It's fitting that we pay tribute to the dedication of those who were busily working in the public's interest at the moment of that terrible blast.

TRAGEDY IN OKLAHOMA CITY

Mr. SIMPSON. Mr. President, I rise to speak briefly about the recent tragedy in Oklahoma.

Mr. President, throughout our land, so many have already spoken out so eloquently about this, that I can add but little to what has already been said. The suffering of the victims, the inhumanity and cowardice of the bombers, the compassion and heroism of our community of citizens, and our solemn resolution to exact justice and punishment—all of these have been powerfully attested to already.

I will therefore limit myself to praise a particular aspect of our President's handling of this crisis.

There has been so much of our American democracy which has shown itself to be worthy of praise and of pride in this last week—from the behavior of ordinary citizens in a time of trial, on up through the labors of rescue and medical teams, through to the highest ranks of our law enforcement agencies, and up to the conduct of the President. I trust that terrorists the world over would be rightly awed and cowed by the great skill, energy, and resolution that has been displayed.

In the wake of such a horrible tragedy, there is a terrible feeling of powerlessness, and it exists for all of us, even those of us at the highest levels of government. We had to hope that the perpetrators would be caught. Many had to wait and to hope that loved ones would be found alive. Even those who were actively engaged in bringing relief and justice had to contend with so many factors outside of their control.

When I think of what the President faced, I am reminded in a small way of Dwight Eisenhower's recollection of the Normandy invasion. He had done all he could to plan and to provide, but once he issued the fateful order—''Let's go!''—his subordinates scrambled to carry out their tasks, and he was left alone with a sudden realization: that he was now powerless to do more than to hope that his orders would be carried out successfully.

I can only imagine that a similar anxiety must have gripped the President as he issued orders which he hoped would bring answers—and arrests—in the wake of this tragedy. He must indeed believe himself to be fortunate that law enforcement agents across the country worked so doggedly and so well, and so successfully, even as much remains to be done.

But even with everything the President had to hope for in terms of carrying out an investigation, there still remained a duty that was his, and his alone, as President of the United States. There is no way for a President to delegate the responsibility of speaking for the Nation, and of providing a voice of resolution and reason when events have gone awry.

This action of the President has served this country so well in the days after the tragic event. Yet now there appears to be some scapegoating by him today. He first voiced the Nation's determination to bring the criminals to justice. He had steadfastly resisted the temptation to blame the tragedy on specific ethnic or ideological groups. And he gave voice to what so many Americans were feeling, the fundamental commitment to law and to peaceful order shared by nearly all Americans, no matter where they stand politically.

It is not a duty to be underestimated. At a time when so many Americans must necessarily feel themselves powerless to fight back against this cowardly attack, the need is great to have their feelings expressed, and to have them channeled into a constructive collective response to this tragedy.

In those first few days, the President, even as he worked to comfort the victims of the attack, succeeded in drawing a clearly understood line as to where this Nation stands. He asserted with great force and clarity that, on the one hand, Americans have a right to be suspicious of government, and to exercise their first amendment rights, their second amendment rights, and every other protected right. But this Nation cannot and will not tolerate the exercise of rights that include violent attacks on Federal officials, on their children, or anyone else.

I pray that none of us, including the President, become vindictive toward any group in America—whether they are Islamic Americans, conservative organizations, talk show hosts, or anyone else—we must remember that virtually all of these people are as horrified by this violence as are we.

The President spoke well soon after the tragedy when he left no doubt that Americans are not divided over these matters, but united in our commitment to law and order, in a way that law-abiding Americans as well as terrorists should be able to understand. And this was an important cathartic process for Americans as we coped with this tragedy.

I close by giving my thanks to those in our government who have worked so hard in these last days to ''bind the Nation's wounds.''

Mr. BRYAN. Mr. President, I was pleased to join with my colleagues in adopting Senate Resolution 110 which condemns the horrendous violence that happened in Oklahoma City and urges the administration to bring to justice those responsible for committing this evil crime. In addition, the measure expresses our deepest sympathy to the families that have lost so much and conveys our gratitude to all the Americans who have been assisting in rescue efforts.

Today, I would like to recognize those individuals from Nevada who have joined in the heartbreaking struggle to help our friends in Oklahoma. Dr. Scott Bjerke, a specialist in critical care at University Medical Center's trauma unit, Dave Webb, a fire specialist with the U.S. Forest Service, Metro Police Sgt. Bill Burnett, and Clark County fire paramedic coordinator chief Steve Hanson all are members of Clark County's elite 60 member Urban Search and Rescue Task Force which headed to Oklahoma City to assist rescue workers. In addition, the Clark County American Red Cross has sent Caroline Johnson, officer for the disaster computer operations, to Oklahoma City. In times of tragedy, there are always heroes. All the Americans who have been devoting endless time and emotions to ease the pain of so many are the true heros of this tragedy. I am proud that Nevadans have united together with the country during this time of such need. I thank these individuals for their commitment to others.

Although we cannot ever heal all the wounds both emotional and physical from this tragedy, I hope that those in Oklahoma will know that Nevadans are praying for them and somehow that will lessen their pain.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is now closed.

COMMONSENSE PRODUCT LIABILITY AND LEGAL REFORM ACT

The PRESIDING OFFICER. Under the previous order, the Senate will now resume consideration of H.R. 956, which the clerk will report.

The bill clerk read as follows:

A bill (H.R. 956) to establish legal standards and procedures for product liability litigation, and for other purposes.

Pending:

Gorton Amendment No. 596, in the nature of a substitute.

The Senate resumed consideration of the bill.

Mr. DODD. Mr. President, I rise this morning to express my strong support for the Product Liability Fairness Act, which is the pending legislative business before the Senate. Balanced reforms in this measure will help to promote fairness in the product liability system, help injured people get fair compensation for their injuries, allow businesses to get out of unjustified lawsuits, and improve safety conditions for working men and women in this country. With these reforms in place we will help alleviate the problems that undermine the present system.

I want to commend at the outset the principal authors of this legislation, Senator ROCKEFELLER of West Virginia and Senator GORTON of the State of Washington, for their hard work. They have worked tirelessly on this effort for a number of years. I am pleased to have joined them in that effort over

the last several years, and as an original cosponsor of this legislation.

It is very clear that our current product liability system does not work. It is broken. I think we have a need and an obligation to try to fix it. Over the years a wide range of my constituents—consumers, manufacturers, small businesses, and working men and women—have identified the key problem. Far too often the results you obtain in a product liability case depend not on the merits of your claim but on your ability to afford good counsel.

The statistics confirm what our constituents have been telling us. Under the present system, injured people must wait too long for compensation. Generally it takes an average of 2½ years for a claim to be resolved. A recent study by the GAO found that it can take up to 5 years for a victim to receive their justified compensation. The delays in the present system can—and I think do—lead to inadequate compensation. Many seriously injured people who lack the resources to pay their medical bills and support their families while waiting a decision cannot afford to go 5 years without compensation. They have no choice but to settle, and to settle in many cases for inadequate amounts.

While the present system is not serving the needs of our injured citizens well, it is also failing to meet the needs of American industry and business. Many of these industries are reluctant to introduce new products. When they look at their potential future liability, they see the different and distinct laws of 55 different States and territories staring back at them.

This uncertainty is particularly difficult for smaller businesses who cannot afford the huge legal costs of the present system. In too many cases companies are forced to run up enormous legal bills only to be vindicated by the courts at a far later date. Who is well served by a system that stifles innovation? Who benefits when businesses are forced to defer investment on research and development? Who wins under that kind of system? Of course, no one does. If American businesses are unable to bring innovative products to the marketplace or are forced to take healthful products off the market then we all lose.

Let me be specific. The search for an AIDS vaccine is a good example. The Commerce Committee of this body has heard testimony from Biogen, a company in the State of Massachusetts. It stopped work on an AIDS vaccine because of product liability fees.

Even more disturbing is the way in which the current product liability system threatens entire industries. The contraceptive industry is one example. A 1990 report issued by the National Research Council and the Institute of Medicine concluded:

> Product liability litigation has contributed significantly to the climate of disincentives for the development of contraceptive products.

As the American Medical Association points out, 25 years ago there were 13 American pharmaceutical companies researching potential products in the areas of contraception and fertility. Now there is only 1—from 13 companies down to 1. Clearly, we need to change the system that has bred these kinds of results. I think we can and we must do better.

Mr. President, with the passage of the Product Liability Fairness Act we will do better. This legislation would improve the product liability system for everyone. I want to emphasize that. This ought not to be a case of pitting attorneys against businesses and businesses against consumers. Everyone will benefit as a result of the improvements in this bill—the injured people who need fast and fair compensation, consumers who need quality products to choose from, and those American enterprises who are on the cutting edge of international competition, and the workers who depend on a strong economy to support their families.

The moderate reforms in this measure would reduce the abuses in the current system without eliminating solid protections for those who are victimized by defective or dangerous products.

I know my colleagues, Senators ROCKEFELLER and GORTON, have already gone through the bill in great detail. So I will just highlight some of the key provisions.

First, this measure would provide a far more uniform system of product liability. By adding more certainty to the system, the excessive costs in the present system would come down. This potential benefit motivated the National Governors Association to support this product liability reform measure. The association has said:

> The United States needs a single predictable set of product liability rules. The adoption of a Federal uniform product liability code would eliminate unnecessary costs and delay the confusion in resolving product liability cases.

Why is it important to quote the Governors here? Because some of the opponents of the bill have asked why we should be making changes at the Federal level when tort law is usually left to the States. That position ignores the fact that 70 percent of all products now move in interstate commerce. If the Governors of this country contend that a uniform Federal code in this area makes sense, then I think we ought to listen to what they are saying.

The provision in the bill that encourages the use of alternative dispute resolution would also help reduce the excessive costs in the current system. Currently, too much money goes to transaction costs—primarily attorneys' fees—and far too little goes to the legitimate victims that have been hurt.

A 1993 survey of the Association of Manufacturing Technology found that every 100 claims filed against its members cost a total of $10.2 million. Out of that total of $10.2 million, the legitimate victims receive only $2.3 million, with the rest of the money going for legal costs and transactional costs. Clearly, we need to implement a better system in which the money goes to those who need it—injured people.

Consumers would also benefit from a statute of limitations provision that preserves the claim until 2 years after the consumer should have discovered the harm and the cause. In many cases today injured people are not sure what caused their injuries, and by the time they figure it out they have often lost their ability to sue. This legislation would provide relief for people in such situations and allow them adequate time to bring a lawsuit.

This legislation also includes a number of provisions that are simply common sense. Under the bill defendants would have an absolute defense if the plaintiff, the one who is claiming the injury, was under the influence of intoxicating alcohol or illegal drugs and the condition was more than 50 percent responsible for that person's injuries.

This provision, it seems to me, is nothing more than simple common sense. Why should a responsible company have to pay for the actions of someone who has, unfortunately, used alcohol or illegal substances? The company should not be held responsible, it seems to me, for that kind of an injury.

The bill also institutes reforms to assist product sellers. They would only be liable for their own negligence or for failure to comply with an express warranty. Product sellers who are not at fault could get out of cases before running up huge legal bills.

But as an added protection for injured people, this rule would not apply if the manufacturer could not be brought into court or if the claimant would be unable to enforce a judgment against the manufacturer. So we have provided a sense of balance here to try to see to it that people are not left without any recourse at all.

Striking a balance is at the heart of this bill. Again I wish to commend my colleagues from Washington and from West Virginia. This is a balanced approach. We need to keep that in mind. There are a lot of amendments that will be offered, and some may seem appealing, but when you consider them keep in mind the totality of what has been done and the balance we have struck.

This bill also contains an important section on biomaterials authored by my colleague from Connecticut, Senator LIEBERMAN. That provision is designed to ensure that manufacturers of lifesaving and life-enhancing medical devices would have access to raw materials which are absolutely critical in this important industry. In recent years, the supply of raw materials has been threatened by litigation. Those are the facts. I commend my colleague from Connecticut for crafting a very promising solution to that problem.

The provisions that I have outlined here, Mr. President, demonstrate the balance that this legislation strikes between consumers and businesses. In the final analysis, the reforms in this bill should strengthen our product liability system for everyone.

Of course, some of my colleagues are opposed to the measure—that is to be expected. They have raised some concerns, and certainly we look forward to the debates in the coming days. But I hope that we can avoid some of the inflammatory rhetoric that has characterized the debate on this issue in the past. This is a critically important issue involving the rights and responsibilities of injured people, of working people, of American industry, and we ought to treat it with the seriousness it deserves.

My involvement with this issue goes back to the early 1980's, Mr. President. At that time I had serious concerns about some of the product liability proposals before Congress. Along with our colleague who retired from the Senate, Jack Danforth, of Missouri, and with the help of Judge Guido Calabresi, who was the dean of Yale Law School at the time, we put together several proposals to deal with product liability. We never got very far with them. In fact, I do not think we got our ideas out of the Commerce Committee. We have come a long way. We are getting closer and closer to passing much-needed legislation in this area.

So I hope my colleagues will support, if necessary, cloture motions to allow us to at least have a chance to debate these issues and to determine whether or not the majority of this body wants to support this legislation.

Let me also say—and my colleague from Washington certainly is aware of this particular concern—there is a lot of attention being paid to the punitive damages section. I have concerns about setting limits in this area. I would much prefer a system that has been tried in a few of our States where the jury determines whether punitive damages should be awarded, but then have the judges determine the amount. In determining the amount, the judge would follow a set of guidelines. This approach, which is the law in Kansas, addresses the concern about excessive or ''runaway'' jury verdicts, while preserving the court's ability to punish certain egregious behavior.

I will not take the time here this morning to go into a longer discussion of this issue because I want the thrust of my remarks to be focused on the totality of the bill.

Again, Mr. President, I think this bill strikes an excellent balance. It is long overdue and represents a great step forward. Because we are so close to enacting these responsible reforms, I caution my colleagues against expanding the scope of the bill. For example, I know that some of my colleagues want to add medical malpractice provisions to the bill. I think that would be a mistake because it would jeopardize our ability to get this legislation enacted.

Because of these concerns, I will not be offering as an amendment a securities litigation reform bill that I coauthored with my colleague from New Mexico, PETE DOMENICI. Clearly there is a temptation to deal with various areas of the law under the broader heading of legal reform. But we need to be sensitive to the particular problems in each area of the law and not lump matters together.

So I will oppose efforts to expand the scope of this bill. If someone were to offer my bill on securities litigation reform as an amendment, I would oppose it. As many years as I have spent on it, it does not belong on this bill. So I hope my colleagues will keep this measure narrowly focused and help move it forward.

Mr. GORTON addressed the Chair.

The PRESIDING OFFICER. The Senator from Washington.

Mr. GORTON. What is the pending business? Are we operating under any unanimous-consent agreement?

The PRESIDING OFFICER. There was an agreement to recognize the majority leader to offer an amendment.

Mr. GORTON. I am authorized to report that the majority leader does not intend to take advantage of his right to offer an amendment at this point. As a consequence, the floor is open for amendments. I understand that the Senator from Kentucky intends to offer an amendment on medical malpractice, which is a very broad and significant amendment, and I hope can be concluded during the course of the day but nevertheless deserves considerable debate.

I think I also should like to announce that, of course, it is really the turn of the opponents to this bill to offer an amendment, and if any of them wish to do so at the conclusion of this debate, I would appreciate their informing me or my colleague from West Virginia so that we can try to see to it that amendments are dealt with in a fair order.

Before I yield the floor, Mr. President, I should like to say how much I admire the forceful and cogent and persuasive remarks of my friend from Connecticut, Senator DODD.

If I may make one or two more comments on a point of the Senator from Connecticut.

Perhaps the most important of all of the points had to do with the balance that adheres in this bill. It is the result of the work of many years and work among Members of somewhat varying opinions other than the proposition that something is broken and needs to be fixed in connection with our product liability laws. So we have not gone all the way as far as we might in drafting this bill.

We have attempted not to go from one extreme to the other extreme, but to come up with a solution that is fair to litigants, and that nonetheless will encourage the research and development of new products, marketing the new products, and the creation of economic opportunity in this country.

I was particularly struck by the forceful way in which the Senator from Connecticut spoke of the balance, the way we reached these goals. I also understand his concern with the present provisions on punitive damages. We and others are working together to see whether or not we cannot come up with a superior solution to that which is included in the bill at the present time.

But I do want to thank him for his most eloquent statement.

Mr. DODD. I thank the Senator.

Mr. MCCONNELL addressed the Chair.

The PRESIDING OFFICER (Mr. SHELBY). The Senator from Kentucky.

Mr. MCCONNELL. I thank the Chair.

Mr. President, I will shortly be offering an amendment, as the distinguished Senator from Washington indicated, with reference to the medical malpractice crisis that we have in our country. I will be offering this amendment on behalf of myself, Senator LIEBERMAN, and Senator KASSEBAUM.

This amendment, Mr. President, would expand the product liability bill to include health care liability cases. Medical malpractice reform is a perfect fit with the product liability reform effort underway here in the Senate. Overlap exists between these two issues, and if we do not reform them together, we could make the liability system even more complicated than it is now.

Take, for example, Mr. President, a lawsuit over an adverse reaction to a drug. The injured patient is likely to sue the doctor who prescribed the drug, as well as the manufacturer and the seller.

Now, Mr. President, if we only pass a narrow product liability bill, the drugmaker and seller would be covered under the product liability reform, but the case against the doctor would proceed under different rules. The result could be two separate cases involving the same set of facts.

Is that an improvement in the legal system? I think hardly is that an improvement.

So I say to my colleagues who support product liability reform, let us take a new look. Medical malpractice reform needs to accompany product liability reform. The problems within our health care liability system establish the need for the reforms contained within this amendment.

First of all, Mr. President, the liability system impedes access to affordable health care for many in our country. The Office of Technology Assessment reports that half a million rural women do not have access to an obstetrician to deliver their babies. Now, I know that is an acute problem in rural areas of Kentucky. The American College of Obstetricians and Gynecologists state that more and more obstetricians are giving up the practice and restricting themselves only to gynecology, one of

every eight, according to their 1990 study.

Let me share a few statistics with you. In Georgia, 75 counties lack maternity care; in Alabama, 2 counties; in Colorado, 19 counties have no maternity care whatsoever.

During the health care debate last year, I received a letter from Dr. Leonard Lawrence, president of the National Medical Association, whose membership consists of African-American doctors. He wrote, Mr. President:

> Minority physicians are particularly impacted by the current medical malpractice crisis. The combined costs of liability insurance and the threat of malpractice suits have caused many of our members to stop practicing in high-risk areas. The effects of these trends are painfully evident in minority communities. Minority physicians who have traditionally made a commitment to serve Medicaid patients are being forced to discontinue these services.

Mr. President, I know many of my colleagues who are opposing the legal reform effort argue that reform will have an adverse effect on women and low-income minority individuals. Well, this information demonstrates that our failure to enact reform is what harms the women and minorities in the United States who need medical care.

The second problem caused by the medical liability system is the decline in medical innovation. While doctors, as we know, practice defensive medicine by ordering unneeded tests and procedures, they are also less likely to take risks with treatment procedures and surgery because of the chances of getting sued. According to the General Accounting Office, a doctor has a 37-percent chance of being sued during the course of his or her practice.

And there is the related issue of biomaterial access on which Senator LIEBERMAN has been our most conspicuous leader. We need to ensure that raw material suppliers will sell their products to those who make important lifesaving devices.

A third problem, Mr. President, concerns the erosion of the doctor-patient relationship caused by defensive medicine. The dean of the University of Kentucky Medical School called my office this week to stress the importance of health care liability reform. He explained how hard it is to get young doctors to develop clinical skills when they can order a battery of expensive tests which will protect them in case of a lawsuit. Apparently, the chance of being sued has nothing to do with whether the doctor acted negligently. GAO reports that nearly 60 percent of all claims are dismissed without a verdict or a settlement.

Medical malpractice victims suffer from the same unpredictability of our civil justice system as other injured persons. Cases take too long to conclude, anywhere from 2 years to more than a decade. Of every dollar spent in the liability system overall in the United States, only 43 cents goes to the injured party. A full 57 cents of every dollar goes to the system itself, the lawyer and the court costs.

So, Mr. President, our goals here are basic and fundamental. First, to promote patient safety. Second, to compensate injured patients fully and fairly, but not to enrich the lawyers and the system; make health care more affordable and accessible; contain the costs of the liability system; strengthen the doctor-patient relationship; and, finally, encourage medical innovation.

Before I explain what our amendment does, I want to be clear about what it does not do. First of all, there is no cap on pain and suffering in this amendment. Doctors' groups advocate a cap on noneconomic damages of $250,000. The House included such a provision in its legal reform bill last month, but we chose to omit a cap on pain and suffering for several reasons.

First, there are circumstances where an individual suffers a serious injury but may have minimal or no economic losses. It seems harsh—not only seems harsh, it would be harsh—to tell such victims who have lost a limb or a sense of hearing, for example, that because they can go back to work, their damages are limited.

For too long, the proponents of reform have been attacked as trying to deprive victims of their rightful compensation. So we felt in introducing our medical malpractice bill that we could offer many, many significant improvements to the system short of limiting pain and suffering. Pain and suffering are part of compensatory damages awarded in an effort to make the victim whole. We can reform the liability system to make it more certain and more fair without limiting an injured party's right to be made whole, and that is why we omitted such a provision. There may be amendments offered to put a cap on pain and suffering, but that is not something that this Senator could support.

The second issue we omitted from our bill was the so-called FDA defense. That provision enables a company which obtained FDA approval for its device or a drug to be shielded from punitive damages. During last year's debate on a motion to invoke cloture on a motion to proceed to product liability, this issue was prominently discussed. Several Senators cited their opposition to this provision which was included in last year's product liability bill, and they cited that as their reason for opposing cloture.

So we wanted to avoid that controversy connected with the full medical malpractice bill. The FDA amendment may or may not be offered at some course during this debate and, as with the cap on noneconomic damages, I welcome the debate. There is no reason not to discuss those issues and let them come to a vote if others would like to proceed with that. But it is important to remember that with regard to the concern drug manufacturers have, they still would benefit to some extent by the cap on punitive damages.

As for our amendment, let me explain what is in it. I talked about what is not in it, now let me talk about what is in it.

First of all, it is basically the same bill with some changes —no, it is basically the same bill that myself, Senator LIEBERMAN and Senator KASSEBAUM introduced which was referred to the Labor Committee.

She, along with other members of that committee, made significant changes in the bill from its introduction as S. 454. The amendment contains a uniform 2-year statute of limitations, which is the same statute of limitations contained in the product liability bill.

The amendment addresses punitive damages in much the same way that they are handled in the product liability bill. Our amendment sets out the standard for awarding punitive damages, either intent to injure, understood the likelihood of injury and deliberately fail to avoid injury, or acted with conscious, flagrant disregard of a substantial and unjustifiable risk. Punitive damages may be handled in a separate proceeding, and the amendment sets out the eight factors that the court may consider in determining the amount. The amount of punitive damages is limited to three times the economic damages or a quarter of a million dollars, whichever is greater.

The definition of ''economic damages'' specifically includes replacement services in the home, such as child care, transportation, food preparation and household care. We sought to be as comprehensive as possible to make clear that those individuals who do not work outside the home would be made whole for their losses. The fact that an injured individual does not earn a significant or, for that matter, any salary will not mean that there would be no economic losses.

I am aware in the Labor Committee that Senator DODD successfully offered an amendment to eliminate the cap on punitive damages. We have declined to incorporate that amendment into this floor amendment because without a cap on punitive damages, you do not have uniformity, you have no chance of getting predictability into the system. To do so would make the medical malpractice section inconsistent with the product liability provisions, and it is important to keep these two issues on very similar tracks.

The amendment provides for periodic payment of future damage awards that exceed $100,000. Periodic payments must be made in accordance with the Uniform Periodic Payments of Judgments Act.

The amendment abolishes joint liability for noneconomic damages, including punitive damages.

Like the product liability proposal, the medical malpractice amendment provides that defendants are only responsible for their proportionate share of the harm caused. Like the proponents of the product liability bill, we

seek to put an end to lawsuits brought against a party because of its deep pocket. The amendment also reforms the collateral source rule to prevent double payment for the same injury. Amounts received by the individual from other sources, except those amounts paid by the individual or close family member, would be deducted from any damage award. The amount of the reduction would be determined in a pretrial proceeding, and evidence regarding the reduction could not be introduced at trial.

Further, Mr. President, the amendment limits lawyers' contingency fees to one-third of the first $150,000 and 25 percent of any amount over $150,000. Clearly, that benefits the victim so that the victim gets more of the money in these cases.

The amendment encourages States to adopt alternative dispute resolution and requires the Attorney General to develop guidelines for the States. The amendment sets forth a number of ADR options, including arbitration, mediation, early neutral evaluation, early offer, use of certificates of merit and no fault.

The amendment also contains a separate subtitle on protecting the health and safety of patients. It provides that 50 percent of punitive damage awards go to the State for licensing and disciplining health care professionals, as well as for reducing malpractice-related costs for health care providers who volunteer in underserved areas.

In addition, this subtitle requires the Agency for Health Care Policy and Research to establish a panel on patient quality and safety. Within 2 years, this agency would take the work of the panel and establish guidelines for health care quality assurance, patient safety, and consumer information. In the interim, this agency would report to Congress on the work of the panel in these areas. Credit goes to Senator JEFFORDS for his hard work on this provision and the great improvement he made on the original bill.

Finally, I want to mention the preemption provision. The opponents of legal reform have all of a sudden become advocates for States rights. They accuse the proponents of reform of hypocrisy for wanting to establish Federal standards in these areas. But I argue we are not the hypocrites. First of all, we are not changing the substantive law of negligence. Whether a doctor or hospital was negligent in the provision or administration of health care will still be a matter of State law. We are not creating any Federal cause of action where none exists. Neither product liability cases nor medical malpractice cases will wind up in Federal courts if they could not be there today.

Second, Congress has the ample power to set national standards in this area. As in the product liability arena, health care is a national issue. We spent weeks debating this subject last year. Medical products and drugs are in the stream of interstate commerce. Health maintenance organizations and other health care providers are national—I repeat national—organizations operating throughout many States. And health insurance is generally sold on a nationwide basis. While a particular doctor-patient relationship may be local in nature, the delivery of health care is part of interstate commerce.

Moreover, the Federal Government, through Medicare and Medicaid, funds a substantial part of the health care system. So the preemption provisions strikes a balance in creating a minimum national standard. Those States which have enacted, or which in the future enact additional restrictions on limitations, will supplement these national standards.

I am aware that Senator ABRAHAM, in the Labor Committee markup, successfully offered an amendment to allow States to opt out of national standards contained in this amendment. We have declined to include his amendment since we believe that preemption strikes the delicate balance needed in this area.

There is much more to say about this amendment, and I am sure we will all have an opportunity to express our points of view during the course of the debate. The effort here is to improve and strengthen the bill so doctors and hospitals are treated similarly to medical device and drug manufacturers and sellers.

Mr. President, this is indeed a national problem.

AMENDMENT NO. 603 TO AMENDMENT NO. 596

(Purpose: To reform the health care liability system and improve health care quality through the establishment of quality assurance programs)

Mr. MCCONNELL. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Kentucky [Mr. MCCONNELL], for himself, Mr. LIEBERMAN, and Mrs. KASSEBAUM, proposes an amendment numbered 603 to amendment No. 596.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. MCCONNELL. I yield to the Senator from Wyoming [Mr. THOMAS].

