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 President, I ask unanimous consent that the order for the quorum call be rescinded.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

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

Mr. KOHL. 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.

Mr. BURNS. 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. BURNS. Mr. President, I rise this afternoon in support of the McConnell amendment to the Product Liability Reform Act that is now being considered before this body. If there was one thing that was made clear last year during the health care debate, it was a need for medical malpractice reform, not just to curb the need for defensive medicine—and some still argue about the extent to which that contributes to our rising costs in medical care—but to get a handle on this incredible amount of litigation our society now seems to take part in.

In Montana I have talked with several of our rural doctors who, through no fault of their own, have outrageous malpractice premiums. I recently had a primary care doctor in my office who pays $38,000 a year in premiums. To those folks who practice in more urban areas and have extended practices, $38,000 might not sound like much. But it is a big ticket in a rural State. To top that off, he is yet to be sued. But, yet, to protect himself, he cannot avoid paying this premium. Of course, we know who pays for that—the people who use his services. On top of this cost of practice, he has overhead expenses, too. It is no wonder the cost of services and fees continues to go up. In fact, I was astounded to find out the other day from a group of doctors what an office call would cost if it were not for a lot of extenuating rules, regulations, insurance, and, yes, Government regulations in their life, and how that increases just the price of an office call.

The McConnell amendment is a perfect fit on this product liability reform bill. I am glad to see the House has included it and that this body is considering it now. The product in this case is health care services. I am not trying to say that people do not deserve malpractice awards. As in any business, people are fallible, judgment is not always true, and accidents do happen. I think we tend to hold health care providers to a higher standard because much of the time they hold our lives in their hands.

But malpractice claims are made more often than necessary. Of the billions of dollars spent on medical liability, 50 cents of every premium dollar goes to the attorneys and not to the injured patients that this system was meant to help. If our goal is to direct health care dollars into the legal system for the attorney fees and court costs, then we should not enact liability reform. However, if the patient is our priority, and if quality of care is important to us, then this provision is essential.

One area that I am very interested in is the contingency reform provisions in this amendment. This provision will help to address some of the sizable costs in the system by limiting an attorney's contingency fee to 33⅓ percent for the first $150,000 and 25 percent of any amount over $150,000. The real travesty of justice here is the amount of the health care liability award that goes to the attorneys. The contingency fee was intended to be the poor man's key to the courthouse. According to the evidence from a 1990 Harvard medical malpractice study in New York, the contingency fee is not serving this function very well.

Most folks with small health care injury claims never get access to the civil justice system because the contingency fee stimulates lawyers to be primarily interested in the big ticket cases. It is the same incentive that drives the lawsuit lottery, encouraging lawyers to take cases with a sympathetic plaintiff even if there is no negligent care. In many States, the contingency fee is growing. Though traditionally the norm is one-third of the plaintiff's payment, the standard is growing to 40 percent and, yes, 50 percent contingency fees are becoming more and more common. This fee covers only the attorney's professional fee. Litigation expenses are deducted separately from the plaintiff's recovery and they, too, can be quite high.

I am proud to say that the Montana Legislature has just passed legislation to cap the fee and reform our medical liability system, the Montana State Legislature that just adjourned prior to the Easter break. I take my lead from my constituents. I always have and I always will. But I also keep a pulse on what is going on around the Nation.

In a recent public opinion strategist poll linking people to groups that represent America's values, I tell you what, attorneys, kind of with us, are running pretty low. But for the sure reason for that, maybe we should examine the system. Incidentally, doctors were near the top of the poll.

So I urge my colleagues to support the McConnell-Kassebaum amendment. After all, it was just a couple of years ago that Senator KASSEBAUM worked on a medical plan, and this was included in her plan then so this is not a new idea. It is an idea that has been accepted by the American people and it is an idea whose time has come. These two amendments together will meet the needs of the injured patients who deserve to be fairly compensated and society which needs to reduce transaction costs and eliminate windfall judgments. But above all, it will allow us to continue to promote the highest quality medical care for our people, our consumers in this country, and maintain that high quality for years to come. It is very important that this be a part of this package whenever we go to conference and when it becomes law.

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. KENNEDY. 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. KENNEDY. Mr. President, I wish to review for the Members where we are this afternoon on the malpractice insurance proposal offered by Senator MCCONNELL, and now added to by Senator KASSEBAUM.

Process is really not always important, but the Senate has a process to ensure adequate consideration to measures such as these. We will have a chance to revisit the substance of some of these measures during the course of consideration of the McConnell amendment. But since I referred earlier to the actions of our committee, I wanted to at least give the Senate an idea of what we have been doing, and what the result of our deliberations has been.

The amendment described by the Senator from Kentucky is not the product of consideration by the Labor and Human Resources Committee. That committee, under the chairmanship of Senator KASSEBAUM, spent a full day this week and half a day earlier this month debating a bill virtually identical to the amendment Senator MCCONNELL has offered today. Members heard each other's arguments, compared their experiences in their own States, and worked in a collegial and good-faith fashion to craft a better bill.

Three very important amendments were adopted. First, there was an amendment offered by Senator DODD that removed the cap on punitive damages, providing a more structured process by which the jury determines whether the punitive damages are warranted and the judge sets the amount.

Now, I just want to mention that punitive damages in malpractice cases are extremely rare. However, of those cases that do merit punitive damages, 68 percent involve sexual abuse of patients by the medical profession. So in addition to a very high standard that was established in the McConnell bill, there is also a cap on the punitive damages. They establish a very high standard, but make it virtually impossible to reach that very high standard.

In the consideration of this bill by the committee, we talked about the egregious nature of sexual abuse in a medical setting, cases in which a woman is anesthetized and then abused, for instance. We thought, even if you are going to have a cap on punitive damages, those circumstances are so outrageous that we should allow an exemption—if women are able to reach the burden of proof established in the

legislation, there should be the ability to go above the cap in the McConnell amendment. This was virtually unanimously supported by the members of the committee. This is a matter of great interest to the women of this country; not just those who have been involved in cases with punitive damages, but as a message to all that this is an issue so reprehensible it is going to receive the attention of the Congress of the United States.

Now, that is out. That is out in the McConnell amendment.

We had a good deal of consideration. We had evidence not only of that kind of activity, we also had evidence where we had doctors who are practicing medicine and committing negligence when they are under drugs and also under alcohol. We wanted to have that as an exemption of punitive damages. No, that was rejected and it is rejected in the McConnell amendment.

We wanted to also lift from punitive damages those circumstances where doctors have their license suspended and still go ahead and perform operations. That was not considered during the course of the discussion and debate.

But we did accept the particular circumstances where punitive damages in malpractice, that there was going to be a recognition that in those cases that are so heinous with regard to taking advantage of women, that that was going to be addressed.

We had a second provision on the issue of damages and that was offered by our friend and colleague, the Senator from Connecticut, that was accepted. That provided that the jury would make the determination as to whether there should be the punitive damages and the judge would make the judgment to set the amount and there would be a criteria as to how that amount would be reached. That was accepted by the committee after good debate and discussion about reviewing what had happened in the States.

I was interested to hear my friend and colleague from Montana say, ''Well, Montana has just adopted a good program on the issue of malpractice.''

Well, he might as well kiss that goodbye, because we are going to preempt that under the McConnell amendment.

I am not sure that everyone understands in this body, when I listen to my colleague say we adopted a program out in Montana and it is on the books now and, thank God, we are going to have a bill that is going to reach the needs of the people of program. Well, I am telling you this program is probably going to preempt it in some form or shape and that will be true about Wyoming and Montana and other States.

But, nevertheless, we brought about some changes with the Dodd amendment on the punitive damages.

And then we had the Abraham amendment that permitted the States to opt out of any and all reforms in this bill. I would have preferred a broader form of nonpreemption language, but the committee debated the matter at length and, with great thoughtfulness, it was the will of the committee that the preemption should be addressed through the mechanism of the Abraham language. And that was after a lot of discussion and debate and a lot of give and take on it. But, effectively, that consideration and those hours of discussion and debate are by the board, and that is gone.

Now 2 days have passed since the markup of the committee. No report has been filed explaining what is either in this bill or reported out of our committee's bill. At least you should have a report of what came out of the committee and then you could explain how that is different in the McConnell amendment. But we have not even waited for that report.

And the text of the bill itself, as amended in the committee, is not even publicly available in typeset for the members of the committee; not even available. And so we are acting on the basis of the explanation of the comments of the Senator from Kentucky and others about the legislation itself.

And now the Senator from Kentucky offers the amendment that basically ignores the work of the committee. That is his right. But it should give some Members pause. Either the committee process is to be respected as a way to improve or refine the legislation or it is a joke. The language of the McConnell amendment has been rejected, much of it, by the Labor and Human Resources Committee. We considered it and decided it should be reported without taking into consideration the Dodd and the Abraham amendment.

So I hope the Members will recognize the circumvention of the committees process. He has the right to do so. But it does disregard the orderly and important consideration of complex and far-reaching legislation.

But it is interesting, Mr. President, that during the course of the consideration of the amendment in the committee, the whole question about how we should deal with the professional liability premiums for obstetricians and gynecologists was considered by the committee as well. That is in the Thomas amendment.

And I refer now to an article by the American Medical News that is right on point of the Thomas amendment.

I ask unanimous consent that the text of the article be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From American Medical News, Feb. 22, 1993]

QUALITY ASSURANCE PRENATAL SYSTEMS REDUCE RISK FOR OBS

(By Greg Borzo)

Professional liability premiums for some obstetrician-gynecologists have fallen dramatically in recent years because of greater physician participation in risk management, quality assurance and documentation of care.

Patient flow charts, checklists, practice guidelines and comprehensive office-wide management systems have played a big part in the drop, even though many physicians regard such tools as cookbook medicine.

''Because obstetrics is a high-risk area, we and other insurance companies have concentrated our efforts on it,'' said Julie Pofahl, director of risk management, Physicians Insurance Co. of Wisconsin (PIC–W), ''Physicians are improving the quality of care and their record-keeping in a variety of ways, and as a result, we have seen lower frequency and severity of claims.''

Their work is paying off. Over the last four years, premiums charged by physician-owned insurance companies have fallen more for obstetrician-gynecologists than for any other specialists, according to the Medical Liability Monitor, an independent newsletter. In 1992, half the companies did not change their premiums, while 35% reduced them an average of 8.3%. In 1989, ob-gyns insured by commercial and physician-owned companies saw rates cut an average of 14.5%; in 1990, 16.3%, and 1991, 10.9%.

One risk management and quality assurance plan, Prenatal Care, appears to be so successful in reducing obstetrics claims that at least three insurance companies are providing it free to any physician they insure, even though it costs more than $500 per system and about $5.40 per patient for materials. Two of them, Colorado Physicians Insurance Co. (COPIC) and Physicians Insurance Co. of Ohio (PICO), also offer a 15% premium rebate to physicians using the system.

Prenatal Care, a comprehensive, integrated system marketed by Advanced Medical Systems in Tulsa, Okla., includes a detailed patient questionnaire and a flow sheet to monitor a pregnancy and remind physicians to perform critical tests. It also includes physician and staff training materials and extensive patient educational handouts.

A 50-form introductory unit costs $395, an instructional videotape $95 and quarterly updates run $99 a year.

