qualifying under part A of title I, a State shall by statute provide that no action, whether in contract or tort, may be brought in a court of the State against a health care provider or entity for damages on account of alleged medical malpractice unless the action is brought within two years from the date of the alleged medical malpractice, except that a minor who has not attained the age of six years may, with respect to medical malpractice alleged to have occurred before the minor attains such age, bring an action at any time before he attains the age of eight years.

### COMPUTATION OF AWARDS

SEC. 223. For purposes of qualifying under part A of title I, a State shall by statute provide that an award for damages in a civil action brought for personal injury resulting from medical malpractice may include actual economic losses suffered by the plaintiff by reason of the personal injury, including the cost of reasonable and necessary medical care, rehabilitation services, and custodial care, loss of services, and loss of earned income, but only to the extent that such costs are not paid or payable and such losses are not replaced, or indemnified in whole or in part, by insurance, or governmental employment or service benefit programs or from any other source except the assets of the plaintiff or of the members of the plaintiff's immediate family.

## PART C—PATIENT GRIEVANCE MECHANISMS

### PATIENT GRIEVANCE MECHANISMS APPLICABLE TO HEALTH CARE ENTITIES

SEC. 225. (a) In order for any State to be eligible for payments pursuant to title XIX of the Social Security Act, with respect to expenditures for any calendar quarter beginning more than 180 days after the date of the enactment of this part, such State must have in effect, in accordance with this section and regulations prescribed by the Secretary, a patient grievance mechanism applicable to all health care entities within the State.

(b) (1) The patient grievance mechanism shall be established by each health care entity within the State. More than one health care entity may join in one patient grievance mechanism.

(2) The mechanism shall be used by health care entities to—

(A) receive and consider grievances of patients of such entities respecting medical care received in such entities and attempt to resolve such grievances to avoid the filing of malpractice claims;

(B) assist in bringing about equitable settlements of any malpractice claims arising out of such grievances;

(C) determine and take direct action within the entities respecting procedures and situations that have or may lead to medical injury incidents, and

(D) provide education for the staffs of the entities designed to prevent the incidents of medical injury to patients in the entities.

Each entity shall take such action as may be necessary to inform its patients and staff of the patient grievance mechanism applicable to the entity.

(3) The patient grievance mechanism shall be required to make quarterly reports to an entity of the State designated by the chief executive officer (with the approval of the Secretary) and to the Secretary on the grievances received by the mechanism, the disposition of such grievances, and the medical malpractice claims arising out of such grievances. Information in the reports respecting grievances and claims shall be classified on the basis of the type of injury, facility, and health care personnel involved and on such other basis as the Secretary may prescribe.

### PATIENT GRIEVANCE MECHANISMS APPLICABLE TO INDIVIDUAL PRACTITIONERS

SEC. 226. For purposes of qualifying under part A of title I, a State shall, through an entity designated by the chief executive officer (with the approval of the Secretary), adopt and enforce a patient grievance mechanism to (1) receive, investigate, and evaluate grievances of patients respecting medical injuries occurring in noninstitutional settings, and (2) assist in the equitable settlement of any claims arising out of such grievances. Such mechanism shall be required to make quarterly reports to the Secretary on the grievances received by the mechanism, the disposition of such grievances, and the medical malpractice claims arising out of such grievances. Information in the reports respecting grievances and claims shall be classified on the basis of the type of injury, facility, and health care personnel involved, and on such other basis as the Secretary may prescribe.

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## APPENDIX B

[Excerpt from the Congressional Record, June 5, 1975]

### CAN THE STATES COPE WITH THE MEDICAL MALPRACTICE CRISIS?

The SPEAKER pro tempore (Mr. MCFALL). Under a previous order of the House, the gentleman from New York (Mr. Hastings) is recognized for 5 minutes.

Mr. HASTINGS. Mr. Speaker, I do not think any of us need to be convinced of the seriousness of the medical malpractice problem. During the last 6 months, we have been bombarded through the media and by affected groups with information about the medical malpractice crisis. Medical malpractice insurers are refusing to write new policies in some States, insurance premiums and claims are increasing astronomically, and we are continuously made aware of the growing numbers of persons receiving medical injuries. Although information regarding the precise magnitude and character of the medical malpractice problem is sometimes spotty and incomplete, there is no question that the data is sufficient to support the fact that we do have a crisis on our hands.

Medical malpractice, as you all know, is distorting the costs and the delivery of health services. It is the fastest growing item of dollar cost in the medical care system today, and allegedly it has a strong influence on the physicians' methods of practice—often in a negative way—resulting in overdiagnosis and overtreatment. It is either the cause or the rationalization of billions of dollars of waste which we cannot afford.

We are now experiencing a strong reaction from the medical community. California doctors went on strike for a month, denying service to the public and causing widespread layoffs and reductions of workweeks of hospital staffs. New York City physicians are beginning a slowdown in protest to legislation recently enacted in that State. Also physicians in Virginia, Maryland, Texas, and other States are following suit.

In addition to the overall negative impact on the health care system, its effect on patients who are injured is of most concern. We know there are far more medical injuries than there are claims, although this gap is narrowing rapidly. Some estimates of medical injuries caused by negligence are as high as 600,000 a year. Claims take years, not months, to settle and in the end the patient gets far less than half of all premium dollars paid by providers of medical malpractice insurance.