AMENDMENT NO. 604 TO AMENDMENT NO. 603

(Purpose: To provide for the consideration of health care liability claims relating to certain obstetric services)

Mr. THOMAS. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Wyoming [Mr. THOMAS] proposes an amendment numbered 604 to amendment No. 603.

Mr. THOMAS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

Mr. KENNEDY. I object.

The PRESIDING OFFICER. Objection is heard. The clerk will read the amendment.

The assistant legislative clerk read as follows:

At the appropriate place in the amendment insert the following new section:

SEC. . SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IN GENERAL.—In the case of a health care liability claim relating to services provided during labor or the delivery of a baby, if the health care professional or health care provider against whom the claim is brought did not previously treat the claimant for the pregnancy, the trier of the fact may not find that such professional or provider committed malpractice and may not assess damages against such professional or provider unless the malpractice is proven by clear and convincing evidence.

(b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subsection (a), a health care professional shall be considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice in which any of whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another professional.

Mr. THOMAS. Mr. President, this is an amendment to the amendment of the Senator from Kentucky which addresses, overall, malpractice liability. This has to do with specific problems that arise in rural areas. It seems to me that rural area families across America deserve access to quality health care, and that is a problem we deal with from time to time. We need to search for solutions that reduce infant mortality rates, provide comprehensive prenatal care and yet allow for us to stand ready to serve in times of emergency. The rural obstetric care amendment is part of that solution.

This amendment to rural obstetric care compliments the effort of the Senator from Kentucky. It addresses a specific problem in rural areas, recruiting and retaining obstetric providers. It helps women obtain quality prenatal care and assists rural communities in developing a reliable and successful health care delivery system.

Some of these liability problems are unique to rural areas, such as limited access, of course, to patient medical care and the history of these patients through a period of time. Some areas in my State have little or no opportunities for prenatal care. The long distance of driving exists. I think, particularly, of one good-sized town of Rawlins, WY, in which, quite often, expecting mothers do the prenatal care in Rock Springs or in Laramie, WY, both of which are more than 100 miles away; and, quite often, they need emergency care in Rawlins when the delivery time comes, and they find themselves going

for emergency care to a different physician. That is basically what we are really talking about here. Because of these distances and because of the unique rural problems, there is a dropout rate in delivery. So that providers delivering a baby often are providers that have not had an opportunity to see the mother prior to the treatment.

Shortage of practitioners in obstetrics, to a large extent, is due to high insurance premiums. So this amendment simply raises the evidentiary standards to clear and convincing for health care services provided during labor or delivery of a baby. It only applies to health care professionals who did not previously treat the individual. It does not apply to providers who are on call or filling in for colleagues who are expected to have that information.

So it is a rather simple amendment that provides for this movement to a higher level of evidentiary standard. There are, of course, a number of questions that could be asked that are somewhat mythical, I think. For instance, does this exempt certain groups of providers? It does not. The usual standard—the preponderance of evidence—remains in place for the doctor's own patient. Two is that it imposes an unusually high burden of proof. That is also not true. The clear and convincing standard is only slightly higher than the standard preponderance of the evidence and is significantly less than the standard of beyond a reasonable doubt. Some ask, does it eliminate the right to trial? It does not. Women are still permitted to sue the provider. And if negligence is found, the woman recovers full damages.

Does it discriminate against women? Wrong. Women in rural areas would benefit. The intent of the amendment is to encourage health care professionals to continue providing obstetrics to women who may not have a physician or who are unable to get to their physician.

Let me quote from Phyllis Greenberg, executive director of the Society for the Advancement of Women's Rural Health Research:

> Unintended adverse reactions in a few should not create a threat of liability so great as to disadvantage the many who benefit.

Part of the benefit of the amendment would be to have an impact and to reduce malpractice premiums for obstetric providers in rural areas.

Let me share a little bit of the problem that we have in some rural areas. Let me compare the premium rates in Wyoming for health care providers: $42,275 a year for OB/GYN specialists, compared to $9,800 for pediatricians, $9,700 for internal medicine, $27,000 for general surgery, $17,000 for emergency physicians, $10,000 for general practitioners without OB/GYN services coverage. On the other hand, $26,000 for general practitioners who have OB/GYN.

We can see clearly that practitioners in small towns that have relatively few opportunities for obstetric services simply do not do it unless it is an emergency and because of the cost.

Further comparing Wyoming's $42,000 average malpractice premium for OB/GYN among the Rocky Mountain States, $22,000 in Idaho, $23,000 in Utah, $25,000 in Montana. So we have a problem and one that I think could be relatively easily mitigated here.

It complements State obstetric liability laws; 25 States have statutes on the book recognizing the need to provide relief for obstetric providers, full-fledged immunities for drop-in delivery cases.

We think, also, that it would help recruit and retain obstetric providers. In rural areas of 105 family practitioners, in Wyoming only 27 provide obstetric services. For specialists, there are only 25 OB/GYN providers in the State delivering babies. That is 52 physicians trained in obstetrics to cover 90,000 square miles.

In the city of Sheridan there are only two providers. We used to have eight. One current provider watched his premium rise from $4,000 a year in 1978 to $35,000 a year in 1995.

There is some background for this proposal, and this amendment was included in Jim Cooper's Managed Competition Act last year and the Rowland-Bilirakis Consensus Act of last year. Bob Michel's Affordable Health Care, a new act, included provisions of this kind. Majority leader BOB DOLE's alternative health reform proposal includes this as well.

So, Mr. President, this amendment to the bill of the Senator from Kentucky helps women and families across rural America obtain quality care. It helps rural communities fend off physician shortages, plaguing health care service delivery systems. It lowers health care costs, so consumers may pay the true cost of medical service instead of that cost inflated by malpractice premiums, and it complements overall malpractice reform.

I yield the floor.

Mr. KENNEDY. Would the Senator be good enough to yield briefly for a question or two on his amendment?

Mr. THOMAS. Happy to.

Mr. KENNEDY. I appreciate the chance to address the Senator on the amendment. I believe this was a matter that was given some consideration in the Human Resources Committee and eventually dropped in the final legislation that was passed out of the committee.

Let me ask a question: For example, effectively this immunizes a doctor from any negligence suit, am I correct, if that doctor had not treated the patient prior to the time of delivery?

Mr. THOMAS. No, I think the Senator is not correct. It simply raises the standard of evidence to the immediate level. It does not immunize if there is malpractice here, if liability is here. The difference and the purpose here is that this physician who delivers this baby has not been a physician that has been in the case for prenatal care and, therefore, is given, under this amendment, simply a clear and convincing standard as opposed to the preponderance of evidence. I think the Senator is not correct.

Mr. KENNEDY. Could the Senator explain why we are having a different standard for the delivering of babies, why we have a different standard than the preponderance of the evidence?

What is the Senator's reason, again, if the Senator would share it. This is somewhat different. I asked to have the amendment read because we had an amendment that was also focused upon obstetricians in the earlier draft of the malpractice legislation, and now we have another approach.

I am just trying to understand. I think it is a different standard that would be for those doctors that would come on and treat an expectant mother. Can the Senator indicate to the Senate why we ought to have a different standard, why doctors ought to be held to a different standard at the time of the delivery of a baby from the preponderance of the evidence standard? What is the rationale? What is the justification of that?

Mr. THOMAS. I think the justification is to provide delivery services for mothers in a community where there would not be services otherwise.

For instance, a general practitioner who might normally deliver babies, because of the cost of malpractice insurance simply does not do that. So the expectant mother has, through the pregnancy, gone to Laramie, 150 miles away.

But then comes an emergency. What we are doing is we are saying to this physician, although the physician does not do this as a normal thing, who is not able to pay this extraordinary amount of money, that we will provide some sort of a higher standard here because the physician is doing this not as a regular practice but as an emergency treatment process.

It is not designed to have anyone with less competency. It is not designed to do that, but to encourage services where there are none.

Mr. KENNEDY. Well, Senator, is this limited just to emergency provisions? I am still trying to get from the desk a copy of the amendment. I apologize to the Senator.

Is this applied solely to an emergency situation as described in the response to my question?

Mr. THOMAS. It applies only to people, to physicians and providers who have—they are either on call or they are part of a group. In that case we would have expected them to participate in the previous information regarding this patient.

So this applies only when we go to this physician not having been involved with them previous to that.

So, basically, yes, it does limit it only to that circumstance where this

physician has not been a party to the care prior to the delivery. That is our intention, Senator. If that is not the case, we would like to make it clear.

Mr. KENNEDY. Well, I have the amendment. As the Senator knows well, effectively the Senator is saying to the mother and the child, effectively, that under this amendment it says, ''The trier of the fact may not find that such professional or provider committed malpractice and may not assess damages against such professional.'' You are immunizing, getting a different standard for those doctors.

Does the Senator know, could the Senator indicate what the basis is for the amendment, where the hearings were, what the testimony has been, who we have heard from?

Mr. THOMAS. Let me suggest a couple of things. First of all, the whole world is not in boxes. There are differences in terms of the availability of services, and we are seeking to deal with that.

Second, it does not immunize, and I already have spoken to that. It simply raises that level of evidence. In fact, it says in the amendment, the Senator I am sure read that, it may not assess damages against such professional unless malpractice is proven by clear and convincing evidence. So it certainly does not immunize it.

Let me say, further, as I said before, the Senator talked about the previous consideration, and it was part of Representative Cooper—we worked, as the Senator knows, and the Senator worked very hard last year in health care. These things were not out of the blue. It was in Mr. Cooper's bill and in the Rowland-Bilirakis bill. It was in BOB DOLE's bill. It is not a new idea, and indeed has been discussed at great length.

Mr. KENNEDY. The Senator's reference with regard to Boston—this applies to Boston as well as rural America. The fact is, you have, in this language, ''* * * the trier of the fact may not find that such professional or provider committed malpractice * * *.'' and then you have, ''* * * and may not assess damages * * *.''

It says it ''* * * may not find that such professional or provider committed malpractice * * *'' That is what the amendment says. You can define it in whatever way you want, but that is what it says. Then it continues, ''* * * and may not assess damages against such professional or provider unless the malpractice is proven by clear and convincing evidence.'' This says ''* * * professional or provider committed malpractice * * *.''

I just wonder why we are, with the amendment—we will have a chance to talk about this in greater detail—but why we are suggesting this particular amendment to the families of this country? I think whether a doctor is delivering—I can see a circumstance where he is immunizing, a particular doctor in a group practice, that they are going to send in the person who has not been working with the expectant mother because they want to have a lesser standard, or immunizing the doctor against malpractice.

Are we trying to encourage the practice of obstetricians who may have lost their licenses or may be under some other kind of penalty? Are we immunizing them against practicing in terms of gross negligence or other kinds of negligence?

This amendment is very clear, and it does apply to Boston. There is nothing in here about rural America. It is talking about all doctors: ''* * * may not find that such professional or provider committed malpractice * * *'' It says ''* * * and may not assess damages * * *'' ''* * * and may not assess * * *'' But it says ''* * * committed malpractice * * *.''

I do not know—is the Senator familiar with where the greatest number of obstetricians are in this country at the present time? And what the rates for malpractice insurance are in those particular areas? You have the highest number of obstetricians in the country now out in Long Island. They have the highest rates of malpractice insurance. What is the point the Senator is talking about?

Where is the testimony that this is going to produce greater services to people in either urban or rural areas?

Mr. THOMAS. If the Senator will yield, it was my understanding you were going to ask questions and not——

Mr. KENNEDY. I am asking the question where is the testimony, where is the hearing? I will be more precise.

Mr. THOMAS. Yes, I already went through that. I told you we went through that last year in several places.

If the Senator will support this, we would be happy to put in, in our second one here, that is only under the definition by the Public Health Service of rural areas.

I am sure that is not the case. I am sure the Senator is not talking about my amendment. He and I have quite a different view of what we ought to do on malpractice, and I understand that.

Mr. KENNEDY. I am just trying to find out what the amendment says. I am just reading the language in here——

Mr. THOMAS. You are—you are misreading.

Mr. KENNEDY. What it says on it, and asking for your explanation.

Mr. THOMAS. We do not read it the same.

Mr. KENNEDY. We have urban areas as well as rural areas. Public health does that. We have what is in the nature of underserved areas in urban areas. So I do not know that helps the Senator's position. I do not understand the Senator.

The PRESIDING OFFICER. If the Senator from Massachusetts will suspend, the Senator from Wyoming has the floor.

The Senator from Wyoming.

Mr. THOMAS. I have tried to explain the answers. No. 1—let me go on just a little bit further.

If the Senator would feel more comfortable, we will be happy to put in ''* * * as defined by the Public Health Service.'' So it would be, indeed, rural areas.

Mr. KENNEDY. Senator, may I ask you, on this point that you just mentioned, are you suggesting that the Public Health Service only defines underserved areas as being rural areas?

Mr. THOMAS. There is a definition, as the Senator well knows. I will cite it for him if he would like; section 330 (b)(3), or 130–27 of the Public Health Service Act, which defines underserved areas.

Mr. KENNEDY. That also includes urban areas; does it not?

Mr. THOMAS. I suspect so. It defines rural areas.

Mr. KENNEDY. What is the Senator's point? Are you trying to say you would offer this if I would agree with it? The point I am making is I do not want poor practice in rural areas or urban areas.

Mr. THOMAS. We are not talking about poor practice. We are talking about providing services where there is none, Senator.

Furthermore, and then I conclude here, I think if the Senator wants to read it fairly, it says ''* * * may not find that such professional or provider committed malpractice and may not assess * * *.'' That is all one sentence. The Senator divided that.

I understand you do not agree. You do not want malpractice insurance. I understand you do not want to change the legal system, Senator, but I do. These are the reasons, and I think very legitimate ones.

Mr. President, I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I was going to ask of the Senator, finally, whether he was familiar with the fact the Senator from Kansas, Senator KASSEBAUM, dropped this very provision when these matters were brought to her attention in the course of the committee. They were dropped by the Senator. That, you know, happens to be the chairman of the Human Resources Committee, where many of these measures were read.

I am asking and inquire why the Senator from Wyoming is convinced of it when the other members of that committee, who have prime jurisdiction, felt they ought to drop it?

Mr. THOMAS. I will answer the question. I ask if the Senator always agrees with the Energy Committee if they drop something?

Mr. KENNEDY. If you could explain why?

Mr. THOMAS. I will. I have explained. I shall explain one more time.

This comes from experience in our own State, Senator. We worked with this sometimes. We have difficulties in

recruiting physicians for these areas. We are seeking to find a way to provide services, in my case, for areas that are basically rural. I am here to defend my constituency, as you are. We have problems and they are unique problems, and I think this is an approach to do that. That is what I am seeking to do.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I cannot possibly understand the rationale. If I could just have the attention of my friend from Wyoming?

I am prepared to see that the people in Wyoming make up their own judgment of malpractice. It is the Senator from Wyoming who is supporting the position that is going to preempt the States. The Senator's point is absolutely correct. Malpractice ought to be decided in the States. It ought to be decided by Wyoming what is in the interests of Wyoming. I am for it.

I think Wyoming ought to make a judgment and decision in terms of the standards, whatever you want to do out there. That is the position of the Senator from Massachusetts. That is not what this bill is going to, and what the Senator is amending. They are basically preempting the States with one Federal standard. And that is different from the product liability.

Product liability applies to products that are shipped interstate. This is the most sensitive relationship between a doctor and a patient. And why does Washington know best on this? The Senator has made my case. He ought to oppose the McConnell amendment for the very reasons that the conditions in Wyoming are different from Massachusetts.

Mr. THOMAS. May I ask a question?

Mr. KENNEDY. They are different from Boston. I will yield for a question, but I—I will be glad to yield for a question.

Mr. THOMAS. Will you explain to me why you were the major proponent of Federal health care last year?

Mr. KENNEDY. Of course. I will be glad to do that. There are very few people who have not heard me explain it.

That is because I think decent quality health care for all Americans ought to be a right and not a privilege, Senator, for Members of the Congress of the United States like you.

Mr. THOMAS. And the Federal Government ought to provide it?

Mr. KENNEDY. Regular order, Mr. President. I have the floor.

The PRESIDING OFFICER. The Senator from Massachusetts has the floor.

Mr. KENNEDY. I have a very good program. I pay $103 a month. The Senator from Wyoming pays about $300 a month.

The difference with the Senator from Wyoming and Massachusetts is that I want the American people—in Massachusetts and Wyoming—to have the same thing that we have. I was also interested during the time of the Contract With America that we came in and said, ''Look. Whatever applies to Congress ought to apply to the American people.'' And everyone made their speeches and supported it. That is what we did.

The other side of the coin is all of those Members that have the Contract With America have national health care. They have good health care. They are covered. The Senator from Wyoming is covered, like 40 million other Americans are not covered, like the additional 1 million that became not covered in the last year of which 800,000 are children who are not covered. The difference with the Senator from Wyoming and the Senator from Massachusetts is I would like to make sure that the people of my State and the State of Wyoming have the same thing the Senator from Wyoming and I have. That is entirely different from what we are talking about in terms of the malpractice and the whole question of liability.

Mr. THOMAS. And States rights.

Mr. KENNEDY. States rights—the Senator is arguing my position on this issue. If I could, I have the floor. I would like to continue.

The PRESIDING OFFICER (Mr. KEMPTHORNE). The Senator from Massachusetts has the floor.

Mr. KENNEDY. I would like to continue.

The PRESIDING OFFICER. The Senator from Wyoming will suspend.

Mr. KENNEDY. Under Senator MCCONNELL's position, effectively you have preemption of the States under any of the State laws that apply anything that is more favorable than is differentiated from the Senator's legislation that advantages the consumers. You preempt State law; preempt them. This great body of leadership that says, ''Why don't we block grants that Washington does not know best, let us let the States do that'', that is what I am for on the malpractice. That is not what the McConnell bill does. And the Senator from Wyoming is offering an amendment on the McConnell bill that will set Federal standards, and preempt States rights. The McConnell bill preempts States rights.

When we offered an amendment in the Human Resources Committee to effectively eliminate the preemption of States, it was defeated. I would welcome the opportunity to cosponsor a second-degree amendment that will preserve that on the McConnell amendment right now. I welcome the opportunity. If you want to preserve the States rights of what Wyoming knows and Wyoming knows best, Massachusetts knows and Massachusetts knows best, let us do a joint amendment right now to the McConnell amendment. I propose that.

Mr. THOMAS. I am a little puzzled. May I ask a question?

Mr. KENNEDY. Yes; certainly.

Mr. THOMAS. First of all, the Senator from Massachussetts talked about the committee, that that which was proposed was dropped at the staff level. It is supported by the chairman. No. 2, the Senator has gone on. I watched. Here is the Senator's States rights business from last year. Do not tell me that you are for States rights. Look at this. Here is your health care package. Tell me there is States rights in that.

Mr. KENNEDY. Would the Senator read the malpractice provisions in there where we do not preempt the States? Will the Senator at least be honest enough in terms of talking about this measure of malpractice, be honest enough to look and find out what our committee did with regard to States rights last year? That is all we are asking. I mean, let us not get away from the fundamental issue which is before the Congress on the McConnell proposal. That is whether we are going to have a Federal preemption of States on the issues of tort reform or whether we are going to let the States make that judgment and that decision. That is the essential part on the whole tort reform debate that we are having here in the U.S. Senate.

The Senator has offered an amendment to that, not to preserve the State of Wyoming rights to make its own judgment. That was not in the Senator's amendment. You have gone to effectively immunize obstetricians from the malpractice and use a whole different standard of evidence at times of trial. That is an entirely different kind of issue. If the Senator wants to have Wyoming do what Wyoming wants on this malpractice, the Senator is welcome to have the opportunity to do so.

Mr. President, unless there is anything further or any other inquiry that the Senator would want, I would like to address the underlying measure that we have before us.

I see the Senator from Kentucky is now here. If I could just ask. As I understand it, this effectively, just for general clarification or point of information, this is basically the measure that was reported out of the Human Resources Committee without the Dodd amendment and without the Abraham amendment and as currently being amended by the Senator from Wyoming.

Mr. MCCONNELL. I say to my friend from Massachusetts, this amendment essentially is not what was reported out of the Labor Committee but rather the bill introduced earlier in the year by myself, Senator LIEBERMAN and Senator KASSEBAUM.

Mr. KENNEDY. The point probably does not make much difference to the Members. Here we have had the measure that was before the Human Resources Committee and had gone through a period of markup by the members of that committee and was reported out just a few days ago reflecting the members' judgment on the Human Resources Committee. Now we have a different measure here on the

floor of the Senate. The Senator is obviously entitled by the rules of the Senate to proceed in that way.

There was a time when we Republicans and Democrats alike were trying to see if we could not work out some of the particular measures. Last year, when we dealt with the malpractice provisions, we ended up with a virtually unanimous vote on the malpractice provisions as part of the overall health care reform—a lot of diversity in this body, a lot of willingness to spend 2½ days in our Labor and Human Resources Committee considering this issue, and, at the end of it, we ended up with a unanimous vote. During the course of the consideration of what is basically the underlying McConnell amendment, I offered that as an alternative. The measure which had Republican and Democrat support. I will get into more description of it later in the course of this debate. And it was rejected. But, nonetheless, the Human Resources Committee reported out that measure. It was reported out. I thought at least if we are going to be debating the malpractice issue that we would have an opportunity to do so. But that is not the circumstance.

Mr. President, let us take in the McConnell amendment the health care liability reform. Let us take the findings. Findings become more important particularly in the wake of what has happened in the last hours over in the Supreme Court on the whole issue of handguns. With these findings we are finding out that the Supreme Court is paying attention, that they have to relate to the follow-on provisions of the legislation. We are reminded about that. We have been reminded over a period of years in circuit courts and now certainly by the Supreme Court.

Let us just begin by taking a look at the McConnell amendment on the findings. It says Congress finds on health care the following: Effect on health care access and costs. And from the title of this finding one would think that this bill is just what the doctor ordered. At the heart of health care crisis facing working families and health care access and cost is that we have 40 million citizens who have no health insurance to protect them against the high cost of medical care, and even those who have insurance cannot be confident that it will be there to protect them in the future if they become seriously ill. The cost of medical care is burgeoning the family budgets all over this country. But just read on.

So we would expect that the rest of the measure will have some relevancy to the effect of health care access and cost. Those are the two elements in the health care crisis, the 40 million Americans who do not have any, increasing numbers that are losing in the employer-paid system, and the continued escalation in terms of the health care cost.

It goes on. The next provision says the civil justice system of the United States is a costly and inefficient mechanism for resolving claims of health care liability and compensating injured patients. I certainly agree with that where we have only 10 percent of the victims of malpractice ever bringing a suit. I have here in my hand Business Week, March 27, shown to me by my good friend, Senator HOLLINGS, from South Carolina, who was here just a few moments ago. It points out in this article of just a few weeks ago:

> One issue often neglected in the debate over malpractice insurance is the system's efficiency in compensating injured patients. The most exhaustive look at this issue is a recent study of 31,000 hospital admissions in New York State by a Harvard University team headed by Paul Weiler, Howard Hiatt, and Joseph Newhouse. Its findings: Some 4 percent of admissions involved treatment-caused injuries. One-fourth of the injuries involved negligence. One-seventh resulted in death.
>
> On average, only one malpractice claim was filed for every 7.5 percent of the patients suffering a negligent injury and only half of these were ultimately paid. So, ''The legal system is paying just 1 malpractice claim for every 15 torts inflicted in hospitals.'' Those suffering nonnegligent injuries—that is, caused by care not yet deemed inappropriate—got nothing. Thus, the study concludes that rather than a surplus, there is a litigation deficit because so many injured people wind up uncompensated.

You have the question now about whether the civil system is working in a way to try and deal efficiently with the malpractice which is taking place and how can it be done more effectively. We had an option and an alternative to do that, which was bipartisan, which has effectively been rejected and now we are back to the McConnell amendment that goes on and talks about, ''The civil justice system of the United States is a costly and inefficient mechanism for resolving claims of health care liability and compensating injured patients.''

I would certainly agree with that. And all the material that we have looked at would certainly underscore that.

Only 10 percent of the victims of malpractice bring a suit. Many victims who receive awards are undercompensated, due to the caps on damages imposed by almost half of the States. When cases go to trial, doctors win 60 percent of the cases in which, independent studies have concluded, they were, in fact, negligent.

So I would support a bill that addresses these problems, although it certainly would not be a serious solution to the problems of cost and access. But this bill only tips the balance further in favor of the health providers and farther against the working men and women who are the victims of the practice.

Let me read on.

And the problems——

This is from the measure that we have before us.

> And the problems associated with the current (malpractice) system are having an adverse impact on availability of, and access to, health care services and cost of health care in the United States.

Two million people lose their health insurance every month, and if you can find one who lost it because of the medical malpractice liability system, I would like to meet him.

We will spend $1 trillion on health care this year. That number will double in the next 10 years. Medical malpractice premiums account for about 1 percent of that total and premiums are not even rising significantly.

Even the AMA cites estimates that the costs of ''defensive medicine'' account for only 2.5 percent of health spending. Both the OTA and CBO concluded that tort reform like the kind provided in this bill would simply not produce any reduction in those figures. Is it not time we got serious about dealing with the health care costs instead of pretending that bills like this will do anything other than victimize patients to benefit providers?

It is interesting that one of the first measures that we are dealing with on health care, with all of the problems that we are facing, with the number of Americans who are not covered, with the increasing number of children who are not covered—and those numbers are increasing—with all the problems that our seniors are having in terms of affording prescription drugs, all the needs that are there in terms of home delivery services, all the difficulties and challenges that we have in terms of the health care crisis, we are dealing with this issue of the malpractice reform in a way that is going to preempt the States from dealing with this issue, which they have had for some 200 years, and at a time where the case I think has yet to be made why this is necessary.

And let me just mention very briefly, I hope those who are going to support it will explain to the Senate why we need it. First of all, the number of malpractice cases has been declining over the period of the last 5 years.

Second, the malpractice premiums for the medical profession have been declining over the period of the last 5 years.

Third, the awards for malpractice that have been made in the various courts have been declining for the last 5 years.

And finally, the profits of the industry, the insurance industry in dealing with malpractice have been going up through the roof, going up through the roof. We are not where we had been a number of years ago when we saw many of these companies saying, look, we just cannot—we are going to get out of this whole area of malpractice. We just cannot afford it. We just cannot go forward with it. We just cannot deal with it.

The fact is this malpractice insurance is enormously profitable to the insurance industry. And rather than leaving the insurance industry, it is highly competitive and more and more companies are going into this kind of

coverage. The publications of the insurance industry reflect that and the profits of the various companies sustain it.

And so we have a situation where there is, Mr. President, an important need in terms of covering the American people. The best estimate is anywhere from 80,000 to 100,000 people die a year from negligence and malpractice—80,000 to 100,000 people die a year, where only a small fraction of negligent malpractice cases are even brought, and where review after review of even those that are brought, where there have been findings that there has been review of those cases by doctors and professional groups, suggests that those findings by and large have been fair and that any review of the total numbers of cases that have been brought over the period of the years would justify additional kinds of findings as well.