COPIC began promoting the system about six years ago, and it appears to have contributed significantly to falling liability rates for obstetricians in Colorado. Statewide, premiums fell from $61,000 five years ago to $33,000 for OBs and remained stable for family physicians who deliver babies.

Only one claim has been filed against Colorado physicians who used the system during the past six years, when it was used for more than 70,000 pregnancies and births, according to Arnold Greensher, MD, a co-developer of the system. Nationwide, two claims have been filed in 150,000 cases since the system was developed 14 years ago.

''The system helps organize patient care and makes sure that nothing gets overlooked or forgotten,'' said George Thomasson, MD, a family physician and COPIC's vice president of risk management. ''This is especially important with the growth of managed care, which leads to fragment the delivery of care.''

SLOW ACCEPTANCE OUTSIDE COLORADO

Nationwide, more than 1,500 physicians use the system in 44 states, and more than 55,000 forms were shipped in 1992, Dr. Greensher said. Physician-owned insurance companies in at least eight states are testing, promoting or giving away the system.

Louisiana Medical Mutual Insurance Co. (LAMMICO), for example, began providing the system to some of its physicians three months ago and plans to make the system available to as many physicians as possible.

But the system isn't in widespread use outside Colorado.

Even though PICO provides the system free and offers its doctors a 15% rebate for using it, only one-third of its OBs and family physicians that deliver babies use it. PICO has been promoting the system for two years.

''Physicians have been reluctant to try this because of two things: inertia and the fact that many hospitals mandate the use of certain forms of flowcharts that preclude the use of something else,'' said Mark Hannon, vice president of the doctor-owned firm.

PIC-W also provides Prenatal Care to physicians. After 1½ years, it has given away materials to about 250 physicians. ''Some obstetricians say that some of the forms are redundant and the manual is too basic to be very useful,'' Pofahl said. ''The system could be more appropriate for family practitioners than for obstetricians.''

CROWDED FIELD

Users and promoters of the system speculate that it has not caught on more quickly because of cost and competition. For years, a host of prenatal care forms and computerized systems have been available.

Chief among them is the Antepartum Record, a five-page form introduced in 1989 by the American College of Obstetricians and Gynecologists. More than 600,000 forms were sold in 1992, one version for about 20 cases per form, the other for a dollar.

''A lot of obstetricians already use the ACOG form and have developed other forms and office procedures based on it,'' Pofahl said. ''Many say they like Prenatal Care's system better but that they don't want to switch because they are just getting adjusted to ACOG or other forms.''

Others complain about the cost of switching and the inconvenience of using two systems during the interim.

While proponents claim Prenatal Care is so comprehensive that it's in a class of its own, physicians, tend to lump all systems and forms together.

''Our is the only true system,'' Dr. Greensher said, ''The other products are just forms.''

Steven Komadina, MD, agrees. Last year, he switched from ACOG's form to Prenatal Care's system, which he describes as nearly foolproof and far more comprehensive. He especially likes the patient education component, which helps the patient realize that she is responsible for her health.

The Albuquerque obstetrician has less use for the manual, but says it's helpful for nurse practitioners, physician's assistants and family physicians.

''It's helping to relieve a crisis in rural Torrance County, about 100 miles away, by giving family physicians there the competence and confidence to provide prenatal care,'' Dr. Komadina said. ''Over half the 250 women delivering there receive no prenatal care.''

Risk-management directors, however, wonder whether the system is used by physicians who need it most. LAMMICO told several ''problem'' physicians last year that it would not insure them unless they used Prenatal Care.

''Doctors who have tried the system up until now are probably the ones with a high awareness of the issues surrounding risk management,'' Gunter said. ''We want to see the impact on those with high claims frequencies.''

Mr. KENNEDY. I will read a portion of it at this time.

Professional liability premiums for some obstetrician-gynecologists have fallen dramatically in recent years because of greater physician participation in risk management, quality assurance and documentation of care . . .

''Because obstetrics is a high-risk area, we and other insurance companies have concentrated our efforts on it,'' said Julie Pofahl, director of risk management, Physicians Insurance Co. of Wisconsin. ''Physicians are improving the quality of care and their record-keeping in a variety of ways, and as a result, we have seen lower frequency in severity of claims.''

Their work is paying off. Over the last four years, premiums charged by physician-owned insurance companies have fallen more for obstetrician-gynecologists than for any other specialists, according to the Medical Liability Monitor, an independent newsletter. In 1992, half the companies did not change their premiums, while 35 percent reduced them an average of 8.3 percent. In 1989, ob/gyns insured by commercial and physician-owned companies also saw rates cut an average of 14.5 percent; in 1990, 16.3 percent; and 1991, 10.9 percent.

One risk management and quality assurance plan, Prenatal Care, appears to be so successful in reducing obstetrics claims that at least three insurance companies are providing it free to any physician they insure, even though it costs more than $500 per system and about $5.40 per patient for materials.

Then it continues.

Only one claim has been filed against Colorado physicians who used the system during the past 6 years, when it was used for more than 70,000 pregnancies and births.

One claim, one claim, in 70,000. And we have an amendment to try and escape from any kind of important liability of malpractice claim in ''70,000 pregnancies and births, according to Arnold Greensher, MD, a codeveloper of the system. Nationwide, two claims have been filed in 150,000 cases since the system was developed 14 years ago.''

In Colorado, the quality assurance system is credited for falling professional liability rates. Premiums fell from $61,000 five years ago to $33,000 for obstetricians.

This makes the case with regards to obstetricians. And they are identified as being the number one specialty in need. And here we have in the American Medical News that spells this out.

Now the fact of the matter is obstetrics and gynecology had significant problems 10 years ago, in 1985, according to the annual liability claims for 100 physicians by the Specialty and Census Division. They were clearly the No. 1 in 1985, virtually double from anyone else.

But since that time, they have had the greatest reduction, some 22.7 percent, from all the other specialities.

And that just makes the point that we made earlier and that is that the greatest problem that we are facing in terms of malpractice today is what is happening to the patients that are being left out in the cold and left behind.

You know, before we begin to shed a great deal of tears for the insurance companies and for other medical professionals, it is important to recognize that you, the taxpayer, are picking up about $60 billion a year in unpaid health bills as a result of malpractice. Someone has to pay. Many of these individuals are without any kind of health insurance or they lose their health insurance. Who do you think pays? It ends up being a burden on the system.

And what we are being asked to do is further immunize the insurance industry that has experienced substantial profits from doing what they were charged to do, and that is to provide insurance in these areas.

And second, and importantly, the McConnell amendment fails to take the kind of thoughtful steps that have been supported by Senator JEFFORDS, Senator DEWINE, and others to take steps to prevent malpractice. We ought to be debating this afternoon what steps are being taken to prevent malpractice in the first place, to keep people healthy.

I know my friend and colleague, Senator WELLSTONE, will be offering an amendment on that particular issue. We made some progress on it in the consideration of the bill before the committee, but not in this bill, not in the McConnell bill. That has all been left out.

Why are we not trying to prevent malpractice before it takes place? Why are we not trying to find out through the data bank who the bad apples are?

The data that is collected and sent to the National Practitioner Data Bank is information about malpractice cases and disciplinary actions taken against doctors. That information is made available to hospitals and to HMO's and to professional associations but is not made available to the general public. Why are we not making it available to the general public? Do you know the answer we heard in our committee? We cannot do that in the committee because the data bank is not insured enough.

I showed in the course of our considerations a book that was 5 inches tall that is published by Public Citizen, ''10,000 Questionable Doctors.'' This book documents State by State information that is available to the public, about the number of licenses revoked, surrendered, or suspended; fines against doctors; criminal convictions; sexual abuse or sexual misconduct with a patient; substandard care; misprescribing or overprescribing drugs; drug or alcohol use; and other offenses.

This is a matter of public record. It is collected in this document by Public Citizen and made available so people can find out about it. We want to make sure that it is done in a comprehensive way, updating information through the data bank. The consumers can find it if they can find this book. If they know the book exists and they know how to find it, they can look up various doctors.

Why do we make it so difficult? Why, if we are trying to prevent malpractice, are we not giving information to the public? What are they scared of? What are the doctors scared about? What are they frightened of? We know. They just do not want to have that information available, which is understandable for

their profession, but do not say to us that a prime need for us on the floor of the U.S. Senate in a health care debate is to deny the American consumer the kind of information that is available already and should be made more accessible.

The data bank ought to be strengthened. We had CBO studies and GAO studies about how its information can be strengthened. And it should be. That is something that we tried to do under the leadership of Senator JEFFORDS in our committee, which was included in the bill, though not as strongly as I would like to see.

So there are some matters that I think are of importance that were considered in some very important debates and discussions in the committee; they are the kind of matters that ought to have been included or addressed in the McConnell bill.

Mr. President, I want to take a few moments of the Senate's time just to review where we are on the issue of the insurance industry, and I refer to the National Insurance Consumer Organization report, which is a March 1993 report, because we now evidently are prepared to say that Montana does not know best how to treat these problems, or Wyoming does not know best how to deal with this; we need to have these Federal standards on the issue involving a doctor and his patient.

I, quite frankly, think this is dramatically different from even the underlying bill, the tort liability bill, where you are talking about various products that go into a State. We are talking, in this circumstance, about the very sensitive personal relationship between a doctor and a patient. There are not many other relationships which are more important and more personal.

We hear so much, we know what we really need locally. But, oh, no, the McConnell amendment is virtually going out to preempt State activities. So we have to know we have a declining need or declining burden on the profession, as we mentioned the OB/GYN, what the recent statistics show.

Consider the number of gynecologists that are graduating from our fine medical schools. That number is not diminishing. The Department of Health and Human Services finds the relationship between needs and supplies in six specialities are far from having a shortage. There is actually an oversupply of obstetricians and gynecologists.

I am glad to work with our colleagues about how we find out how to deal with underserved areas, but this is not the answer. You have the underserved areas. You have to deal with the burden a young person has when they graduate from college or from medical school, what their financial burden is, because they cannot make the sufficient resources, if they are going to go into a rural and underserved area, as they do in an urban area or in some of these specialities. You have to understand that they do not get the kind of support they would get if they would practice their medicine in one of the fine medical institutions. They are denied that.

Third, they fall further behind their classmates in terms of upgrading their skills. That is troublesome.

Fourth, in too many areas that are underserved, they do not have as good an opportunity for education for the children of these young people that want to go to school, and the parents, as dedicated as they are, do not want to disadvantage their children.

There are a whole series of reasons. But to tie in the fact that we have underserved areas in this country and that the principal reason is because of the insurance to the OB/GYN just does not hold.

Mr. President, I want to just again refer to the studies that were done by the various State organizations, insurance associations and their review of what is happening on medical malpractice insurance in their particular States. One of the States that they have reviewed is a State that has a number of the features that have been included in the McConnell amendment, and this is what they point out.

In 1991—and I will include the appropriate parts of this study in the RECORD for reference for Members over the weekend —in 1991, insurers writing medical malpractice insurance in the United States earned a return of $1.419 billion or 15.9 percent of net worth. This is the profit after dividends to doctors and hospitals of 4.2 percent, over $200 million. Investment income amounts to almost 50 percent of premium, due to lost reserve. Economists testified in insurance rate matters that returns of 13 to 16 percent on net worth are appropriate for this line of insurance. Here it is for this line of insurance, 13 to 16 percent guaranteed. I think most Americans would want to have that kind of investment if they could be assured of that kind of profit.

