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 President, I ask unanimous consent that the order for the quorum call be rescinded.

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

BIPARTISAN MEDICARE REFORM BILL

Mr. FRIST. Mr. President, before we left for the Fourth of July recess, we passed historic legislation to improve Medicare, to strengthen Medicare, and to offer for the first time a prescription drug benefit through the Medicare Program for our seniors and individuals with disabilities. We worked hard in that endeavor to produce a bipartisan consensus, working together on both sides of the aisle, with this common mission, this common goal, and we succeeded.

We were successful in passing a bipartisan bill that for the first time since 1965, in the history of Medicare, offers access to this new prescription drug benefit, and at the same time reforms, modernizes, and strengthens Medicare in a very significant way. Both individuals with disabilities and seniors collectively, 40 million people, will have health care coverage that in the future will be responsive to their needs in order to achieve that goal of health care security after the age of 65 or, if you are an individual with a disability, in the near future.

It is responsive to them directly but also in a way that will allow the Medicare Program to take advantage of the great innovations in technology, in new prescription drugs that can make people's lives better, which will improve the quality of life.

I mentioned the fact that this was bipartisan legislation. I think it is important that we showed a spirit of cooperation in taking on an issue many people in the United States thought would be too partisan and too political. We addressed it in a bipartisan fashion with the leadership of Chairman GRASSLEY and Senator BAUCUS in a way that was reasoned, showed common sense, and that accomplished that goal of significant modernization while at the same time adding a new benefit. We identified the issue. We tackled it head on, and we delivered a bill that reflected the priorities of both sides of the aisle.

That demonstrated to me, and I think to the American people, that even in a very evenly, closely divided Senate, if we share a common goal we can indeed move America forward on issues that are important to the American people.

Coming back from recess, we will very shortly begin the conference where once again both sides of the aisle will work together, the Senate and the House, to fashion a final product that will be a resolution of the differences between that House and Senate bill. I am confident in that process we will have the same resolve and determination in meeting that goal, that we will be able to bridge those differences, and develop a strong bill that can be supported in a bipartisan way and signed by the President of the United States. Both Chambers are committed to accomplishing this, to doing it right, and to getting it done.

PRESIDENTIAL TRIP TO AFRICA

I do want to comment on the President's trip to Africa. I commend President Bush for his bold leadership and his personal, as well as governmental—meaning the Senate, the House, and the executive branch—commitment to the pressing needs of Africa. President Bush will be leaving this afternoon for Africa to see firsthand the opportunities, and indeed the challenges, that exist on that continent.

Approximately once a year I have had the opportunity, since being in the Senate, to go to that continent, to a range of countries, several of which he will be going to. The countries I usually go to are the Sudan, Kenya, Tanzania, and Uganda. He will visit a range of other countries.

I think it is important for members of the executive branch as well as Members of this body and the House of Representatives to go firsthand and see the ravages that occur as a product of this little virus, HIV/AIDS, to see the impact of malaria, to see the impact of resistant tuberculosis and, at the same time, to look at the issues that surround the security of those nations as well as international security.

The President's trip will highlight a positive, substantive agenda that the administration has put on the table. Part of that agenda and vision is this AIDS initiative which we addressed in the Senate a little over a month ago, a 5-year, $15 billion commitment that this body passed and was ultimately signed by the President. This global HIV/AIDS initiative is the largest international public health initiative on a single disease, a single entity, in the history of this country.

I look forward to taking a delegation of U.S. Senators to Africa sometime in August—next month—to advance our collective effort in this regard.

As I mentioned earlier in opening the Senate, we have a very challenging month ahead with medical liability, with energy, with the appropriations process, which will be well underway in a few days, with the judicial nominees, with State Department authorization. There is a lot to accomplish. I am confident we can meet the goals I set out this afternoon. I look forward to working with my colleagues to make this one of the most productive sessions thus far.

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

The PRESIDING OFFICER (Mr. ROBERTS). Without objection, it is so ordered.

PATIENTS FIRST ACT OF 2003—MOTION TO PROCEED

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of Calendar No. 186, S. 11, the Patients First Act of 2003.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. FRIST. Mr. President, with that objection, I now move to proceed to S. 11. I understand that Members on the other side of the aisle are prepared to debate the motion itself. The majority whip, Senator MCCONNELL, is prepared to open our debate on this issue as well.