Here is Business Insurance: ''Insurance Malpractice Coverage in Stable Condition.''

Despite the rapid change in health care delivery, the price of medical malpractice and professional liability coverage for health care organizations remains stable and capacity is plentiful. Most hospitals and health care systems will renew their liability coverage as in 1994 in part because of a decrease in claims severity and frequency for most health care organizations.

It goes on and talks about there is more capacity, there are more players than 3 years ago.

It seems like every month a new insurer wants to underwrite medical liability coverage for health care organizations.

Business Insurance, the publication for the insurance industry, says this is an area to get in, the profits are there. The total numbers, the statistics show that the awards, the numbers of cases, the judgments are going down and that the principal problem that is out there is people who are subject to malpractice are not being compensated. And what are we doing here with the McConnell proposal?

What are we doing here? We are effectively saying to Wyoming, to all 50 States, that we know best on the issue of tort reform; that we are going to have a preemption, one-way preemption. If your State, for example, was to provide some additional kinds of protections in terms of consumers, we will preempt you.

Now, in the Labor and Human Resource Committee, the Abraham amendment said: All right, we will preempt you, but if the State wants to get out from underneath the preemption, that will be accepted. And that was accepted by the committee.

But not in the McConnell amendment; not in the McConnell amendment. It is a one-way preemption.

I see other Members who want to speak to this issue, so at this time I will just conclude.

It is difficult for me to understand, Mr. President, why we are taking an issue which is so personal, involving a doctor and a patient, in which the States have worked out their own accommodations, where the Congress is not being pleaded to by the States for Federal action, and while the industry itself is successful, experiencing record profits in this area—I will get into that later on in the discussion—why we are being compelled to say that we will have a one size fits all, effectively saying that we here on this issue, which is so personal between a doctor and a patient, so personal, that we are going to have to have a Federal solution. And that is what the McConnell amendment is doing.

I find it just troublesome, as I mentioned earlier, where we have all the challenges that hard-working families are facing in this country, that workers are facing, wondering whether they are going to continue to have the coverage that they have today, where working families are worried about whether their parents are going to be covered, where working families read about the cuts in Medicare that are going to be coming down the road, where most of our seniors are paying $1 out of $4 in terms of out-of-pocket expenses for additional health care needs. They are concerned about them. They are concerned about their children, whether their children are going to get decent quality health care.

And we see, with the Carnegie Commission report and the other reports, the total number of children that are not being covered. With all the needs that are out there, here comes the U.S. Congress and Senate saying, ''On this one, we are going to look out for the industry and the AMA.'' That is what this is all about. That is what this is all about.

Mr. President, basically, there should be adjustments, there should be changes made in the current system. We ought to be encouraging alternative dispute resolutions. We ought to give experimentation to the States to be able to do that.

In our proposal last year, we even had limitations in terms of the contingency fees in a bifurcated way, in terms of the early payments and later kinds of payment. We dealt with collateral issues. We dealt with the experimentations that would be taking place in States so that they could develop practice guidelines and consider, if they used practice guidelines, whether we could create rebuttable presumptions.

We talked about encouraging States to develop enterprise liability. We even supported creating no-fault liability so that States would create the funds and all that individuals would have to be able to do is show that need, not even negligence, to be able to recover. We were prepared to consider all of those measures.

Those of us who are opposed—at least this Senator is opposed—to the McConnell amendment understand that we have to provide some changes and some alterations. We were prepared to do so and are prepared to do so. We made some changes even in this proposal that was initially put forward before our committee during the course of the deliberations. But we, at this time, do not have that measure before us.

I see other Members who want to speak, and I will come back to address this issue at a later time.

Mr. WELLSTONE addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. WELLSTONE. Mr. President, I have the floor. I wonder if I could just for a moment have a discussion with my colleague from Connecticut. I know he was here for a while, but I stayed on the floor. I do not want to push in front of him. Would my colleague mind if I went forward with my remarks right now?

Mr. LIEBERMAN. Mr. President, I appreciate the courtesy of my friend from Minnesota. It may sound a little strange, but if he is prepared to speak at length, I would be happy to allow him to go forward.

Mr. WELLSTONE. I say to my colleague, I am prepared to speak at length.

Mr. LIEBERMAN. I had guessed that.

Mr. WELLSTONE. Would that be all right?

Mr. LIEBERMAN. Yes. I appreciate the Senator's kindness.

Mr. WELLSTONE. Mr. President, I was at a gathering yesterday with citizens from all over the country. Their personal stories are often not a part of this debate, but they should be. Many of them have been injured, many of them have been hurt, some of them have lost loved ones. God forbid that any of this should happen to any of us or our families or our loved ones.

Mr. President, the question that they were asking was: What is the purpose of the underlying bill, this ''Product Liability Fairness Act?'' I see nothing fair in it, and I will talk about that, or this amendment, the McConnell amendment, or the second-degree amendment to the McConnell amendment.

What is this rush to somehow protect whom from claimants? Why the effort to tip the scales of justice against people who have been hurt, all too often in behalf of people who have been negligent, all too often on behalf of large corporations, insurance companies, you name it?

Mr. President, I will get to the specifics of this medical malpractice amendment, and I will talk about the underlying bill as well, but I would like to start out on a more personal note as a Senator of Minnesota.

Mr. President, let me first of all make it clear that in some editorials it has been suggested that this debate is really a debate between the trial lawyers of the United States of America and the rest of the country. That is just simply not true. There are many citizens, the consumers of this Nation,

that I think also need to be and have been present in this debate.

So with a little bit of hesitation, I will use some pictures—but this comes with the permission of Minnesotans, of the families affected—because I think the faces of people that are affected by this, I think the people themselves, their voice ought to reach into this Chamber now.

Kristy Marie Brecount was a happy—''was,'' past tense—active 7-year-old girl from Edina when she went to the hospital to get her tonsils removed, as many children her age do.

I do not know where the hospital was and in no way am I suggesting that this was in Edina. That is not the point.

It was an elective procedure. The hospital personnel improperly hooked up the machine that was to provide the anesthesia for the operation. They attached the hoses backward. As a result, she received 10 times the amount of anesthesia she was supposed to get, leading to a fatal cardiac arrest.

This is a picture of Kristy.

Here are the questions I would ask about this amendment, as I understand it. And I have not even had a chance to look at all of it, because it just came up on the floor.

If it was clear that the hospital personnel had acted intentionally or ''with conscious, flagrant disregard'' for Kristy's safety, do you think, I ask my colleagues, that $250,000 is enough to punish and deter the hospital personnel from doing it again?

Is $250,000 too much? And if my colleagues say it all depends on the history or the size of the hospital, then I would say that is precisely the point. It is a case-by-case situation. So why at the Federal level preempt this? Why take away from aggrieved citizens their right to seek redress for grievances within our court system?

Is $250,000 too much? And if you do not know the statistics, this does happen to citizens—80,000 deaths a year from negligence, 300,000 citizens hurt or injured a year. And we put caps on punitive damages?

Gina Barbaro. Gina had just turned 6 when she got sick with flu-like symptoms. Her mother took her to a chiropractor. Her symptoms at the time were headaches, fever, vomiting, shakes, delirium, rash on her foot, ear, knees, and down her legs. The chiropractor prescribed herbs and oils and sent Gina home.

By the way, we are not talking about the vast majority of doctors, chiropractors, you name it. We are talking about a few, sometimes, if you will, rotten apples in the basket.

The chiropractor prescribed herbs and oils and sent Gina home. The next day she was back with worsened conditions and severe redness to her right eye. The chiropractor, believing the problem stemmed from Gina's pancreas, sent her home again. Her temperature reached 105, and the color of the iris of her right eye changed.

Upon the third trip to the chiropractor, the chiropractor finally suggested that Gina go to the hospital for evaluation. The hospital staff determined Gina had a virulent strep infection that resulted in her losing the sight in her right eye. She also had numerous other complications. The eye had to be removed. A year and a half later, Gina continues to have continuing care, including cardiology, ophthalmology, infectious disease, and pediatrics.

I just showed you a picture of Gina, and now I ask the following questions: Assuming that the jury finds that the chiropractor's negligence in failing to send Gina to a hospital sooner was 70 percent responsible for her damages, and the negligence of the practice for which the chiropractor worked was 30 percent responsible because they hired the chiropractor in the first place. The jury awards Gina $100,000 in noneconomic damages for her pain and suffering and disability and fear.

If the chiropractor is unable to pay the full amount of his fair share, who should be stuck with the loss, Gina or the practice? And by the way, Mr. President, to go to one of the points that my colleague from Massachusetts, Senator KENNEDY, made, in the Labor and Human Resources Committee, one of the more important things we did to the medical malpractice amendment yesterday is that we had an opt-out provision.

In my State of Minnesota, we have struggled with this question of joint liability. I am not a lawyer, but I can see it is a really difficult question. The question: If you are not really responsible for the whole extent of the damage, and maybe only a small percentage because another party says they are insolvent, bankrupt or whatever, should you have to assume the whole cost? So we tried to work out different kinds of formulas at the State level.

This amendment preempts States from doing that. I am, in part, here to fight for my State. And by the way, Mr. President, it makes no sense whatsoever to me that if you are going to have a Federal preemption—and you should not—there are two issues: Why do we have a Federal preemption which, as I understand this amendment, goes in only one direction: States are preempted if they want to have stronger consumer protection than the norm we set here, but not preempted from having less consumer protection. Talk about a stacked deck. In any case, why would we not, as we did yesterday in committee, at least allow States to opt out of this?

This amendment professes to reform medical malpractice, but it is less about cutting back on the incidence of medical malpractice —how do we prevent this in the first place—than it is about making it harder for people to avoid becoming the victims of medical malpractice, making it more difficult for those victims to receive compensation for their injuries and making it easier for those who commit medical malpractice to get away with it.

This amendment is an attack on consumers. First and foremost—and I use the word ''attack'' carefully—it is an attack on the elderly and on families with children and on working Americans. Why else would this bill devalue compensation for low- and middle-income victims? That is right, this amendment says that when a person is hurt, it is their economic damages, usually including lost wages, that they have the best chance of getting back. But for noneconomic damages, it will be harder to get compensated. In other words, if your damages tend to be more in pain and suffering and less in lost wages, since you make less money, you are more likely to walk away with a smaller percentage of your compensation, and that is wrong if you have lost a child, or if you are infertile because of malpractice of a doctor, maybe an obstetrician. If you have been maimed, then I do not know why your loss is any less important than someone else's loss. Since when did we start making a calculation about justice based upon the income and wealth of families?

Mr. President, with regard to the second-degree amendment, lessening standards so that an obstetrician does not have to live up to the same standards by way of consumer protection, thus making it more possible to be able to deliver that kind of care in rural areas, makes no sense whatsoever.

I am from the State of Minnesota and greater Minnesota, rural Minnesota is an important part of our State. Minnesotans want to make sure that we have more doctors, nurses, advanced nurse practitioners in our communities delivering health care. But I do not believe the citizens in my State believe that the way to get that done is by moving away from consumer protection by lessening standards. People want affordable care, they want dignified care, they want humane care, and they want high-quality care.

Mr. President, yesterday in committee I offered an amendment, and I certainly will offer this amendment on the floor of the Senate. I did not believe we were actually going to have a medical malpractice amendment on the floor. I offered an amendment in markup that would have opened up the National Practitioner Data Bank—and for those who are now listening to this debate, I need to spell out what that is—granting consumers access to the same kind of information about their doctors that hospitals and HMO's currently receive.

In other words, if we are really interested in the problem of medical malpractice and we want to prevent it, that is really what people want to see happen, that is what doctors and chiropractors and nurses and nurse practitioners want to see happen, then one would think that consumers could have the same information, access to the same kind of information about their doctors that hospitals and HMO's currently receive. Eighty thousand people

die every year due to medical negligence, and consumers should have the right to know whether or not there has been a finding against the doctor because of malpractice or if a doctor has essentially been barred from practicing at a hospital or, for that matter, within a State. By the way, sometimes—and I could give examples—doctors move to other States, change their names, and then harm other citizens in the country, and those citizens have no way of finding out, unless they want to go all around the States in 50 different court systems. But that amendment was defeated yesterday. Once again, consumers lose and a variety of different powerful trade associations and their Washington lobbyists win. I will most definitely, Mr. President, offer that amendment on the floor.

Mr. President, the plaintiffs ask the question: Why the legislation? Why the legislation that essentially tips the scales of justice against us? Victims of malpractice do not know they are victims until they are injured. Perpetrators of malpractice know who they are. They have been sued before, and if they do it again, they can expect to be sued again. So they can walk the Halls of Congress in droves, but the victims—the people who will be affected by this amendment—do not even know who they are yet. We can only talk about them in the abstract, though I have tried to give specific examples.

Mr. President, I recognize that many of my colleagues feel they have to vote for something they can call tort reform, so they can go home and tell their constituents that they have struck a blow against the lawyers. But I urge them to see past this temptation to the real truth. They are striking a blow, if they support this second-degree or its underlying amendment, against their own constituents, against regular people who, God forbid, one day will be the victim of a bad doctor, bad drug, or defective product. If we pass these amendments, we will be hurting people, and that is not something that any of us were elected to do.

Mr. President, I have to say, on the health care front—and I have a few comments on this overall product liability bill as well—that it is amazing to me that we go through a health care debate for the better part of the last Congress and we have the General Accounting Office and the Congressional Budget Office and they talk about the trillion-dollar industry and how we can contain costs. As I remember the numbers, the cost of purchasing medical malpractice insurance, combined with defensive medicine—in other words, doctors say it is not just the cost of purchasing insurance—the total amounts to about 2 percent of the overall costs in the health care industry. Again, I, too, quote from a Business Week piece:

> On an average, only one malpractice claim was filed for every 7.5 patients who suffered a negligent injury, and only half of these were ultimately paid. So, ''the legal system is paying just one malpractice claim for every 15 torts inflicted in hospitals.'' Those suffering nonnegligent injuries—that is, caused by care not yet deemed inappropriate—got nothing. Thus, the study concludes that rather than a surplus, there is a litigation deficit because so many injured people wind up uncompensated. So many injured people wind up uncompensated—overall, a very small percentage.

But let me shout this from the mountaintop that is the floor of the U.S. Senate: When the insurance industry moves into this debate and they want to get their way, they do quite well, apparently, given this kind of amendment. Last session we learned that the way you can most effectively contain health care costs would be to put some limit on what insurance companies charge. But nobody talks about that. That proposal is off of the table.

That is not what we want to do. We do not want to focus on containing health care costs in some kind of fair, rational way. We do not want to focus on how to cover children and women expecting children. We do not want to focus on how we can move forward on home-based long-term care so that elderly people, people with disabilities, can live at home in as near to normal circumstances as possible and with dignity. We do not want to talk about situations where young people, because they have diabetes or because they have had a bout with cancer, find they are no longer covered by an insurance company, or their rates are so high they cannot afford to purchase that insurance.

None of that is being done. We do not want to talk about the 40 million Americans that are uninsured. We do not want to talk about all of the American citizens in this country who are underinsured. We do not want to apply the standards we live by, where we have good coverage and make sure the citizens we represent get the same coverage.

No. Instead, we have an amendment here that is stacked in favor of large companies and against consumers, against regular people, against people who are injured, against people whose loved ones, in fact, in some cases have died as a result of medical malpractice; there is no way people can have information and knowledge about those doctors who have been found guilty of this kind of practice. No, we do not do that, nor do we take any effort to prevent it.

We do not do anything to protect the consumers. We move away from those standards and we have these caps on punitive damages; we say that when a child passes away, that is what she is worth. Not to mention the fact—and I hate to say this on the floor of the Senate because I admire the vast majority of the medical profession and, for that matter, the health care industry in this country—but, by golly, one of the ways you stop some of this practice by those who really have done irreparable harm to citizens, whether they be a doctor or a hospital or corporation, you name it, is you make sure that they know if there is a repeat of this, or they do it again, they will pay dearly.

Mr. President, yesterday I took part in an event that I only wish could have been witnessed by every one of my colleagues in the Senate. Had they seen it, I cannot believe that we would be here today on the floor of the Senate considering this underlying product liability bill, much less these amendments.

The event was a meeting of people who had been harmed by defective products and negligent doctors. All of these people have been claimants—the very people that this legislation is designed to protect against, the very people that these amendments are designed to protect against. They have all been through the legal process, and without its protections, they would not have gotten what compensation they did receive.

Do not let me hear people frame this debate as if it is a debate between everybody in the United States of America versus the trial lawyers. Not true. Having been through the process and seen how difficult it is to even get compensation today for their injuries and punish those who hurt them, these people yesterday—and they are here today as well—have an angry question for supporters of this so-called Product Liability Fairness Act: Why are we doing this? Why are we trying to make it harder for citizens who have been injured by products or malpractice, or citizens who have sometimes even been killed because of this, to seek redress of grievances in our court system?

These citizens I met with yesterday are not the ones with the money and sophistication. Rather, they are the ones that are taken advantage of. They are the ones that are hurt, the ones that wrongdoers try to force into unacceptable settlements. They were here yesterday bearing witness to the damage that could be wrought by manufacturers of defective products and negligent doctors.

They represent the downside of supporting this amendment. They are a reminder of why we have a civil justice system that has been called the great equalizer.

Why through this amendment and why through this underlying bill are we trying to move away from a court system that has been a great equalizer? It is especially so for citizens who have been hurt, for citizens who sometimes have died as a result of defective products or medical negligence.

Mr. President, in this underlying bill there are three basic provisions that have people up in arms. I agree with them 100 percent. Limiting punitive damages—which is part of this amendment as well—would have allowed corporations that hurt them to avoid punishment. It would have allowed industry to work them into what is called the death calculus. For those who were listening, that is the calculation by which a company can decide whether it

is economically worth it to keep marketing a product that harms consumers. It is where a company can ensure that the bottom line is the only line.

The cap on punitive damages in this bill also works to discriminate against lower- and middle-income plaintiffs. People—as I said before—like the elderly, children, and the vast majority of working Americans.

Under this bill, a manufacturers' egregious behavior will receive a lesser punishment if that behavior is against a person who makes less money and therefore has lower economic damages. Same with this amendment on medical malpractice. That is for exactly the same behavior, exactly the same harm and exactly the same defendant. This is an absurd result and it is an indefensible one.

Mr. President, let me take an example. Jack, a data entry clerk, is severely injured by the explosion of a defective diesel generator made by the Acme Generator Co., leaving him in a wheelchair for the rest of his life. His hospital bill is $40,000, but he misses out on 1 year of work, which amounts to $30,000 in lost wages. So his total economic damages are $70,000. The jury determines that Acme's behavior was egregious enough to merit $500,000 in punitive damages. But this bill operates to cap these damages at $250,000.

On the other hand, Bob, who sells commercial real estate, receives the identical injury when he uses one of Acme's generators. His hospital bill also amounts to $40,000 and he, too, is confined to a wheelchair for the rest of his life. When he misses a year of work it costs him $200,000. When the jury tries to punish Acme with $500,000 in punitive damages in his case, the punishment sticks.

This raises a good question: Why is it less punishable to hurt Jack? There is another good question. Was $250,000 enough to properly punish Acme?

I say to my colleagues again, it also applied to the amendment on medical malpractice where there is a cap set and it applies again. If a person does not know, if a person has followed these two examples and the answer is they do not know because a person needs more details, then that person has no business voting to support this one-size-fits-all underlying legislation or this one-size-fits-all amendment.

If the State of Minnesota and the State of Illinois have their own models and have attempted to deal with some of these tough problems so that we avoid some of the excessive litigation, so that we can figure out, I think, a really tough issue with joint liability, then we should let them do so.

We certainly should not have an amendment or a bill that represents a Federal preemption against State standards only if those standards protect consumers or are stronger on consumer protection. Lower consumer protection is fine. This is the inevitability of a stacked deck.

Mr. President, let me put a face on these questions. I want to make it clear I have thought long and hard about this. I feel so strongly that this debate has not dealt with people that I have sought permission for this, and I would not do it otherwise. Let me put a face on this.

Think of LeeAnn Gryc, from my State of Minnesota, who was 4 years old when the pajamas she was wearing ignited, leaving her with second- and third-degree burns over 20 percent of her body.

An official with the company that made the pajamas had written a memo 14 years earlier stating that because the material they used was so flammable, the company was ''sitting on a powder keg.'' When LeeAnn sued for damages, the jury determined that her economic damages were $8,500, and also awarded $1 million in punitive damages.

This is a picture of LeeAnn, what happened to her. Let me ask, was the jury wrong? Should the company have gotten away with only $250,000 in punitive damages, as this bill would have required? Unless a person is comfortable answering the question yes, a person should not be supporting this underlying bill.

Was this too great an award for this family? Unless a person is in favor of a cap and a person thinks more than $250,000 would be too much for this child and her family, a person should not support this bill.

This legislation will have a very, very, real negative impact on consumers. It is unconscionable.

Mr. President, when I saw the damage done by defective products to so many people as I did yesterday, I could not help but feel some of the pain they must have felt and still must be experiencing.

What is it like to be blinded, confined to a wheelchair, unable to parent a child, lose a child, live with brain damage? These are real and palatable harms that many plaintiffs in product liability and medical malpractice actions have to deal with. We should not pass amendments or legislation that provide them with less protection or restrict their ability to seek legitimate and fair redress for grievances in compensation for what has happened to them and to prevent it from happening again to others.

Historically, the primary goal of tort law was to compensate the victim, to make the victim whole. This reflects the view that it is better to have a wrongdoer who was partly responsible for the harm pay more than their fair share, if that is what is necessary to make sure that the victim is fully compensated.

It is not an easy choice, Mr. President, to require somebody to pay more than their fair share. This is an issue that I really struggle with. But it is a choice that this legislation seems to be willing to let stand.

If the harm is of a particular type, a type that can be shown in medical bills, lost wages, and other things that a person can get receipts for, that is one thing. But for noneconomic damages, like juries award for disfigurement, pain and suffering, and inability to bear children, the bill says that it is not important to make victims whole if that is the kind of damage they sustain. Two different standards between economic and noneconomic damages.

I would be very interested in why some of my colleagues think that people who suffer that kind of harm should be relegated to second-class status.

Mr. President, again, there are faces, there are real people who will be hurt by this legislation.

Think of Nancy Winkleman from Minnesota who was in a car crash. I met her a few weeks ago. Because a defective car underride bar failed to operate properly, the hood of her car went under the back of a truck and the passenger compartment came into direct contact with the rear end of the larger vehicle. Without the benefit of her car's own bumper to protect her, she was severely injured, losing part of her tongue and virtually all of her lower jaw.

Despite extensive reconstruction surgery, her face and her ability to speak will never be the same.

Real people, real faces. I cannot imagine the pain that Nancy must have undergone, or the pain that she undergoes every day. If one of the responsible parties in her case was unable to pay its fair share, should she go uncompensated for some of that pain? Or should the other responsible parties have to make it up? Unless you are certain that it is more important to protect those other responsible parties than to compensate Nancy for her pain, you should not support this bill. If you do, you will be hurting people, real people.

Finally, there is the statute of repose prohibiting suits to recover damages for harm caused by defective products that are over 20 years old. This is one of the most arbitrary and indefensible provisions of the bill. What possible justification is there for this? After all, if a product is defective and does not hurt anybody until it is over 20 years old, is the harm of the victim any less? Is the responsibility of the manufacturer any less?

Here is a face you can attach to these questions as you consider them. Think of Jimmy Hoscheit—with his permission—who was at work on his family farm when he was a boy. Jimmy, too is a Minnesotan. I met him a few weeks ago. He was using common farm machinery, consisting of a tractor, a mill, and a blower, all linked together with a power transfer system much like the drive train on a truck. The power of the tractor is transferred to the other equipment by way of a spinning shaft, a shaft covered by a freely spinning metal sleeve. The sleeve is on bearings so that if you were to grab the sleeve it

would stop moving while the shaft and side would continue to powerfully rotate at a very high speed.

Apparently when Jimmy leaned over the shaft to pick up a shovel, his jacket touched the sleeve and got caught on it. However, instead of spinning free of the internal shaft, the sleeve was somehow bound to the shaft, became wrapped in Jimmy's jacket and tore Jimmy's arms off. His father found him flat on his back on the other side of the shaft.

The manufacturer could have avoided all of this if it had just provided a simple and inexpensive chain to anchor the shaft to the tractor.

Now I ask you: Should Jimmy be able to bring a suit against the manufacturer? What if the product was over 20 years old?

A similar question can be asked about 6-year-old Katie Fritz, another Minnesotan whose family I was actually privileged to meet yesterday. Katie was killed in 1989 when a defective garage door opener failed to reverse direction, pinning her under the door and crushing the breath out of her.

I met the Fritz family yesterday, her mother Patty and her sons. It is a really courageous family. And it is really hard for them to talk about it. Patty Fritz had tears in her eyes—who would not? I am a father and a grandfather. Mr. President, you are a father. But you know Patty and her family have the courage to take what has happened to them and be able to speak out in behalf of others.

We all know how long some of these machines can last. If that garage door opener was over 20 years old, Katie's family could not have sued the manufacturer. There would not be any question of capping punitive damages or having joint liability for noneconomic damages they simply would not be allowed in the courthouse door.

That is what this legislation does. Explain to me the justice in that? What is the overriding public policy interest that is so important that this bill should shut Katie's family out of court, or other families like Katie's family, out of court? If you are not clear about this, if you are not sure that there is such a public policy interest here, you should not support this legislation.

This legislation and these amendments right now before us will hurt people, real people. To me, as I look at this legislation and I look at this amendment before us, this is not a close call. At a time when many in Congress are bent on cutting back on regulations that protect the health and safety of our citizens and on reducing public support for people if they get hurt and need help, the courts are the last resort. We cut back on the regulation, we cut back on the protection, we cut back on the ability of public agencies to protect people, and now we shut off the courts, the last resort. That is where regular people can try to deal with wealthy, sophisticated defendants on a relatively level playing field. And now what we are trying to do is change that and make it an unequal playing field. And even now it is extremely hard to get a reasonable settlement or award. Why are we considering legislation to make it even harder?

So I started out talking about the second-degree amendment. Then I talked about the McConnell amendment. Now I have talked about the underlying bill. I urge my colleagues from the bottom of my soul to please oppose not only these amendments, which I did not think would be on the floor, but this bill. Do not close your eyes. See the faces of the people the bill would hurt. See the faces of the people the bill would hurt. See their faces.

I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. DEWINE. Mr. President, once this second-degree amendment of my colleague from Wyoming is disposed of, it is my intention to offer an amendment to the underlying amendment offered by my colleague from Kentucky that will strike from that amendment the cap on punitive damages that amendment places on a specific area and that specific area is sexual assaults of patients by doctors.

Understandably this is a rarity, but the facts are that many times when punitive damages are awarded by juries against doctors, against medical providers, the juries do it in cases where there have been sexual assaults—a case where the patient has been put under anesthesia, the doctor then proceeds to sexually assault the patient. It is certainly a rarity. But, Mr. President, I cannot find any moral justification for this U.S. Congress saying to the 50 States, saying to the people across this country, in that particular case we deem it wise to impose our will on the States and to say, in the case of that sexual assault, there is going to be a cap, there is going to be a limit on what that jury can return in punitive damages against that particular individual.