According to studies undertaken by the California Department of Insurance, properly capitalized insurers should hold only about a dollar of net worth for every dollar of premium for this line of insurance. This is medical malpractice. Had insurers not retained so much previous profit, America's medical malpractice insurance return on net worth would have been 29.2 percent. Mr. President, 29.2 percent—a remarkable high return—which is almost double the profit required to reward the risk of underwriting medical malpractice. And in the six States that undertook tort reform, studied by the GAO office, profits in 1991 averaged 122 percent above the national average, implying possible insurer profiteering in these States.

(Mr. SANTORUM assumed the chair.)

Mr. KENNEDY. It is those provisions which are basically and fundamentally included in the McConnell amendment, at a time when you have 100,000 Americans that are dying, you have no pressure in terms of the increased premium costs, a decline in judgments and in the number of cases that are brought. And in the six States which have effectively brought about these kinds of no joint and several—the collateral charges, the limits on the fees for doctors and all the rest, they are having 122 percent above the national average. Here we are debating a health matter before the U.S. Senate, with all of the health issues that are affecting working families in this country, for all those parents that are going to go home tonight and wonder whether they are going to still have jobs because of downsizing or cutbacks in defense, or because of all the challenges in our economy, wondering whether they are going to have it; or whether those families know whether they are going to get it tomorrow, or the 800,000 new children are not covered on the basis of last year alone.

Here we are taking action that is going to provide that kind of a guarantee to the insurance industry. I thought we were here to represent the working families, working men and women, the children, the older people. We hear the reports that are coming out of our Budget Committee about further cutbacks in Medicare for elderly people. That is an enormously important problem. I think we ought to have some adjustments if it is part of an overall and comprehensive reform. But here in the first order of business in the Senate we are looking out after these insurance companies. This has to be a matter that must be of concern to all Americans.

I will include the segments of the most recent report which came out in the last 2 days, Mr. President. I will mention just one interesting observation about the most recent reports. Insurance companies have now reduced malpractice liability premiums commensurate with a drop in malpractice claims payments in recent years in California and the Nation. Insurance companies have reaped excessive profits—in 1993, paid out 38 cents of every premium dollar.

Well, Mr. President, that is what we are addressing here. We will hear a great deal about, well, can we not do something about the person that is the victim of malpractice? Yes, we can and we should. That is why out of our Human Resources Committee last year we came out urging the States to have alternative dispute resolutions, and to build on the existing programs adopted in the States that go for early resolutions, to experiment with practice guidelines and enterprise liability, even no-fault liability programs, all of those matters to try and look out after the consumer. All of that has passed and gone out. All of that experimentation is out. All of the efforts to try and prevent malpractice, all of those are out. All we are dealing with is bottom-line issues. What is going to happen on the bottom line for those medical insurance companies? That is the issue. Let us not fool ourselves about it.

A recent article that gives a characterization of malpractice coverage in a stable condition says this—and this is Business Insurance, March 28, 1994, 2 months ago:

Insurers view medical malpractice, hospital professional liability, and related coverage as profitable lines these days, Broker says. In fact, some insurers are looking to increase malpractice accounts in an attempt to offset the meager earnings in the commercial market.

There is more capacity and there are more players than 3 years ago. More market and capacity than there were 3 years ago. It seems like every month a new insurer wants to underwrite medical liability and coverage for health care organizations.

Is this what we are hearing from our colleagues that are crying crocodile tears about all of our specialties that cannot do it and are not able to serve our poor, underserved people in this country? That is hogwash. See what the insurance industry says, not what some of us who have serious concerns about this whole kind of approach say. Look at what Business Insurance says about it. It seems like every month a new insurer wants to underwrite medical liability coverage for health care organizations. As long as companies are making profits that exceed the average property casualty profit line, they will want to underwrite this coverage.

In other words, boys and girls, you want to get on the gravy train, get on the malpractice gravy train, as it is today. We are going to even make it better for you with the McConnell amendment.

Mr. President, we must have other measures which are of greater urgency and importance for us to be addressing than that particular measure.

It seems to me that at the appropriate time—and I see others that want to address the Senate—I will offer the amendment which I offered in the committee, which basically was the substitute amendment which was accepted unanimously last year in the Human Resources Committee by all Republicans and Democrats.

Let me tell you what it is about. It is a reasonable question to say, all right, we know what you are against. We have problems. What are you for?

Let me briefly summarize what this amendment would do.

The amendment that I will offer at an appropriate point is identical in content to the malpractice reform subtitle of the health care reform, favorably reported by the Labor Committee. It seems to me that this is the appropriate vehicle to report to the full Senate because it was the product of carefully measured bipartisan deliberation. In that regard, it stands in sharp contrast to what the measure is that is before the Senate this evening.

Many of the current members of the Labor Committee will remember that we spent the better portion of 2 days thoroughly discussing and improving the malpractice title of the health care bill. For example, there was considerable debate about the preemption issue. We resolved that by accepting a Coats amendment striking preemption language that had been in the original mark.

It was a debate in a series of amendments regarding attorneys' fees and the result was a deliberative process. We limited those fees from the percentage that originally appeared in the Clinton bill. We sharpened the State demonstration programs authorized in the bill, adding a proposal by Republicans to explore no-fault liability programs. That said, if you have injury, you are able to collect right away; you do not have to prove negligence, and you can be reimbursed right away. It will not be as much as if you had gone through a court procedure, but you will get resources quickly in response to medical injury. A few States are doing that. We are encouraging that as a way to assist fellow citizens and to see whether it works. Eventually, we reached a bipartisan consensus on sensible medical malpractice reform provisions.

There are some who wish to go further in the area of damage caps, which my impression of the language in that subtitle, was broadly acceptable to every member of the committee.

The reforms the Labor Committee approved last year included mandatory alternative dispute resolutions; a limitation on attorney's contingency fees, collateral source reduction, periodic payments of awards, a State option to require certificates of merit before filing actions, and State demonstration projects to determine alternative approaches to malpractice.

These are meaningful, major kinds of reforms to the system that we had, and not only with regard to the malpractice. We had important and significant reforms in the areas of preventive health care, which I will not get into at this time.

These are the provisions we all agreed upon. They are sane, rational reforms which we crafted ourselves over lengthy bipartisan deliberation.

Although I would greatly prefer to see them included in a far more reaching health reform bill that would guarantee health security, they remain acceptable to me as an alternative to the measure which we are considering on the floor of the Senate. They will improve the malpractice system without unduly limiting the right of consumers to compensation for injuries sustained as a result of negligent medical care.

I submit that it is preferable to adopt these carefully consider reforms, rather than rushing to approve a bill that we have not sufficient time to address.

Now, Mr. President, it seems to me that that is a responsible, thoughtful product of give and take by Members, that come here with a wide variety of different thinking on the issue of malpractice reform.

We saw considerable debate that took place for a day and a half in our committee. We were able to make some adjustments. Still, it was not reported out in a bipartisan way. Nonetheless, we made some progress. That has effectively been discarded.

At an appropriate time I will offer that amendment perhaps as a second-degree amendment to the McConnell amendment. An additional amendment, Mr. President, that I intend to offer, would make clear that the reforms in this bill do not preempt State law.

I see the Senator from West Virginia. I have about 10 more minutes. If the Senator had a statement or intervention to make, I would be glad to yield, but otherwise if it is agreeable, it would be about 10 more minutes.

The preemption amendment would make clear that the reforms in the bill do not preempt State law, but apply in situations where there is no relevant State law. But where a State legislature has enacted a reform or affirmatively chosen not to enact to reform, the State's choice would prevail.

We hear much from the new majority in Congress about the States rights and the decentralization of power. We see proposals to turn over the administration of Federal entitlement programs to the States in the form of block grants, and we are told that there is much wisdom in State governments which are closer to the people than the Federal Government. However, in this bill, the opposite philosophy prevails.

Suddenly States cannot be trusted. States cannot even be allowed to write the laws to govern consideration of tort cases that have been their responsibility for over 200 years, about 100 years, recognized in court opinion.

Apparently in this area, Congress has all of the answers. It is especially strange that this bill preempts State laws very selectively. Only laws that benefit consumers are preempted, while those that benefit doctors and insurance companies are allowed to stand. Preemption of State tort laws is generally disfavored, but this result-oriented brand of preemption is especially unfair. One sided preemption. One sided.

We can make the case on the issues of tort that States should be able to make their own judgments. That is certainly the conclusion that we reached last year. However, in this particular program they say, all right, the States can make it as long as they are making what is favorable to the industry and not the consumer. That is the bottom line.

It is one-way preemption against the consumer, against those working families, against those children, against those parents, in favor of those insurance companies that are making the record profits.

There is a product liability bill on the floor, and I have serious concerns about many aspects, but at least there

is a plausible basis for Congress to create Federal standards to govern the liabilities of manufacturers who sell products in a nationwide market.

Undoubtedly, interstate commerce is at stake in the context of product liability, but the medical malpractice is typically a legal dispute between an individual, between his and her doctor, within the boundaries of a single State. Interstate commerce is hardly at the heart of the transaction, so there is no justification for imposition of Federal standards.

When we considered malpractice in last year's health bill, Members of both sides of the aisle were anxious to protect the reforms that their legislatures had enacted. Everyone recognized the need to proceed slowly for overturning 200 years of law in 50 States, and by unanimous vote we deleted that language that would have preempted inconsistent State lawsuits.

The amendment basically carries forward that valuable lesson from last year's debate that States that the basic principle, that this bill does not preempt State law. If a State has taken no action in a particular area, this Federal law will apply; but if a State has found a better way to address a problem in light of conditions in that State, we should not substitute a Federal solution in a field that States have occupied for 200 years of American history.

So there would be a preemption amendment. I would hope that this would be successful. There are other approaches that have been mentioned, by Senator ABRAHAM and others, who have addressed that.

Finally, I would just say that many were absolutely amazed at the inclusion of a loser-pays concept, included in the legislation which was included in the bill that was before our committee. I understand it has been changed. I think, wisely so.

We could be in the extraordinary case where an individual was able to win their case in the courts, and because they had not accepted a previous kind of offer, effectively would have been required to pay the attorney's fees for the other side, even though they got a finding that there had been negligence and they had been endured medical malpractice.

Now, the loser-pays system has been a part of English law. There is an excellent article from the bar association, recently pointed out, and as the Economist magazine, one of the distinguished magazine commentaries both on American and English public affairs has pointed out, they are moving in the direction of the United States for well-documented reasons. And that is because the unfairness and injustice that that creates.

We had a proposal before to move in their direction. It was not enough to have the punitive damage caps or the repeals of joint and several, which have been out there for many years which had loser pay. We had one-way preemption and we have no access to the data bank.

That was the major flaw—the cap on punitive damages, no matter how egregious the circumstance was going to be, in spite of the high standard that would have to be reached in order to be able to claim punitive damages, the repeal of joint and several so that even in a circumstance we could see the tragic circumstances where that individual in Florida that lost one leg, he was also a diabetic, so he was disabled. Hence, he did not have the loss of much wages and economic damages. Since he is getting disability, the disability was paying in, that would be an offset to what the insurance would have to pay if there was negligence in that particular case. That is absolutely crazy. That is absolutely crazy.