It would be my intent later today to file a cloture motion on the motion to proceed to this medical liabilities reform bill. This vote would then occur on Wednesday of this week. I look forward to the very important debate on this truly national crisis, and I encourage Members who want to speak to come to the floor today. We will be debating this legislation today as well as tomorrow. We encourage Members to come to the floor today.

I yield the floor.

The PRESIDING OFFICER. The distinguished Senator from Kentucky is recognized.

Mr. MCCONNELL. Mr. President, there is perhaps no more vexing challenge confronting this Congress than improving the quality and affordability of health care for all our citizens.

Just a few weeks ago, this Senate took historic action to strengthen and modernize Medicare by providing seniors new choices and adding a prescription drug benefit. During the past year, this Senate passed legislation to provide new resources to the scientists at the National Institutes of Health and to strengthen our Nation's defenses against the threat of bioterrorism.

While we shouldn't minimize the importance of these initiatives, the Senate has not addressed one of the most fundamental problems limiting American access to quality health care; that is, reforming our Nation's flawed medical liability system.

Our current medical liability system encourages excessive litigation, drives up costs, and is literally scaring doctors out of the medical profession. All too often, these lawsuits result in exorbitant judgments that benefit personal injury lawyers more than they compensate injured patients. I am pleased that the Senate will soon consider legislation, the Patients First Act, authored by Senator ENSIGN, to address many of these shortcomings.

As we debate this legislation over the next several days, Members will use some complex actuarial terms such as ''combined loss ratios,'' ''asset allocation,'' and ''the McCarran-Ferguson Act'' to illustrate their points. While they may be important, I believe it is more important that we recognize this is a real crisis facing real families.

Let's look first at this photo of Tony and Leanne Dyess with their family. This picture was taken prior to July 5 of last year. On that evening, Tony was critically injured in a car accident while on his way home from work in Gulfport, MS. Immediately after the crash, Tony was rushed to Garden Park Hospital, right there in Gulfport, suffering from serious brain injuries that required immediate medical attention.

Tragically, nearly all of the specialists capable of treating this type of head injury had left Gulfport because of the medical liability crisis and none was available to treat Tony Dyess.

Tony had to be airlifted to University Medical Center in Jackson, MS. Six excruciating hours passed before he received the surgery he needed to relieve the swelling in his brain. As Dr. FRIST can explain to us, every minute is critical when treating patients who have experienced serious brain trauma.

While the doctors in Jackson saved Tony's life, they were unable—unable—to prevent him from suffering permanent brain damage. As a result, Tony will require constant care and medical attention for the rest of his life.

The Senate was fortunate to hear from Leanne Dyess when she testified before a joint HELP-Judiciary Committee hearing on the medical liability crisis earlier this year. I thank her for her willingness to share her story with the American people and ask unanimous consent that her testimony be printed in the RECORD following my remarks.

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

(See exhibit 1.)

Mr. MCCONNELL. Mr. President, let's consider the case of Melinda Sallard. This is a picture of Melinda Sallard and her daughter. They live in Arizona.

In 2002, the administrators at Copper Queen Community Hospital in Bisbee, AZ, were forced to close their maternity ward because their doctors' insurance premiums had risen by 500 percent.

A few months later, Melinda awoke at 2 o'clock in the morning with sharp labor pains. Since her local hospital stopped delivering babies because of the medical liability crisis, Melinda and her husband were faced with a 45-mile drive to Sierra Vista in order to reach the nearest hospital with a maternity ward. As many of us who are parents know, babies do not always wait for the hospital, particularly when that hospital is almost an hour away.

Melinda gave birth to her daughter in a car on a desert highway heading to Sierra Vista. When the newborn was not breathing, her levelheaded mother cleared the child's mouth and performed CPR. After resuscitating the infant, Melinda wrapped her in a sweater, and the new family completed the journey to Sierra Vista. Thankfully, both mother and daughter survived. However, it is unacceptable that expectant mothers should be forced to drive past a perfectly good hospital and drive 45 miles through the desert to deliver a child.

Unfortunately, these are not isolated anecdotes but just a few examples of the impact runaway litigation is having on patients in every corner of our country. Patients across America—from the Pacific Northwest to the Southeast, from New England to the desert Southwest—are facing a medical liability crisis.