I hope and would anticipate that this amendment will not be a controversial amendment, it will be something we can all agree on. But I wanted to notify my colleagues and Members in the Chamber that in a short period of time I do in fact intend to offer that particular second-degree amendment.

Mr. President, I yield the floor.

Mr. SPECTER addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SPECTER. I thank the Chair.

Mr. President, I have sought recognition to comment briefly on the pending amendment offered on health care liability reform. I heard about it this morning at about 11:15. Today, like so many days in the Senate, is a very complicated day. Shortly we will be conducting hearings in the Judiciary Committee on terrorism, which I am due to chair. There is a ceremony starting in a few minutes on the steps of the Capitol to commemorate the victims of the Holocaust. But I wanted to come over for just a few minutes to comment about this pending amendment on health care liability reform.

My review so far has been cursory because of the limited time available, but it is my understanding that this amendment, which is a fairly thick document, is the bill which was reported out of the Labor and Human Resources Committee earlier this week. It is my thought that this legislative proposal now offered in the form of an amendment really warrants some very, very considerable study. It is being added onto the bill on product liability, which is already complex. The health care liability reform amendment is really a piece of legislation which I think requires a committee report, requires time to study and to reflect, and some judgment.

When we are dealing with the whole area of tort reform, we are building on a field which has had encrustations of judicial decisions over decades, or really centuries. As I said earlier this week in a brief statement on product liability, some reform, I think, is necessary. And in the practice of law, my profession, I have represented both plaintiffs and defendants in personal injury cases. But the reform process needs extraordinary care because the common law has developed one case at a time with very careful analysis, contrasted with the legislative process where frequently in hearings only one or two Senators may be present, and the markups, as carefully as we can do them, do not really produce the kind of legal and factual analysis which the courts have developed in the common law. But I do think there is room for improvement.

Last night, I spoke in favor of Senator BROWN's amendment to tighten up rule 11 to deter frivolous lawsuits. So there are places where we can improve the system with a very, very careful analysis. But I do not think it is realistic to take up this entire legislative package on health care liability reform with the kind of analysis which is required to protect the interest of all the parties, both plaintiffs and defendants.

As is the custom of the Senate under the rules of the Senate on the pending legislation of product liability, we have a different committee report which analyzes the hearings, sets forth the facts and conclusions that Senators may use as a basis for their consideration of the legislation, which we do not have on this amendment.

It would be my expectation that the managers would move to table. I have not consulted with them. But the Senator from West Virginia, Senator ROCKEFELLER, has commented about his interest at least in keeping the current legislation limited to product liability, and the distinguished Senator from Washington has commented about making sure that any amendment has

at least 60 votes so that we do not have legislation that will not stand the 60-vote rule on cloture.

I note that the majority leader has come to the floor. I shall be very brief.

I would like to put in the RECORD two studies of the malpractice field which I think would be of interest to my colleagues to review, and I will read just a couple of paragraphs which articulate the conclusions of these studies.

First, I refer to an article in the Annals of Internal Medicine of 1992 entitled ''The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims'' by a distinguished group of doctors.

Objective: To explore how frequently physicians lose medical malpractice cases despite providing standard care and to assess whether severity of patient injury influences the frequency of plaintiff payment.

This is a study of a ''total of 12,829 physicians involved in 8,231 closed malpractice cases.''

Under the conclusions section, the study essentially reports that, ''Our findings suggest that unjustified payments are probably uncommon.''

There is a fair amount to the analysis and a fair amount more to the conclusions. But I leave that for the readers in the CONGRESSIONAL RECORD.

I would next cite an article in the New England Journal of Medicine from July 25, 1991, captioned ''Relation Between Malpractice Claims and Adverse Events Due to Negligence'':

Abstract—Background and Methods. By matching the medical records of a random sample of 31,429 patients hospitalized in New York State in 1984 with statewide data on medical-malpractice claims, we identified patients who had filed claims against physicians and hospitals.

And the conclusion:

Medical-malpractice litigation infrequently compensates patients injured by medical negligence and rarely identifies, and holds providers accountable for, substandard care.

I would also like to put into the CONGRESSIONAL RECORD, Mr. President, an article from the New York Times of Sunday, March 5, which is particularly applicable to the second-degree amendment which has been filed here relating to obstetrics. This article reported on a study of New York hospitals with the captioned headline: ''New York's Public Hospitals Fail, and Babies Are the Victims.'' It is a fairly lengthy article. But a couple of paragraphs are worth quoting.

Each year, for the last decade, dozens of newborn babies have died or have been left to struggle with brain damage or other lifelong injuries because of mistakes made by inexperienced doctors, poorly supervised midwives and nurses in the teeming delivery rooms of New York City's public hospitals.

Some of the most prestigious medical schools and private hospitals are paid by the city to provide care in its sprawling hospital system. But an examination by the New York Times shows that many of these private institutions have left life-and-death decisions to overworked nurses and trainee doctors who are ill prepared to make them.

The effects can be seen across the system, from the surgical suites to the clinics. But nowhere are the consequences more devastating than in the delivery rooms where the course of a young life will be changed forever by a few minutes delay in the malfunctioning monitor or a lapse of attention.

Some hospital and city officials have known about the problem for years, and have worked mightily to keep them from the public. They fear a loss of public confidence and a flood of lawsuits.

Quoting further from the report:

These cases are catastrophic and costly. Many of these infants are now grown children suffering from multiple and severe disabilities who require lifetime hospitalization or intensive home care.

I would also cite a report by the Congressional Budget Office, the independent arm of Congress, and their conclusions in 1992:

Restructuring malpractice liability would not generate large savings in U.S. health care costs. Malpractice premiums amount to less than 1 percent of national health care expenditures. Thus, the premiums directly contribute little to the Nation's overall health care costs.

These are just a few comments, Mr. President, which I say I am abbreviating because the distinguished majority leader is on the floor. I have other commitments, having come over just when I heard the introduction of the amendment.

I ask unanimous consent at this point that the articles that I referred to from the New England Journal of Medicine, the Annals of Internal Medicine, and the New York Times be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows;

[From Annals of Internal Medicine, Vol. 117, No. 9, Nov. 1, 1992]

THE INFLUENCE OF STANDARD OF CARE AND SEVERITY OF INJURY ON THE RESOLUTION OF MEDICAL MALPRACTICE CLAIMS

(By Mark I. Taragin, MD, MPH; Laura R. Willett, MD; Adam P. Wilczek, BA; Richard Trout, PhD; and Jeffrey L. Carson, MD)

Objective; To explore how frequently physicians lose medical malpractice cases despite providing standard care and to assess whether severity of patient injury influences the frequency of plaintiff payment.

Design: Retrospective cohort study.

Setting: Physicians from the state of New Jersey insured by one insurance company from 1977 to 1992.

Participants: A total of 12,829 physicians involved in 8231 closed malpractice cases.

Measurement; Physician care and claim severity were prospectively determined by the insurance company using a standard process.

Result: Physicians care was considered defensible in 62% of the cases and indefensible in 25% of the cases, in almost half of which the physician admitted error. In the remaining 13% of cases, it was unclear whether physician care was defensible. the plaintiff received a payment in 43% of all cases. Payment was made 21% of the time if physician care was considered defensible, 91% if considered indefensible, and 59% if considered unclear. The severity of the injury was classified as low, medium, or high in 28%, 47%, and 25% of the cases, respectively. Severity of injury had a small but significant association ($P < 0.001$) with the frequency of plaintiff payment (low severity, 39%; medium severity, 42%; and high severity, 47%). The severity of injury was not associated with the payment rate in cases resolved by a jury (low severity, 23% medium severity, 25%; and high severity, 23%).

Conclusions: In malpractice cases, physicians provide care that in usually defensible. The defensibility of the case and not the severity of patient injury predominantly influences whether any payment is made. Even in cases that require a jury verdict, the severity of patient injury has little effect on whether any payment is made. Our findings suggest that unjustified payments are probably uncommon.

The fear of medical malpractice has resulted in significant physician dissatisfaction and has contributed to the decrease in the number of persons entering the field of medicine (1, 2). Further, physicians have stimulated legislation for tort reform, increased the practice of defensive medicine, and avoided ''risky'' patients (3–7).

Physicians' apprehensions about malpractice stem from several perceptions (7). Perhaps foremost is the concern that the malpractice resolution process is unfair (8). Because standards are unclear and possibly inconsistent, physicians are afraid of being sued and of losing the case despite their having provided standard medical care (9). Further, juries are seen as unjustifiably rewarding patients solely on account of the severity of their injuries.

We explored the influence of physician care and the severity of patient injury on the malpractice process. Contrary to many perceptions, our study suggests that physicians usually win cases in which physician care was deemed to meet community standards and that the severity of patient injury has little bearing on whether a physician loses a case.

METHODS

Data source

We obtained our data from The New Jersey medical Inter-Insurance Exchange, a physician-owned insurance company. This company insures approximately 60% of the physicians in New Jersey. Since 1977, demographic information on physicians and detailed descriptive information on every malpractice claim have been entered into a standardized computer data-base.

Study design and population

We did a retrospective cohort study that included physicians insured for any time between 1977 and 1992. During this period, 12,829 physicians were insured and 11,934 cases were filed, of which 80% are currently closed. Because the time from an incident until its resolution can vary greatly, we chose 1 January 1986 as a cutoff point for the incident data because 96% of cases that occurred before this date were closed by 1992. After excluding 14 cases that lacked peer review results, we evaluated 8,231 closed cases.

Study variables

The insurance company's assessment of whether a physician's actions represent standard medical care is based on medical criteria and is not supposed to be influenced by legal concerns. First, the physician is contacted, and if he or she admits error, the case is labeled ''indefensible—insured admits deviation,'' and no further review is done. Otherwise, the case is reviewed by a claims representative employed by the insurance company. If the physician's performance is thought to be clearly medically defensible, the case is labeled ''no peer review, clearly defensible.'' Otherwise, a peer review process ensues in which a physician from the same specialty is chosen from volunteer physicians, many of whom have performed this

service regularly for several years. This physician-reviewer then participates in a discussion of the case with the claims representative, the defense attorney, and the defending physician or physicians. Based on the standard of medical care currently practiced by physicians of similar training and experience in the community, the physician-reviewer classifies the claim as ''defensible'' if standard care was provided, ''indefensible'' if not, and ''defensibility unclear'' if the reviewer is unsure. A slight variance to this standard procedure occurs for neurosurgery and orthopedics cases because, historically, experts hold divergent opinions about the appropriate approach to some routine problems. Therefore, a panel of physicians is used instead of one physician-reviewer, and the majority vote is considered final. For every case, we summarized this process of the assessment of physician care as defensible, indefensible, or unclear.

If a plaintiff receives financial compensation through either a settlement or a jury verdict, the terminology ''payment'' is applied. For the subset of payments resulting from a jury verdict, the term ''award'' is used. We created four categories of payment: less than $10,000; $10,000 to $49,999; $50,000 to $199,999; and $200,000 or more. All dollar amounts are adjusted to represent 1990 dollars.

The insurance company classifies the severity of the patient's injury using the industry standard National Association of Insurance Commissioners Index (10). This index has nine categories of increasing severity. We collapsed this into three categories: low (no injury, minor injury with no disability, or minor injury with temporary disability); medium (major injury with temporary disability, minor injury with moderate disability, or major injury with moderate disability); and high (grave injury with moderate disability, brain injury with impaired life expectancy, or death).

The stage of resolution is the point in the legal process at which the case is resolved. A case is created when the insurance company is notified of a plaintiff's claim of damages. A suit occurs when this complaint is filed with the court. Discovery refers to the process by which lawyers collect information about the case.

Statistical analysis

Statistical significance was assessed by chi-square tests as appropriate (11).

RESULTS

The characteristics of the 8231 closed cases are summarized in Table 1. Physician care was considered defensible in 62% of the cases and indefensible in 25%. In almost half of the latter cases, the physician admitted error. The remaining 13% of cases were unclear as to defensibility. Payment was made in 43% of all cases, with 52% for less than $50,000 and only 15% for greater than $200,000. The median payment was $45,551 (range, $24 to $3,965,000). The severity of the injury was classified as low in 28% of cases, medium in 47%, and high in 25%.

TABLE 1.—MEDICAL MALPRACTICE CLAIM FACTORS

Factor	Closed Cases (n = 8231)
	n(%)
Physician care:	
Defensible	5132 (62)
No peer review, clearly defensible	2378 (29)
Insured found defensible by peer review	2754 (33)
Indefensible	2000 (25)
No peer review held, insured admits deviation	881 (11)
Indefensible (breach of standard)	1119 (14)
Unclear	1099 (13)
Payment:	
No	4730 (57)
Yes	3515 (43)
<$10,000	744 (21)
$10,000 to <$50,000	1089 (31)
$50,000 to <$200,000	1141 (33)
$200,000 or more	541 (15)
Severity of injury:	
Low (no injury or minor injury with no or temporary disability)	2334 (28)
Medium (minor or major injury with moderate disability or major injury with temporary disability)	3824 (47)
High (grave injury, brain injury, or death)	2087 (25)

Physician care

Evaluation of physician care correlated closely with the likelihood of financial payment. A payment was made in 21% of the cases considered defensible, in 91% of the cases considered indefensible, and in 59% of the cases considered unclear. The amount was not directly related to judgments of defensibility (P = 0.16 [for linear trend]).

Most cases closed early in the process (Fig. 1 not reproducible in RECORD); 67% were closed before discovery was completed. Only one quarter of the 12% of cases requiring a jury verdict resulted in payment to the plaintiff. Of these awards, the median payment was $114,170 (range, $3281 to $2,576,377). For each stage, the percent of cases that resulted in payment strongly correlated with physician care (P < 0.001). For example, in those cases that closed before a suit was filed, payment was made to the plaintiff in 6% of defensible cases, in 69% of cases in which physician care was deemed unclear, and in 93% of indefensible cases. In addition, physician care influenced the stage of resolution. A jury verdict was required for 15% of defensible cases, for 10% of cases in which defensibility was unclear, but in only 5% of indefensible cases (P < 0.001 [for linear trend]). Even in the 12% of cases that required a jury verdict, physician care correlated with the likelihood of a jury award: 21% if defensible, 30% if unclear, and 42% if indefensible (P < 0.001 [for linear trend]).

Severity of injury

The influence of the severity of the claimant's injury on the resolution process is summarized in Table 2. A similar distribution of physician care was seen in every severity category. The likelihood of obtaining any payment showed a small (<8% difference between low and high claim severity) but statistically significant (P < 0.001) trend toward an association between increasing severity and the likelihood of payment. These findings remained consistent when all nine severity-of-injury levels were analyzed.

TABLE 2.—RELATION BETWEEN SEVERITY OF INJURY AND PHYSICIAN CARE, PAYMENT, AND STAGE OF RESOLUTION

Variable	Severity of injury		
	Low (n = 2326)	Medium (n = 3820)	High n = 2085)
	n (%)		
Physician care:			
Defensible	1407 (61)	2456 (64)	1269 (61)
Indefensible	525 (23)	907 (24)	568 (27)
Unclear	394 (17)	457 (12)	248 (12)
Payment:			
No	1420 (61)	2186 (57)	1111 (53)
Yes	906 (39)	1634 (43)	974 (47)
<$10,000	521 (70)	181 (24)	41 (6)
$10,000 to <$50,000	276 (25)	534 (58)	179 (16)
$50,000 to <$200,000	97 (9)	637 (56)	407 (36)
$200,000 or more	12 (2)	182 (34)	347 (64)
State of resolution:			
Before suit filed	891 (38)	544 (14)	219 (11)
After suit, before discovery complete	930 (40)	1927 (50)	1005 (48)
After discovery, more than 45 days before trial	80 (3)	189 (5)	142 (7)
Within 45 days of trial	140 (6)	395 (10)	238 (11)
During trial, before verdict	102 (4)	270 (7)	186 (9)
Verdict or after	183 (8)	497 (13)	296 (14)

The amount of payment correlated closely with the severity of the injury. The median payments for injuries of low, medium, and high severity were $7,189, $50,000, and $115,089, respectively. These findings also remained consistent when all nine severity-of-injury levels were analyzed, except in the case of death. In cases of death, the median payment was $94,346, whereas for the remaining high-severity injuries, the median payment was $210,807.

In contrast to the overall findings, in cases requiring a jury verdict, the severity of injury was not related to the likelihood of payment (P>0.2). However, the severity of the injury did correlate with the payment amount (P=0.03) (Table 3).

TABLE 3.—CASES REQUIRING A VERDICT: RELATION OF PHYSICIAN CARE AND INJURY SEVERITY TO FINAL AWARD STATUS

Variable	n(%)			Payment				
	Award							
	No (n=740)	Yes (n=236)	Total	< $10,000	$10,000 to < $50,000	$50,000 to < $200,000	$200,000 or more	Total
Physician care:								
Defensible	605 (79)	161 (21)	766 (100)	8 (5)	33 (20)	62 (39)	58 (36)	161 (100)
Indefensible	59 (58)	42 (42)	101 (100)	0 (0)	8 (19)	13 (31)	21 (50)	42 (100)
Unclear	76 (70)	33 (30)	109 (100)	2 (6)	8 (24)	11 (33)	12 (36)	33 (100)
Severity:								
Low	141 (77)	42 (23)	183 (100)	3 (7)	15 (36)	16 (38)	8 (19)	42 (100)
Medium	372 (75)	125 (25)	497 (100)	5 (4)	24 (19)	52 (42)	44 (35)	125 (100)
High	227 (77)	69 (23)	296 (100)	2 (3)	10 (14)	18 (26)	39 (57)	69 (100)

DISCUSSION

In most of the malpractice cases included in our analysis, a physician was judged to have provided medical care that was defensible, and the plaintiff did not receive any payment. Although physician care strongly influenced the overall process, the severity of the patient injury had little effect on the probability of any payment. Most cases closed at an early state, so a jury verdict was rarely needed. For the small number of cases that required a jury verdict, only 24% resulted in payment to the plaintiff and the severity of injury did not influence the probability of payment.

The determination of physician care was a good predictor of the outcome of a case. For the cases that were felt to be indefensible, the payment rate was 91%. This high payment rate is expected because the insurance

company uses the determination of physician care to decide whether to offer to settle a case. In contrast, in the cases where physician care was classified as defensible, the payment rate was 21%.

Several factors may explain why payment occurred in cases class classified as defensible. First, the determination about physician care was made very early after a claim was generated and may have been inaccurate as more information became available. Second, a physician-based review process may be biased toward assessing physician performance in the physician's favor. Third, the insurance company may err toward an initial determination of physician care as defensible to avoid unnecessary payments. The possibility that new information rendered the original assessment of defensibility incorrect was supported by the fact that 68% of defensible cases that resulted in payment were settled before trial, in half of these before discovery was complete. Further, only 15% of defensible cases that resulted in payment represented awards made to the plaintiff by a jury. In addition, because the physician has the right to refuse to settle and the insurance company is physician-owned, many of the defensible cases that resulted in payment were probably misclassified as defensible. Therefore, although we can only speculate on the number of cases that were inappropriately lost by the physician, our data suggest that inappropriate payments are probably uncommon.

Severity of injury

Although the findings of previous studies are inconsistent (7, 8, 12, 13), we found that the severity of patient injury had little influence on the probability of plaintiff payment. We anticipated that a jury would be more likely to rule in favor of the plaintiff if the patient had a more severe injury. Similarly, we expected that the plaintiff's attorney might negotiate a payment for the plaintiff more frequently in cases in which injury was of higher severity than those in which injury was of lower severity.

We also found that the assessment of the standard of care by a peer review panel was not related to the severity of injury. This finding differs from that of a recent study, which found that the patient's outcome strongly influenced reviewers' opinions of the appropriateness of care (14). The contradictory findings may reflect the fact that the physician-reviewers in that study had only abstracted data of selected cases. In our study, the malpractice cases were judged during the actual processing of the case, with the medical records available for review and with the treating physician available for additional insight.

We suspect that our results can be generalized even though our study was done in a subset of physicians from one state. In a previous study, we found that the demographic characteristics of the physicians in our database were similar to the overall population of physicians in New Jersey and varied only slightly from national figures (10, 15, 16). In addition, the frequency of payment, average amount of payment, severity of injury, stage of resolution, and proportion of claims involving only one physician are consistent with the findings of other studies (10, 13, 17). Thus, despite the implicit nature of judgments about defensibility, our results should be generalizable to other physician-patient populations.

These results have implications for tort reform. This insurance company felt liability was unclear for only 13% of cases, and a jury verdict was required for only 12% of all cases. This suggests that much of the efforts in the malpractice process involves determining the facts of the case and negotiating the amount of settlement rather than resolving disagreements about the presence of liability. Neither the patient nor the physician is served by this extremely inefficient and costly process, which results in delayed payments to injured parties and casts a prolonged cloud over physicians. Our experience in determining physician defensibility suggests that arbitration panels may be successful in assessing liability. Unfortunately, our data shed little light on the costs and benefits of a ''no-fault'' system because most injuries do not enter the current malpractice resolution process (18).

In summary, our analyses suggest that, in malpractice cases, the physician's care is usually defensible and that the plaintiff usually does not receive any payment. The severity of patient injury affects the payment amount but has little influence on whether monetary damages are received by a plaintiff, especially in cases that are decided by a jury. Further efforts to clarify the frequency of unjustified payments are needed, but our data suggest that such payments are uncommon.

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Relation Between Malpractice Claims and Adverse Events Due to Negligence—Results of the Harvard Medical Practice Study III

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Abstract Background and Methods. By matching the medical records of a random sample of 31,429 patients hospitalized in New York State in 1984 with statewide data on medical-malpractice claims, we identified patients who had filed claims against physicians and hospitals. These results were then compared with our findings, based on a review of the same medical records, regarding the incidence of injuries to patients caused by medical management (adverse events).

Results. We identified 47 malpractice claims among 30,195 patients' records located on our initial visits to the hospitals, and 4 claims among 580 additional records located during follow-up visits. The overall rate of claims per discharge (weighted) was 0.13 percent (95 percent confidence interval, 0.076 to 0.18 percent). Of the 280 patients who had adverse events caused by medical negligence as defined by the study protocol, 8 filed malpractice claims (weighted rate, 1.53 percent; 95 percent confidence interval, 0 to 3.2 percent). By contrast, our estimate of the statewide ratio of adverse events caused by negligence (27,179) to malpractice claims (3570) is 7.6 to 1. This relative frequency overstates the chances that a negligent adverse event will produce a claim, however, because most of the events for which claims were made in the sample did not meet our definition of adverse events due to negligence.

Conclusions. Medical-malpractice litigation infrequently compensates patients injured by medical negligence and rarely identifies, and holds providers accountable for, substandard care. (N Engl J Med 1991; 325:245–51.)

The frequency of malpractice claims among patients injured by medical negligence has been the subject of much speculation and little empirical investigation. Two fundamental questions about malpractice litigation have been how well it compensates patients who are actually harmed by medical negligence, and whether it promotes quality and penalizes substandard care. If negligent medical care infrequently leads to professional censure or a malpractice claim, then the deterrence of substandard care may be suboptimal[1,2] and the civil justice system will compensate few patients for their medical injuries.[3] If, as some allege,[4] sizable numbers of malpractice claims are filed for medical care that is not negligent, then the costs of claims may be excessive, and the credibility and legitimacy of malpractice litigation as a means of obtaining civil justice may be reduced.

Footnotes at end of article.

Danzon[5] estimated on the basis of reviews of medical records and claims data from California in the mid-1970's[6] that for each malpractice claim, 10 injuries were caused by negligent care. That study estimated only the relative frequency of claims and negligence; without a method of determining the fraction of claims that did not involve negligence, Danzon could not estimate the probability that a claim would follow medical negligence.

To calculate this probability, the Harvard Medical Practice Study linked clinical reviews of 30,195 inpatient records with statewide records of malpractice claims. Linking these two data sets permitted a determination of the frequency with which negligent and nonnegligent medical care, as evaluated by a team of physician-reviewers, led to malpractice claims.

METHODS

Data from medical records

Our review of the records of a random sample of 31,429 patients discharged in 1984, drawn from 51 hospitals across New York State, is described in detail elsewhere.[7] In brief, the review proceeded in three stages.

In the first stage, a group of specially trained nurses and medical-records administrators used standard protocols to screen records for at least 1 of 18 events signaling a possible adverse event.

In the second stage, medical records that met at least 1 of these 18 criteria were referred to two physicians who independently evaluated the cause of the patient's injury and whether there had been negligence. The physicians first decided whether the patient had suffered an injury caused at least in part by medical management. Injuries that either prolonged hospitalization or led to disabilities that continued after discharge were deemed to be adverse events. Negligence was considered to have occurred if the medical care that caused the adverse event was below the expected level of performance of the average practitioner who treated problems such as the patient's at that time.

Physicians recorded their judgments about causation and negligence on an ordered, categorical scale ranging from ''no possible adverse event (or negligence)'' to ''virtually certain evidence of an adverse event (or negligence).'' Reviewers also judged the degree of disability resulting from the adverse event and described briefly the nature of the injury, its relation to medical management, and the negligent act or omission.

In the third stage, when the two physicians disagreed on the existence or description of an adverse event, the discrepancy was resolved by a supervising physician who was blinded to their decisions and made his or her own judgment about causation and negligence.

Injuries were classified as adverse events, and then as negligent, when the average of the two final physicians' evaluations represented a judgment of at least ''more likely than not.'' Multiple reviews permitted the analysis of results under alternative assumptions about thresholds for identifying causation and negligence.

The record review produced five groups of cases: (1) cases that met no screening criteria for adverse events or negligence, (2) those referred for review by the physicians but without evidence of an adverse event, (3) cases of ''low-threshold adverse events'' with judgments of causation that were borderline or lower, (4) cases of adverse events with no evidence of negligence, and (5) cases of adverse events due to negligence.

We performed sensitivity analyses to identify possible biases due to missing records or misclassified reviews. To assess the effect of false negative findings in the stage 1 screening by medical-records administrators, we conducted a second review of a random sample of 1 percent of all the records located.[7] A second team of physicians independently reviewed 318 records from two hospitals to assess the reliability of the initial physicians' reviews.[8]

Several months after the initial visits, the participating hospitals searched against for missing records and explained why some charts remained unavailable. At six randomly selected facilities, our medical-review team conducted another three-stage review to determine whether adverse events were more likely to have occurred when records were missing. At the remaining hospitals, the medical-records administrators referred for physician review only cases for which there was evidence of legal action in the patients' charts. At all hospitals, we obtained identifying data on patients for later use in matching the records with data on malpractice claims.

Data on malpractice claims

The data on malpractice claims included all formal claims filed against physicians and hospitals and reported to the Office of Professional Medical Conduct (OPMC) at the New York Department of Health. The data base at the OPMC lists claims according to the defendant, not the patient making the claim. We have referred to each claim in the OPMC records as a ''provider claim.'' Because one patient could sue several defendants for a single injury, the number of defendants exceeded the number of patients. We have referred to counts of claims by patients as number of ''patient claims.''