Those are the kinds of circumstances. When we have joint and several, and we eliminate those, and we eliminate the payment, the legitimate payment, to those individuals that ought to be decided on the basis of the jury, someone pays—and it is the American taxpayers—$60 billion. That is who ends up paying, if the insurer that is supposed to provide that kind of coverage, and is obligated to do so, if they are in the insurance business, does not do so.

We also know the dangers of adding onto that the collateral provisions, which in many instances diminishes in a dramatic way the payments to individuals who otherwise would be entitled to payments in a court of law. That has been a factor.

Then one of the most extraordinary matters we were facing in our bill is, even if you got the punitive damages, if you were able to get some punitive damages, part of those punitive damages were going to go to fund some quality control measures. That made absolutely no sense at all.

So I hope we will have a chance. We are glad to work with the leadership to try to get an orderly way of addressing some of these issues. It is not our intention—at least not my intention—to delay Senate action. But I do think we just had the measure that came up this afternoon when many of us were over on the Judiciary Committee. My colleague, Senator SIMON, and other members of our committee were at the Judiciary hearing on terrorism; and we had the mark-up on the Judiciary Committee earlier today on regulatory reform, which a number of us are involved in. We want to meet our responsibilities. But on important measures like this, the Senate is entitled to at least give some consideration to matters which are going to have an enormous impact on fairness and on justice and on the quality of health care for the American people.

One of the aspects of health challenges that we are faced with—we have the issue of access and the availability of health care. We have the costs of health care, the fact that it continues to rise. From $1 trillion, it will double by the year 2002 to $2 trillion. We have to do something about getting a handle on those health care costs. We have to do something in terms of making it available, particularly to the children. Of the 40 million people who have no health care coverage, about 15 million children in our country have no health care coverage. We have to do something about those. But we have to do something about quality as well, and this is something that deals with quality and it is a step backwards, not a step forward. And it should not be accepted.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, what is interesting about all of this is that the business at hand is something called the Product Liability Fairness Act. I want to be very frank about my disposition towards the amendment which is at this moment before us.

This is not a unique situation in the Senate. Senators have the right to come forward and offer amendments to legislation that are outside the scope of the legislation before the Senate. We have seen that done ever since I came to the Senate, from both sides of the aisle. And sure enough, Senators from Kentucky and Connecticut and Wyoming are using their rights to ask the Senate to decide whether to attach a series of provisions dealing with malpractice to a bill dealing solely and only with product liability.

An entire day disappears. Whether there is passage or not, it will not be a part of the final version of this legislation. It will get vetoed, it will get taken out one way or other. It is an exercise of folly, which is sad. And I will express my views.

I am deeply committed, as committed as anybody in this body, to health care reform. And I see malpractice reform as an integral part of the solution to the crisis that faces the self-esteem and the condition of our physicians, our hospitals, and the American people, and I think of those in my own State of West Virginia in particular.

Mr. President, I have watched the Senate come very close to the point where we might enact a product liability bill during the past 6 years. We actually got 60 votes several years ago; 60 was written down on the table here in front of us. The majority leader at that time, under the rules, stopped the vote and we spent the next 45 minutes while he found two Senators who had voted yes to change their votes to no. So we lost.

Now that we have 20-minute votes, that is much harder to do. I am very happy for that. But we have come very close. And I take product liability reform extremely seriously. I think it is something that needs to happen both for consumers and for businesses in this country. I think it is important for America. I think it is important for the American people. I take product liability seriously and anything which comes in the way of product liability,

and a chance—and perhaps the last chance that we ever have—to assemble a coalition that is willing to go for this. Now we have other amendments.

You have to understand, as I am sure the President does, that people better start making a decision around here. Do you want to have the fun of making wonderful speeches and putting on what I think is very good legislation, amendments in terms of malpractice reform? Or do you want to have product liability? You are probably not going to have both.

Today has been interesting. I did not schedule a lot because I thought we were going to be dealing with product liability, and all of a sudden we are dealing with something called malpractice reform that has to do with health care.

Now the Senator from Massachusetts is talking about a whole series of amendments, so I assume this will go on for a long time. There are some people in this body who have not yet quite decided whether this bill, called product liability reform, is in fact good public policy. That may be more on this Senator's side than the side of the Presiding Officer. But there are some people who have not quite decided whether this bill should be used to enact good public policy on product liability.

Or are we just making points about other things that we are interested in? Which I might be interested in. But at some point people have to make a choice. Are we going to do product liability or are we going to do a whole series of things which then end up negating the chance to get product liability?

I have been working on product liability for 9 years; some have for 13. I made a variety of tabling motions yesterday to express very clearly my view about that. In fact, there was one that was a Heflin-Rockefeller amendment, which does not comport with the natural tendencies that surround product liability. I am trying to make the point that I want this to be a pure product liability bill.

The Senator from the State of Washington, Senator GORTON—extraordinarily skillful, extraordinarily insightful, extraordinarily disciplined—believes, as I do, that if we are going to get 60 votes to stop the filibuster that will surely be there and will come at some point, it is going to be very close. And he agrees that we should focus, as I agree we should focus, on product liability.

It is a very complicated subject. It is a very complicated subject to explain, particularly when explained by a nonlawyer such as myself, much less a skilled lawyer such as my colleague from the State of Washington.

The majority leader can schedule a separate time, its own special time to take up malpractice reform such as the malpractice reform legislation that, in this case, was adopted just on Tuesday by the Senate Labor Committee. But in good conscience I, as manager on the Democratic side of the aisle, cannot take the risk when the chances are good of enacting product liability reform, making reforms to a broken, dysfunctional product liability system—that these will all be torn asunder, weakened, scattered about by a series of other amendments, in this case dealing with a very, very important subject called malpractice reform. I do not have any choice but as to my conclusion, and at the appropriate time I will move to table this amendment and the underlying amendment, and other amendments associated with it. I have no choice.

With cosponsors from both sides of the aisle, with a long history of strong support in this body, Senator GORTON and I have been on this floor all week talking about our rather grave concern about the problems in the current patchwork of unpredictable, unfair matters associated with product liability. This Senate has before it a very carefully constructed bill to improve the system to make it less costly, to make it more predictable, to make it more fair for everyone. And enacting product liability reform is what I believe the goal should be for the Senate at this moment, as of all of this day, as of all of the moments that remain.

Yesterday, as I indicated, we moved to table a number of amendments which were related to a legal system and lawyers, but were beyond the scope of product liability legislation. So I moved to table them. The malpractice reform amendments offered today are analogous to previous broadening amendments which were offered and then tabled.

I hope that we can reach an agreement on a course of action that provides for a meaningful debate on the pros and cons of malpractice reform, and in the near future. As I have indicated, I think if we could do this before July 4, it would be very, very good. That might be an option which would address any concern that there will not be another timely opportunity to deal with malpractice reform.

The medical community in my State wants malpractice reform more than anything else that exists. They want it desperately. I also do. Given another moment on another day, a bill in the range of what has been presented this day would have my vote; that is, the kind of amendment on malpractice which has been presented by Senator MCCONNELL would have my vote. I would argue for it vociferously. I might disagree with some of the points that have been made about it, but not the majority of its provisions. I hear from doctors all the time, I hear from hospitals all the time about the importance of malpractice reform to them as essential health care professionals in my State. We have had ongoing dialog on this issue, and I know I can say that I understand what they want. I understand the problems of health care.

I have done a lot of work on health care over the last 8 years or so. I very much want to be able to improve the climate for practicing medicine in West Virginia for all providers. I want to do all I can to make sure that we have an adequate supply of all needed health care professionals in my State, particularly OB–GYN's and health care providers which are in short supply in almost every county—in some counties in the State of the Presiding Officer; in most counties in my State.

I also believe good malpractice reform will help improve the quality of health care services in my State, malpractice reform can be in the best interests of patients and their health care professionals alike.

What is interesting is that malpractice is also a state of mind preventing a lot of people from going into medicine. There are a lot of doctors now who have told me they do not want their sons or daughters to go into medicine. It is not worth it, they say. Every patient they face is a potential litigant. We are a litigious society, sadly and shockingly so.

Yesterday, I had a long visit with Dr. Jim Todd, executive director of the American Medical Association; Dick Davidson, of the American Hospital Association; and Tom Skully, of the Federation of American Health Systems, another group representing a large number of hospitals in this country. They said nationwide the doctors and hospitals whom they represent, and that is a very large collective membership, want strong malpractice reform enacted as soon as possible. I shared with them my strong desire to help toward passage of that end. But let me say that we cannot do both things at the same time.

If we pass medical malpractice and it is incorporated into the product liability bill, some votes from this side will fall off and the entire tree will collapse. You put too many decorations on a Christmas tree, and at some point the bow simply falls and everything drops off.

I do not think it is very complicated. I think this really is a test of who wants product liability reform and who does not. I can understand the opponents of product liability reform adding on all kinds of amendments. I can understand that to deter, to generally scatter attention, and to dilute. But I cannot understand those who favor product liability doing that.

This is not just a question of the House agenda, the Contract With America. There is a lot of concern on my side, Mr. President, about this bill—it is very real on my side—that it is going to be loaded up with what came over from the House. I think one of the things that the other side is learning now is that, if they were to put forward a series of amendments, they will not get as many votes as they thought they would, and the votes really will not be there to do the job. It will not be there on our side, almost

for certain, and they will not be there on the other side.

So here we are. I may not agree with every provision of malpractice reform advanced by some. But I want to see it done. I want that clear. This is, in a sense, my issue as much as any issue in this body. I have physicians, hospitals, and others—and patients in West Virginia—who need to have this happen. I just want to be certain that no one misunderstands my position. Despite the concern that other Members have expressed about attaching malpractice reform onto product liability, I have no intention of ducking the issue of the need to deal with malpractice reform. I understand what is going on.

I am interested in why the Senator from Kentucky chose to offer his original malpractice bill as an amendment as opposed to what was marked up in the Labor Committee. The majority of the provisions of Senator MCCONNELL's bills are ones which most of us supported in the past on one piece of legislation or another. I am also interested in hearing the rationale for Senator THOMAS' second-degree amendment regarding rural care.

But, in the end, I just return to Senator MCCONNELL's underlying malpractice reform amendment and I say, do we not have to choose? I feel we do. We cannot have it both ways. I fear that, if this amendment, as much as I might be interested in it, were to prevail, it would peel off votes from my side of the aisle, and product liability would lose. I do not want that to happen. The Senator from Washington does not want that to happen. It has been our pledge from the beginning that we are going to try to keep this bill as clean as possible; clean—only product liability. Anything outside, we work against.

So I hope my views on this are understood. I repeat that at the appropriate time, I will move to table the various amendments that deal with this subject.

I thank the Presiding Officer and I yield the floor.

Mr. JEFFORDS addressed the Chair.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. I wish to comment just briefly on the comments of the minority manager of the bill. I wish to assure him that coming from a State that suffered as much from the problems of product liability reform, having lost much of our machine tool industry and a big cause of that being the big differences between the liability of our own businesses in this country and those of our foreign competitors, I will not do anything in any way to destroy the opportunity to have product liability pass, and I think I speak for the Members on my side of the aisle.