Due primarily to the efforts of the medical profession, States have been very active in considering legislation to deal with this problem. According to the American Medical Association, over 200 bills pertaining to medical malpractice were introduced in State legislatures this year. These bills cover a wide range of issues, including the availability of medical malpractice insurance, the statutes of limitation for filing suits, limits on liability, the powers of medical licensing boards to deal with negligent physicians, the establshment of State insurance funds, and limits on contingency fees for plaintiff lawyers.

The State legislatures deserve considerable praise for their serious consideration of efforts to deal with the medical malpractice problem. A large number of States, in fact most of the States with the most serious problems, have passed legislation dealing with medical malpractice. States with an immediate crisis of availability of medical malpractice insurance, for example, authorized joint underwriting or State pools of insurers to assure the availability of insurance. Some appeared to go further than others in facing up to the problem. But despite these considerable efforts by the States, the results are not uniformly promising.

Most State legislation which was enacted, for example, did not deal with the matter of limiting contingency fees, although there is general agreement among experts that this needs to be done. This is true also of collateral benefits, structured payments as opposed to lump sum payments, and loss prevention or risk control programs. From the reports I have received from the States where crises existed and where legislation has passed, considerable doubt is expressed that the legislation will effectively reduce the number of claims, the size of awards, or the increases in their insurance premiums. Most medical societies appear to be planning to promote needed changes in future sessions of their respective State legislatures. They are calling for more fundamental reforms of the medical malpractice claims settlement process.

When I introduced the Medical Malpractice Claims Settlement Assistance Act on April 17 I spoke of the need for a strong State solution to the problems of medical malpractice. Both health care providers and medical malpractice insurers have been subject to State laws and regulations, and it appeared to many Members of Congress, the administration, and providers and insurers that State action was the most desirable course to take.

It is the relatively limited response of the States to a problem that is so enormous and growing so rapidly that forces me to the conclusion that the Federal Government must assume a more active role in solutions to medical malpractice. Congress must be mindful, too, of the impact that the medical malpractice is having on Federal programs such as medicare and medicaid, and the impact it could have on any national health insurance legislation that might be enacted.

In this case, Federal involvement will hopefully mean a solution arrived at with the participaion of the States, insurers, providers, and other interested parties. Hopefully, the Federal mandate can be limited. But, if a comprehensive response is not forthcoming from the States, the Federal Government must assume ultimate responsibility for seeing to it that effective solutions, both public and private, are achieved in dealing with the medical malpractice crisis.

Mr. Speaker, I would like to emphasize to my colleagues that I make these remarks with my legislation, H.R. 6100, the Medical Malpractice Claims Settlement Assistance Act in mind. H.R. 6100 recognizes the primary role of the States' in dealing with the medical malpractice situation. I believe it is a reasonable approach by which the Federal Government could act in concert with the States to deal effectively with the medical malpractice dilemma.

A summary of H.R. 6100 follows for the consideration of my colleagues:

BILL SUMMARY

The Medical Malpractice Claims Settlement Assistance Act would utilize a temporary program of voluntary reinsurance over the amount of $200,000 to assure the continued availability of coverage for those States who would qualify. The Secretary is authorized to conduct certain studies, collect certain data and information, and undertake pilot programs.

In order to qualify, States would have to establish programs of arbitration. Although all medical malpractice claims would be required to be arbitrated before seeking judicial recourse, the arbitration would be nonbinding, but the decision would be admissible as evidence in any court action.

Scheduling of attorney's contingent fees would be required that would reduce the percentage of fee as the size of the award increased.

The State would be required to limit the statute of limitation to 2 years from the time of an alleged medical malpractice occurence for an adult. For minors less than 6 years of age, an action may be brought at any time until he reaches the age of 8.

States would be required to establish statewide patient grievance mechanisms so that consumers can register concerns relating to individual medical professionals. The statistical data on all such incidents must be reported quarterly to the Secretary of HEW.

States would be required to regulate the computation of demands, which requires that awards shall be reduced by payments for the same purpose from other sources such as insurance, or govermental employment, or service benefit programs.

They would be required to establish rules which would require that arbitration panels would, where appropriate, award periodic rather than lump-sum payments on behalf of injured patients.

All health care institutions and facilities that receive medicaid payments would be required to establish risk control programs to act as patient grievance mechanisms to directly intercede in actual or potential medical malpractice situations.

The program undertaken by individual institutions or groups of institutions, is intended to prevent medical malpractice injury incidents, alleviate patient grievances that could lead to a malpractice claim, and, where necessary, bring about equitable settlements in the early stages of such incidents.

In addition, education programs would be required for staffs and patients alike so that all will be aware of its existence and function. Statistical data on medical injury incidents must be maintained and reported quarterly to the Secretary of HEW.

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## APPENDIX C

### The Medical Malpractice Insurance Crisis—A Summary of the Problem and Its Relation to Dermatology

(June 11, 1975—Max B. Rubin, M.D.; Denny L. Tuffanelli, M.D.)