New York statutes and regulations require regular reporting of claims by domestic and out-of-state insurance carriers,[9] self-insurance programs,[10–12] and all hospitals.[13] Both the Insurance Department and the Department of Health formally advised all insurance and health care organizations about the needs of our study and about the reporting mandates.[14] The OPMC allowed us complete access to all computer files and paper abstracts. The OPMC data base, which contained 67,900 provider claims reported from 1975 through May 1989, became our starting point for estimating patient claims, computing lengths of time between injuries and claims, determining the chances that payment would result from a claim, identifying claimants in the sample, and linking their claims to the sampled patients' hospital records. When necessary, members of the study team contacted and visited individual hospitals to supplement the OPMC data with more comprehensive information.

To test the robustness (resistance to errors in assumptions) of the estimate of the frequency of claims, we calculated the number of patient claims for 1984 in three ways. First, we summed the case-sampling weights (the population of patients represented by each sampled record) of the claims linked to medical records through the matching process described below and extrapolated from the sample to the New York State population. Second, we calculated the number of patient claims from the OPMC's statewide records for injuries that occurred in 1984, regardless of when the patient filed the claim. Third, we estimated the annual frequency of patient claims by averaging the number of claims filed by year from 1984 through 1986. Averse events discovered in 1984 would probably have been reflected, if at all, in malpractice claims filed during this period.

Matching process

Our study protocol precluded interviews with patients about malpractice claims. Claimants were identified by linking their hospital records to OPMC claims records. This linkage proceeded only after the completion of the review of medical records. Physician-reviewers were unaware of the existence of a claim unless the medical record mentioned it.

We used both computer-based and manual matching techniques to link the records of patients in the sample to malpractice claims. Identifying characteristics for linking patients to claimants included the patient's name, address, ZIP Code, social security number, and age, the geographic location where the injury occurred, and the hospital from which he or she was discharged. Lack of complete data on the identifiers with strong discriminating power such as the social security number forced us to rely on a combination of matching characteristics. The matching algorithm, described in detail elsewhere,[7] allowed for errors of differences in the spelling of names, so that actual matches were erroneously excluded.[15] Manual matching, a common step in record-linkage procedures,[16] helped to confirm links because of the amount of descriptive information not in machine-readable format. The OPMC requested additional descriptive data from the insurers to assist us in confirming or ruling out matches.

After identifying the sampled patients who had filed claims, we considered whether their allegations of malpractice referred to the medical care delivered or discovered in the sampled hospitalization. A team consisting of an attorney experienced with malpractice data, a health services researcher, and a physician-lawyer compared clinical information from the review of medical records with coded data and summary descriptions from the OPMC claims records. This team rated by consensus its degree of confidence in the match by first eliminating cases for which the group was confident that no match existed and those that lacked sufficient information to permit a judgment. For all other cases, the team's degree of confidence in the match was rated on a six-point confidence scale (Table 2).

Estimates of statewide rates of adverse events and claims

The medical-record-sampling design permitted us to extrapolate from the sample to the population of all patients discharged from hospitals in New York State in 1984. The analysis of the cases that produced claims required separate adjustments sampling weights to account for missing records. These adjustments assumed that the rate of claims among the patients whose hospital records were never found equaled the rate among those whose records were initially not located but were found on follow-up. The standard errors of rates of claims account for the effects of a stratified, unequal-cluster sampling design.''

RESULTS

Adverse events and adverse events due to negligence

As we reported in detail earlier,[8] the three-stage review of medical records detected 1133 adverse events (after adjustment for double counting of the same hospitalizations). Two hundred eighty adverse events, representing 1 percent of all discharges (95 percent confidence interval, 0.8 to 1.2 percent), were judged to have been caused by negligence (Table 1).

TABLE 1.—RESULTS OF THE REVIEW OF A SAMPLE OF 31,429 MEDICAL RECORDS FROM NEW YORK STATE, 1984 [1]

Category	Number of records	Comments
Sample selected	31,429	Random sample from 51 hospitals.
Records not located on initial visit.	1,234	
Records screened for possible AE (first stage).	30,195	
Records referred for physician review after screening.	7,817	Satisfied 1 or more of 18 screening criteria.
Reviewed by physicians for presence of AE and neglience (second stage).	[2] 7,743	Two physicians judged the likelihood of AE and neglience indepenently.
Reviewed by a third physician to resolve disagreement (third stage).	1,808	Third review provided majority opinion.
AE's identified	1,133	Majority of reviewers' combined confidence level at least ''more likely than not'' (adjusted for incidence).
AE's due to negligence identified.	280	Majority found AE caused by negligence with confidence level at least ''more likely than not'' (adjusted for incidence).

[1] AE denotes adverse event.

[2] Seventy-four of the 7817 records referred for review in stage 2 were not reviewed. Case-sampling weights were reallocated among the 7743 cases actually reviewed.

Analysis of Matched Records

Ninety-eight patients in the sample filed claims against 151 health care providers (Table 2). Not all these patients alleged malpractice during the episodes of care covered by the study. When we considered only matches designated ''more like than not,'' we linked 47 of these malpractice claims to the sampled hospitalizations. These 47 cases represent a rate of malpractice claims per discharge in New York State of 0.11 percent (95 percent confidence interval, 0.06 to 0.16 percent).

TABLE 2.—RESULTS OF MATCHING MALPRACTICE CLAIMS TO HOSPITALIZATIONS IN NEW YORK STATE, 1984 [1]

Decision on Matching (Confidence Score)	Number	Percent
Claimants in sample	98	
Medical records reviewed	[2] 30,121	
Claimants linked to sampled hospitalizations:		
Virtually certain (6)	41	41.8
Strong evidence (5)	2	2.0
More than likely (4)	4	4.1
Subtotal	47	
Claimants in sample but not linked to sampled hospitalizations:		
Not quite likely (3)	1	1.0
Slight-to-modest evidence (2)	0	0.0
Little evidence (1)	1	1.0
Definite nonmatch	44	44.9
Insufficient data	4	4.1
AE discovered after discharge [3]	1	1.0
Subtotal	51	

[1] AE denotes adverse event. Because of rounding, percentages do not total 100.

[2] Seventy-four of 30.195 records located were not reviewed. None of the cases involved claimants. Case-sampling weights have been reallocated among the usable observations.

[3] AEs that occurred during the sampled hospitalization and were discovered after discharge have been omitted.

In most cases, the reviewing team's judgments went clearly for or against linking the claim to a sampled hospitalization. For example, in 30 of the 44 cases in which there was considered to be no possible match, the main reason was a mismatch between the date of the injury or the date when the claim was filed and the date of the sampled hospitalization. In the four cases for which there were insufficient data, we chose to vote against linkage rather than guess. None of these cases involved adverse events. Another matched case did not qualify for inclusion according to the sampling design because the adverse event was discovered after the sampled hospitalization, rather than before or during it.[7]

Table 3 shows the distribution of malpractice claims according to the five groups of cases defined by the outcome of the medical-record review. The percentage of claimants in each subgroup increased as the findings of the reviewers increased in severity from ''no screening criteria met'' to ''adverse events caused by negligence.'' For all outcomes groups, the rate of malpractice claims was low. The chance that an injury caused by medical negligence would result in litigation was 1.53 percent (95 percent confidence interval, 0 to 3.24 percent).

TABLE 3.—RATE OF PATIENT MALPRACTICE CLAIMS IN THE SAMPLE OF 30,121 MEDICAL RECORDS FROM NEW YORK STATE, 1984 [1]

Group of Records	Number of Discharges in Sample	Number of Claimants in Sample	Estimated Number of Claimants in new York	Estimated Rate of Claims per Discharge (95% CI) [2]	Comments
Cases not referred by MRA	22.378	12	899	0.045 (—)	5 Cases: alleged failure to diagnose during outpatient visit.
Cases referred: no possibility of AE	6,275	14	1,000	0.18 (—)	9 Cases: physician-reviewers knew about claim, found no AE. 4 Cases: disagreement settled by third reviewer.
Low-threshold AEs (less than likely)	335	3	92	0.30 (—)	1 Case: one of two reviewers found negligence.
AEs (more than likely) not caused by negligence	853	10	561	0.79 (—)	6 Cases: one of two reviewers found negligence.
AEs (more than likely) caused by negligence	280	8	415	1.53 (0–3.24)	1 Case: single reviewer only.
Total	[3] 30.121	47	2967	0.11 (0.06–0.16)	

[1] CI denotes confidence interval, MRA medical-records administrator, and AE adverse event.

[2] Based on population-based estimates on discharges. For example. 1.53 percent = 415 of 27,179. See Figure 1.

[3] Seventy-four of 30,195 cases did not undergo physician review; they were dropped from the calculations of population estimates, and their weights were reallocated among the usable observations.

For 12 of the 47 matched observations, the medical-records administrators found that none of the 18 screening criteria were satisfied, and the review process ceased without participation by the physicians. Five of these 12 claimants alleged the failure to diagnose a condition during outpatient visits before the sampled hospitalizations. Among the remaining 35 cases, all of which were reviewed by physicians, clinical judgments about the cause of the adverse outcome and the contribution of negligence were often contradictory. In some cases the two physicians disagreed on the presence of an adverse event in the second stage of the process, and a third physician resolved the issue by finding no adverse event. In others the physicians agreed on causation but differed about the occurrence of, or their levels of confidence about, negligence. In nine cases, the reviewing team knew of pending malpractice claims but found no evidence of adverse events. (Details of the reviews of the 47 cases are available elsewhere.*)

*See NAPS document no. 04877 for three pages of supplementary material. Order from NAPS c/o Microfiche Publications. P.O. Box 3513. Grand Central Station, New York, NY 10163–3513. Remit in advance (in U.S. funds only) $7.75 for photocopies or $4 microfiche. Outside the U.S. and Canada add postage of $4.50 ($1.50 for microfiche postage). There is an invoicing charge of $15 on orders not prepaid. This charge includes purchase order.

Statewide estimates of adverse events due to negligence not resulting in malpractice claims

Ninety-eight percent (weighted rate) of all adverse events due to negligence in our study did not result in malpractice claims (Fig. 1—not reproducible in RECORD). The group of these cases for which the reviewers could determine the existence of disability and for which their combined score indicated either ''strong'' or ''certain'' evidence of negligence can be extrapolated to about 13,000 discharges statewide in 1984. Within this group, 58 percent of the patients had only moderately incapacitating injuries and recovered within six months. the remaining patients—those with moderate-to-severe disability—correspond to about 5400 patients discharged from hospitals in New York State. Over half these patients were under 70 years of age and thus likely to have lost wages as a result of the injury.

Follow-up reviews of medical records and claims

Medical records located after intensive follow-up were a richer source of claims than those found on the initial hospital visits, but there was no difference in the rates of adverse events or negligence between the initial review and follow-up.[7] twelve of the 580 patients whose records were found during follow-up filed malpractice claims against 18 providers, and four of these claims related to the treatment received during the sampled hospitalizations. The rate of claims among these patients (0.66 percent; 95 percent confidence interval, 0 to 1.37 percent) was six times higher than the rate for the initial review (0.11 percent), but the difference was not statistically significant.

In the cases of three of the four newly identified patient claims related to the sampled hospitalizations, one physician-reviewer found evidence of negligence whereas the other did not. Thus, the combined scores were below the threshold for a finding of negligence. The fourth case was not reviewed because the follow-up protocol for that hospital did not call for physician review.

Relative frequency of negligence and malpractice claims

By combining the results of the initial and follow-up reviews, we estimated the number of claims statewide to be 3570, or a rate of claims per discharge of 0.13 percent (95 percent confidence interval, 0.08 to 0.18 percent) in 1984. This estimate suggests a ratio of negligence to claims of 7.6 to 1 (27,179 to 3570). Our inability to link four claims to hospitalizations (or to rule out linkage) because of insufficient data had little effect on this

figure. If two of these four claims had been matched to the sample, the relative frequency would have changed little (7.3 to 1). The sample-based estimate of the number of patient claims statewide (3570) is comparable to the estimate based on the OPMC records of the number of patient claims for injuries in 1984 (3780) and the average annual number of patient claims filed from 1984 through 1986 (3670). thus, claims occur only 13 to 14 percent as often as injuries due to malpractice. Our estimate of the fraction of adverse events due to negligence that led to claims is, however, far lower (1.53 percent).

DISCUSSION

Other studies have examined the frequency of negligence in relation to the total number of claims.[5,6] Our study has taken the next step by matching individual clinical records with individual claims records to determine what fraction of instances of negligence leads to claims. Our data suggest that the number of patients in New York State who have serious, disabling injuries each year as a result of clearly negligent medical care but who do not file claims (5400) exceeds the number of patients making malpractice claims (3570). Perhaps half the claimants will eventually receive compensation.[7,18]

Why so few injured patients file claims has not been widely researched. Many may receive adequate health or disability insurance benefits and may not wish to spoil longstanding physician-patient relationships. Others may regard their injuries as minor, consider the small chance of success not worth the cost, or find attorneys repugnant.[19] Trial lawyers usually accept only the relatively few cases that have a high probability of resulting in a judgment of negligence with an award large enough to defray the high costs of litigation. A final possible explanation is that many patients may fail to recognize negligent care.[20]

Our results also raise questions about whether malpractice litigation promotes high quality in medical care. Historically, there has been scant empirical analysis of this issue.[21] Our data reflect a tenuous relation between proscribed activity and penalty and thus are consistent with the view that malpractice claims provide only a crude means of identifying and remedying specific problems in the provision of health care. Our findings also support recent comments about the limited usefulness of the rate of claims as an indicator of the quality of care.[22] Unless there is a strong association between the frequency of claims and that of negligence, the rate of claims alone will be a poor indicator of quality[23] because rates can easily vary widely at the same underlying frequency of negligence or adverse events. The filing of a claim could, however, signal a need for further investigation because of the likelihood that an actual adverse event or actual negligence prompted the complaint.

Our study differs from previous work in that it goes beyond statements about the rate of negligence in relation to the rate of malpractice claims. The relative frequency 7.6 to 1 does not mean, as is commonly assumed,[24] that 13 to 14 percent of injuries due to negligence lead to claims. As the linking of the medical-record reviews to the OPMC claims files has shown, the fraction of medical negligence that leads to claims is probably under 2 percent. The difference is accounted for by injuries not caused by negligence, as defined by our protocol, that give rise to claims.

This finding does not mean that the 39 cases of claims in which our physician-reviewers did not find evidence of an adverse event due to negligence are groundless under prevailing malpractice law. Our study was not designed to evaluate the merits of individual claims. Patients sometimes file claims regarding medical outcomes that do not qualify as adverse events by our definitions; without access to the full insurance records, we cannot assess the prospects of individual cases.

More generally, the process of and criteria for making decisions about causation and negligence differ in a scientific study and in civil litigation. In this study, majority rule determined whether there had been an adverse event or an adverse event due to negligence. Our reviewers sometimes disagreed about causation and negligence; when only one found negligence, the case did not qualify as an adverse event due to negligence (except in the rare case when there was only a single reviewer). In a lawsuit, a single expert opinion might be sufficient to support a finding of negligence; under our protocol it would not. When experts differ, the final judgment is especially sensitive to the process of decision making.[25] Thus, our findings are not directly comparable to the results of civil litigation.

Although this lack of strict comparability should warn us against drawing conclusions about the merits of individual malpractice claims, it does not undermine our findings about the small probability (under 2 percent) that a claim would be filed when medical negligence caused injury to the patient. This result remains robust in spite of the possibility of misclassification of individual cases, the effect of using different criteria for negligence, and the likelihood of missing medical records and missing data on malpractice claims.

Disagreement about or misclassification of an individual case need not bias our results. In the duplicate review of subsample of 318 medical records, reported earlier,[8] a second team of physicians did not identify the same group of adverse events as did the first team, but they did find about the same incidence of adverse events and adverse events due to negligence. A replication of the study might generate the same rates of adverse events and negligence but would not necessarily classify the same claims as backed up by evidence of negligence. Therefore, as in other studies based on implicit review of medical records,[26] disagreement about individual cases does not imply bias in our estimates.

The use of less criteria for negligence would not alter the rate of claims among the cases of adverse events due to negligence, but it would affect the overall frequency of negligence as well as estimates in this and earlier studies of the ratio of adverse events due to negligence to claims (7.6 to 1). New criteria for negligence would change our estimate of 1.53 percent only if they affected the rate of negligence among the claims differently from the rate of negligence among cases in which no claim was made. Our data suggest, however, that an increase in the rate of adverse events due to negligence among cases in which no claim was made matches any increase in the rate of negligence among claims. Had a judgment by either physician-reviewer that negligence had occurred been sufficient to count a case as an adverse event due to negligence under our protocol, the probability that an adverse event due to negligence would result in a malpractice claim would remain virtually unchanged (1.51 percent).

The existence of overlooked adverse events due to negligence would also not influence this estimate unless the proportions of cases of negligence missed among the claimants and among the nonclaimants were unequal. The medical-records administrators might have overlooked adverse events due to negligence during the first-stage screening. As reported earlier, however, the medical-records administrators missed evidence of negligence in only 4.5 percent of the charts randomly selected for a duplicate review.[8] Alternatively, the hospital records might have met none of the criteria for further review but still have involved negligent care.

On the one hand, undercounting instances of negligence among the cases in which malpractice claims were made would cause the estimate of 1.53 percent to be low. Although we cannot calculate the probability that an adverse event due to negligence took place among the 12 malpractice claims that were classified as having no evidence of negligence, we can calculate that probability for the claims found on screening to have evidence of negligence (0.20) (Table 3). The assumption that these 12 cases should have been identified as positive (as having evidence of a possible adverse event) would raise the estimate of the probability of litigation among adverse events due to negligence from 1.53 to 2.2 percent.

On the other hand, the medical-records administrators might also have missed adverse events due to negligence that were not in litigation, thus causing our estimate to be too high. Medical-records administrators may have been more likely to miss adverse events in the records of nonclaimants than in those of claimants because evidence of legal action was 1 of the 18 screening criteria. Assuming that 4.5 percent of the negative screens were falsely negative, as suggested by the duplicate review, and that the rate of adverse events due to negligence among these missed cases equaled the rate among the cases in which no claim was made that were identified as positive on screening, there would be additional adverse events due to negligence among the nonclaimants. Assuming further a much lower rate of negligence among the cases in which no claim was made that had truly negative screens, for example 1/20 the rate of those identified on screening as positive, the estimate of the rate of claims among the adverse events due to the negligence would be lowered from 1.53 to 1.2 percent.

These potential biases in the medical-records review are small as compared with the size of the confidence interval produced by sampling variation. Even with a rate at the upper limit of the 95 percent confidence interval (3.2 percent), the probability that a claim would be filed when a patient was injured as a result of medical malpractice remains well below previous estimates.

Malpractice claims would have been missed—another possible source of bias—if we had failed to locate a claimant's medical record and could not identify a claim through the record-matching process. The results of the extensive follow-up search for missing records suggest that hospitals may have selectively withheld the medical records of some claimants, but not of large numbers of them. The higher rate of claims per discharge in the records identified at follow-up is within the degree of variation expected with small samples. In addition, hospitals may have relinquished all records without regard to patient out-come but may have failed to report malpractice claims to the OPMC. The effort of the state government to achieve complete reporting suggests that we used the most complete, reliable data available, although no external sources can substantiate the completeness of the data.

Unrestricted access to medical records and full reporting of claims would not eliminate potential bias due to claims relating to medical care received in 1984 but not yet filed by May 1989, when our data collection ended. According to the OPMC data base, 90 percent of claims were filed within 4.4 years of the date of the injury. In addition, 43 percent of the adverse events were due to medical care

that was provided before the sampled hospitalization in 1984.[7] Thus, we expect that fewer than 10 percent of all possible claims were absent from the OPMC data base and that our estimates of the incidence of litigation are no more than 10 percent too low.

The similarity of sample-based and population-based estimates of the frequency of patient claims makes substantial bias due to missed claims unlikely. The similarity of the estimates suggests that in linking claims to medical records we missed few actual matches, and that by 1989 few claims related to our sample of hospitalizations from 1984 remained to be filed.

The results of this study, in which malpractice claims were matched to inpatient medical records demonstrate that the civil-justice system only infrequently compensates injured patients and rarely identifies and holds health care providers accountable for substandard medical care. Although malpractice litigation may fulfill its social objectives crudely, support for its preservation persists in part because of the perception that other methods of ensuring a high quality of care[27,28] and redressing patients' grievances[29] have proved to be inadequate. The abandonment of malpractice litigation is unlikely unless credible systems and procedures, supported by the public, are instituted to guarantee professional accountability to patients.

[We are indebted to Matthew Jaro, M.S., record-linkage consultant, for his expertise in computer-based record linkage.]

FOOTNOTES

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[From the New York Times, Mar. 5, 1995]

NEW YORK'S PUBLIC HOSPITALS FAIL, AND BABIES ARE THE VICTIMS

(By Dean Baquet and Jane Fritsch)

Each year for the last decade, dozens of newborn babies have died or been left to struggle with brain damage or other lifelong injuries because of mistakes made by inexperienced doctors and poorly supervised midwives and nurses in the teeming delivery rooms of New York City's public hospitals.

Some of the most prestigious medical schools and private hospitals are paid by the city to provide the care in its sprawling hospital system. But an examination by The New York Times shows that many of these private institutions have left life-and-death decisions to overworked nurses and trainee doctors who are ill prepared to make them.

The effects can be seen across the system, from the surgical suites to the clinics. But nowhere are the consequences more devastating than in the delivery rooms, where the course of a young life can be changed forever by a few minutes' delay, a malfunctioning monitor or a lapse of attention.

The delivery room disasters affect a broad spectrum of women, from those who do not visit a doctor until their labor pains begin to the healthiest and most conscientious of mothers-to-be.

Vilma Martinez, a 25-year-old Brooklyn factory worker, languished in the delivery room of Woodhull Medical and Mental Health Center in Brooklyn for 14 hours in July 1993, as nurses first struggled to deliver her baby, then desperately searched for a doctor. The baby's father watched in horror as a monitor showed the baby's heartbeat fade, then stop. In the end, no doctor came. The baby was stillborn.

Miriam Miranda, 35, was diabetic and H.I.V.-positive when she entered North Central Bronx Hospital in February 1994 to deliver here baby. Her problems would have tested the skills of the most experienced doctor, but a midwife was put in charge. When complications arose, the midwife struggled on by herself. Deprived of oxygen during labor, the baby died after 77 days. In internal documents, the hospital has conceded that the delivery should have been handled by a doctor.

These cases are more than the isolated tragedies that can occur in any hospital. Serious injuries to newborns are frequent in the delivery rooms of some of New York City's public hospitals. And delivery room crises have flared periodically in most of the public hospitals over the last decade.

It is not possible to say precisely how many of the 31,000 deliveries each year are mishandled. Most records detailing medical mistakes are kept secret, even from the parents of the children involved.

But a computer analysis by The Times showed that the death rate for babies of normal weight born at the public hospitals was substantially higher than the rate at private hospitals in New York City. For babies weighing more than 5.5 pounds, the cutoff doctors use as a gauge of general good health, the death rate in the first four weeks after birth at the public hospitals was 80 percent higher than that for babies born at private hospitals: For every 1,000 births of normal-weight babies at a private hospital, there was one death, while at the public hospitals, there were 1.8.

The public hospital also had higher rates in most categories of serious birth injuries, the study showed. And the rates were higher even after taking into account the differences in the health of mothers at the private and public hospitals. The Time analyzed city and state records of all births in the city in 1993, the latest year available.

Some hospital and city officials have known about the problems for years, and have worked mightily to keep them from the public. They fear a loss of public confidence and a flood of lawsuits.''

In a striking 1992 report, never made public, City Comptroller Elizabeth Holtzman analyzed the lawsuits of 64 children who had been left brain-damaged or permanently crippled because of negligence in the delivery rooms. Some of the suits were more than a decade old, and all had been settled in the previous three years.

Those lawsuits alone cost the city $78 million, the report said, and another 793 were pending.

''These cases are catastrophic and costly,'' the report said. ''Many of these infants are now grown children, suffering from multiple and severe disabilities, who require lifetime hospitalization or intensive home care.''

In a third of the deliveries, no senior physician was present, even though complications were evident before the deliveries began, the report said.

The New York City Health and Hospitals Corporation, the agency that runs the public hospitals, is the nation's biggest urban hospital system. Its network of 11 hospitals, 76 clinics and 5 chronic care centers is used by one in five New Yorkers. One quarter of the 130,000 babies born in the city are delivered in public hospitals.

With 50,000 employees and a $3.8 billion budget, the hospital corporation is a major economic force in some of the poorest communities. It has stood for decades as a testament that New York, more than any American city, is committed to equal health care for all.

But in recent years, events have converged to raise questions about the system's survival. It faces increasing competition from private hospitals, internal problems and a governor and mayor who believe that New York can no longer afford its expensive array of social services.

In a six-month examination of the agency, The Times reviewed confidential hospital documents, court filings and other public records, and interviewed more than 100 physicians, administrators and city officials. Four current and former high-level officials of the hospital agency confirmed that delivery room problems are grave and have plagued the system for years.

Efforts to resolve the crisis over the last decade have been halting and ineffective, even though a quarter of the babies born in New York are delivered at public hospitals, and obstetrics is a major portion of the hospitals' business.

Dr. Bruce Siegel, who became president of the hospital agency a year ago, said in a recent interview that he had not seen a pattern of problems in delivery rooms, but acknowledged that in some hospitals, young doctors are poorly supervised.

''I would certainly not be surprised that we had more adverse outcomes'' than in private hospitals, he said, ''figuring that we treat poor people, sick people, that the concentration of people have drug problems, low socioeconomic status, various infectious diseases and many other things is going to be clustered in our hospitals.''

The computer analysis by The Times showed that over all, women who deliver babies in public hospitals are at higher risk for problems than women who use private hospitals, though a vast majority are healthy and get prenatal care. But it also showed that the difference in the women's own risk factors was not large enough to explain the higher rates of newborn deaths and injuries at public hospitals.

Dr. Siegel said the data used in the analysis were not reliable because the public hospitals did not accurately report risk factors to the state. The Times analysis found little evidence, however, that underreporting was greater at public hospitals than at private ones.

New York City has run public hospitals for more than a century, but the system was reorganized three decades ago in an ambitious attempt to raise the quality of medical care for the poor to the standards of the best private hospitals. To shore up the public hospitals, each was paired with a private hospital or medical school that was paid by the city to provide doctors and oversee care.

Last year, the city paid more than $500 million to such prestigious institutions as the Albert Einstein College of Medicine, Mount Sinai Medical Center, Montefiore Medical Center and the Columbia University College of Physicians and Surgeons.

But a review of current and historic documents shows that the plan never lived up to expectations.

Nearly 30 years later, there are still two classes of medical care in New York City: one for people who can afford private doctors and hospitals, and another for those who must rely on the public hospitals.

In private hospitals, women are met by their own doctors, who oversee their labor and deliveries. But in public hospitals, babies are delivered by whomever is on duty, and a woman may never see a doctor.

Officials of the private institutions that provide care in the public hospitals acknowledge that many delivery rooms are understaffed, and that midwives and trainees have sometimes been given more responsibility than they can handle. But they contend that the city has not given them money to provide enough experienced doctors to handle every shift adequately in overcrowded hospitals.

WITHOUT A DOCTOR, A TINY BEAT FADES

Vilma Martinez remembers the time, 10:04 P.M., and the silence and, most particularly, the wordless message of the nurse, who drew a finger across her throat as if she were slashing it with a knife. The meaning was clear: The baby was dead.