However, I feel I must bring to his attention and the attention of my colleagues that there is a very noncontroversial aspect of the MCCONNELL amendment which, if passed, would move us a long way towards two very important matters in the health care area. First of all, it would assist in preventing medical malpractice, which is probably the most important thing we can do. What we want to do is to provide the opportunity to gather the information which would be necessary to be able to prevent the occurrence of malpractice by having sufficient guidelines and information available to doctors so that the number of incidents of malpractice will be decreased.

And second is to protect consumers. We are moving into an area right now where we have managed care throughout this country. Health care reform is going on. Notwithstanding the fact that we failed to pass anything of any substance last year, health care reform is going on. But the managed care concept raises real serious problems for consumers as to how they can be protected when they get into situations where choice of the doctor may not be what they intend or even available to them. How can they get information on what is available to see if the care they are going to get or the doctor or physician they have is one that is qualified?

So I am referring to a part of the McConnell amendment that is under subtitle B that is called ''Protection of the Health and Safety of Patients,'' and most particularly section 32, which is entitled, ''Quality Assurance, Patient Safety, and Consumer Information.''

We are now in the information age, and with all of the computer internets, all the information that is able to flow back and forth, we have an opportunity to give to the health care providers the ability to know what is good care and what is not good care, to have information on outcomes to be able to determine as to what should be done and what is good care and what is not good care.

All this bill does is to provide an organized system for obtaining this information in various ways and making it available for those purposes. No one disagrees with that.

So I would hope, if nothing else, we can include these things which are totally noncontroversial to this bill if it should prove the malpractice provisions otherwise might bring the bill down. What it does is establish an advisory panel to coordinate and evaluate methods, procedures and data to enhance the quality, safety and effectiveness of health care services provided to patients. No one disagrees with that.

In order to do that, the panel that would be set up will assure that the members of the panel include representatives of the public and private sector, entities having expertise in quality assurance, risk assessment, risk management, patient safety and patient satisfaction.

What it does, it establishes these objectives, again for which there is absolutely no problem with anyone.

The survey shall include gathering data with respect to, first, performance measures of quality for health care providers and health plans; second, developments in survey methodology, sampling, and audit methods to try to determine what is going on; third, methods of medical practice and patterns and patient outcomes; and fourth, methods of disseminating information concerning successful health care quality improvement programs, risk management and patient safety programs, practice guidelines, patient satisfaction and practitioner licensing, all things we know are essential to be able to give us the kind of information we must have to protect the consumer and as well to give guidance to the medical profession to reduce the opportunity for malpractice.

In addition, ''the administrator shall * * * establish health care quality assurance, patient safety and consumer information guidelines. Such guidelines shall be modified periodically. Such guidelines shall be advisory in nature and not binding.''

So we are not doing anything that anyone can disagree with but will be so important to provide the information that is necessary, made available through internets and whatever else, to ensure that we are getting the best care possible that is available. So I do not think anyone can disagree with these provisions which the McConnell substitute attempts to accomplish.

So I would urge my colleagues, be assured that there are many good things that are noncontroversial and very important to the improvement of our health care system which are in the McConnell substitute and which are not things that should give us any concern at all.

So I hope, as we go forth here, if the minority manager of the bill is correct in that malpractice is going to be so controversial that it will not pass, that something which the sooner we get started the sooner we will be able to prevent medical malpractice and the sooner we give protection to consumers ought to go forward in some way along with this bill rather than have to wait, so that we can get to the business of providing that kind of information and that kind of assistance to both practitioners and to consumers.

Mr. President, I yield the floor.

Mr. WELLSTONE addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, might I ask, are there other colleagues who want to speak right now? If not, I wonder if I could suggest the absence a quorum for a moment with the understanding that I would have the floor.

Mr. DOMENICI. Mr. President, I am going to speak at length, but I would like to take 2 minutes now and then I will sit down and come back later or whatever time is available. Could I do that?

Mr. WELLSTONE. Mr. President, that would be fine.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, later on I will speak to the overall issue of judicial and jury reform as it applies to civil litigation in the United States, but I thought I might just tonight express for the Senators at least what my head tells me about this system. I was looking around for some judicial stalwart who might have addressed the issue, and I found that Supreme Court Justice Lewis Powell described punitive damages as follows:

It invites punishment so arbitrary as to be virtually random.

Now, the reason I bring that up is because I believe that it is absolutely true, and so what we get in certain advertisements across the country and in statements in the Chamber, is the random damage award that was proper or somewhat proper. But we do not hear the hundreds that were randomly wrong, wherein the jury was taken advantage of by emotions and awarded huge punitive damages when they were not warranted. We also don't hear about the even bigger issue of what this does overall to our litigation system. Clearly it invites more litigation because the random winner may be a big winner.

Now, what does the random nature of the potential for a big win mean to our litigation system? Mr. President, it means cases get settled that are not worth anything. That is obvious. A company has to settle lawsuits because they cannot take the chance of the random verdict.

Now, I am very pleased that Justice Powell said it that way. I have said it is the worst way to regulate human behavior in America. If you are trying to find standards to have people hold their performance to, the worst way is to ask juries to set the standard. For nobody knows what it will mean and clearly juries have all the latitude in the world when you add punitive damages to the system. It leaves all kinds of impressions with those who are supposed to be bound in some way, by changing their conduct to a high or better standard.

Now, the Justice went on to say the following, which sort of hits my last remarks: Because juries can impose virtually limitless punitive damages, in Justice Powell's words, they act as—And I say this to my good friend from Washington, let me quote it perfectly as he said it—they act as a ''legislator and judge without the training or experience or guidance of either.''

That is a pretty good way to say it. Who told juries what the standard of conduct is or what a company ought to pay if they violate some kind of standard of the ordinary man or ordinarily prudent man? No one. So they are told that by words that lawyers express, when they are not trained in the law and they are not trained in what kind of damages we ought to extract from people who do not behave according to a norm.

So I come to the floor to laud those who are looking for reform in this system. And I specifically tonight just had a few remarks with reference to punitive damages. Clearly, there are cases where punitive damages should lie. On the other hand, there is not going to be a perfect solution to the dilemma we find ourselves in. If we conclude that since we cannot come up with a perfect system on punitive damages since there are a few cases that are entitled to extraordinary kinds of punitive damages for one reason or another, that we cannot solve that problem, we will never do anything.

We will leave in place a system that is so arbitrary as to be virtually random. We will run around this country talking about that as if it were a real, bona fide, honest-to-God system when it is nothing like that. It is so arbitrary as to be virtually random. And that is no system. That is no system of assessing damages.

Mr. President, obviously I have not been down here during the past week. Some will probably say, ''You have already said enough.'' But obviously, I will say a little more, because I have some pretty strong feelings about it.

I close with a parting shot. I wonder if our Founding Fathers and the common law of England from which we continue to say we derived all these marvelous rights, I wonder if they ever would have had in mind that we would send a malpractice case of the type we are sending the juries, or product liability of the type we are sending to the juries. I believe if you had asked the Founders, they would have said, ''Of course not. They ought to be arbitrated by people who know something about it.''

I yield the floor.

Mr. WELLSTONE. Mr. President, I had a chance to speak at some length today, so I will not respond to my colleague from New Mexico. I appreciate his remarks. I tell him as a good friend, I should have known when he said it would be 2 minutes, it would be a little more than 2 minutes. But he is eloquent and he is a very, very important voice here in the Senate.

Mr. President, I ask unanimous consent that the Thomas amendment be set aside so that I may offer an amendment.

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

Mr. WELLSTONE. I thank the Senator from Washington.

AMENDMENT NO. 605 TO AMENDMENT NO. 603

(Purpose: To modify provisions regarding reports on medical malpractice data and access to certain information)

Mr. WELLSTONE. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Minnesota [Mr. WELLSTONE] proposes an amendment numbered 605 to the McConnell amendment No. 603.

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

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

The amendment is as follows:

In section ___32(c)(1) of the amendment, strike subparagraph (B) and all that follows through the end of the section and insert the following:

(B) an estimation of the degree of consensus concerning the accuracy and content of the information available under subparagraph (A); and

(C) a summary of the best practices used in the public and private sectors for disseminating information to consumers.

(2) INTERIM REPORT.—Not later than 1 year after the date of enactment of this title, the Administrator shall prepare and submit to the Committees referred to in paragraph (1) a report, based on the results of the advisory panel survey conducted under subsection (a)(3), concerning—

(A) the consensus of indicators of patient safety and risk;

(B) an assessment of the consumer perspective on health care quality that includes an examination of—

(i) the information most often requested by consumers;

(ii) the types of technical quality information that consumers find compelling;

(iii) the amount of information that consumers consider to be sufficient and the amount of such information considered overwhelming; and

(iv) the manner in which such information should be presented;

and recommendations for increasing the awareness of consumers concerning such information;

(C) proposed methods, building on existing data gathering and dissemination systems, for ensuring that such data is available and accessible to consumers, employers, hospitals, and patients;

(D) the existence of legal, regulatory, and practical obstacles to making such data available and accessible to consumers;

(E) privacy or proprietary issues involving the dissemination of such data;

(F) an assessment of the appropriateness of collecting such data at the Federal or State level; and

(G) the reliability and validity of data collected by the State medical boards and recommendations for developing investigation protocols.

(3) ANNUAL REPORT.—Not later than 1 year after the date of the submission of the report under paragraph (2), and each year thereafter, the Administrator shall prepare and submit to the Committees referred to in paragraph (1) a report concerning the progress of the advisory panel in the development of a consensus with respect to the findings of the panel and in the development and modification of the guidelines required under subsection (b).

(4) TERMINATION.—The advisory panel shall terminate on the date that is 3 years after the date of enactment of this title.

SEC. ___33. REQUIRING REPORTS ON MEDICAL MALPRACTICE DATA.

(a) IN GENERAL.—Section 421 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131) is amended—

(1) by striking subsections (a) and (b);

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively;

(3) by inserting before subsection (d) (as redesignated by paragraph (2)) the following subsections:

''(a) IN GENERAL.—

''(1) REQUIREMENT OF REPORTING.—Subject to paragraphs (2) and (3), each person or entity which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 424, information respecting the payment and circumstances of the payment.

''(2) PAYMENTS BY PRACTITIONERS.—Except as provided in paragraph (3), the persons to whom paragraph (1) applies include a physician, or other licensed health care practitioner, who makes a payment described in such paragraph and whose act or omission is the basis of the action or claim involved.

''(3) REFUND OF FEES.—With respect to a physician, or other licensed health care practitioner, whose act or omission is the basis of an action or claim described in paragraph (1), such paragraph shall not apply to a payment described in such paragraph if—

''(A) the payment is made by the physician or practitioner or entity as a refund of fees for the health services involved; and

''(B) the payment does not exceed the amount of the original charge for the health services.

''(b) INFORMATION TO BE REPORTED.—The information to be reported under subsection (a) by a person or entity regarding a payment and an action or claim includes the following:

''(1)(A)(i) The name of each physician or other licensed health care practitioner whose act or omission is the basis of the action or claim.