Over the past several months the existing medical malpractice injury compensation system in the United States has become dangerously overloaded and is close to collapse in several states. This unparalleled crisis is one of both the availability of medical malpractice insurance and the cost of that insurance to health care providers. Physicians in at least seven states face the loss of all malpractice coverage within the next three months. Where coverage is available the cost is rapidly approaching the point where the individual high-risk provider can no longer afford the yearly premiums.

Dermatologists, among those physicians least burdened by the problem, are bound to be affected by any change in the system as a whole. For this reason the following discussion will seek to explore some of the complex and interrelated causes of the medical malpractice problem. The role of health care providers, consumers, insurers, and the legal system will be discussed. An attempt will be made to summarize proposed federal and state solutions to the medical malpractice insurance problem as well as discussing the positions taken by various interested groups. Some suggestions are offered for the steps that organized dermatology should take to effectively deal with the problem. The recent National Conference on Medical Malpractice sponsored by Representative James Hastings and the American Group Practice Association provided a forum for discussion of this critical problem. Because a full transcript of the conference will be available shortly no attempt has been made to summarize the presentations as made by each individual speaker. The material provided at that conference, both written and spoken, has been summarized, along with information obtained from the Report of the Secretary's Commission on Medical Malpractice (DHEW Pub. no. (os) 73–88).

*Magnitude of the problem*

In attempting to assess any facet of the medical malpractice insurance problem, it is immediately apparent that there is a lack of accurate statistical information on which to base any conclusions. The excellent report of the Secretary's Commission on Medical Malpractice, which is the most comprehensive study yet performed, is now over 2 years old and its conclusions may no longer be valid. There is virtually no data available on the extent of medical malpractice in physicians' offices as most of the data collected is from hospital records. It is estimated that at least 74% of all medical malpractice claims arise out of incidents occurring in hospitals. Since hospital records are obviously easier to study than records of private practitioners, very little data has been gathered in the area of greatest concern to dermatologists: the private office.

In 1960, the national cost of medical malpractice insurance was estimated to be 60 million dollars; the figure today approaches a billion dollars and is bound to go higher if present trends continue. If one includes the cost of "defensive medicine", which includes tests and procedures performed by physicians to protect themselves from future malpractice claims, the cost of medical malpractice in this country now approaches 5 billion dollars annually. It has been estimated by Dr. Roger O. Egeberg of HEW that the number of medical injuries per year may be as high as 2 million in hospitals alone and that the number of injuries caused by negligence may be as high as 700,000 per year.

There are probably over 20,000 medical malpractice *claims* per year and the number is increasing at a rate of between 9% to 13% per year. It is estimated that only a small fraction of those individuals ever involved in an incident of medical negligence or injury ever seek restitution through the courts. While there are many more injuries than malpractice claims, it should be noted that approximately 30% of the "claims" are in fact merely possible claims reported by doctors and hospitals to their insurers and are never brought to the attention of the insurer by the involved patient. It is probably true that this "claims lag" is likely to decrease in the future.

The average claim is settled for much less than is thought to be the case. In at least half the malpractice cases, the payment amount has been $2,000 or less, with over 90% of cases less than $20,000. When a malpractice case reaches the courts, the average settlement is approximately $8,000 and this amount is increasing at a rate of 13% per year. While the number of million dollar claims has been few in relation to the total number of claims, the impact on the system has been dramatic. There have probably been fewer than 100 settlements of a million dollars or more, but these and other high-dollar amount settlements are generally reported in the popular press and thus may stimulate other claims. Large settlements have provided the basis for many complaints about unnecessarily large attorneys' fees.

*Role of providers*

At the present time, one out of five physicians can expect to be sued in his professional lifetime. One out of seven doctors in some high risk specialties (neurosurgery, orthopedics, anesthesiology, plastic surgery, obstetrics and gynecology) can expect to be sued each *year*. Physicians feel increasingly more vulnerable to personal catastrophic liability losses despite their belief that they

are practicing quality medicine. They feel impotent in the face of unilateral actions by insurers which they are powerless to control. The age, sex, training and qualifications of physicians has nothing to do with who gets sued.

It is often the best physician, willing to perform the most risky procedure, who is the most likely to be sued. The claim is not for the commission of a negligent act, but rather for the unhappy results of an unsuccessful outcome of treatment. Any physician may find himself the recipient of the anger and frustration of a patient or his family who has experienced an unavoidable medical accident in the course of treatment. The physician who is involved in a malpractice claim may face years of uncertainty and countless hours of efforts not directly related to the care of patients.

Malpractice insurance premiums for individual physicians are approaching $45,000 annually in some states for high-risk specialties. It is estimated that premiums for dermatologists in California and New York are approaching $7,000 and, when hazardous X-ray and cosmetic procedures are included, the premiums must certainly be higher. New physicians entering the health care system in some states cannot obtain malpractice insurance coverage at any price.

These pressures make it difficult for part-time practitioners and those nearing retirement, with reduced patient loads, to remain in practice. Thus, the effective number of providers of health care is reduced. While it is apparently not a significant factor at present, the availability and cost of medical malpractice insurance can be expected to affect choice of specialty and locality of practice of an increasing number of physicians in the future.