As many of our colleagues will recall, I offered an amendment to the generic drug legislation just last year that included some very modest medical liability reforms. During that debate, I called our colleagues' attention to this map produced by the American Medical Association. At that time, the AMA had identified 12 States, those States that are depicted on the map in red—this was a little over a year ago—as experiencing a medical liability crisis. The States shown on the map in yellow were ones at that time with significant problems which were nearing a crisis.

As I am about to illustrate, the situation has grown worse in the past year. The AMA reports there are now 19 States experiencing a medical liability crisis, with the addition of Wyoming just today.

Unfortunately, my own State of Kentucky is one of those States now facing a medical liability crisis. Knox County Hospital in Barbourville, KY, which is in the eastern part of our State, recently announced it would no longer deliver babies because its doctors could no longer handle the malpractice premiums. The hospital averaged about 200 deliveries per year. These mothers-to-be will now be forced to travel an additional one-half hour through Kentucky's mountain roads to the next closest hospital.

Not surprisingly, these expectant mothers are upset. One mother-to-be told the Lexington Herald Leader: ''To have to see someone new at the last moment is just horrible. You develop a close bond with your doctor, almost like family. You don't want a stranger.''

In another part of our State, Dr. Susan Coleman, up in Danville, was forced to give up delivering babies after her premiums doubled from $44,000 a year to $105,000 a year—even though she has never lost a jury verdict or paid an out-of-court settlement. More than two-thirds—84 of 120—of Kentucky's counties have either one or no obstetricians who will deliver babies.

This crisis has hit Kentucky's teaching hospitals as well. These valuable institutions not only train our future doctors, they also tackle many of the most difficult medical procedures. Earlier this year, the University of Louisville Obstetrics Department was just days away from closure because it could not find insurance for its doctors.

As I travel through Kentucky, I am approached frequently by doctors who plead for reforms we are proposing today. Some have already packed up their practices and moved across the river to Indiana, which has medical liability reforms. Many more doctors are thinking about following them.

Kentucky is now one of these States facing a medical liability crisis. So, Mr. President, Kentucky now goes from yellow to red.

Let's talk about Connecticut. This year, 28 OB/GYNs in Connecticut announced they could no longer afford to deliver babies because of rising medical liability premiums. According to the Connecticut State Medical Society, each doctor would deliver approximately 100 babies a year. This means that 2,800 Connecticut patients must now find new doctors because of the medical liability crisis.

Dr. Sally Crawford of Norwich, CT, provides a compelling example. She retired from medicine this year at age 55 because she could no longer afford her medical liability premiums. She had never been sued, but her liability insurance premiums became so expensive, they cost her $124,000 a year.

Dr. Jose Pecheco's insurer stopped offering medical liability insurance, so he shopped around for a new policy. When he learned that a new policy with ''tail'' coverage would cost him $150,000 a year, he did what Dr. Crawford did; he retired.

Why are insurance premiums for doctors rising? They are rising because the size of jury verdicts and settlements is rising at an alarming rate. According to the Hartford Courant, the average payment made of one of the State's major insurers to resolve claims increased from $271,000 in 1995 to $536,000 in 2001. When so many experienced physicians such as these take early retirement or curtail services, it is not surprising that the AMA has now designated Connecticut a crisis State. So Connecticut goes from yellow to red. Connecticut is now a State in crisis.

Let's take a look at North Carolina. Time magazine recently featured the story of Dr. Mary-Emma Beres, a family practitioner in Sparta, NC, who had always loved delivering babies. However, when she learned her malpractice premiums were about to triple, she was forced to give up her calling. Now Sparta is left with one obstetrician for difficult cases, and some women who need C-sections must now take a 40-minute ambulance ride to the next nearest facility.

We have heard several examples about escalating premiums that cause some doctors to retire early, but what impact is the medical liability crisis having on doctors at the beginning of

their careers? The same article in Time features the story of Martin Palmeri, a medical student at East Carolina University. He had his heart set on a career in obstetrics, but after witnessing a medical liability trial in North Carolina, he decided ''the risks of the specialty were greater than the rewards.'' He is now considering a less risky specialty.

The crisis has hit North Carolina hospitals particularly hard. According to McNeary Healthcare Services, small rural hospitals in North Carolina experienced an average increase in liability premiums of 180 percent in 2002 alone.

The crisis is impacting patient access to emergency care in Cabarrus County. The county's Level III trauma center was facing possible closure this year when its 17-member emergency medical group was faced with an 88-percent increase in premiums for reduced coverage. It is no wonder that North Carolina is facing a medical liability crisis, and North Carolina now moves from a yellow State to a red State, a State in crisis.