''(ii) To the extent authorized under title II of the Social Security Act (42 U.S.C. 401 et seq.), the social security account number assigned to the physician or practitioner.

''(B) If the physician or practitioner may not be identified for purposes of subparagraph (A)—

''(i) a statement of such fact and an explanation of the inability to make the identification; and

''(ii) the name of the hospital or other health services organization for whose benefit the payment was made.

''(2) The amount of the payment.

''(3) The name (if known) of any hospital or other health services organization with which the physician or practitioner is affiliated or associated.

''(4)(A) A statement describing the act or omission, and injury or illness, upon which the action or claim is based.

''(B) A statement by the physician or practitioner regarding the action or claim, if the physician or practitioner elects to make such a statement.

''(C) If the payment was made without the consent of the physician or practitioner, a statement specifying such fact and the reasons underlying the decision to make the payment without such consent.

''(5) Such other information as the Secretary determines is required for appropriate interpretation of information reported under this subsection.

''(c) CERTAIN REPORTING CRITERIA; NOTICE TO PRACTITIONERS.—

''(1) REPORTING CRITERIA.—The Secretary shall establish criteria regarding statements described in subsection (b)(4). Such criteria shall include—

''(A) criteria regarding the length of each of the statements;

''(B) criteria for entities regarding the notice required by paragraph (2), including criteria regarding the date by which—

''(i) the entity is to provide the notice; and

''(ii) the physician or practitioner is to submit the statement described in subsection (b)(4)(B) to the entity; and

''(C) such other criteria as the Secretary determines appropriate.

''(2) NOTICE OF OPPORTUNITY TO MAKE A STATEMENT.—In the case of an entity that prepares a report under subsection (a)(1) regarding a payment and an action or claim, the entity shall notify any physician or practitioner identified under subsection (b)(1)(A) of the opportunity to make a statement under subsection (b)(4)(B).''; and

(3) by adding at the end the following new subsection:

''(f) DEFINITIONS OF ENTITY AND PERSON.—For purposes of this section—

''(1) the term 'entity' includes the Federal Government, any State or local government, and any insurance company or other private organization; and

''(2) the term 'person' includes a Federal officer or a Federal employee.''.

(b) DEFINITION OF HEALTH SERVICES ORGANIZATION.—Section 431 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151) is amended—

(1) by redesignating paragraphs (5) through (14) as paragraphs (6) through (15), respectively; and

(2) by inserting after paragraph (4) the following paragraph:

''(5) The term 'health services organization' means an entity that, directly or through contracts or other arrangements, provides health services. Such term includes a hospital, health maintenance organization or another health plan organization, and a health care entity.''.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—The Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.) is amended—

(A) in section 411(a)(1), in the matter preceding subparagraph (A), by striking ''431(9)'' and inserting ''431(10)'';

(B) in section 421(d) (as redesignated by subsection (a)(2)), by inserting ''person or'' before ''entity'';

(C) in section 422(a)(2)(A), by inserting before the comma at the end the following: '', and (to the extent authorized under title II of the Social Security Act (42 U.S.C. 401 et seq.)) the social security account number assigned to the physician''; and

(D) in section 423(a)(3)(A), by inserting before the comma at the end the following: '', and (to the extent authorized under title II of the Social Security Act (42 U.S.C. 401 et seq.)) the social security account number assigned to the physician or practitioner''.

(2) APPLICABILITY OF REQUIREMENTS TO FEDERAL ENTITIES.—

(A) APPLICABILITY TO FEDERAL FACILITIES AND PHYSICIANS.—Section 423 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11133) is amended by adding at the end the following subsection:

''(e) APPLICABILITY TO FEDERAL FACILITIES AND PHYSICIANS.—

''(1) IN GENERAL.—Subsection (a) applies to Federal health facilities (including hospitals) and actions by such facilities regarding the competence or professional conduct of physicians employed by the Federal Government to the same extent and in the same manner as such subsection applies to health care entities and professional review actions.

''(2) RELEVANT BOARD OF MEDICAL EXAMINERS.—For purposes of paragraph (1), the Board of Medical Examiners to which a Federal health facility is to report is the Board of Medical Examiners of the State within which the facility is located.''.

(B) APPLICABILITY TO FEDERAL HOSPITALS.—Section 425 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11135) is amended by adding at the end the following subsection:

''(d) APPLICABILITY TO FEDERAL HOSPITALS.—Subsections (a), (b), and (c) apply to hospitals under the jurisdiction of the Federal Government to the same extent and in the same manner as such subsections apply to other hospitals.''.

(C) MEMORANDA OF UNDERSTANDING.—Section 432 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11152) is amended—

(i) by striking subsection (b); and

(ii) by redesignating subsection (c) as subsection (b).

SEC. ___34. ADDITIONAL PROVISIONS REGARDING ACCESS TO INFORMATION; MISCELLANEOUS PROVISIONS.

(a) ACCESS TO INFORMATION.—Section 427(a) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137(a)) is amended to read as follows:

''(a) ACCESS REGARDING LICENSING, EMPLOYMENT, AND CLINICAL PRIVILEGES.—The Secretary (or the agency designated under section 424(b)) shall, on request, provide information reported under this part concerning a physician or other licensed health care practitioner to—

''(1) State licensing boards; and

''(2) hospitals and other health services organizations—

''(A) that have entered (or may be entering) into an employment or affiliation relationship with the physician or practitioner; or

''(B) to which the physician or practitioner has applied for clinical privileges or appointment to the medical staff.''.

(b) ADDITIONAL DISCLOSURES OF INFORMATION.—Section 427 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137) is amended by adding at the end the following subsection:

''(e) AVAILABILITY OF INFORMATION TO PUBLIC.—

''(1) REPORTS, GUIDELINES AND REGULATIONS.—

''(A) INITIAL REPORT.—Not later than 3 months after the date of enactment of the Health Care Liability Reform and Quality Assurance Act of 1995, the Secretary shall prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives a report that contains recommendations for improving the reliability and validity of such information.

''(B) GUIDELINES AND REGULATIONS.—Not later than 180 days after the date of enactment of the Health Care Liability Reform and Quality Assurance Act of 1995, the Secretary shall establish guidelines and promulgate regulations providing for the dissemination of information to the public under sections 421, 422, and 423 of the Health Care Quality Improvement Act of 1986. With respect to such guidelines and regulations the Secretary shall determine whether information respecting small payments reported under section 421 shall be disclosed to the public. In addition, the Secretary shall ensure that such information shall include information on the expected norm for information reported under such section 421 for a physician's or practitioner's specialty. Such expected norm shall be based on assessments that are clinically and statistically valid as determined by the Secretary, in consultation with individuals with expertise in the area of medical malpractice, consumer representatives, and certain other interested parties that the Secretary determines are appropriate.''.

(c) CONFORMING AMENDMENTS.—Section 427 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137) is amended—

(1) in subsection (b)(1), in the first sentence, by striking ''Information reported'' and inserting ''Except for information disclosed under subsection (e), information reported''; and

(2) in the heading for the section, by striking ''**MISCELLANEOUS PROVISIONS**'' and inserting ''**ADDITIONAL PROVISIONS REGARDING ACCESS TO INFORMATION; MISCELLANEOUS PROVISIONS**''.

Mr. WELLSTONE. Mr. President, I really look forward to what will be, I believe, broad-based support for this amendment.

I say to my colleague from Washington, my understanding is that, hopefully, we will be able to submit amendments tonight, there will be time for debate on Monday, and sometime Monday we hope there will be votes on these amendments; is that correct?

Mr. GORTON. Mr. President, the Senator from Minnesota is correct. That is what we are trying to do.

Mr. WELLSTONE. Mr. President, let me simply say that this amendment deals with the National Practitioner Data Bank. The data bank contains really important information on adverse actions that are taken against doctors, and in some cases information on actual payments made in malpractice judgements.

Mr. President, the problem is not most of the doctors in the country; most of the doctors are very good doctors. The problem is that this information right now is readily available to managed care plans and hospitals and medical societies but not available to consumers.

I have talked with a number of colleagues on both sides of the aisle. I think that this amendment which I have worked on for some time now really is an effort to provide consumers with this kind of information. I think it will be well received.

We have done some good work on, first of all, strengthening the data collection; good work in responding to some of the concerns that have been raised by doctors; very good work in terms of responding to concerns raised by consumers across the country and by many consumer organizations.

Mr. President, the idea, of course, is that we would ask the Secretary of HHS [Health and Human Services], within 6 months to develop essentially a plan to make sure that this information is available to consumers so that they could have some sense about the record of doctors who are treating them.

Unfortunately, sometimes, too many times—and I have some really heart-rendering testimony by citizens in the country that have, in a tragic way, been on the receiving end of this—you will have a doctor who will move, who will have had an adverse action taken against him by a State medical society or hospital as a result of whole patterns of malpractice, and then move to another State, and sometimes even change his name. Then the same kind of egregious practice is committed again at great harm to consumers. It happens too often.

There is just simply no reason why in this, if you will, more highly sophisticated data entry and computer age, we cannot make this information available to consumers.

I say to my colleagues, that we are not talking about cases in which somebody has just launched a complaint against a doctor. We are talking about cases where there has actually been an adverse action taken against a practitioner's license or clinical privileges or where there has actually been a malpractice payment made with the record being clear.

So I have submitted this amendment tonight, and I look forward to the debate on Monday.

In 3 months, the HHS Secretary comes back to the Senate and then 3 months after that, the Secretary of Health and Human Services then has to have promulgated regulations to disclose the information to consumers in a useable way.

So we have a real opportunity to do something that I think would be extremely important in preventing malpractice from taking place in the first place, which is really, I think, the goal of any kind of reform effort.

I yield the floor. I thank the Senator from Washington for his courtesy.

Mr. FEINGOLD addressed the Chair.

The PRESIDING OFFICER (Mr. BENNETT). The Senator from Wisconsin.

Mr. FEINGOLD. Mr. President, first of all, I note with interest the Senator from Minnesota's liberal interpretation of 2 minutes, as well. But it was well worth it when you listen to him, because I not only agree with his approach in this amendment, but his eloquence on the floor today and throughout this piece of legislation is a very important part of dealing with the amendment and dealing with what this bill is all about. So I appreciate his courtesy.

AMENDMENT NO. 603

Mr. FEINGOLD. Mr. President, I rise today to oppose the underlying amendment offered by the junior Senator from Kentucky. I do so on the same grounds that I oppose the underlying legislation.

This sort of liability reform is not needed, it is not justified, and it is certainly not fair to injured consumers and patients.

I am very glad I was on the floor a few moments ago to hear the junior Senator from West Virginia indicate his intention to move to table this underlying amendment. Even though we may disagree on the underlying legislation as a whole, I am pleased to see his consistent effort to make sure that this bill does not get completely out of control and try to revamp our entire civil legal system when we are supposedly debating one particular aspect of it.

Mr. President, I know that others have already spoken out against the underlying amendment and spoken directly to the question of how justified and how needed it is.

I would like to add my voice to this particular chorus and make two points about this amendment and the direction it is taking us.

First, I have to note with a lot of regret that the first issue raised in the new Republican Congress dealing with the tremendous health care dilemma this Nation is facing has to do with malpractice and health care liability reform.