There is no doubt, however, that true medical malpractice negligence does exist. Failure to keep up with recent developments, overconfidence by competent specialists, and abuses of the medical care system for personal financial gain (e.g. unnecessary surgery) are all common causes leading to the institution of medical malpractice claims. Poor communication between the physician and patient has been cited by both sued physicians and patients who have instituted claims as the most common cause of medical malpractice suits. Failure to adequately inform patients of risks and possible outcomes of medical treatment is a common failure of communication leading to claims which has been supported in the courts. The depersonalization of the health care delivery system, the anonymous hospital and plethora of increasingly more specialized physicians attending the individual patient have also contributed to a weakening of the doctor-patient relationship and resulted in an increased number of suits.

No responsible physician would contend that negligent physicians should be exempt from responsibility for their action. Self-discipline by groups of physicians has been made extremely difficult because the courts often fail to support the attempts by local and state medical societies and licensing boards to expel poor doctors. It is all too easy for a physician whose license has been revoked to continue practicing and, thus, continue to commit negligent acts. It is often difficult for the plaintiff in a malpractice suit to obtain expert medical testimony due to a reluctance of physicians to testify against each other.

Hospitals as providers of health care face an equally challenging crisis in the availability and cost of medical malpractice insurance. Premium rates have increased one thousand percent over the past eight years and are increasing even faster today. Current costs for liability at some excellent hospitals where advanced and highly specialized treatment is available approach ten dollars per bed per day. The Argonaut Insurance Company will cease to insure hospitals in fourteen states on July 1, 1975. The American Hospital Association has proposed a captive re-insurance company to provide coverage for member hospitals. It is obvious that the hospitals cannot continue to absorb the increased cost of malpractice insurance premiums unless they pass these costs directly on to their patients.

*Effect on consumers*

Rapid advances in many areas of medical science have increased patient awareness of the possible benefits of medical treatment. The corollary of this is that patients are more likely to be disappointed if the health care system is unable to fulfill their expectations. The injured patient, whether the injury is due to medical malpractice or to the unfavorable outcome of treatment is, nevertheless, injured. His prospects for fair and adequate compensation for his physical and economic suffering are poor under the current system.

It has previously been stated that only a small fraction of those patients who are the victims of medical malpractice ever institute a claim. It has been estimated

by insurers that 46% of all claims lodged with them are meritorious; that is, there was an act of malpractice.

It takes, however, an average of five years to settle malpractice claims arising in any one year, and it often takes ten years to settle all claims made for that year. Patients must, therefore, suffer the needless hardship of waiting for compensation. Settlement of a claim nets only an average of 16 cents to 38 cents per dollar of settlement. In most courts, the percentage of the total judgement which will be paid to the attorney as his contingency fee may not be discussed in court. The settlement, which may be adequate were the patient to receive the entire amount, is therefore inadequate because the attorney charges one-third to one-half of the settlement as his fee.

Inflation and changing costs of medical care also introduce inequities in the provision of long-term care for permanently injured patients. In attempting to deal with this problem, juries have often awarded enormous lump sums to patients to provide for their care and maintenance for what would be expected to be a normal lifespan. Should the patient die in advance of this expected lifespan, these lump-sum payments revert to the patient's heirs, thereby removing money from the system which must be replaced through premium increases. While these instances may be few in terms of the total number of cases, they serve to drastically increase the cost of malpractice insurance premiums to all providers.

*The role of the law and lawyers*

The trend in the courts over the past several years has been to broaden the general concept of liability. Medical malpractice liability is only one area in which this has occurred. Trial lawyers contend that the tort system performs a social good by forcing physicians to practice good medicine or face suit for negligence; the physician is therefore accountable to the injured patient through the courts.

The gradual evolution of precedents in the courts over the past 15 years has broadened the definition of malpractice itself to include more than just simple negligence. The concept of "informed consent", that it is the responsibility of the physician to advise the patient of the risks and possible outcomes of any proposed treatment, has become a prominent doctrine in recent malpractice cases. It is difficult however to establish appropriate criteria of information: what is adequate information? and what is significant risk?

*Res ipsa loquitor* ("the thing speaks for itself") shifts the burden of proof to the physician who then must prove he was not negligent. Because medicine is an inexact science, this doctrine may evolve to the point where physicians may be unable to prove they were not at fault should a bad outcome occur.

Statutes of limitation, as long as six years in some states, may not even begin to run until the patient becomes aware of the injury. This so-called "discovery rule" as applied in some states may allow a minor child to sue for damages which occurred *in utero* after he reaches age 21. Other problems include the "locality rule", in which a physician may be held to be accountable for acts not conforming to accepted standards of care in his community. The "collateral benefits rule" allows the plaintiff to keep from the jury other sources of compensation, thus needlessly inflating settlement awards. In recent months in jurisdictions such as California and New York, where malpractice cases are most frequent, a disturbing trend toward holding doctors legally responsible for diagnostic errors and errors of judgment has emerged.

The jury system of deciding negligence cases has been increasingly criticized as the malpractice problem has worsened. Lay persons, serving on juries, don't often have the expertise to properly evaluate medical results. They may be swayed by emotional arguments to find for the plaintiff even though no malpractice has been committed. Plaintiffs, however, are only successful in approximately 20% of the cases which reach the courts. Except for states such as California, New York, Illinois, and Pennsylvania the jury generally finds for the doctor.