After that, she remembers little. But she can return to the morning of the day, when the labor pains started, and recall with some precision the 14 hours that led up to the stillbirth of her only child. It was a boy—6 pounds 13 ounces—and his heart had been beating steadily and strongly when she entered Woodhull Medical and Mental Health Center at 8 A.M. on July 23, 1993.

Officials of the hospital will not discuss what happened to Ms. Martinez or explain why no doctor came to her aid. Ms. Martinez and her boyfriend, Tomas C. Abreu, the baby's father, have filed a lawsuit against Woodhull and the New York City Health and Hospitals Corporation. They, too, declined to discuss the case, but their recollections are recorded in court depositions that provide searing accounts of a day of joy that dissolved into worry, then panic, the despair.

Their version of what happened is supported in large part by the notes of the nurses who tried, with increasing desperation, to find a doctor, and when they could not, tried to deliver the baby themselves.

Ms. Martinez, an emigrant from the Dominican Republic, was 23 when she learned in December 1992 that she was pregnant. She and Mr. Abreu, who was also from the Dominican Republic, had minimum-wage jobs at a glass and mirror company and had been living together for about two years in the East New York section of Brooklyn.

Her health was good and her pregnancy was uncomplicated. She took her vitamins conscientiously and went to Woodhull for monthly, and later weekly, checkups.

So there was no cause for concern when the labor pains began about 7 A.M. on that Friday morning in July. By 7:45 A.M. she was in the car with Mr. Abreu and her mother, and by 8 A.M., they had arrived at Woodhull, the strikingly modern medical complex that rises above the warehouses, storefronts and working-class homes of Greenpoint and Williamsburg.

After an hour, a nurse on the seventh floor, the maternity floor, motioned for her to climb on a gurney.

Because Ms. Martinez understood little English and the nurses and midwives spoke no Spanish, their communication was limited to gestures and facial expressions. It went that way the entire day. Forty percent of the people in the area around Woodhull speak primarily Spanish, but no one on the staff translated for Ms. Martinez.

Eventually, she was put in a little room where she spent the long day. About noon, a nurse inserted an intravenous line in her arm. The contractions gathered strength as a monitor kept track of the baby's heartbeat, and her mother and Mr. Abreu hovered near the bed.

About 5 P.M. she began bleeding heavily and it seemed to go on and on ''like a blood bath,'' she recalled.

Near 7:30 P.M., she was screaming from pain, and someone who seemed to be a doctor went to the door of the room. He spoke to the nurses, but left almost immediately. ''He didn't even touch me or anything,'' she recalled.

A nurse's note at 7:40 P.M. described another sign of trouble—''prolonged decelerations'' in the fetal heart rate. The rate often drops during contractions, but should rise again. Prolonged drops can mean the baby is not getting enough oxygen.

So the nurse called for the doctor and the midwife, according to the log. The doctor examined Ms. Martinez and gave instructions that she should not push, the log said. Neither Ms. Martinez nor Mr. Abreu recalled the doctor's actually having examined her. The nurse's notes do not explain why the doctor left.

Soon, the baby's head was visible and the nurse and the midwife shooed Ms. Martinez's mother out of the room.

They began struggling to get the baby out, Ms. Martinez said, turning her this way and that, even face down for a while. They tried turning the baby's head, too, but nothing seemed to work. The baby was stuck. She recalls being ''crazy, desperate with pain.''

* * * * *

The final two hours were the most harrowing, the couple said. They were left mostly alone in the room, with no idea where the nurses had gone, as the heart monitor bleeped, spewing yards of paper that recorded the baby's struggle for life.

Mr. Abreu recalled watching the glow of the monitor and the tiny heart-shaped light, ''like a little heart that seemed to be beating.'' He kept up a constant patter to reassure her, but she kept asking for a doctor. ''She was saying, 'I am going to die.' ''

Mr. Abreu left the room in search of a doctor, and was told that the doctors on duty were on the eighth floor performing a Caesarean section. He returned to the room and stood vigil. Then he noticed that the baby's heartbeat was slowing markedly. Ms. Martinez recalled that he left the room again, ''just desperate.'' And she remembered hearing him ask—beg—for a doctor.

But all he could find was a nurse, so he took her back to show her the monitor. ''I was also looking at the heart, at the little heart,'' he said. ''It had stopped.''

An entry in the nurse's log at 9:20 P.M. notes ''continuous'' fetal heart rate decelerations. At that point, the midwife ''said to call in an M.D.,'' according to the log. But two doctors were busy doing a Caesarean section and a third was occupied in the emergency room, the log said.

''We cannot get an M.D. to see the patient,'' the nurse wrote.

To Ms. Martinez, the midwife seemed desperate. ''She didn't even put on her gloves in order to grab the child,'' Ms. Martinez said. The midwife shouted for her to push and someone pressed on her abdomen. They got the baby out, and started slapping and pounding, but he did not draw a breath or make a sound.

Finally, a doctor entered the room. The midwife turned to him, and silently drew a finger across her neck.

''I started to scream and scream,'' Ms. Martinez said. ''A mother, while she is giving birth, how can she feel when that is happening? I was desperate.''

Others came, and as the doctors and nurses whispered among themselves, Mr. Abreu asked them to explain what had happened. ''But they wouldn't tell me a thing,'' he said. ''All they were saying was that the baby was dead.''

DISASTER REPORTS ARE SUPPRESSED

Delivery room disasters became frequent a decade ago, when a wave of new immigrants began crowding into aging hospitals, increasing pressure on medical staffs already overburdened.

As deliveries rose more than 30 percent in the 1980's, even the most diligent staffs were overwhelmed. The overflow fell to nurses, midwives and residents, doctors in their first years after medical school.

Then, at some busy obstetrics wards, including Lincoln Medical and Mental Health Center in the South Bronx and North Central Bronx Hospital, the residents were pulled out. Their training programs had been shut down because the national officials who accredited them feared that the public hospitals were tossing young medical school graduates in over their heads.

The effects of the crowding and staff shortages were felt immediately.

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For example, Dr. Wayne Cohen, who in 1984 ran North Central Bronx Hospital's obstetrics department, recalled that a number of newborns were injured as the hospital became more reliant on nurse-midwives, who were not trained for the frenetic pace and difficult deliveries. A typical big-city hospital might have five or six serious birth injuries a year, he said. But, at North Central

Bronx, he said, ''There were twice that number of everything, and I didn't get to hear of everything.''

At Metropolitan Hospital Center, in East Harlem, officials called in the police in the late 1980's because several newborns mysteriously suffered broken arms or legs. Police officials say they never determined the cause, or or when the babies were injured.

About that time, officials of the hospitals corporation grew so alarmed after some serious incidents at Lincoln that they complained to New York Medical College, which provides the medical care at Lincoln.

But in a vast system that bounces from crisis to crisis, from budget shortfalls to political scandals, officials of the Health and Hospitals Corporation were unable to put together all of the pieces to perceive what was rapidly becoming a systemwide crisis.

In 1983, alarmed by a rise in malpractice awards, analysis for the city's Office of Management and Budget began a far-reaching, confidential study. After poring over 2,000 lawsuits, they found a disturbing patter: Many of the worst cases involved residents in the delivery rooms and elsewhere who nervously bumbled through with little guidance from senior doctors.

The 165-page report, completed in 1991 was ignored. Its authors said the patterns had continued, but by the time the study was printed and bound, lawyers for the city said it was based on old information.

A year later, Ms. Holtzman, the City Comptroller, finished her report. ''The enormous cost of impaired newborn cases in both human suffering and taxpayer dollars requires the City's attention,'' it said.

Among its findings were these: In 12 of the 64 cases reviewed, the staff failed to react promptly to signs of fetal distress; in 5, the staff failed to perform adequate fetal monitoring; in 9, the staff ''unreasonably delayed'' Caesarean sections; in 11, oxytocin, a drug used to induce labor, was improperly administered.

As Ms. Holtzman prepared to make her report public, the hospitals corporation blocked its release, arguing that it was based on privileged information.

Alan G. Hevesi, her successor, said he was unaware of the report until The Times requested it. He released a copy, saying that it was too important to remain secret.

Delivery room disasters had become a recurring theme in confidential weekly meetings held by the hospital agency to analyze its most mishandled cases. In these discussions, known as quality assurance meetings, officials speak bluntly, naming doctors and upbraiding administrators with the understanding that by state law, none of what they say leaves the room.

Most delivery rooms in the system have come up for sharp criticism at these sessions, usually because of mistakes by unsupervised trainee-doctors and midwives, said four participants in the weekly meetings, who spoke on the condition that they not be identified. Over the last five years, the delivery rooms of four hospitals have been cited more frequently than the others, said the participants. These hospitals are Woodhull, Kings County Hospital Center in Brooklyn, North Central Bronx and Lincoln.

Over the same five years, the State Health Department, which regulates hospitals, has rebuked the four hospitals and Coney Island Hospital in Brooklyn for delivery room mistakes, state records show.

Regulators found instances in which overworked staffs, including residents, misdiagnosed serious conditions and made patients wait perilously long for treatment.

In interviews, officials of most of the hospitals acknowledged delivery room problems, but said that they had made significant improvements in recent years.

At Woodhull, for example, officials said the director of obstetrics was forced out late last year after a series of mistakes by the staff in the delivery room.

''I'm not going to make any apologies for Woodhull,'' said Dr. Siegel, the head of the hospitals agency, who added that he was replacing the private corporation that runs Woodhull, Woodhull Medical Associates. He said that many of the hospital's patients were going elsewhere because of Woodhull's reputation for poor care.

''That obstetrics department is closing down on its own,'' Dr. Siegel said.

At Lincoln Hospital, officials said they were working on their problems, which they said were caused by poor supervision of residents and unreasonable waiting times for women seeking prenatal care. ''We were asking for trouble,'' said Roberto Rodriguez, the executive director. ''We were taking a risk.''

Jean Leon, the executive director of Kings County Hospital, said she has seen no delivery room problems since she arrived in July, 1994.

Howard Cohen, the director of Coney Island Hospital, said any problems at his hospital were caused by the press of high-risk patients.

Officials at North Central Bronx said their problems resulted from poor supervision and understaffing.

LIFE OR DEATH WITHOUT A DOCTOR

By the time Michael Elias Cottes was born on Feb. 11, 1994, his left shoulder and arm were broken. He was so hopelessly stuck after 20 hours of labor that the obstetrician cracked his tiny bones trying to wrest him free.

Still, his birth was a moment of triumph for his mother, Miriam Miranda. She had come to terms with her having the AIDS virus, and had sought out prenatal care with something approaching zeal. At 35, she had beaten back gestational diabetes and even learned to give herself insulin injections.

So, when the doctor at North Central Bronx Hospital finally extracted the silent child and rushed him out of the delivery room, Ms. Miranda allowed herself to rejoice, savoring the minutes as she waited for the doctor to bring her baby back. ''I was so happy,'' she recalled in an interview.

But the doctor returned alone and in tears ''Miranda,'' she said, ''we did what we could. The baby was without oxygen for 10 minutes.''

Michael lived for 77 days, probably deaf and blind.

Throughout the torturous hours of labor, Ms. Miranda had been in such pain that she was only vaguely aware of the drama unfolding around here. She did not know that the midwife had seen signs of serious trouble on a monitor. And she did not know that by the time the doctor arrived, it was already too late to do much for the baby.

Last March, officials of North Central Bronx held a private meeting and admitted among themselves that the hospital had made some mistakes in her case. Specifically, they acknowledged, such a complex delivery should have been handled by a doctor from the start, according to an internal report obtained by The Times.

From the time of her first prenatal visit at North Central Bronx, Ms. Miranda was seen almost exclusively by midwives. They did the pelvic exams, weighed and measured her and drew blood for routine tests. ''They told me it was a boy,'' she said in a recent interview, ''a boy who was doing good.''

As soon as she learned she was pregnant, Ms. Miranda did everything she could think of to have a healthy baby. She quit a steady job as a cafeteria worker in Puerto Rico, and with her two children moved to New York City, where, she believed, she would get the best possible care.

''She wanted to have this baby,'' said Tracy Stockham, the state case worker who helped Ms. Miranda navigate the complex bureaucracy of services for H.I.V. positive women. ''She said, 'This will be my last child because I'm infected.'''

In her seventh month, when a test showed that she had developed diabetes, her midwife said that she lacked the expertise to continue with the case. But instead of turning Ms. Miranda over to an obstetrician, the midwife referred her to another midwife.

Still, Ms. Miranda did well. At 10 A.M. on Feb. 10, 1994, at the end of her 40th week, she entered the warren of small labor and delivery rooms on the hospital's seventh floor, where a midwife administered Pitocin, a powerful drug that induces labor.

By 3 A.M. the next day, 17 hours later, the baby was still not out: According to hospital records, the fetal monitor, which keeps track of the baby's heartbeat, showed irregularities.

This meant one of two things: Either the baby was not getting enough oxygen through the umbilical cord, or the monitor was not giving an accurate reading, a common occurrence.

So the midwife faced life-and-death choices. She could prick the baby's scalp with an electrode to check its blood for oxygen, possibly exposing him to the AIDS virus. She could let the labor take its course and hope that all was well. Or, she could summon a doctor to perform an emergency Caesarean section.

There is no explanation in the hospital records for why a doctor did not intervene earlier.

She recalled that he cried only once during the final two weeks of his life. As it turned out, he was not infected with H.I.V.

Once, she bundled him up and proudly brought him to visit Ms. Stockham, the caseworker who had sent her to North Central Bronx.

''The baby was constantly gasping for air,'' Ms. Stockham recalled. ''Miriam said: 'People are saying Michael can't see or hear. But when I sing to him, he turns to me.'

''I had to look inside myself,'' Ms. Stockham said, ''and say, 'Did I do the right thing by sending her to this hospital?'''

YOUNG TRAINEES LEFT UNSUPERVISED

Young doctors just out of medical school are the backbone of New York's public hospitals. There are more than 3,500 of these trainees, or residents, working in the system to get experience and learn specialties.

Because the system depends so heavily on them, it is crucial that the hospitals attract top graduates. A need to improve the quality of residents was one reason the city entered into its partnership with New York's most renowned private medical institutions 30 years ago. The theory was that the private hospitals could use their reputations to attract the best medical school graduates, then rotate them through the public system.

But for a variety of reasons, some of these private institutions have set up separate residency programs for the city hospitals, which have generally attracted graduates with poorer qualifications.

Virtually all the residents working at Presbyterian are graduates of medical schools in the United States, including some of the most prestigious in the country. But only 34 percent of the residents working at Harlem graduated from schools in this country. The rest were trained at foreign schools, many in developing nations.

Foreign medical school graduates, especially those from developing countries, are generally less desirable to hospitals because they may be unfamiliar with the newest technology and treatments, hospital corporation officials say. Dr. J. Emilio Carrillo, who was president of the corporation from 1990 to 1991, said he frequently complained that some training programs had far too many students educated overseas.

Columbia officials said that Harlem Hospital decided decades ago to have its own residency program in order to attract black graduates who might one day practice in the neighborhood. Dr. Edward B. Healton, associate dean of Columbia and medical director of Harlem Hospital, said that the Harlem program was not as popular as Columbia's, and had difficulty attracting graduates of United States medical schools.

Mount Sinai School of Medicine runs three hospitals, one private and two public. Most of its residents rotate through all three. But in some specialties, there are separate residency programs at each hospital. In these fields, more than 95 percent of the residents working at Mount Sinai are graduates of medical schools in the United States. But that is true of only half the residents at the city-owned Queens Hospital Center. And only 68 percent of the residents in the program set up separately for Elmhurst Hospital Center in Queens graduated from schools in this country.

Under their city contracts, the private hospitals are also supposed to supply attending physicians, the senior doctors who supervise residents. But virtually every study has accused the private hospitals of leaving residents largely unsupervised.

The hospital most frequently cited for leaving care to residents is Kings County Hospital Center, one of the nation's busiest and biggest.

In November 1991, the State Health Department concluded in a scathing report that there was ''inadequate, and in some cases nonexistent'' supervision.

A month later, on Dec. 23, Roxane Murray, a healthy 24-year-old who had just received an honorable discharge from her Army Reserve unit, entered Kings County to deliver her second child. By Christmas Eve, Ms. Murray was in a coma, and 17 days later, she was dead.

Her medical records relate a chaotic 27 hours, during which much of her care was provided by residents. The chain of events that led to her death began when a fetal monitor malfunctioned, making it impossible to determine the baby's condition. So a decision was made to do a Caesarean section, and a first-year resident in obstetrics was allowed to perform the operation. In the recovery room, a first-year resident in anesthesiology supervised Ms. Murray's care.

She hemorrhaged for at least one hour before the attending physician, the senior doctor on duty, checked on her and then left. Because Ms. Murray continued to hemorrhage, the residents ordered intravenous prostaglandin, the drug of choice to stop the bleeding, but the hospital pharmacy did not have any. So they tried a prostaglandin suppository, a less effective treatment.

Later, as Ms. Murray lapsed into unconsciousness, the attending physician and the chief resident performed a hysterectomy to control the bleeding. It didn't work.

Several hours passed and senior doctors in the obstetrics department did exploratory surgery. They found four liters of blood in her abdomen and quickly tried to tie off an artery that was gushing, but accidentally sliced through a nearby vein. She never regained consciousness. The baby, an 8-pound 14-ounce boy, and his brother are being reared by Ms. Murray's mother.

State regulators, called in by the family's lawyer, Michael V. Kaplen, excoriated the hospital for ''ineffective, inappropriate treatment.'' At no point did any doctor or resident call in an expert in hematology, who might have got the bleeding under control, the regulators said.

In addition to residents, there is a little-known class of trainee doctors working in New York hospitals. They are house doctors, medical school graduates who have either failed or not yet taken licensing examinations.

Hospitals turn to them when they have trouble attracting fully qualified doctors, or cannot fill night and weekend shifts. The graduate is granted a two-year ''limited permit'' by the state to practice only in one hospital under close supervision.

Dr. Siegel, the head of the hospital agency, said he was not happy with the use of house doctors and was moving to phase them out.

Until last December, shortly before his limited permit expired, Narpat S. Panwar was one of them. A native of India and a graduate of the University of Guadalajara Medical School in Mexico, Dr. Panwar had been trying unsuccessfully to pass the national examinations for 14 years when he was hired by Woodhull hospital in 1993 to work as an obstetrician.

Dr. Panwar was on duty over the Fourth of July weekend in 1993 when Paula Toala arrived to deliver her baby. He saw her through an extremely difficult 10-hour labor.

Eventually, he got the baby out, but only then found what the trouble had been: The infant, whose mother was average size, weighed an extraordinary 13 pounds.

Dr. Panwar had twisted and stretched the neck and shoulders severely enough to cause nerve damage, the family's lawyer, Jesse S. Waldinger, said in papers filed in a malpractice suit. The child suffers from Erb's palsy, a nerve injury that has limited movement in her right arm, he said.

''This is a case that was screaming for a Caesarean section,'' Mr. Waldinger said. In the court papers, he argued that Dr. Panwar should have called for assistance.

Dr. Panwar, 51, is now practicing in West Virginia and has obtained a full license after passing his examinations. He declined to discuss the case. The city is fighting it.

BRONX MUNICIPAL TAKES GIANT STEPS

Bronx Municipal Hospital Center, a sprawling complex that has served the east Bronx for 40 years, is one public hospital that has made significant progress toward solving its delivery room problems.

Hospital officials have acknowledged that through the 1980's newborns were injured there because of mistakes by unsupervised residents working in an overcrowded maternity ward.

In June 1992, jolted by major lawsuits, the hospital pushed the Albert Einstein College of Medicine, which oversees care at Bronx Municipal, to revamp the delivery room.

Midwives were instructed to call for help at the first sign of trouble, and residents were told not to perform Caesarean sections without a senior doctor in the room. One nurse was specifically assigned to spot the problem cases and try to make sure that a similar mistake did not occur again.

''The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing,'' said Dr. Wayne Cohen, the medical director of Bronx Municipal Hospital.

The drop in delivery injuries to mothers and infants was swift. The program cost about $750,000.

In 1993, the change was noticed at the hospital agency's headquarters, where Edna Wells Handy, the general counsel, said she had already concluded that injuries to newborns were among the worst problems facing a troubled system.

Ms. Handy said she asked the city for $1.5 million in 1993 to expand the Bronx Municipal program to two other hospitals struggling with delivery room problems. But by the time the proposal made its way through the bureaucracy, there was a new mayor and a new administration at the hospital corporation with little knowledge of the delivery room crisis or her proposal.

''If it really works, I'll do it,'' Dr. Siegel said in an interview Feb. 15. ''I'm disturbed that I hadn't heard about it before.''

Mr. SPECTER. I thank the Chair. I yield the floor.

Mr. DOLE addressed the Chair.

The PRESIDING OFFICER (Mr. KYL). The majority leader.

Mr. DOLE. Mr. President, thank you.

(The remarks of Mr. DOLE pertaining to the introduction of legislation are located in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

AMENDMENT NO. 604 TO AMENDMENT NO. 603

Mr. LIEBERMAN. Mr. President, what is the pending business?

The PRESIDING OFFICER. The pending business is the Thomas amendment, amendment No. 604.

(Mr. MCCONNELL assumed the Chair.)

Mr. LIEBERMAN. I thank the Chair.

Mr. President, I rise to speak first on the underlying bill, S. 565, and then to take the opportunity to say a few words on behalf of the underlying amendment offered by the distinguished occupant of the chair, the Senator from Kentucky [Mr. MCCONNELL], of which I am proud to be a cosponsor.

Mr. President, I want to first discuss the Product Liability Fairness Act of 1995 and particularly congratulate Senators GORTON and ROCKEFELLER for producing a product liability bill that really has garnered broad bipartisan support. I am hopeful, finally, after all these years of effort, that this bill will, in fact, not only be a good bill but will become a very good law.

Thanks are also due to Senator PRESSLER and others on the Commerce Committee for enabling us to take this bill up so early in this session, all of us having seen similar bills supported by a majority of Members of the Senate nonetheless go down to defeat because of gridlock caused by a clock that was running out.

Mr. President, this debate is now a few days old. Perhaps what has surprised me most in the debate are those arguments that have been made on behalf of the status quo in our civil justice system. There is certainly room for disagreement about how best to make our civil justice system fairer and more rational, but, frankly, it is hard for me to understand how anyone can say that our current system does not need substantial reform. It is inefficient, unpredictable, costly, slow, and unfair. Its lottery-like nature costs everyone too much—plaintiffs, defendants, manufacturers, product sellers, and consumers.

Mr. President, in my view, you can add the civil justice system to the list of fundamental institutions in our country that are broken and in need of repair. For me, repair begins with remembering what may be lost in the debate and the reality of the system today, which is that the purpose of the system is first to compensate people who are injured as a result of someone else's negligence; that compensation is at the heart of the system. And, second, and in doing so, to deter future negligence by that or other parties.

In our time, unfortunately, the civil justice system has too often become a game of legalistic sophistry, of bullying, of bluffing, a game which overcompensates lawyers, undercompensates victims, particularly seriously injured victims, and costs all the rest of us an awful lot of money in higher prices for consumer products, for health care, higher premiums for insurance, fewer jobs, and fewer new products to improve and protect our lives.

And, of course, all of that, in sum, contributes to the cynicism and mistrust of our legal system felt by average Americans, no matter what the participants in the system feel about it, and that cynicism and mistrust is profoundly corrosive and ultimately may be the most significant cost of our civil justice system in America today.

Mr. President, opponents of this bill like to cast the debate in either/or terms—either you are pro-business or pro-consumer; either you are pro-innovation or pro-safety.

But I respectfully suggest that sort of rhetoric misses the point and prevents us from discussing this issue in a fair and rational manner. The fact is that this bill, the underlying bill, S. 565, is both pro-business and pro-consumer, pro-innovation and pro-safety.

It is aimed at putting liability back where it should be, on the parties who are actually responsible for any harm caused to an individual, and so best able to prevent that injury and compensate the victim.

Mr. President, I did not always support a national or Federal approach to product liability reform or tort reform generally, and I can understand the hesitancy, particularly of some of the Members, to support Federal involvement in what traditionally has been a province of the States.

In fact, in my previous public incarnation as attorney general of Connecticut, and a member of the National Association of Attorneys General, I had some real skepticism about some of the earlier Federal product liability legislation. It would have swept away virtually all State product liability laws and repealed the doctrine of strict liability for product defects.

This bill is not that extreme, but what changed my mind was listening to people in Connecticut. As I traveled the State, I kept finding that product liability laws were being raised as a major concern of business men and women from small and large manufacturing companies who were trying to make a living, who were trying to create jobs. They told me of problems they experienced with the product liability system, and of the expense of defending themselves, even when they win. They told me of the costs of settlement to avoid paying litigation costs—not because there was real negligence—and of the time and energy that product liability suits diverted away from the business of designing new products and bringing them to market.

So I listened to those folks, and I came to understand the necessity of Federal action and, of course, to understand the reality and appreciate the reality that we are one country; that products travel from State to State; that people using them travel from State to State; and that there is a crying need out there in the interest of every State and our country, our economy, the equity of our society, to build a floor of fairness, a common system that will protect the rights of all.

Mr. President, the debate really should center around users and consumers, because ultimately it is the consumers who suffer most from the status quo. Consumers are the ones who do have to pay the higher prices in order to cover product liability-related costs. If a ladder costs 20 percent more because of liability-related costs, it is consumers, not the businesses, who end up paying the 20 percent premiums.

Consumers are the ones who suffer when valuable innovations do not occur or when needed products, like life-saving medical devices, do not come to market or are not available in our country any longer because no one will supply the necessary raw materials. The inadequacies and excesses of our product liability system are quite literally matters of life and death for some people whose lives depend on medical devices that may no longer be available in the United States.

This is not a theoretical problem. Life-saving and life enhancing products are at risk today—now—and doctors and patients are justifiably worried because raw material suppliers have stopped selling their materials to medical device manufacturers.

I am very proud to say that included in the underlying bill, S. 565, is a bill that I was privileged to introduce last year and again this year with my friend and colleague from Arizona, Senator MCCAIN, the Biomaterials Access Assurance Act of 1995, which is intended to address this emerging crisis in the medical device sector of our economy, which is a lifesaving sector. I know there will be amendments addressed to that section of this bill, and I look forward to speaking in more detail at that time.

Mr. President, even for its intended beneficiaries, people who are injured by defective products, the legal system hardly can be said to work well. The GAO, in a five-State survey, found that product liability cases took an average of 2½ years just to reach trial. If the case was appealed, it took on average another year to resolve. That is a very long time for an injured person to wait for compensation.

The underlying bill, S. 565, will shorten that time. In some instances, too, our product liability laws have enacted barriers to a lawsuit that just do not make sense. For instance, in some States, the statute of limitations—that is the time within which a lawsuit can be brought—begins to run even though the injured person did not know they were injured and could not have known that the product was the cause. In those States, the time in which to bring a suit can expire before the person injured knows or could ever know there is a suit to bring.

No one will argue that this bill will cure all the ills in our product liability system. That would require a truly gargantuan overhaul, and I doubt we could reach agreement as to what that would look like. But we can, I believe, work to enact a balanced package of reforms that work step by step to eliminate the worst aspects of the current system, to restore some balance to our product liability system. I am confident that S. 565 does just that.