Like Kentucky and North Carolina, the AMA has recently added Arkansas to its list of States facing a medical liability crisis. In Ashdown, AK, the emergency room at the Little River Memorial Hospital was in danger of closing when it could not find an insurance carrier. It was only able to stay open after obtaining new insurance coverage at a 300-percent increase in premiums. According to a recent survey by the Arkansas Medical Society, 90 percent of doctors have practiced expensive and often unnecessary defensive medicine; 80 percent of doctors are less willing to perform high-risk procedures; 71 percent of physicians surveyed in Arkansas stated they were considering early retirement; and one-third of Arkansas physicians are considering moving their practices.

Doctors in Arkansas who want to care for the State's frailest patients are in a particularly difficult bind. There are currently no insurers writing new policies for doctors who treat nursing home patients, and those doctors who have coverage report a whopping 1,000-percent increase. Let me say that again: There are currently no insurers, none, in Arkansas writing new policies for doctors who treat nursing home patients, and those doctors who have coverage report a whopping 1,000-percent increase.

Why? Jury awards and settlements are rising faster than insurers can raise their premiums to meet these increased costs. From 1992 to 2000, the amount that doctors and insurers paid out in jury verdicts and settlements tripled, but then it doubled again in 2001. In that year, for every $1 an Arkansas medical liability insurer received in premiums, it had to pay out $1.61 in jury awards and settlements. Arkansas, as you can imagine, is now confronting a medical liability crisis. So Arkansas moves from a yellow State, which indicates a State with problems, to red, indicating a State in crisis.

Next we turn north to Missouri. This April, St. Joseph Health Center in Kansas City was forced to close its trauma center when its neurosurgeons decided to leave. Last April, Overland Park Regional Medical Center in suburban Kansas City closed the only trauma center ever in suburban Johnson County, KS. This means residents of southern Kansas City and the millions of motorists who pass through on I–35 or I–70 have limited access to a trauma center in an emergency. Now critically injured patients in Kansas City must be transported to either the University of Kansas Medical Center or the Medical Center of Independence, but even that may not be for long. Because of exorbitant medical liability premiums, the two neurosurgeons who service the Independence Medical Center are packing up their practice and moving on November 1.

But this crisis isn't limited to just Missouri's major cities. In May, Dr. Julie Wood was forced to close her rural family practice in Macon because she could no longer afford her $71,000 malpractice premium while treating Medicare and Medicaid patients. Macon's other two family doctors recently stopped delivering babies in order to reduce their insurance premiums, making the nearest point of care for expectant mothers nearly an hour away.

All of that explains why Missouri unfortunately is now facing a medical liability crisis and moves from a State with problems to a State in crisis.

Let's look across the Mississippi River to Missouri's neighbor, the great State of Illinois.

Time magazine recently ran a cover story entitled ''The Doctor is Out,'' highlighting the plight of Dr. Alexander Sosenko of Joliet, IL, and his patients.

Dr. Sosenko's insurance carrier recently dropped him and his cardiology partners, even though the practice had never lost or settled a single malpractice case. The one offer of insurance the practice received would have raised their annual premiums from $14,000 per doctor to nearly $100,000 per doctor.

Dr. Sosenko and his colleagues are trying to determine their next step, but he is clearly worried about his practice's 6,000 patients. He told Time: ''We doctors can move, but our patients can't.''

Dr. Sosenko's cardiology practice is not the only one in Joliet coping with a medical liability crisis. The town is quickly losing all of its neurosurgeons.

In February, two Joliet neurosurgeons gave up performing brain surgery, leaving the city's two hospitals without full-time coverage for head trauma cases. The situation may soon get worse for Joliet's patients. The town's last remaining neurosurgeon must now pay $468,000 a year for insurance and is considering leaving the State. If seriously injured patients need the trauma services of a neurosurgeon, then they will have to travel another 45 minutes to the next nearest trauma center.

These problems are not confined to Joliet. The Chicago Tribune reports that for specialties such as neurosurgery and obstetrics, medical liability rates have increased by more than 100 percent and could climb even higher later this year. So it is no wonder the AMA has now observed that Illinois is experiencing a medical liability crisis.

Mr. President, I am sorry to say that this week the AMA added a 19th State to its list of States facing a medical liability crisis. Dr. Willard Woods of Wheatland, WY, was forced to give up delivering babies earlier this year. Throughout his career, he delivered 2,500 babies, which is most of the young people within Wheatland and the surrounding communities.