The role of the aggressive lawyer is most frequently cited by physicians as a cause of the increased number of malpractice suits. Attorneys, however, claim that they protect physicians from frivolous suits by accepting only the cases they consider to have merit. It is estimated that lawyers accept only one out of every eight cases presented to them. One-third of the rejected cases are not rejected on merit but rather because the potential dollar settlement is too small to make the effort to recover damages worthwhile for the attorney.

The contingency fee is at the heart of the attorney fee system. One-third to one-half of malpractice claim settlements is the usual attorney's contingency fee. The attorney must wait to recoup his investment in time and overhead until the claim is settled, probably insuring that non-meritorious cases reach the courts less frequently than if the lawyers operated on a purely fee-for-service system. However, when large lump-sum settlements are made, the contingency fee provides for astronomical dollar amounts to be paid to attorneys. This needlessly adds to the cost of the settlement of claims and further reduces the benefits paid to plaintiffs. Total abandonment of the contingency fee system would prohibit access to the courts to those unable to afford an initial retainer or attorney's fee. Thus, patients with limited resources and legitimate claims would be denied equal compensation for medical malpractice injuries. There is no evidence to date that no-fault auto insurance has led to an increase in the number of lawyers entering the medical malpractice field in states where no-fault insurance has been enacted.

## ROLE OF INSURERS

Malpractice liability insurance has always been a small part of the general liability insurance business, and there have always been few companies writing malpractice insurance policies. Only 1.1% (in 1970) of the total premiums paid for all types of liability insurance were for medical malpractice insurance. The high cost of settling claims, 29% of every premium dollar, has contributed to the inefficiency of the system for compensating injured patients.

Insurance companies, while they claim they want to remain in the medical malpractice insurance business, are nevertheless leaving the field. The insurers claim that they are unable to accurately predict their risk at present due to the dramatic and rapid increase in the number of claims and the size of settlements. The so-called "long tail" of claims made for every given year makes it difficult to establish premium rates. It is estimated that it takes ten years to settle all claims arising in any given year. The statistical pool of events is too small for accurate actuarial analysis within confidence limits which would insure adequate protection of reserves and profits for insurers. The companies deny that premium increases and reduced availability of insurance has resulted from reserve losses in the recent economic slump and stock market decline.

The traditional medical malpractice insurance policy, in which the provider is covered regardless of when the claim is submitted if the incident occurred during the policy year will probably undergo some change. Some insurers will begin using a "claims made" type of policy which covers physicians only for claims made during a particular year. Physicians, if they ceased practice, would therefore be forced to continue buying coverage for claims made in future years for incidences occurring in prior years, or be vulnerable to catastrophic liability loss. The "claims made" policy is a protective device for insurance companies; it allows them to more accurately base their rates on expected losses.

*Proposed alternatives and solutions*

The National Conference on Medical Malpractice provided a forum for interested groups to propose alternative short- and long-term solutions to the medical malpractice insurance problem. Legislative remedies proposed by members of Congress were discussed and proposals were heard from various state groups, the AMA, the insurance industry, and individual experts. We have attempted to summarize the major solutions below.

*Federal Solutions*

H.R. 6100 (Hastings): The Medical Malpractice Claims Settlement Assistance Act.

This bill, prepared as a result of the information gathered at the National Conference, provides for federal reinsurance over $200,000 for malpractice claims. Qualified states would have to establish programs of arbitration which would then be the required method of handling malpractice claims before the judicial approach is used. The bill provides for control of attorneys' contingent fees, reduces the statute of limitations to a reasonable two years, provides for the establishment of patients' grievance mechanisms, established rules for the awarding of periodic rather than lump sum large payments to injured patients, requires the establishment of risk-control programs, and provides for the cum-

mulation and reporting of statistical information on malpractice. No penalties for federal assistance are imposed.

S. 188 (Nelson) : Federal Malpractice Insurance Act.

This bill establishes in HEW a national medical malpractice development fund patterned after the federal riot and flood reinsurance programs. Insurance companies selling medical malpractice insurance could voluntarily pay into the fund and the fund would guarantee payments over $25,000 (a figure which would be adjusted based on experience). In addition, a variety of studies of medical malpractice problems would be ordered to evaluate alternative solutions to the current system of handling medical negligence injury.

Under the provisions of this bill insurance companies would be protected against catastrophic losses and would therefore be encouraged to remain in the medical malpractice insurance marketplace. They would potentially be able to control and therefore possibly lower premiums.

S. 215 (Inouye and Kennedy) : National Medical Injury Compensation Act of 1975.

This act would create a Federal no-fault compensation system for medical injuries which would rapidly compensate an injured patient (up to a maximum monthly dollar amount) regardless of whether the injury was caused by negligence or poor outcome. The patient would therefore not have to wait until his case was settled to receive compensation.

The bill would be self-funded through premiums paid in by participating physicians. The physician would on a voluntary participation basis, pay an annual premium to the federal government and in return his patients would get benefits for injuries resulting from his treatment. In order to guarantee a high standard of quality medical care and prevent abuse of the system the provider would agree: 1) that his services be subject to review by his area's PSRO; 2) to comply with national standards of licensure; 3) to obtain a "confirming consultation" before performing specified types of surgery; and 4) to treat Medicare patients at the prevailing rate of reimbursement.