Mr. President, I want to speak now about the underlying amendment, which I have been pleased to offer with the occupant of the chair, Senator MCCONNELL, and also Senator KASSEBAUM. This legislation was introduced in February and subsequently considered and reported out, though in slightly different form, by the Labor Committee. To put it simply, this bill is designed to reduce the inefficiencies and mitigate the unintended effects of our malpractice system.

This amendment is aimed at trying to improve a series of problems in our medical malpractice system that are comparable to those which the underlying product liability bill attempts to resolve or improve in our basic product manufacturing system. And again, it is consumers who are paying the extra money to support the current inefficient system that overcompensates the less injured, undercompensates the more seriously injured, and gives an awful lot of money to those who are keeping the system going, particularly lawyers.

Our present system for compensating patients who have been injured by medical malpractice is ineffective, inefficient and, again, in many respects, unfair. The system promotes the overuse of medical tests and procedures defensively by doctors who have told me, and I am sure told every other Member of this Chamber, they would not order this test, it is not medically necessary, but they do it to protect themselves from the fear of a possible lawsuit.

The Rand Corp. has estimated the ways in which the current defensive practice of medicine actually costs the victims of malpractice. Rand has estimated that injured patients receive

only 43 percent of the money spent on medical malpractice and medical product liability litigation. That is 43 cents out of every dollar, and victims often receive their awards only after many, many years of delay because of the ornate process, the bullying and bluffing that the current rules of malpractice encourage.

In fact, I would say that our current medical malpractice system is a stealth contributor to the high cost of health care. It is why those of us who worked to adopt a bipartisan health care reform bill always felt that if we could do something about medical malpractice and the cost it adds to the system, we could reduce concretely, not speculatively, the cost of health care.

The American Medical Association tells us liability insurance premiums have grown faster than any other physician practice expense. The cost of liability insurance is estimated at $9 billion—that is just for the insurance—$9 billion in 1992.

Incidentally, my friend and colleague from Massachusetts, Senator KENNEDY, opposing the underlying amendment, said that the insurance companies are doing very well, making a lot of money in medical malpractice coverage.

That is a strange argument to make against this amendment. This amendment was not put in for the benefit of the insurance industry. This amendment was put in for the benefit of patients, doctors, and all of us who pay health insurance premiums or pay the cost of doctor care, which is inflated because of the current system.

So it is an interesting argument that the insurance companies are doing well at it. But it is not relevant to the purpose of this amendment. In fact, it may in some ways justify our amendment. It may suggest another reason why the current system needs to be shaken up.

Let me go back to defensive medicine and try to detail briefly its impact on the current system because it is even greater than the direct cost of liability insurance. The Office of Technology Assessment—our own office here—has found that as high as 8 percent of diagnostic procedures are ordered primarily because of doctors' concerns about being sued. That does not sound like a high percentage, but it amounts to billions of dollars. These defensive practices alone—sometimes difficult to measure—present a hidden but very significant burden on our health care system.

There is a well regarded consulting firm called Lewin-VHI. They have stated that hospital charges for defensive medicine were as high as $25 billion in 1991. That is an enormous figure. Basically what they are saying is that as much as $25 billion of the costs—this is not paid by strangers out there, this is paid by each of us in our health insurance premiums—is the result not of medical necessity but because of defensive practice occasioned by the existing medical malpractice legal system.

Taxpayers and health care consumers bear the financial burden of these excessive costs. Liability insurance and defensive medicine insurance premiums also drive up the cost of Medicare and Medicaid and therefore exacerbate an increased Federal budget deficit. Further, in specialties such as obstetrics—the subject of the second degree amendment pending in the Senate—where malpractice premiums have skyrocketed, malpractice liability is reducing access to quality health care.

The American College of Obstetricians and Gynecologists reports that malpractice costs for their professionals increased 350 percent between 1982 and 1988; and that by 1988, 41 percent of the obstetricians and gynecologists surveyed indicated that they had made changes in their practice patterns, including stopping seeing high-risk patients—the people who most need their care—because of their concerns about medical malpractice suits.

I can mention a group of doctors I know in the greater New Haven area, where I am from in Connecticut, who have ceased delivering babies and have changed their practice exclusively to gynecology because of their concern about medical malpractice lawsuits.

The amendment we are discussing today that Senator MCCONNELL and I have put in will begin to address these problems—these perverse, unfair effects, inefficiencies of our current system, and they will do so by directing a greater proportion of malpractice awards to victims. That is what the system, as I said at the outset, was supposed to be all about. How can we compensate the victim of genuine malpractice?

Let us be clear. There is nothing in this bill that would at all limit the liability of a physician who was guilty of malpractice and injured a patient. The whole aim is to put the burden of the law on that negligent physician so that that physician is being called upon to compensate the victim of that malpractice—not to impose a collective burden that results in everybody's premiums being raised and everybody's costs of health care being raised. The current system compels the practice of defensive medicine and in settling out lawsuits for fear of suffering greater liability in the current malpractice system, which too many people think is really a kind of lottery.

The current bill also will discourage frivolous lawsuits and enhance the quality assurance programs we all want. Key provisions of the reform include, No. 1, establishing a uniform statute of limitations, 2 years; No. 2, allowing periodic payments for awards greater than $100,000; No. 3, applying several—not joint and several—liability for noneconomic damages, pain and suffering. There is a concept—joint and several liability started out in the law as a way of proportioning responsibility when an accident was caused by a number of different parties working together in a way that caused negligence, and often it was not clear which one actually caused it. So they said everybody could be held liable regardless of the percentage of negligence. It now has grown to a point where what it really means is that somebody who is not liable, or liable very little, if they happen to have deep pockets, they can be held fully liable. That is the wrong message to send.

The whole idea of our civil justice system should be to establish a basic principle, which is, if you do something wrong, you have to pay. If you hurt somebody, you have to pay. If you do not, you should not have to pay. What kind of cynicism is developed when somebody who did little or no wrong ends up having to pay the whole bill because somebody else slipped away?

Our amendment also adopts the basic proposal of the underlying bill that punitive damages—which have been much discussed here and are an essential part of the continued bullying and bluffing that goes on in our tort system—be limited to $250,000 or three times economic damages, whichever is greater. Attorneys fees will be limited in our amendment—contingency fees to 33⅓ percent of the first $150,000 award and 25 percent on anything above $150,000. As my mother would say, I suppose, do not worry about the lawyers, they are still going to be able to live pretty good lives.

In medical malpractice cases, it would strengthen the standards for awarding punitive damages, strengthen State licensing boards and quality improvement programs by using 50 percent of punitive damage awards to fund investigations and disciplinary actions to prevent malpractice.

That is a great section of this proposal. I am proud to have worked on it with Senator MCCONNELL. As far as punitive damages are awarded, let us not take 50 percent of that money and throw it into the pot for a contingency legal fee, but let us use it to fund investigations by the States into the way medicine is being practiced, to ferret out those doctors who are practicing in a way that may be negligent, and to make sure they are subjected to disciplinary actions.

Mr. President, the bill also provides Federal leadership to strengthen health care quality in another way. The Senator from Vermont [Mr. JEFFORDS] has helped improve this amendment and bill in committee in this regard—by requiring the Agency for Health Care Policy and Research to convene an advisory panel to coordinate and evaluate methods, procedures, and data to enhance the safety and effectiveness of health care services. The panel will report on how to get better information into the hands of medical consumers, patients, so they can reward high-quality doctors and health plans with their business, let the market speak with full information and, of course, avoid risky practitioners or health plans that do not have adequate records in this regard.

It is part of the effort of the advisory panel to look at ways to strengthen the national practitioner data bank. It is a very helpful data base the Federal Government keeps on penalties, such as license revocation, taken by State licensing boards and hospitals against doctors who have or might put patients at risk, particularly doctors that may move from State to State. The data bank contains data on malpractice awards. These data are now available to hospitals and group practices, and it helps them screen doctors. Ultimately, I think we ought to make it available to the public as well. This amendment would set that process into motion.

Mr. President, many of the reform ideas in the Liability Reform and Quality Assurance Act were proposed and cosponsored by both Democrats and Republicans in the last Congress as part of a comprehensive health care reform effort. A number of those ideas were embraced last year by a group of us who participated in the bipartisan Senate so-called mainstream coalition.

We did not have a chance to debate those issues here on the floor in the last Congress. I am delighted that we now have that opportunity, and I am very proud to again join with the occupant of the chair, the Senator from Kentucky [Mr. MCCONNELL], in proposing this amendment, this underlying bill, which I believe is a genuinely moderate malpractice reform bill.

I hope my colleagues will join in supporting this amendment.

I yield the floor.

Mr. KYL. Mr. President, let me begin by complimenting the Senator from Connecticut for his very fine remarks in support of the legislation that we have introduced. I have had the pleasure to work for 8 years with his House colleague, NANCY JOHNSON, in the House of Representatives, who has been a leader in this area, and who has educated me and assisted greatly in the development of reform measures. I know that he shares with me his deep regard for his colleague and my former colleague from the House of Representatives, NANCY JOHNSON. I want to compliment both for the fine work that has been done in developing legislation and proposing it as an amendment to the underlying bill here today.

I support the McConnell-Lieberman amendment to the Gorton-Rockefeller product liability bill. As I have traveled around my own State of Arizona for several years now, the cry has been that we have too much taxation, regulation, and litigation.

There is simply a growing awareness by so many small business people, by so many other representatives of business or families, that there is something out of whack here. There is something out of balance in our society that is preventing America from competing, that is pitting citizen against citizen, that is removing the element of responsibility from our society, and most of all, hurting all as citizens and as consumers because of what some have called the litigation lottery.

I think that the Senator from Connecticut is correct that what the opponents of this legislation must argue is that the status quo works. Yet, I think that almost no person can deny that fundamental reform is necessary.

I practiced law for 20 years in my home State, Mr. President. I have a deep respect for the legal system as a result of that. Individuals who have been injured through the negligence of physicians or other parties do have their day in court. They are fairly, and I suggest, proportionately compensated for the injuries which are sustained as a result of the negligence of those who have treated them.

It cannot be suggested that people today are not permitted full and complete recovery and all of the opportunity the law brings for their recoveries. Clearly, a strong and equitable civil justice system is an essential component of a free society like ours.

Having said all of that, it is also true that what has served the few well, the injured plaintiffs well over the years, has come to ill serve society as it has gotten out of balance. The net result is that everyone as consumers are suffering as a result of the litigation lottery that I spoke of a moment ago.

The high cost of civil litigation and the excessive medical malpractice recoveries have greatly contributed both to the high cost of insurance and high consumer prices.

There is another way in which this explosion has hurt. It has hurt the doctor-patient relationship. As has been noted, a physician now treats in fear that what he does may result in a lawsuit, with the result that too many diagnostic services are ordered or prescriptions or other kinds of treatments are ordered, with the result that the costs go up.

The same kind of psychological well-being that a patient seeks from a physician is broken down when that physician sees the patient as a potential lawsuit. This is not good for either the physician community or for the individuals who are being treated.

In addition, the current medical malpractice system actually encourages litigation and resulting exorbitant out-of-court settlements. Let me cite some examples:

The Senator from Connecticut cited Lewin-VHI, a consulting firm, which in 1994, studied and concluded that the direct medical liability costs have been growing at four times the rate of inflation—four times the rate of inflation. I do not think we can suggest that somehow this system has simply kept up with everything else in society. It is exploding at the rate of four times the rate of inflation.

In 1998, according to the study, defensive medicine is projected to add $38 billion or more per year to national health care costs.

If we are going to talk about true health care reform, Mr. President, we cannot do so honestly, without addressing this issue. It is not the sole answer. There is much else that must be done. But clearly this is one of the things which must be done. To pretend that we can have health care reform without addressing this problem in the bill that has been introduced is to deny a fundamental reality of our society today.

The practice of defensive medicine, of course, is understandable. No one likes to be sued. According to a 1994 study by the Institute of Medicine, 40 percent of all physicians and 70 percent of all OB/GYN's will be sued during their careers.

Mr. President, I believe it was you earlier this morning who talked about the fact that in many communities we do not have any more OB/GYN's. We have GYN's, but nobody is wanting to deliver babies any more because of the large number of cases in which, when something has gone wrong or the baby is not perfect, the physician ends up being sued.

There are many communities in my own State that are no longer served by obstetric physicians because of this phenomena. Mr. President, it was discussed this morning, the number of communities, particularly smaller communities, in your State and around the country that no longer have this service.

So in order to bring this potential recovery in the litigation lottery for a very few, women all over the United States and families all over the United States suffer the consequences because their communities no longer provide this kind of service, and it puts a health risk to the people in the communities.

Mr. President, my wife was involved in the March of Dimes effort for several years helping to raise money for something they called the ''Mom mobile,'' a large van that would provide prenatal services in the outlying areas of our State where there were no physicians to provide those services anymore. Among the reasons is this problem that we are talking about here today.

Mr. President, also discussed was the extraordinarily negative impact that this has on the minority physician. I think, therefore, we all must recognize that when too many people are creating too much of a burden on the system, it affects all of America. It affects all Americans. When that occurs, we must acknowledge that something is wrong, that reform is necessary, and that it is not a matter of not wanting people who deserve to be compensated to recover. No one is arguing that. We are simply saying that we need to both permit their recovery, but also ensure that there are not excessive costs built into the system because the system has gotten out of balance.

With this matter of defensive medicine having achieved the degree of cost in our society that it has, I think it is undeniable that the problem has to be addressed.

Medical liability costs do not result in a productive use of our health care resources. Another study I would like to cite, the Competitiveness Center of the Hudson Institute, noted that of the billions of dollars spent on medical liability insurance, 57 cents out of each premium dollar goes to lawyers rather than to the injured patient.

This study also found that medical liability costs add $450 in direct and indirect costs to each hospital admission.

So where is the benefit to the people for whom we have so much compassion, who deserve to recover for injuries that they have sustained because of someone's fault when over half of the money goes to the system, goes to the lawyers? And these large costs are added to the hospitals and eventually, of course, to the insurance premiums, and when added to the other defensive medicine practices drive insurance costs up for everyone, preventing some people from being able to afford insurance.

In other words, again, millions of Americans are suffering because the system, which is designed to help the few who are injured, has gotten so far out of balance.

There is another study, a Rand study, which I believe has it somewhere in the neighborhood of 40 percent of the funds that are recovered going to victims and almost 60 percent going to administration or to the attorneys involved in the handling of the cases.

The Hudson Institute study that I referred to a moment ago concluded the fear of lawsuits contributes more than 5 percent to hospital operating expenditures. That is again part of defensive medicine, of which we have been speaking.

Ironically, our tort system also inhibits reimbursement for legitimate malpractice claims because of the high cost of retaining legal counsel and the length of time between the date the suit is filed and the resolution of the claim. In other words, these high costs have a tendency to snowball because of the cost of defense. The plaintiffs have to spend more time, their lawyers, so the costs of defending increase. That is another factor driving up the costs of the premiums. Again, that affects all of us and prevents some people from actually being able to be insured.

I just had to make one reference to a comment that the Senator from Minnesota made earlier today on the floor. He talked about compensation in the form of punitive damages. I think it is important to make it very clear that while punitive damages are a component of our legal system, they have a very narrow and specific purpose in a very limited number of cases. Punitive damages were never intended as compensation. Punitive damages were intended to act as a disincentive for bad conduct in the future, to punish someone who was so recklessly in disregard of the rights of others that that party had to be punished so that the bad act would not be repeated.

There is a lot of discussion of whether or not the punitive damages that are recovered should even go to the plaintiff, because they are not designed as compensation. You cannot get punitive damages unless you have already been compensated. That is the law. The compensation is in two forms. The so-called economic damages, which have two components: All of the medical bills and costs associated with the treatment and recovery for the injury, and the loss in economic wages or other cost factors associated with the effects of the injury on the injured party and the party's family. Those are designed to fully compensate for all of the dollar losses, past, present, and future.

In addition to that, because we are a caring society and understand that there is more than just dollar loss, we compensate for what are called noneconomic damages, or sometimes called pain and suffering. And this is just. This is fair. This is necessary.

We often say that no amount of money can compensate for certain kinds of injuries, and that is true. Yet, as a society, we recognize that some kind of payment is appropriate for those who have suffered. So we provide for that kind of compensation.

There may be an amendment later on that suggests that there needs to be an upper limit to that compensation; that beyond a certain amount, we are talking about a litigation lottery and not something that would reasonably compensate for this pain and suffering. That will be reserved for a later time. But that is not involved in the bill that you, Mr. President, have introduced, the Senator from Kentucky and the Senator from Connecticut have introduced.

As a result, I do not think we should be confused about this matter of punitive damages. By putting a cap on punitive damages, as this legislation does, we are not detracting from the compensation of the victim. We are simply adding a disincentive for further bad conduct. And there is a point at which you are not adding to the disincentive, by providing multiple punitive damages awards, for example.

I am confident that in the discussions we engage in here, ultimately a reasonable balance can be achieved that will both restrain the spiraling tort litigation costs and recoveries and also afford citizens injured through the negligence of others just and reasonable compensation. That is our goal.

I believe the amendment that has been offered here is a step in the right direction. I will not review the contents of the amendment. It has been well described by both the Senator from Kentucky this morning and a moment ago by the Senator from Connecticut. But it does reform the statute of limitations to make it uniform. It does cap the punitive damages. It provides for joint and several liability reform so, in effect, innocent parties do not end up paying the expense just because one of the so-called guilty parties cannot be found or is unable to economically respond in damages. And it also has a limitation on attorney's fees.

I guess I will just conclude by reflecting on that for just a moment. As I said, I practiced law for 20 years and I have a deep respect for the legal profession. It is very important that lawyers be adequately compensated in order to have the incentive to take cases. That clearly is a part of the contingent fee aspect of many of these kinds of cases.

But it is not too much, I think, to say that as we all begin to look on how we can reduce the cost of health care in our society, so that we do not have to resort to a kind of socialized medicine that many of us feared was going to be the result of the debate last year in the Congress, if we are going to reform it ourselves, then we have to look at a variety of things, including ways in which we can make it easier for Americans to buy insurance, to reduce the cost of health care, and a part of that is to reduce the overhead, including the attorney's fees that are involved.

To a point, it is necessary to provide an incentive to take the cases. But beyond that point, it again becomes a part of this lottery, when in these multimillion-dollar recoveries the attorney receives over half of what is awarded to the plaintiff. This amendment is an effort to try to return some balance and provide that a good share of the recovery, if there is a recovery, goes to the plaintiff, to the injured party, rather than to the system and to the lawyers.

So I am very much in support of the McConnell-Lieberman amendment, and I am hopeful when we have concluded the debate on this, there will be sufficient support in this body to approve the amendment so this bill can go to conference and, in conjunction with our House colleagues, develop a piece of legislation that the President can sign and finally get us on the road to reform in our litigation system in the United States of America.

I yield the floor.

The PRESIDING OFFICER (Mr. THOMPSON). The Senator from Illinois.

Mr. SIMON. Mr. President, I rise in opposition to this amendment. I heard Senator KYL say this is one important issue in the whole issue of health care that should be addressed. And I agree with that. The difficulty that we face is we tend to go—and the Presiding Officer is a new Member here and he will see this in his years here—we tend to swing the pendulum from one extreme to the other, instead of finding a sensible middle ground.

I remember some years ago—maybe 8, 10 years ago—I had a dinner meeting with the president of the American Trial Lawyers Association and a few others, and I said, ''Let's try to see if we can find a sensible middle ground here.''

Unfortunately, I think at that point, many of my friends in the Trial Lawyers Association felt no change was necessary, nothing was needed. Now, the pendulum is going to swing much further than I think is in the national interest. And if we swing the pendulum way over here, it will not be too many years and the pendulum will swing back in the opposite direction too far, unless we can find a sensible middle ground.

The big issue is the reality that we have 41 million Americans without health care coverage. The most conservative estimate is that by the end of this century, just 5 years from now, it will be 50 million. No other Western industrialized nation has anything like that. In every other Western industrialized nation, everyone is covered.

If you live in Italy, everyone is covered. If you live in Denmark, everyone is covered, as you are if you live in Japan, if you live in Germany, Norway, Sweden, Great Britain, France, and so forth. We clearly have to do better by the citizens of our country.

But the question I face is a question in the State of Illinois where, in the Labor Committee the other day, I mentioned the Chicago Sun-Times story from February of this year, talking about the medical malpractice watchdog agency that ensures that we maintain quality care for the citizens of Illinois. My guess is what is true in Illinois is true in other States.

That watchdog agency is dominated by members of the medical profession. And the Chicago Sun Times aptly said the watchdog agency is ''not a watchdog. It is a pussycat.'' And they went into all the statistics.

Just as an example, 86 percent of the physicians who were found to be on drugs in the State of Illinois were given probation and 14 percent suspended for any amount of time at all. You are more likely to be suspended if you are a college athlete or a pro football player or basketball player in Illinois than if you are a physician where you are dealing with the lives of people. That just does not make sense.

I look at this bill. I say will this help? On the contrary. It reduces the penalties that may be available. They have the story of one physician who has now been sued 119 times for malpractice. They have had complaints. They went into some gruesome stories, and the State disciplinary board has done nothing. He has been sued not 9 times, not 19 times, but 119 times, and the State disciplinary board does nothing. Is this bill going to improve quality of care in Illinois? The answer, unfortunately, is it will not.

Yesterday a man named Jim Fairly from Illinois stopped by my office. He was walking with a cane. He had broken a hip, and had consulted a physician about a remedy. The physician, who had never practiced this type of medicine, recommended a prosthesis, which was unnecessary and which became infected, causing lifetime damage. He sued his physician and won. I do not think we should reduce the penalties in this kind of a situation.

Is there a problem? Yes. I frankly think what we put into the health care bill that came out of the Labor and Human Resources Committee last year dealt properly with it by reducing the awards to lawyers. I think that is the way you deal with it, not some of these other changes that are in here.

And in terms of punitive damages, it is very interesting. I see my colleague from Nevada on the floor. I cannot think of a single instance in my years in the House and the Senate—and I would guess he cannot think of a single instance in his years here —where we have reduced the penalty for anything, for any crime. We have increased the penalties for drug possession, selling drugs, use of weapons, all kinds of things, increased mandatory sentences, and everything else. Here for the first time in my 21 years in Congress we will be saying, even if you violate commonsense, humanitarian impulses, even if you as a physician or a hospital do not use due diligence in protecting the lives of people, we are going to reduce your penalty. I cannot think of another instance where we have done that. I just do not think it makes sense.

Limit punitive damages to $250,000? What about the hospital in Tampa, FL, which just a few weeks ago amputated the wrong leg of a patient? Should a punitive damages award there be limited to $250,000? Or the same hospital, ironically, because of not handling a situation well with a 77-year-old person, where a therapist disconnected the ventilator and the person died? Should punitives there be limited to $250,000? I do not know what damages should be, but I do not know why we should limit it to $250,000.

What about the Boston Globe health columnist—ironically a health columnist—39 years old, mother of two, who was administered an overdose of chemotherapy and she died? Or the story last week of the 8-year-old boy in Denver who went in for a routine ear operation and the person administering the anesthesia fell asleep and the boy died? Should we decree a maximum award of $250,000 on punitive damages? I do not think we ought to be doing that.

I also would add—I hope maybe that our colleague from Michigan, our new colleague, Senator SPENCER ABRAHAM, will introduce the same amendment he introduced in the Labor Committee giving the States the right to opt out of the Federal standard. Right now this amendment says States can be less firm, less tough, but you cannot be tougher than this bill. Senator ABRAHAM says let us give the States the option. I think that makes sense. Establish a standard, if you will, but give States the option. And the suggestion by Senator DODD that was accepted in our committee that a jury could find whether there are punitive damages, and then the judge would assess the damage, should also be restored.

There are other problems here. One is a problem suggested by the Supreme Court decision yesterday, a 5-to-4 decision. I happen to disagree with it. But it says you cannot limit guns near a school. They said this in a 5-to-4 decision. You cannot limit guns near schools because you are not dealing with interstate commerce. What about a physician who takes off the wrong leg of a patient? Is that interstate commerce? I think there is a real question on that.

I do not think this has been touched upon in the debate so far, but this bill does away completely with joint and several liability for noneconomic damages. I do believe that is an area that ought to be changed. If you are 1 percent responsible, you should not have 100 percent of the damages assessed against you. But to simply eliminate all joint and several liability in this area makes no sense at all.

Finally, I would add, the amendment offered by Senator THOMAS from Wyoming on the question of obstetrics practices, it is dealing with a real problem, but I think it provides a standard that we don't normally require in civil cases, and it is a standard that is much too severe. I would be pleased to work with him and with the others in this body to see that we get health care in rural areas. It is a real problem. I think this is the wrong way to deal with this problem.

Finally, again, Mr. President, I would just remind this body that we should not be going from one extreme to another. We ought to find a sensible middle ground. This is not a sensible middle ground. If this passes and if it should be signed by the President —and I hope the President will not sign it if it passes—but if it should be passed and be signed by the President, then inevitably there are going to be enough abuses that we will see the pendulum swing way back in the other direction. I think we ought to try to fashion a good, sensible, middle ground, bipartisan agreement. And I hope somehow out of the coalitions that take place on this floor we can move in that direction.

Mr. President, I do not see anyone else here seeking the floor. I question the presence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. McCONNELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. McCONNELL. Mr. President, several of our colleagues made some assertions earlier in the debate today on the underlying amendment that I would like to respond to.

First, the number and frequency of health care liability claims is, in fact, increasing. This is not in dispute. It

cannot be because we are turning out more doctors who commit more negligence. It is, in fact, the prospect of a willful verdict or a settlement that encourages people to sue.

According to estimates based on the AMA physician masterfile and other liability data from the AMA, the average rate of claims have increased every year since 1987.

Let us just look at the 3-year period from 1991 to 1993. In 1991, 33,424 medical professional liability claims were filed. In that year 1991, 33,424 medical professional liability claims were filed. In 1992, 38,430 claims; in 1993, 42,828. In just a 2-year period, the number of claims jumped by 28 percent.

As far as the assertion that malpractice insurance costs are not increasing, the data shows otherwise. While premiums stabilized in the late 1980's, rates are starting to climb again.

According to the Medical Liability Monitor, more than half of the doctors have experienced, for both 1993 and 1994, in the area of 9 to 15 percent increases, far in excess of the inflation rate.

As for the assertion that 80,000 people die each year from malpractice, it is just not true. That claim is made by the Consumer Union based on a 1991 study done by Harvard. Harvard researchers studied New York City in 1984, 1 year. Of the 51 hospitals studied in that year, 1984, they found 71 deaths out of 31,000 patient records where malpractice was the reason for death. There is simply no statistically sound way to get 80,000 deaths nationwide from 71 deaths in New York City in 1984. In other words, Mr. President, let me repeat. There is just no statistically sound way to get to 80,000 deaths nationwide from 71 deaths in New York city in 1984 alone.

The Harvard researchers themselves rejected the Consumer Union conclusion during last year's health care debate. In fact, that was in a letter to Representative PETE STARK.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. Mr. President, I rise today to express my support for the McConnell amendment before us. As the Senator from Kentucky has stated, it reflects the work of the Committee on Labor and Human Resources. We worked cooperatively on this product. The committee held hearings last month to review the issues of medical malpractice in greater depth.