Dr. Woods described his situation in the Washington Post. He said:

> I love delivering babies. I really love delivering the babies of women I delivered a couple of decades ago. And I know this community needs an obstetrician. But you can't practice without insurance. And I can't get coverage for deliveries anymore.

Since Dr. Woods stopped delivering babies, mothers with complicated pregnancies must now make the 3-hour round trip to Cheyenne. Sadly, Wyoming, too, is now facing a medical liability crisis.

So why are premiums rising so quickly that good physicians such as Dr. Coleman, Dr. Crawford, and Dr. Woods are forced to give up their practices? The primary reason is rapidly increasing jury awards.

As this chart clearly shows, the Jury Verdict Research Service reports that the median award made by a jury has more than doubled between 1996 and 2000. As you can see, between 1996 and 2000 the median jury awards have gone up dramatically, actually more than doubling. In fact, the median liability award jumped 43 percent in just 1 year—from $700,000 in 1999 to $1 million in 2000.

This chart depicts growth in liability claim payments. Not surprisingly, the increase in jury awards has led to similar increases in the dollar value of settlements reached out of court.

As this chart shows, the average claim—including both jury awards and out-of-court settlements—has risen sharply in the past 6 years, rising from $176,000 in 1995 to approximately $325,000 in 2001.

The crisis will continue to grow worse until Congress acts. If we miss yet another opportunity to pass meaningful liability reforms, I have no doubt that more of these yellow States will turn red next year as they find themselves facing a medical liability crisis.

Thankfully, President Bush has outlined several commonsense legal reforms that Congress can adopt to address this crisis. The President's proposal is based on the Medical Injury

Compensation Reform Act, commonly called MICRA, which California adopted back in 1975.

As this chart shows, California MICRA reforms have kept medical liability premiums affordable for California's physicians. Since the reforms were adopted back in 1975, California's total premiums have risen 182 percent, while the rest of the Nation's have risen 573 percent—three times the California increase.

In short, while medical liability premiums across the country have taken off over the last 25 years, California's have remained relatively stable.

So what do the California MICRA reforms mean for the average doctor and his patients? Quite a bit, as this chart shows.

This chart lists the going market rate for an insurance policy with the largest insurer in each of the following cities. It should be noted that Colorado has passed meaningful liability reforms that are very similar to California's reforms. These take a look at Los Angeles, Denver, New York, Las Vegas, Chicago, and Miami. Doctors in Los Angeles and Denver, where States have enacted reforms, pay less than those in States that have not enacted comprehensive reforms.

For example, an obstetrician in Los Angeles, with the State's MICRA reforms, can expect to pay $54,000, while his colleague in Miami is looking at a bill of more than $200,000. As you can see, Florida is certainly a medical liability crisis State.

Similarly, a surgeon in Los Angeles or Denver can expect to pay about one-half as much as a colleague in Las Vegas or Chicago. These same surgeons would face an enormous liability bill—about $175,000—if they moved their practices to Miami.

Senator ENSIGN has shown a great deal of leadership on this issue dating back to his days in the House of Representatives. He has incorporated the best parts of the President's proposal and MICRA, the California law, into the legislation before the Senate, S. 11, the Patients First Act of 2003.

While I would allow the author of this legislation to explain it in detail, I will briefly describe some of the important reforms included in the Patients First Act.

First and foremost, the Patients First Act allows patients to recover 100 percent of their economic damages. This can include hospital bills, lost wages, therapy, and rehabilitation costs and a wide variety of additional expenses a victim might incur. So all of the economic losses would be recovered.

In addition to recovering every dime of economic damages, patients can receive additional sums up to $250,000 to compensate for ''pain and suffering.'' The $250,000 is a substantial amount of money, identical to California's MICRA limit. But it still places at least some limit on unquantifiable noneconomic damages in order to prevent doctors from being driven out of business.

Let's look at punitive damages. In those rare instances where a medical professional acts in a malicious or particularly egregious manner, the Patients First Act also allows victims to recover punitive damages the greater of $250,000 or twice the economic damages. This is in addition to recovering full economic damages and up to $250,000 in noneconomic damages.

The legislation establishes a standard of ''fair share'' liability. What this simply means is doctors and hospitals will not be held liable for harm they did not cause. Simple justice. Doctors and hospitals won't be held liable for harm they didn't cause which is possible today and would not be possible after the passage of this act.