The bill would also abolish the contingency fee system, paying any fees to attorneys out of the medical injury compensation insurance fund. No part of any no-fault benefits would be paid to the lawyer. Patients would not be forced to accept no-fault settlements, but could go to court to recover damages instead.

S. 482 (Kennedy and Inouye) : National Medical Malpractice Insurance and Arbitration Act of 1975.

This legislation requires non-binding arbitration of medical malpractice disputes. The provisions of the legislation would allow providers to voluntarily join the plan and pay an annual premium to the federal government. They would receive insurance coverage and be required to abide by the same conditions of participation as described above for S. 215.

The claimant could either accept the decision of the arbitration panel or sue, but the result of the arbitration would be admissible as evidence in court. Contingent fees would be controlled on a sliding schedule of percentage of plaintiff's awards. The federal insurance would apply only in states which enacted legislation consistent with the federal act.

*State solutions*

A detailed analysis of alternative solutions now under consideration by the various state legislatures is beyond the scope of this report. Most of the better bills contain features designed to modify the current system rather than to entirely replace it. Most plans provide for state-funded reinsurance, guarantees against catastrophic losses for insurers, or some form of asset pooling to dilute loss risk.

Approximately 25 states now have or are considering some form of arbitration. This ranges from voluntary non-binding arbitration to statutory-binding arbitration. This method of settling malpractice claims is attractive because it can lead to the settlement of claims faster than the current system. Arbitration probably will eliminate expensive cost of defending malpractice insurance claims and can circumvent those problems already discussed as inherent in the present lay-jury system. Arbitrators, if selected carefully, would be able to bring specialized knowledge to bear on particular problems, and thus ensure fair compensation for medical malpractice injuries free from emotional arguments.

*Insurance industry solutions*

The American Insurance Association will shortly distribute to state legislators a model bill that will seek to establish Joint Underwriting Associations. These JUAs will pool the resources of all personal injury liability carriers in a particular state, including automobile insurers.

This would reduce the potential for catastrophic loss for each insurance company and would serve to keep in operation a viable insurance marketplace. This may be an effective short-term proposal, but it makes no attempt to correct inequities in the present system which have lead to the current crisis. It is unlikely that anything but self-protective solutions are to be expected from the insurance industry.

*Provider solutions*

In general, solutions proposed by the AMA and other organized medical and hospital groups have suggested minor modifications of the existing system which generally favor physicians. No major changes in the system are proposed however. Still in preparation is a model bill which the AMA will soon make available to state societies.

*No-fault solutions*

S. 215 and other no-fault solutions proposed under a variety of titles at the National Conference on Medical Malpractice all essentially provide that the person injured by medical treatment be compensated regardless of the liability of the provider. We do not believe that the concept of no-fault is a workable one at present, since there is an area between negligent and non-negligent injury which, due to the nature of medical practice, is always undefinable. Since no set of guidelines can be complete enough to encompass every potential medical injury, great difficulty will ultimately be encouraged in defining what is and what is not a "compensable act". Similarly, all no-fault plans provide some form of quality assurance mechanism to preserve the accountability of physicians if negligence occurs. At some point it must be decided whether a given act was negligent or non-negligent and this may be similarly impossible. We believe that if a comprehensive no-fault insurance plan is adopted, we may potentially be exchanging one set of inequities for another. No studies have yet been done to estimate the cost of no-fault programs, which may be many times that of the present system. If *any* injury could result in a claim, the cost could become burdensome, particularly if the no-fault program was self-funded solely through provider premiums.

*What should be done by organized dermatology?*

As has been stated, there is a striking lack of data about the malpractice experience of office-based physicians including most dermatologists. We believe it is absolutely essential that a comprehensive study be performed as soon as possible in order to determine the actual experience of dermatologists with medical malpractice. It may be possible to secure a government grant through the Department of Health, Education, and Welfare in order to expedite this survey. A detailed questionnaire should be constructed and mailed to all Academy members in order to gather statistical information on the causes of malpractice claims against dermatologists and the outcome of these claims. It will be esssential to guarantee anonymity to all respondents to insure their participation in the survey. It might be advisable to distribute the questionnaire with a covering letter signed by the President of the American Academy of Dermatology encouraging participation and guaranteeing that no individual questionnaire would be made available to anyone but those actually preparing results.

Based on the data provided by this survey, suggestions for the avoidance of malpractice by practicing dermatologists could be made. The results of the survey could be published in the *Archives of Dermatology* outlining the most frequent malpractice pitfalls and presenting suggested remedies. The results of the survey could be incorporated into a special course or seminar to be held at the annual meeting of the American Academy of Dermatology.

Academy members could be encouraged to attend such a malpractice prevention course at least once every two years. This would increase attendance at the national meeting by just those physicians who would most benefit from exposure to the most recent developments in dermatology. The Academy should also encourage attendance by its members at regional and local clinical meetings.