As I understand the amendment of the Senator from Kentucky, this bill does not include two of the amendments that were brought forward during our committee markup. I would like to point out that one of these amendments was omitted with the agreement of the Senator who authored the amendment, and the other related to punitive damages.

Mr. President, this country needs legal reform. We are now, by far, the most litigious country on Earth, and we are paying a huge price as a result.

I speak today as a physician and as a U.S. Senator—as a physician who has practiced for the last 17 years, every day, taking care of patients, one on one. As a physician, I have seen firsthand on a daily basis the threat of litigation and what it has done to American medicine. I have watched my medical colleagues order diagnostic tests that were costly and unnecessary to the diagnosis or to the care of a patient, and they are ordered for one purpose: To create a trail—in many cases a paper trail—to protect them in the event a lawsuit were ever to be filed. It is called defensive medicine, and it happens every day in every hospital across America. It alters the way medicine is practiced and it is wasteful.

So who pays for all of this? The American people do. Insurance companies simply pass these costs along in terms of higher premiums. Physicians, providers, hospitals pass the costs along in the form of higher health care costs, all of which contribute to making overall health care more inaccessible.

Rural providers have a particular problem. They have nowhere to shift these increased costs. In my own practice, I practiced in a large academic institution. I had a large patient base. I had a good mix of payers to share these costs. However, the rural physician—and we have seen this specifically in the field of obstetrics, obstetrical care in rural areas—the rural physician has nowhere to go. As a result, the rural doctor either decides to cease services in areas of medicine where litigation risks are high, or worse, but all too often, the rural doctor simply packs up and goes somewhere else where the cost can be spread over an adequate population base. The result hurts these rural areas. There is a maldistribution of physicians, and this contributes to that maldistribution. The result threatens, again, both access and quality of care in this country.

Every State has passed some type of medical liability reform. However, these reforms vary widely. The McConnell amendment serves to establish national minimum standards such as a uniform statute of limitations. Some of my colleagues have expressed concern that this bill preempts State laws.

Mr. President, I would like to address the issue of States rights. We, as policymakers, must determine what and when the Federal role is appropriate. In the case of civil justice reform, the Federal role is to respond to the failures of the system and to respond to the impact on overall health care costs. As a physician, as one who deals daily with patients, one on one, who has devoted his life to caring for individuals, this system is failing and we need to respond appropriately.

Medical liability judgments have tripled since the 1970's. Yet, less than half of the billions paid in medical liability rewards each year actually go to the injured patients.

If we fail to reform the malpractice system, we fail the victims of malpractice. The amendment before us will not prevent a plaintiff with a meritorious claim from suing and recovering; it will in fact improve his or her chances. The courts will be clogged with fewer spurious lawsuits in cases that now lag on for 1, 2, 3, 4, or more years. They will move more quickly.

In closing, I fully support this amendment. It will make our civil justice system more responsible, more accessible, more predictable, and most important, more equitable. As a physician, I truly believe that better medicine will be practiced, to the benefit of each and every American.

Thank you, Mr. President.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. ABRAHAM). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. HARKIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HARKIN. Mr. President, I am concerned about the circumstances under which the underlying McConnell amendment is being considered. The Labor Committee considered this very language earlier this week. Yet, two of the amendments passed in committee have been stripped from this version of the bill.

So what is the point of the committee process if in looking at these things deliberatively, investigating them, if the product of the committee actually is dropped? I might add it has been dropped in a matter of 1 day. Even the bill that passed the committee was too extreme a measure to receive my vote, but it was at least better than the amendment we have before us.

Mr. President, it is clear that medical malpractice liability is having an impact on health care costs and on the availability of medical services, especially in rural areas. I have had a number of physicians and hospital groups come into my office to express concern about the costs of malpractice premiums and defensive medicine.

I would like to speak about the Thomas amendment that is now before the Senate. I understand the concerns of my colleague from Wyoming.

Over the years I have fought hard to recruit and maintain health care providers in rural areas. We changed Medicare reimbursement for physicians practicing in rural areas. I have been a strong supporter of increasing Federal support for telemedicine that helps providers in rural areas. What's more, I

have been a long-time supporter of the National Health Service Corps.

Clearly, we have not done enough to get physicians in rural areas. During the health care debate, I supported a whole range of provisions to increase the number of providers in our rural communities. So this is a goal I support strongly.

But I believe that the Thomas amendment before the Senate is the wrong way to go in trying to get more physicians in rural areas. The procedure adopted by the Senator from Wyoming is overly broad and unnecessary. The usual liability standard that applies to a physician who has never seen a patient before is to act as a reasonable physician would under the circumstances.

It is unnecessary to raise the evidentiary standard to clear and convincing. This action would create a unique, protected class out of all potential defendants.

Black's Law Dictionary says that clear and convincing proof is proof beyond a reasonable—that is, well-founded—doubt. The level of proof is extremely high.

So Mr. President, if we adopt the Thomas amendment, we would have one class of providers, OB/GYN's who saw the woman for the first time when they delivered the baby. This is the narrowest of the narrowest of the narrowest of classes. We would say in that one specific case that the evidentiary standard would have to be clear and convincing. All the others, of course, are a preponderance of the evidence.

Again, it makes no sense to do this because the same standard should apply for all physicians; that is, reasonable care under the circumstances.

As long as the OB/GYN delivering the baby has, in fact, utilized procedures that are reasonable under the circumstances, then that physician cannot be held liable. It is when they do not use procedures that are reasonable under the circumstances that they may become a potential defendant.

My concern extends beyond the Thomas amendment, however, to the whole area of medical malpractice. Studies have shown about 1 percent of all hospital patients suffer from that sort of negligent injury. Many of them do not receive compensation for those injuries from any source.

However, three to five times as many cases are filed where the patient suffered no compensable injury or where the injury was not negligently inflicted. The policymakers need to address how to reduce the number of claims brought with no good reason while assuring justice for the claims that are justified.

However, the McConnell amendment does not do that. Instead, it is clearly anticonsumer and would move America in the wrong direction. This bill would impact those with the clearest cases of injury who are being undercompensated under the current system and would not reduce the number of cases brought when no compensable injury occurred.

Some suggest that this bill would reduce the cost of medical malpractice. Unfortunately, that is not the case. The only way to reduce the real cost of medical malpractice in financial and human terms is to reduce the incidence of medical malpractice. Once the malpractice occurs, the only question being determined by the courts is, Who should bear the cost? Should it be the injured patient or the people or the institutions that inflicted the injury?

While malpractice events are very rare, it is clear that when these events do occur, the party responsible should make the party whole. We should attack malpractice the same way we fight highway accidents. No one, I believe, has suggested that the way to reduce the cost of motor vehicle accidents is to make it harder for people to get compensation. Would any reasonable person argue that we can cut down the number of highway accidents if we only make it harder for people to get compensation for those accidents? I do not think anyone could make that kind of an argument.

We have, however, reduced costs by making vehicles safer by the use of seatbelts, by vigorous enforcement of drunk driving laws, and by raising the drinking age, among other actions. All of these attacked costs of accidents by preventing the accidents from happening in the first place. This bill does little to help get the small number of physicians who are repeatedly found liable for malpractice out of the operating rooms and out of their medical offices.

Further, we are in different circumstances this year than last. If the Federal Government is going to develop a comprehensive national health care strategy, it would be appropriate to consider malpractice reform as one aspect of that strategy. However, a freestanding bill such as the one before the committee today—that is, the amendment before the committee today—is an unjustified interference with a matter traditionally under control of the States, with no strong Federal regulatory interests.

I find it quite curious that the very people who are arguing everything else should be turned over to the States, in this instance say the Federal Government knows what is best.

I am not one of those who say that it ought to all be one way or all the other way. I think there are some areas in which the Federal Government's interest is prevalent; there are others in which the State government's interest is prevalent.

When I look at questions of Federalism, I base my approach on whether something ought to be done by the States or the Federal Government by looking at the past, whether or not there is any overriding reason why things should be changed from what we have done in the past.

For instance, for the entire past history of the United States, product liability malpractice cases compensation has all been under the jurisdiction of the States. I now see no overriding reason why the Federal Government must now step in. States can handle it, and they have handled it and they are handling it, and they ought to continue to handle it.

Again, I have in the past supported civil justice reforms in instances where a convincing Federal connection has been shown. I believe such was the case in the general aviation product liability reform bill introduced by Senator KASSEBAUM, and which I voted for last year. It did pass and was signed into law by the President. I believe there was an overriding Federal interest.

However, in this instance I see no convincing reason to deprive the States of their traditional role.

I think, Mr. President, that when we look at medical malpractice we really have to separate fact from fiction and understand the mythology that is out there. About 1 percent, as I say, of hospital patients become victims of negligent medical injury. That is not very many, 1 out of 100. Roughly half of those are very minor. But about a quarter of them result in death or serious disability.

The Harvard Medical Practice Study estimates that about 150,000 patients die annually as a result of medical mishaps. About half of those deaths due to negligence.

Of patients who suffer negligent injuries, only about 2 percent file claims for compensation. I think that is very important. Of all of the patients who suffer negligent injuries, only about 2 percent file claims for compensation, and many of these will receive no compensation at all for their injuries. Of those who do, the compensation on average is less than the economic losses suffered. More precisely and more perversely, as the size of the losses goes up the fraction covered by the settlement or award goes down. That is, those who suffer the least serious injuries generally receive compensation two or three times their actual losses. But those who suffer the most devastating injuries and losses receive compensation equal to only a fraction of the losses they have suffered.

On the other side of the ledger, cases of nonnegligent injuries—noninjuries—the 99 percent of hospital patients not entitled to compensation under the law, the best estimate was that about 0.8 percent of these people file claims for compensation. About 0.8 percent. What we are saying is for every valid claim brought there are three to five filed that should not be. Most of those are dismissed somewhere along the litigation process.

This is a system, I think, in which there has been a lot of myth and a lot of misunderstanding. The tort liability system provided compensation of only about $7.7 billion, according to a Rand Corporation study, about 4 percent of

the total. They pointed out in a recent year Americans suffered about $175.9 billion in direct losses. The tort system only compensated for $7.7 billion of that. So, as an accident compensation system, the tort system really does not do a very good job, frankly. But it may yield a very powerful deterrent effect. Perhaps that is really the basis for keeping the tort system, because we do want to send a strong signal that people have to act prudently. People have to act reasonably. People cannot act negligently. And if they act negligently then they have to be responsible for their actions.

We hear a lot of talk around here about responsibility. I introduced a welfare reform bill today. A lot of people talked about responsibility on behalf of welfare recipients. I agree with that. But I think people ought to act responsibly, and if they do not act responsibly and people get injured then the people who acted negligently have to be held accountable.

This is not a new concept. As I stated earlier, this goes back in common law for hundreds of years. I think it has provided in our country, and in Great Britain, a system that does engender responsibility. So that is really what we are talking about. We should not turn our back on centuries of practice without good cause.

In the area of medical malpractice I agree there are some problems, and I may offer amendments dealing with some of them. But I would proffer this question to those who want to drastically change the medical malpractice system, the tort liability system, as we would under the McConnell amendment and the Thomas amendment thereto. I would question, then, if we really want to lose the quality of care that Americans have come to reasonably expect in our health care system.

I do not think anyone doubts that we have a very high quality of care. We may lack access in rural areas and other areas, and we may lack coverage of certain people, but no one can doubt that the quality of care of our health care system is very high. I heard speech after speech last year, on both sides of the aisle, about how we do not want to denigrate in any way or reduce in any way the quality of care. We want to keep a high quality of care. We want to do whatever we can to promote a higher quality of health care in this country.

My question, then, to those who would change the medical malpractice tort liability system is how are you going to keep a high quality of care if those who are the practitioners of medicine are told that if they act negligently and without reasonable care and concern, they do not have to worry, that they are not going to be held liable, because there will be limits on recovery. Or in the case of the Thomas amendment, which would require a mother to prove her case of malpractice by clear and convincing evidence—what would that do to the quality of care? That is missing in this debate. I was listening to the others talk today earlier. I think we have to bring it down to that. If we want a high quality of care we better hold those who practice medicine to a very high standard.

Doctors are perhaps the highest compensated of any profession in our country, and I do not deny them that. I could not be a doctor. I have said many times that those who practice medicine, God bless them—especially in rural areas where they are on call 24 hours a day, 7 days a week—frankly I do not think they get paid enough, many times. So I am not saying they should not be paid well—they earn it in most cases.

What I am saying is that they are well compensated and we should hold them to a high quality of care. I do not know of any doctor who would purposely inflict injury or damage on a patient. I suppose there may be a twisted mind out there somewhere that would do that, but I do not believe that is the case. But there are those who may be in a hurry, they may think ''I will cut a corner here, cut a corner there. It will be all right. Maybe I will not have to do this procedure.'' When in fact there is a set procedure, there are standards to which doctors are supposed to adhere. And if they adhere to those, if they act in a reasonable manner under the circumstances, they are not liable. They are not liable for what happens to an individual because of unforeseen circumstances, things beyond their control.

There is not a jury in this country, I do not believe, that would convict a doctor or a hospital if something happened to a patient that was totally beyond their control, unforeseen. It is the things that are in their control that can be foreseen—it is that lack of due care and diligence—that causes tort feasors to be held accountable and liable.

Again, we get back to this quality of care. We want to keep a high quality of care and therefore we want our medical practitioners to be highly trained, highly qualified. We want them to continue their education, their medical education; to be recertified all the time. And we want to make sure when they practice medicine they adhere to the highest possible standards.

One way to do that is to say, ''Look, if you do not, you are going to be held liable in a tort liability system that has been time-tested over 600 years to make sure people do in fact act responsibly.''

Mr. President, I read over some recent malpractice cases. I think, if you read them, what you find is that these are people like you and me. These are people, ordinary citizens, going on about their business. Yet, the medical practitioners who treated them did not adhere to reasonable procedures under the circumstances and are liable.

I think there is always concern when any of us go to a hospital and are put under a doctor's care. We put a lot of faith and trust in our doctors, we really do. And 99 percent of the time, that trust is well placed. I think, as Senator WELLSTONE said earlier, one rotten apple can spoil the basket. It could spoil the basket even more if we do not have a tort system that holds these people accountable.

I sum up by saying the Thomas amendment is way out of the ballpark because it exempts a very narrow class from being responsible at all. The McConnell amendment takes the malpractice bill that passed the Labor Committee just 2 days ago, strips out the amendments that were offered, and then offers it as an amendment on this bill. As I said, I could not even support the bill as it came through the committee even with the amendments. Now this makes it even worse.

So I assume motions will be made to table the Thomas amendment and the McConnell amendment. I hope those motions are successful. I think the quality of care, especially the quality of health care in this country, would drop precipitously if either one or both of those amendments were adopted.

Mr. President, I yield the floor.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. KASSEBAUM. Mr. President, I rise in strong support for and to offer a few remarks on behalf of the amendment put forward by my colleague Senator MCCONNELL, Senator LIEBERMAN, and myself.

I think this amendment is a moderate, measured approach to medical liability reform. It is very difficult for us to debate any type of liability reform in the Congress, in the Chamber of the Senate or in the House of Representatives, without getting into worst case scenarios. There is none that we are more sensitive regarding, I think, than medical liability reform.

I have a great deal of confidence in the Senator from Kentucky [Mr. MCCONNELL] and the Senator from Connecticut [Mr. LIEBERMAN], who have spent a lot of time trying to bring forth the difficult aspects of this issue in the most acceptable consensus that really does give us some successful and constructive results to a problem that really troubles everyone in one way or another.

I know that we have already heard some of the specific provisions of the McConnell amendment, but if I may, Mr. President, I would like to reiterate some of them that I think are particularly useful and important to remember. One, that there is full recovery of economic and noneconomic damages.

The amendment allows injured patients to recover complete compensatory damages. It places no limitations on the amount claimants may recover for economic damages such as out-of-pocket medical expenses, rehabilitation costs, lost wages, cost of domestic services, and noneconomic damages such as pain and suffering, mental anguish, and loss of companionship. The amendment that is before us currently contains a cap on punitive damages of $250,000 or three times the economic losses, whichever is greater.

I understand there are discussions ongoing now with Senator SNOWE and others about punitive damages. I would just like to say for myself, Mr. President, whatever agreement can be reached—I think Senator MCCONNELL as well is a party to this—if we can reach an agreement with the chairman, Senator GORTON, on what type of punitive damages language we would want to have, I think there would be strong support for that. So that is still ongoing and debated.

There is a limit on attorneys' fees to ensure that injured patients recover a greater share of their medical liability awards. The attorneys' contingency fees are limited to 33⅓ percent of the first $150,000 award and 25 percent of awards in excess of $150,000. This is identical to the provisions contained in the bill that Senator KENNEDY introduced last year.

There is also the State alternative dispute resolution. Many in the legal profession and outside the legal profession believe we need to do more to encourage alternative dispute resolution, to promote the resolution of claims in a more convenient and timely—and let me stress timely—manner because years can go by in which most of those who need assistance are frequently tied up in the courts waiting to see what happens. This will be a means of getting a more timely redress and in an affordable manner.

The amendment encourages States to experiment with the alternative dispute resolution and requires the U.S. Attorney General to provide technical assistance to States regarding various ADR mechanisms.

Finally, thanks to the contributions of Senator JEFFORDS, the amendment requires the Agency for Health Care Policy and Research, in consultation with public and private sector entities, to establish guidelines on quality assurance, patient safety, and consumer information.

This is a small step in the right direction and one that has to be taken with some care, but I think we would all agree that a better means of obtaining information for consumers would be beneficial and useful.

Much has been said in the Chamber today both pro and con, and I do not like to be repetitive, but I think there are some things that are worth repeating. While we have different thoughts on this, I think all of us are struggling to find some better means of addressing tort reform and answering the problems that exist today in a society in which we have all become so very litigious, that as we weave this web of ever greater litigiousness, I think we are doing a great disservice to those perhaps most in need of redress in the courts.

The current liability system carries great human and economic costs. It does not work well for anyone—not for doctors, not for hospitals, not for families, and not for injured patients.

Under the present system, it takes an average of 5 years from the time a patient is injured to resolve a malpractice case. That is really inexcusable.

The Rand Corp. has found that only 40 cents of every dollar spent in medical liability litigation reaches injured patients. The rest goes to court costs and attorneys' fees.

The United States has the world's most expensive tort system. At 2.3 percent of GDP, U.S. tort costs are substantially higher than those of any other country and two and a half times the average of all developed countries.

The Harvard Medical Practice Study, based on a review of 31,429 medical records in 51 New York hospitals, found that only 1 in 16 injured patients actually received compensation. On the other hand, the study concluded that half of the malpractice claims that were filed were without merit.

Moreover, according to a 1992 survey by the American College of Obstetricians and Gynecologists, 12.3 percent of the OB/GYN's nationally gave up obstetrics in 1992 as a direct result of liability concerns.

I know in my own State of Kansas, it is becoming increasingly difficult, if not impossible, to find obstetricians and gynecologists who will go into the smaller, more rural communities because of the high cost of insurance that they must carry versus the number of patients that they may see. So it becomes an increasingly difficult problem in ways that we perhaps do not realize.

I would just like to say a few additional words about the preemption provisions of the McConnell amendment. I know this is a concern to some and I am sympathetic to that. How far do we go at the Federal level to preempt the various State laws that provide, in this case, guidance for litigation?

I do not believe there is a need for absolute uniformity in this area. But I do believe it is important to set some very clear, minimum Federal standards that all States must meet.

Let me just explain why I think that is important.

The amendment does not preempt States from going further with medical malpractice reforms that they may decide are necessary. They may go further.

California, for instance, now caps noneconomic damages at $250,000. I think this is the best way to balance the need for some State flexibility with the need for greater certainty and predictability in the system.

When I mention California capped noneconomic damages, let me just reiterate, this amendment does not cap noneconomic damages. But California would not be preempted because it would go even further.

What this does, to a certain extent, is set a floor below which there could not be changes made and, therefore, it adds a certainty and a predictability that I think will enable cases to be resolved in a timely fashion. Without some sense of specificity, I think we lose this timeliness, lose the ability to move the process forward.

I believe that setting a minimum level of medical liability reforms is necessary to continue development of a cost-effective private health care system.

Moreover, there is a direct and compelling Federal interest in reforming our outmoded medical liability system. One-third of the total health care spending in this country is paid by the Federal Government through Medicare and Medicaid Programs.

Finally, as my colleague, Senator FRIST, knows perhaps better than anyone else in this body, health care services are increasingly becoming regional, if not national. Senator FRIST from Tennessee was a surgeon prior to his coming to the U.S. Senate.

For example, some of the finest medical facilities in the United States, such as the Mayo Clinic in Minnesota, Stanford University in California, Barnes Hospital in Missouri, and the Cleveland Clinic in Ohio—and I do not want to leave others out—are examples of important regional centers that treat patients from across the Nation and around the world.

That is why, it seems to me, the more we can begin to start with some very important but moderate approaches to medical liability reform, I think we take a big step forward in assuring not only the access and timely access to redress, but we also provide the stability and some assurance of what actually is out there in the way of costs.

It should not, in any way, close the doors to those who need redress in the courts. But it should make us all mindful of being able to change the system that is getting out of hand. And in our own responsibility, whether it is here on the floor of the Senate or individually, we have to address and take responsibility for a growing environment that I think creates problems for each and every one of us.

Mr. President, I would just like to strongly urge my colleagues to support the McConnell-Lieberman-Kassebaum amendment. I know that we have a somewhat bumpy path ahead on this, but I am hopeful that we can move forward with the debate. Those who object have laid out some of their objections. But I think it is time for us to vote and move forward and get to the heart of the matter.

Thank you, Mr. President.

I yield the floor.

Mr. GORTON addressed the Chair.

The PRESIDING OFFICER. The Senator from Washington.

Mr. GORTON. Mr. President, I should like to say how much I appreciate the thoughtful presentation of my colleague, usually seatmate, the chairman of the Labor Committee, on which I serve, the Senator from Kansas, in this connection. She has felt the necessity of moderate, not extreme, reforms in medical malpractice legislation for many years. And she now, I believe, has had the first opportunity ever to discuss legislation of that sort on the floor of the U.S. Senate. I strongly suspect it may not be the last such time, but it at least marks a thoughtful and balanced beginning presentation of a serious challenge to our entire health care system.

Mrs. KASSEBAUM. Mr. President, I thank the Senator from Washington. Senator GORTON has provided, I believe, a very important vehicle in his product liability legislation to which we are wanting to add this amendment and want to do so in a constructive way that will be an addition to the product liability bill before us.

I know that Senator MCCONNELL, Senator LIEBERMAN, and myself want to do all that we can to be supportive of the product liability bill and we want to work to make any changes in the medical liability reform amendment that would fit with the broader product liability bill. To that end, I think, as the Senator from Washington knows, we will do all we can to be helpful.

Thank you, Mr. President.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. KOHL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KOHL. Thank you, Mr. President. I rise today as a supporter of product liability reform to discuss an important issue which this reform effort has so far failed to address and I believe should be addressed.

The problem is excessive court secrecy. Far too often the court system allows vital information that is discovered in product liability litigation and which directly bears on public health and safety to be covered up, to be shielded from families whose lives are potentially at stake and from the public officials that we have appointed to protect our health and safety. All this happens because of the so-called protective orders, which are really gag orders, issued by courts and which are designed to keep information discovered in the course of litigation secret and undisclosed.

Typically, injured victims agree to a defendant's request to keep lawsuit information secret. They agree because defendants threaten that without secrecy, they will refuse to pay a settlement. Victims cannot afford to take such chances, and while courts in these situations actually have the legal authority to deny requests for secrecy, typically they do not, because both sides have agreed and judges have other matters that they prefer to attend to.

So, Mr. President, secrecy has become the rule in civil litigation, even though it causes harm and suffering to millions of other Americans. For example, 1 million women who received silicon breast implants in the 1980's were denied crucial information demonstrating the hazards of implants. The information was uncovered in a 1984 lawsuit, but it was kept secret by a court order until 1992. So what do we say to these women? How do we, as a civilized society, justify the secrecy orders that prevented them from making informed choices about what they were putting into their bodies?

What do we say to the scores of young children injured while playing on defective merry-go-rounds that remained on the market for over a decade because many lawsuit settlements concerning this sickening product were kept secret from the public and from the Consumer Product Safety Commission. These children, most of them under 6 years of age, lost their fingers, their hands, and feet.

Another case involves Fred Barbee, a Wisconsin resident whose wife, Carol, died because of a defective heart valve. We learned in a Judiciary Committee hearing more than 4 years ago from Mr. Barbee that months and years before his wife died, the valve manufacturer had quietly, and without public knowledge, settled dozens of lawsuits in which the valve defects were clearly demonstrated.

So when Mrs. Barbee's valve malfunctioned, she rushed to a health clinic in Spooner, WI, thinking, as did her doctors, that she was suffering from a heart attack. As a result of this misdiagnosis, Mrs. Barbee was treated incorrectly, and she died.

To this day, Mr. Barbee believes that but for the secret settlement of heart valve lawsuits, he and his wife would have been aware of the valve defect and his wife would be alive today.

As a last example, Mr. President, let me tell you about a family which we must call the Does because they are under a secrecy order and afraid to use their own names when talking to us. The Does were the victims of a tragic medical malpractice that resulted in serious brain damage to their child. A friend of the Does is using the same doctor, but Mrs. Doe is terrified of saying anything to her friend for fear of violating the secrecy order that governs her lawsuit settlement. Mrs. Doe is afraid that if she talks, the defendant in her case will suspend the ongoing settlement payments that allow her to care for her injured child.

What sort of court system prohibits a woman from telling her friend that her child might be in danger? Mr. President, the more disturbing question is this: What other secrets are currently held under lock and key which could be saving lives if they were made public?

Last year, during debate on the product liability bill, we began a discussion about court secrecy reform, and we should continue that discussion today. I favor a simple change in the system that would not prohibit secrecy but merely send a signal to judges to more carefully consider the public interest before drawing the veil of confidentiality over crucial information.

That change would work as follows: In cases affecting public health and safety, courts would apply a balancing test. They could permit secrecy only if the need for privacy outweighs the public's need to know about potential health or safety hazards. This change in the law would ensure that courts do not carelessly and automatically sanction secrecy when the health and safety of the American public is at stake.

At the same time, it would still allow defendants to obtain secrecy orders when the need for privacy is significant and substantial. The court secrecy reform I have suggested is not antibusiness. Business people want to know about dangerous and defective products, and they want regulatory agencies to have the information necessary to protect the public.

And so in summary, Mr. President, the product liability bill that we are debating today is all about striking a better, more reasonable balance between plaintiffs and defendants in product liability lawsuits. The change that I propose in our court secrecy laws is also about striking a better balance in product liability lawsuits, a better balance between the private parties involved in litigation and the millions of American consumers who today are being kept in the dark in many cases because of court secrecy.

I hope my colleagues who support product liability reform will recognize the need to deal with this very serious issue. Reform, after all, is a two-way street. I thank the Chair and I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. GREGG). The clerk will call the roll?

The assistant legislative clerk proceeded to call the roll.

Mr. KOHL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGE OF THE FLOOR

Mr. KOHL. Mr. President, I ask unanimous consent that my Judiciary Committee law clerk, Julie Selsberg, be given floor privileges during the debate on the product liability legislation.