We are not talking about providing universal health care coverage to all Americans. We are not talking about legislation that says if you get sick, you have a right to see a doctor. We are not you talking about providing community-based, long-term care for the elderly and people with disabilities. We are not talking about addressing the skyrocketing costs of prescription medicines so the elderly will no longer have to choose between their prescription drugs and their food and heating bills.

No, Mr. President, we are not talking about any of these issues that were so frequently debated by both parties last year. Everybody said they were important issues that merited our attention, but none of those have come forward in these months that we have been in the 104th Congress.

We are not talking about these issues because it is the belief of some on the other side that most of our health care problems are based on the so-called liability crisis faced by doctors and hospitals.

Mr. President, that is not to say it is not an important issue. That is not to say it does not deserve our attention in the broader context of health care reform. But I think that right now the 38 million Americans who do not have health insurance, if they hear this, must be saying, ''Are you kidding me?'' Because there are people who are walking around right now without health insurance at all. It might be the factory worker who has lost his job and his health insurance along with it. It might be the young mother who has a preexisting condition and is unable to find an insurer. It might be the young child who was paralyzed in an automobile accident and whose health benefits have run out because of an arbitrary cap.

Instead of addressing true reforms that would actually improve some of these situations, we are instead debating an amendment that would limit the judicial remedies of those who have been the victims of malpractice and negligence by a few bad actors in the health care profession. Proponents have compared it to the malpractice reforms passed by the State of California several years ago, and there seems to be some disagreement about the actual success of those reforms in terms of their effect on liability insurance premiums and also about the overall costs to the California health care system.

But there is one fact that cannot be disputed: Despite the so-called liability reforms in California, there are millions and millions of Californians

today who lack affordable and adequate health insurance. In fact, a recent study by the UCLA Center for Health Policy Research shows that there are 6.5 million Californians without health insurance; 6.5 million people in one State. There are more uninsured children, workers, and families in California than there are residents of my State, and my State is one of the top 20 States in population. Almost 23 percent of the State of California is currently uninsured, well above the national average of over 18 percent.

What does this tell us? It tells us that these kinds of liability reforms are not that much help to those who are most at risk in our health care system. And it tells us that suggesting liability reform is beneficial or central to health care consumers is a little bit farfetched.

But there is another point I want to make about this amendment. The supporters of this amendment have tried to make the argument that such reforms will save many health care dollars and, in the end, will be beneficial to all involved—health care consumers as well as doctors and administrators. This is analogous to the arguments put forth by supporters of the underlying legislation, that in the end, the reform on product liability laws will be of benefit to consumers as well as the manufacturers, who are principally to benefit.

But they certainly are not beneficial or fair to the victims of negligence in the health care system. It seems that just about every day you pick up a newspaper and there is a story of some horrible tragedy that was needlessly caused by negligence, error or even worse. One recent headline in the Washington Post reads: ''Hospital Gave Two Men Fatal Overdoses.'' This Associated Press story describes how a Boston hospital just recently disclosed an incident in 1991 where two skin cancer patients were mistakenly given overdoses of a treatment drug. They were, in fact, given three times the recommended dosages. Both men first lost their hearing, then their livers and kidneys failed. Within weeks, both men were dead.

According to this news account, there have been at least 10 chemotherapy dosage errors since 1990 in hospitals located in eastern Massachusetts. Six of those patients have died.

Mr. President, for me, it is the case of Karin Smith that most reminds me of the tragedies that often take place in the health care system and often needlessly.

Karin Smith was just 22 years old and an ambitious certified public accountant living in my State in Nashotah, WI, when she first went to her HMO concerned about some vaginal bleeding she had experienced of late. For 3 years, Karin tried to convince her doctors at her HMO that she was sick. She made 15 office visits and 10 phone calls.

At one point, she had bled for 35 straight days before passing out. During this time, the HMO took three Pap smears and sent them out to a clinical laboratory to be analyzed. Unfortunately, the results were misread.

How were they misread? It turns out that the director of the laboratory had paid the lab's technician on a piecework basis for reading Pap smears. In 1989, the technician had read 31,000 slides for the laboratory in question and another 16,000 slides for a different laboratory. That is a total of 47,000 slides just in 1989. The American Society of Cytology recommends a maximum of 12,000 slides a year for the sake of quality control.

So this person had overdone this practice to the detriment, potentially, of his or her ability to do the job right four times more than the recommended amount of slides.

In 1991, Karin left her HMO and saw a gynecologist outside of that plan. Within 2 weeks, her doctor correctly diagnosed Karin as having advanced cervical cancer. Last summer, Karin testified before a Senate subcommittee looking into the health care problems facing our country. I would like to read very briefly from the statement Karin gave that day, Mr. President. Karin said:

> Although the doctors at my HMO kept telling me I was basically OK, I knew better. My only alternative was to see a gynecologist outside of the plan, who immediately suspected I had cervical cancer. His suspicions were confirmed by a surgeon shortly after our initial visit.
>
> Had my cancer been diagnosed at the time the first Pap smear was misread by my HMO, I would have had a 95 percent chance of survival. However, due to their gross incompetence and shameful errors, I am now dying.
>
> I am only 28 years old and am told by my doctors that I will probably not live to see my 30th birthday. My cancer has spread through my lymphatic system, from my pelvis to my abdomen, and as of 2 weeks ago to my neck. The fifth vertebrae of my upper spine is so completely infiltrated with cancer that at any moment I may become paralyzed.
>
> Since my diagnosis 2½ years ago, my life has been consumed by one horrifying medical procedure after another. I have endured three separate courses of radiation, 6 months of inpatient chemotherapy and seven surgeries. At times, I have laid in a hospital bed, isolated from my family, friends, even my husband, because my immune system was so suppressed that a minor cold could destroy me, or my frail body was riddled with infection, or radioactive materials were implanted into my internal organs and I writhed in pain. . .
>
> Although the physical treatment has left me with disfiguring scars from my pelvis to my neck, the emotional scars cut much deeper. I'm so young, yet my career as a CPA is over. . . I'm married to a wonderful man, but I'll never bear his children. . . Our lives have been forever changed by this unnecessary and senseless tragedy.
>
> In addition to myself, several other women in the Milwaukee area have been forced to suffer this plight because of the HMO's gross failure to provide safe and competent medical care. One woman died last year, she was only 40. . . Her Pap smear was misread just like mine. Another woman, whose tests were also misread is just waiting to die.

Those are Karin's remarks. In September 1993, Karin Smith wrote an op-ed piece in the Milwaukee Journal on the very issue we are debating today, tort reform. Karin did some extensive research for this article and found that in Wisconsin, between the years 1976 and 1988, just four physicians accounted for nearly 18 percent of losses paid in claims.

In short, Karin discovered a trend in Wisconsin that reflected a national pattern, and that pattern is that a few bad actors in the health care field were causing a plurality of the problems. And instead of focusing on appropriate sanctions for these few individuals, we are instead considering limitations on the ability of injured consumers, such as Karin, to recover damages that will make them whole once again.

Mr. President, last year I met Karin Smith in the reception room a few feet from where I am right now. Today, Karin Smith is dead. Unfortunately, Karin's fight against her cancer has come to an end. Karin Smith passed away in March of this year. She was 29 years old.

On April 12, just weeks ago, the district attorney of Milwaukee County announced that he was filing criminal charges against the laboratory for the deaths of Karin Smith, as well as Dolores Geary, a 40-year-old mother of three who also was a victim of the laboratory's errors. This is believed to be the first time that a medical laboratory as opposed to a doctor has been charged with a crime. In this case the crime is reckless homicide.

Mr. President, I have spoken out today because Karin did everything in her power while she was alive to make her story known. She wrote letters to the newspaper; she testified before Congress, and she never stopped fighting for the rights of victims like herself. Karin Smith was the victim of not mere negligence or error but of reckless behavior by a few bad actors in what is otherwise an honorable and very dedicated profession.

In the Milwaukee Journal Karin wrote:

> It is a common perception that tort reform is strictly a battle between doctors and attorneys. What is painfully ignored is that victims are in the middle of this war. This is ironic, because these are the very people whom the tort system was designed to protect.

Mr. President, I could not have said it any better. It was designed to protect innocent consumers like Karin, the victims of that negligent behavior. Remedies should be available to make injured individuals whole again. It was not designed in order to protect the economic interests of those who are the cause of the injuries.

Mr. President, I think it is relevant to briefly comment on how the underlying McConnell amendment would have affected the case of Karin Smith. For starters, the McConnell amendment would extend the cap on punitive

damages that is contained in the underlying bill for product liability cases to cases of medical malpractice. That means that had she not reached a settlement, a Wisconsin State jury would have been prohibited by Federal law from awarding more than $250,000 or three times the economic harm in punitive damages.

Mr. President, what are Karin Smith's economic injuries? I am not sure, honestly. I do not know what the earnings of a CPA in her early twenties are. I know the parties involved should be punished for their actions, and, hopefully, with a strong enough sanction that will send a message to others in the health care system that such conduct will not be tolerated. In the end, this decision should be made by a jury in Wisconsin, comprised of everyday Americans, who for over 200 years have been capable of administering justice in a fair and equitable manner. Most importantly, how dare any Member of the U.S. Congress tell a Wisconsin jury that the appropriate punishment for the taking of Karin Smith's life must be no more than $250,000?

Where does this Congress get the right to make that decision? That is not all this amendment would do. The extension of the elimination of joint liability for noneconomic damages to medical malpractice cases is equally mortifying for individuals who find themselves in the same predicament Karin Smith found herself in. I cannot even begin to imagine, Mr. President, what Karin's noneconomic damages were—her pain, her suffering. How do you put a price tag or a cap, for that matter, on Karin's inability to bear children and raise a family? How do you quantify the pain and suffering associated with a cancerous growth that spreads from your pelvis to your neck? I am not sure I could. I do not envy any judge or jury that would be charged with the responsibility of calculating that.

But imagine if Karin's case had gone to trial, suppose the lab had misread Karin's test results and the HMO that sent the results to the lab were found to be liable in this case; suppose the lab became insolvent and was unable to pay the percentage of noneconomic damages that it was found to be responsible for? What would happen in that case under the underlying amendment? Should we watch out for the best interest of the HMO here and deny Karin her due compensation for the incredible degree of pain and suffering she went through? Should we say that the HMO is partly, if not largely, responsible for Karin's injury, and they must shoulder the responsibility for making sure that Karin and her family are adequately compensated?

I think when you ask these questions in terms of the real people involved, the right answers become quite clear. Karin Smith was right, Mr. President. This is not really a battle between lawyers and doctors. The medical profession in this country is outstanding and should not be maligned because of the foolish actions of a few in the health care system. We clearly have a health care crisis in this country. Millions and millions are uninsured, costs are skyrocketing, and the health of our Nation is being compromised. I strongly urge the supporters of this amendment to join with those of us who believe that we need comprehensive health care reform, and we need it now. Only that kind of real reform will solve the problems that this amendment claims to address.

Mr. President, I ask unanimous consent that two items be printed in the RECORD. The first is a statement that Karin Smith delivered at a Senate hearing last year, and the second item is the op-ed piece from the Milwaukee Journal in 1993.