We believe organized dermatology should attempt to encourage the develop-

ment of solutions at the state level rather than at the federal level. Of the proposed federal solutions, H.R. 6100 (Hastings) offers a reasonable and efficient temporary solution to the problem and should be strongly supported by the American Academy of Dermatology. The Academy could support S. 188 the Federal Malpractice Insurance Act as long as no federal standards for providers are amended to that legislation. The Academy should also support H.R. 1378 (Rostenkowski), a bill which provides for studies of medical malpractice insurance problems to be performed by the National Academy of Sciences. We do not believe that the Academy should support the provision S. 215 or S. 482, as both these bills would needlessly limit the freedom of the individual dermatologist. We do not believe at present that the Academy should support any form of no-fault insurance for the reasons already cited.

We believe some form of arbitration system on the state level provides the most likely avenue for improvement of the present system. The Academy should explore the creation of a pool of objective expert witnesses who would be available to assist arbitrators or actually engage in the arbitration of malpractice claims involving dermatologists.

Operating on the state level, organized dermatology should support local legislation which provides for short-term solutions designed to maintain the availability of medical malpractice insurance; these solutions include Joint Underwriting Associations and state reinsurance funds. Model state bills should include provision for arbitration of malpractice claims but not completely prevent access to the courts by individual claimants. Proposed state legislation should be expected to alter many of the areas of difficulty cited earlier which have led to inequities in the system.

All modifications of the present system should basically be directed toward providing comprehensive medical malpractice insurance for health care providers at a reasonable cost. These changes must, however, provide for more rapid and more widespread compensation for medical injuries. We believe that much of the present problem has occurred because the current system has been called upon to provide compensation for non-negligent medical nijury and the poor outcome of non-negligent medical treatment. If these factors are removed from the system, perhaps by including a provision for the compensation of these patients through a national catastrophic health insurance bill, and if the appropriate legislation is enacted, the overloaded medical malpractice insurance system can begin to function efficiently.

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## APPENDIX D

### Panelist Recommendations: National Conference on Medical Malpractice

During the course of the Conference, acknowledged experts in the field of medical malpractice made recommendations as to how the impact of medical malpractice might be lessened. Listed below are those reommendations along with the persons who made them, and the institutions they represent.

Dr. John Coury, Member of the American Medical Association Council on Legislation:

1. State legislatures must provide immunity for physicians serving on peer review boards, sitting in judgment of fellow professionals.
2. States must require insurance companies to give a regular accounting of all malpractice actions brought against its policyholders.
3. There should be good samaritan acts to protect physicians who are called in to handle emergencies or perhaps treat patients who are not their own.
4. There should be a requirement of an affidavit of merit when the plaintiff attorney files a claim.
5. There should be limits on contingency fees, similar to those imposed in New Jersey.
6. There must be some limiting of the guarantee of favorable treatment outcomes unless there is an assurance in writing.
7. There should be a limitation placed on windfall recoveries and some consideration given to compensating injured patients on a regular as needed basis—perhaps monthly.
8. There must be a ceiling on damages.

9. There should be an elimination of the injury speaks for itself doctrine—res ipsa loquitur.

10. An agreement between a patient and a physician to arbitrate claims should be permissable.

Dr. Edward D. Henderson, chairman of the Professional Service Committee of the American Academy of Orthopedic Surgeons.

Dr. Henderson stated that the following reforms were agreed to by the New York Medical Association and the New York Bar Association. It was assumed that these reforms were endorsed by the American Academy of Orthopedic Surgeons:

1. A court system of speedier trials, similar to the Federal court method of scheduling.
2. A test of the arbitration system.
3. Standardization of the informed consent procedure.
4. Reduction of contingency fees.
5. Rejection of the no-fault system as being too expensive.
6. Acceptance of the disclosure of collateral sources in court.
7. Making available to the courts a peer specialist group.
8. Early specification of charges in bills of particulars and exchange of expert reports.
9. Reduction in the statute of limitations.
10. Defined limitation of awards.

Mr. Robert Cartwright, president of the Association of Trial Lawyers of America:

1. There should be continuation of the present tort law system for settling medical malpractice claims.
2. Better safety techniques and procedures should be established by health care providers.
3. Screening panels and other devices should be used to cut down on the number of malpractice cases.
4. There should be public disclosure of medical malpractice information regarding premiums collected, payouts, and all other matters.
5. There should be redistribution of premiums among health care providers.
6. Premiums should be established for medical malpractice based on the gross receipts of the physician to deal with problems confronted by the young doctors and those cutting back on practice as they near retirement.
7. There should be arbitration of claims with estimated potential settlement values of $25,000 or less.
8. Laws should be enacted to protect members of boards which discipline physicians who are incompetent, unfit, or unqualified to practice.
9. Laws should be enacted to make information obtained by peer review committees privileged information.

Mr. Thomas Vehlin, Representative, St. Paul Fire and Marine Insurance Company:

1. Medical malpractice insurance policies should be offered on a claims-made rather than occurrence basis.

Ms. Adrienne A. Astolfi, Director, Hospital and Health Care Sector of the National Commission on Productivity proposed the following:

1. That, any new approach considered for adoption be analyzed carefully in terms of its impact on the total economy and the total health care delivery system so that it does not shift the burden of malpractice costs from one sector of society to another, from one professional group to another or from one part of the health system to another.
2. That any Commission, panel, committee that is established to address the medical malpractice issue have at least one representative from the public—the consumer.
3. That the doctors, lawyers, insurance companies, and policy makers fully analyze the effect on the patient in terms of quality of care and costs, before any new approach to the malpractice issue is adopted.
4. That the primary focus of any new approach to resolving this problem be the patient or consumer.
5. That the significance of the doctor/patient relationship be emphasized to physicians through their respective associations especially among physicians practicing in those States where the largest number of malpractice suits have been filed.

6. That regardless of the approach finally adopted to resolve this dilemma, it does not discourage practicing physicians from continuing to practice or discourage new physicians from serving the public.

7. Additional studies be conducted to address the issue of variation in the number of malpractice suits and the cost of malpractice insurance variation among the individual States. Perhaps we only have problems in a handful of States—are suits significantly on the increase in every State?

8. That the social and cultural forces in our society that have given rise to more "litigation-oriented" public be identified and examined especially since medical malpractice claims are increasing at an annual rate of 13–14 percent.

9. That studies be conducted to determine if the breakdown in the physician/patient relationship is one of the major reasons for our malpractice crisis. In 1971, a study was performed in which both physicians who had been sued or threatened with suit and those who were not surveyed as to their perceptions of the cause of medical malpractice suits. Both groups responded that the major cause of medical malpractice suits was the poor communication between the patient and the physician. I suggest we also conduct an up-to-date survey of patients who did sue to obtain their opinions. Have any of the malpractice suits filed been against physicians who were the family physicians for 10 or 20 years?

10. If we're looking at the total health system, we should study, analyze, examine the other pieces of it in terms of medical malpractice, such as outpatient clinics, home care programs, and preventive health programs, which are not directly associated with a hospital but in which medical malpractice claims may arise.

Eli Bernzweig, Special Assistant to the Acting Federal Insurance Administrator of the Department of Housing and Urban Development:

1. Every effort should be made to reduce the number of iatrogencic injuries, whether caused by medical malpractice or not.

2. A settlement system should be devised to meet the needs of all injured patients by providing prompt restorative medical treatment and just compensation for disabilities they have sustained.

3. Better ways should be developed to monitor and control the quality of care independent of the issue of medical malpractice.

Mr. Clark C. Havighurst, Professor of Law, Duke University:

1. There should be testing of medical adversity insurance. Medical adversity is defined as an unfavorable outcome caused by medical treatment. The physician would assume strict liability for such unfavorable outcomes, and his insurance rates would be based on the cost of incidents occurring under such a system. Mr. Havighurst proposes that certain specific results would be declared to be compensable, generally events which would be avoidable, and, therefore, those events the physician would have both the ability and the incentive to reduce. Only those results would be considered for compensation, and all others would be handled under the traditional tort system. The purpose of the system would be to simplify the system of compensation for injuries while retaining provider incentives for improving the quality of care.

Dr. Joseph B. Davis, chairman of the insurance trustees of the American Group Practice Association:

1. Risk control programs should be instituted by physicians to reduce the number of medical malpractice incidents and to encourage early settlements of alleged medical malpractice incidents. A major purpose of risk control programs is to encourage a professional awareness which will reduce the occurrence of patient injuries through malpractice, to establish procedures for handling alleged malpractice incidents and to provide an environment which will lead to a minimal number of patient or employee injuries.

Dr. David S. Rubsamen, Editor, Professional Liability Newsletter:

1. Payment of future medical costs should be made on a month-by-month basis, referred to as the structured medical settlement.

2. Collateral sources of services and payments should be included in determining medical malpractice settlements.

3. The contingency fee system should be preserved but with regulated fees to avoid "huge windfalls."

4. The jury should be eliminated, and replaced either with an arbitration system or with specialty judges, similar to those that now handle patents and

bankruptcy matters. The proposed arbitration system would be binding upon the parties.

Dr. Joseph Sadusk, Jr. Senior Consultant to the Permanent Medical Group:

1. The present court system should be replaced with compulsory arbitration or a commission approach.

2. There should be periodic rather than lump sum payments.

3. Reasonable limits should be established on the amounts of awards, with instructions to the jury that such awards are not taxable.

4. There should be a redefinition of the statute of limitations.

5. There should be a replacement of the present contingency fee arrangements with either a fee for service system or a sliding scale contingency fee.

6. There should be Federal action to:

a. Declare the field of professional and hospital liability an uninsurable risk, until otherwise defined at a later date.

b. Establish, under the Secretary of the Department of Health, Education and Welfare a Commission on Malpractice Reinsurance to protect the insurance industry against catastrophic losses, and,

c. Continuation of such a program for not less than five years, nor more than 10 years.

Mr. Melvin Stark, Senior Vice President in charge of Government affairs for the American Insurance Association:

1. A state regulated, privately operated joint underwriting associations composed of all carriers writing personal injury liability insurance should be developed in all States experiencing an insurance availability crisis.

2. Mr. Stark then stated that the following issues must be dealt with: the collateral source rule, the contingent fee, limits on levels of compensation, the discovery rule, and the statute of limitations.

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