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

STATEMENT OF KARIN SMITH

My name is Karin Smith and I am grateful for the opportunity to speak before this subcommittee on an issue that is so crucial to us all. Today, I want to share with you my personal story of how an HMO has cost me my life.

I am a member of a staff model HMO called Family Health Plan. It's headquartered in Milwaukee, Wisconsin and has 105,000 members.

I am 28 years old and have advanced cervical cancer, which is the direct result of a three year misdiagnosis by my HMO. For three years, which consisted of 15 office visits and 10 phone calls, I complained about gynecological problems I was experiencing. And even though my medical records were documented with the classic physical characteristics and symptoms of cervical cancer, no doctor at my HMO ever made the correct diagnosis.

Because of my continual complaints, the HMO did perform three biopsies and three pap smears. All of which indicated cancer. Yet, all but one were misinterpreted as benign by the lab my HMO had contracted with.

During those three years, my symptoms progressed rapidly. . . Minor bleeding became profuse, accompanied by fatigue and passing out. I was frustrated by the medical care I was receiving and I was scared by what appeared to be an obvious deterioration in my condition. Although the doctors at my HMO kept telling me I was basically okay, I knew better. My only alternative was to see a gynecologist outside of the plan, who immediately suspected I had cervical cancer. His suspicions were confirmed by a surgeon shortly after our initial visit.

Had my cancer been diagnosed at the time the first pap smear was misread by my HMO, I would have had a 95% chance of survival. However, due to their gross incompetence and shameful errors, I am now dying. I am only 28 years old and am told by my doctors that I will probably not live to see my 30th birthday. My cancer has spread, through my lymphatic system, from my pelvis to my abdomen and as of two weeks ago, to my neck. The fifth vertebrae of my upper spine is so completely infiltrated with cancer that at any moment I may become paralyzed.

Since my diagnosis two and a half years ago, my life has been consumed by one horrifying medical procedure after another. I have endured three separate courses of radiation, six months of inpatient chemotherapy and seven surgeries. At times I have laid in a hospital bed, isolated from my family, friends, even my husband, because my immune system was so suppressed that a minor cold could destroy me, or my frail body was riddled with infection or radioactive materials were implanted into my internal organs and I writhed in pain.

I have spent countless days and nights nauseated and sick from both the radiation and the chemotherapy. The chemotherapy alone, caused me to vomit almost every day for the six months I was in treatment. Every third week I would be admitted into the hospital for six days where drugs that made me so terribly sick would flow through my body. I was bald for nearly a year and all of my activities were severely restricted.

Next week, I am scheduled to begin radiation to the left part of my neck and under my left arm. One can only imagine, in fear, what the side effects to this treatment will be . . . And as my last hope, I am currently, awaiting news from my doctors to find out whether or not, I am a candidate for a bone marrow transplant.

Although the physical treatment has left me with disfiguring scars from my pelvis to my neck, the emotional scars cut much deeper. I'm so young, yet my career as a CPA is over . . . I'm married to a wonderful man but I'll never bear his children . . . My parents will outlive their youngest child . . . This hasn't only affected me. This has shattered the lives of everyone around me. How does one explain this to my husband, my parents, my sister and brother, my friends . . . All of our lives have been forever changed by this unnecessary and senseless tragedy.

At this point, my personal medical future is plagued by this nightmare. Now, I feel I must focus my concern on the medical future of our country. If we allow HMO's to be the foundation of the proposed medical system, we are encouraging one of the most important professions of our country, to put the financial interests of their bottom line before the medical needs of their patients.

It was no coincidence that the lab which was contracted by my HMO performed inferior work, the owner was on the HMO's board of directors and in order to retain the HMO's business, he was forced to ''meet or beat'' lab prices from the competition. I think that's what President Clinton now calls ''managed competition . . .'' ALl of the contracts will be negotiated this way.; It's a system that encourages the lab to provide services at artificially low prices, which leads to lack of quality control and excessive work loads.

To add insult to injury, the technician who misread all of my pap smears was reading 5 times the federally recommended number of slides. She also worked at, as many as, four other labs in Milwaukee at the same time. And when she was fired from my HMO's contracted lab for falsifying records in 1991, the HMO hired her directly to supervise their new in house gynecological laboratory.

In addition to myself, several other women in the Milwaukee area have been forced to suffer this plight because of the HMO's gross failure to provide safe and competent medical care. One woman died last year, she was only 40 . . . her pap smear was misread just like mine. Another woman, who's tests were also misread is just waiting to die.

We can't change my future. But I can give you a look into your own. I am an example of what health care in this country will become as proposed by the Clinton administration and it horrifies me. I have experienced, first hand, the overwhelming lack of continuity of care, lack of communication, lack of responsibility, lack of accountability and lack of humanity which are the hallmarks of managed care plans in this country today.

We all know that there is a serious health care crisis in this country . . . no one should

be denied access to care. We need a realistic, rational health care system that will prevent financially self interested groups from continuing to prey on unsuspecting medical consumers. We need a health care system that allows choice, provides accountability and incorporates a serious medical malpractice prevention program. As a victim of malpractice, I implore you . . . please do not let this administration strip away the rights of victims like me. Please let my HMO experience be your guide . . . Understand that managed care is part of our health care problem . . . It is not the solution.

[From the Milwaukee Journal, Sept. 15, 1993]

TORT REFORM ISN'T SOLUTION TO EASING HEALTH CARE WOES

(By Karin Smith)

The President's health care proposal is going to be released within the next few weeks. It is well known that tort reform will be included in his package. There is speculation that the proposed plan will limit pain-and-suffering awards for medical malpractice victims to $250,000. This would not only be unconstitutional, but grossly unfair.

Let me explain.

Five years ago, I was a healthy, 22-year-old woman. Today, I am a victim of both cervical cancer and medical mismanagement. In 1988, I belonged to Family Health Plan (FHP), a Milwaukee-based health maintenance organization. When I began to experience vaginal bleeding, I sought care from FHP.

Between June of 1988 and May of 1991, my symptoms gradually progressed from minor bleeding to profuse bleeding, to fatigue and passing out. During this time, I made nearly 20 calls to doctors within my HMO to complain of the problems. Also during this time, three Pap smears and three biopsies were performed.

Unfortunately, my cries for help were not heard, and all of my laboratory tests, with the exception of one Pap smear, were misread. When I left FHP in May of 1991 and sought the opinion of a gynecologist outside of that plan, my diagnosis was made within two weeks.

Since my diagnosis two years ago, I have undergone five surgeries, three separate two-month courses of radiation and six months of chemotherapy. I was recently informed that unless I have radical surgery this fall to remove a part of my spine and replace it with a piece of my rib, I will probably be paralyzed by spring.

Because of the three-year delay in diagnosis, my chance for cure has dropped from 95% to around 10%. Even if I am fortunate enough to survive this tragedy, I will be plagued with chronic health problems and a lifetime of uncertainty.

Few would disagree that this is an egregious case that has led to needless emotional and physical pain. Certain legislators and health care specialists believe that my non-economic damages should be limited to $250,000. The state Senate has passed a bill to that effect.

According to the Health Care Financing Administration, national health care expenditures total $675 billion. The American Medical Association says doctors pay $5.6 billion in medical insurance premiums. As an accountant, I can easily calculate the cost of malpractice premiums to be less than 1% of all health care expenditures. Even the Congressional Budget Office has said that changing the medical liability system will have little effect on total health spending.

Furthermore, several states have already placed caps on pain-and-suffering awards. History has shown this has not reduced malpractice premium expenses. The reality is that very few plaintiffs are awarded high amounts. In Wisconsin, almost 70% of claimants have received no payment at all, and only 85 claims have ever exceeded $200,000.

It is important to mention that our country could save an enormous amount of health care dollars by adopting a strict national policy for disciplining doctors.

In Wisconsin, between 1976 and 1988, the top 10 physician defendants accounted for 2.4% of the 2,904 claims filed and 23% of the total payments made. During this time, four physicians were involved in more than one claim over $400,000. The four physicians accounted for 17.8% of all losses paid in that year. Clearly, a small percentage of doctors is responsible for a large portion of claim dollars.

It is common perception that tort reform is strictly a battle between doctors and attorneys. What is painfully ignored is that victims are in the middle of this war. This is ironic, because these are the very people whom the tort system was designed to protect.

The issue of capping pain-and-suffering awards comes down to one question: Do we allow all citizens the right to a jury trial at which their peers decide a fair level of compensation for pain and suffering, based on the extent of the individual's damages and the facts?

If the answer is no, we are violating the constitutional rights of the most seriously injured victims, while protecting the careers of the most grossly negligent doctors.

Mr. FEINGOLD. I thank the Chair and I yield the floor.

Mr. GORTON. 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. DOLE. 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. DOLE. Mr. President, I advise my colleagues that it is our hope to have an agreement here in the next few minutes. And if the agreement is reached, then there will be no more votes this evening and no votes on Monday. There will be a number of votes starting at 11 o'clock on Tuesday morning, maybe as many as four or five.

So I indicate to my colleagues that I do not believe there will be any more votes this evening. We will know for certain in matter of minutes.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

UNANIMOUS-CONSENT AGREEMENT

Mr. DOLE. Mr. President, we have reached an agreement on the medical malpractice amendments. It has been cleared by the Democratic leader, Senator DASCHLE. I will now read the consent.

I ask unanimous consent that all amendments regarding medical malpractice only be in order for the duration of Thursday's session of the Senate and Monday's session of the Senate, except for one amendment each, which may be offered by the majority and minority leaders, or their designees.

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

Mr. DOLE. Mr. President, I further ask that any votes ordered on or in relation to the pending Thomas amendment, or on or in relation to the Wellstone amendment, and any other second-degree amendments that may be offered to the McConnell amendment occur in sequence at 11 a.m. on Tuesday, May 2, and that the final vote in sequence be on or in relation to the McConnell amendment No. 603, as amended, if amended.

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

Mr. DOLE. For the information of all Senators, this agreement means that any Senator who wishes to offer an amendment regarding medical malpractice must offer and debate that amendment today and/or Monday, and those votes will occur beginning at 11 a.m. on Tuesday, and thereafter medical malpractice amendments would no longer be in order to the bill except for an amendment that may be offered by each leader or their designee. I assume that would be the managers of the bill.

So having reached that agreement, I can announce there will be no more votes this evening. The Senate will not be in session tomorrow because both the Republicans and the Democrats have conferences tomorrow.

The Senate will come in at noon on Monday, be back on the bill on Monday. We may come in at 11 a.m. for morning business. There will be no votes on Monday, but we expect a lot of debate on Monday. And then rollcall votes will start at 11 a.m. on Tuesday.

Mr. GORTON. Mr. President, will the majority leader yield?

Will the Senate come in on Tuesday and have any time before 11 o'clock on Tuesday in which Members can speak to their amendments?

Mr. DOLE. I would be happy to make that arrangement. In other words, come in at 10:30 and speak for 5 minutes on amendments which we have already discussed. They can offer amendments on Monday.

Mr. GORTON. They can offer amendments on Monday. But I suggest to the leader that there be at least an hour before 11 o'clock for Members to summarize their amendments.

Mr. DOLE. We set aside the hour between 10 and 11 to discuss any of the amendments. We try to divide it up so everybody is treated fairly. We may come in at 9:30 for a half hour of morning business.