The Patients First Act also protects the injured by ensuring that a majority of any jury award or settlement goes to the patient who is actually hurt and not their personal injury lawyer.

Finally, this legislation preserves State flexibility on damages by including what is commonly referred to as a flexicap. Recognizing that different States have adopted different approaches to address this crisis, the Patients First Act allows States to establish their own limits on damages. Under the flexicap provision, in any State that has adopted limits on economic, noneconomic, or punitive damages, those State limits, not the Federal limits, will apply.

The flexicap also applies prospectively. If any State legislature believes the monetary limits established in this bill are too generous or not generous enough, it can simply enact a statute to change the limits within that State.

Mr. LOTT. Mr. President, will the distinguished Senator from Kentucky yield for a couple questions on these issues?

Mr. MCCONNELL. I will be happy to yield.

Mr. LOTT. Mr. President, I know the Senator from Kentucky is presenting his prepared statement, and it really has been quite interesting, and I share his concern. My State is one of those first States to be in red. We have a crisis in health care delivery. We are losing doctors to retirement, leaving the State, or leaving part of their practice, like OB/GYNs getting out of the OB part of their practice. The Senator made a particular point. I think the bill is a good solution, and it is based, as Senator MCCONNELL said, on the California plan that has been successful that does have some limits on punitive damages.

The Senator from Kentucky just made a point about the abilities of the States to act differently if they so choose. Will the Senator explain that? I did not understand that was in the bill. I am very interested because one of the complaints I have heard is that we are imposing our will on the States and the State legislatures cannot act, if they want to or if they will, although not many of them have. Will the Senator from Kentucky expand on that point?

Mr. MCCONNELL. Mr. President, I say to my friend from Mississippi, the argument typically made for this type of legislation is that we are interfering with the rights of the States. What we have done in this measure is to give the States an opportunity to act, to, in effect, supercede what we have done to make it less generous or more generous, depending on what they may conclude. A State is given an option to address this crisis in a way that is different from the way we addressed it within certain guidelines. By doing that, we do make an effort to respect the State's right to act.

Mr. LOTT. Mr. President, if the Senator will yield further, I say to the Senator, just coming back from my State, I had occasion to meet with doctors, hospital administrators, and civilians who are having problems, like some of those the Senator pointed out earlier. I also met with some of the attorneys who raise the point that the States should be allowed to act.

My own State legislature tried to deal with this issue and made a little progress, but it is still very weak. Our crisis is getting worse, and we are losing particularly those critical services that we need in our trauma systems, for instance.

The point I wish to make or ask the Senator to further expand on is, they say: What is the Federal role in this situation? Why is it necessary for the Federal Government to become involved? My response has been, clearly, there is a Federal application for medical liability that may not exist in other areas because of the impact it is having on Medicare. The additional threat of these lawsuits, the defensive medicine, the additional costs of medical liability insurance are causing all kinds of additional costs to be added to our Medicare system. I have heard billions of dollars, and I am going to find out in the next day or so what is the approximate amount that is being added each year to the cost of Medicare.

We are trying to improve Medicare and trying to add prescription drugs, but there are other costs that are being heaped on to the system that are very destructive.

I think the answer is, more than in any other area where we tried to get some legal reform, there is a Federal application in medical liability because of the impact it is having on the Medicare system.

Does the Senator from Kentucky care to respond?

Mr. MCCONNELL. Mr. President, I say to my friend from Mississippi, I do not know the exact figure—maybe my staff does—but clearly it has had an impact on the cost to the Federal Government. In addition, these doctors are moving back and forth across State lines seeking a place where they can practice their profession without basically giving away their services.

Kentucky happens to be next to Indiana which adopted standards similar to California some two decades ago. I have met a number of doctors in Louisville and Henderson who are contemplating simply moving across the river to even afford to continue to practice their profession.

At least in two ways it impacts at the Federal level, with interstate movement of doctors seeking a place to go where they can practice their profession, and the direct costs to the Federal Government under Medicare.

Mr. LOTT. A similar situation exists in my State. We are right next to Louisiana and not a State one would think would have the type of reforms they have in place. It is very easy to move from Mississippi to Louisiana. They serve different patients in a different State and medical liability costs are probably half of what they are right across the border.

What worries me more is we have doctors leaving tremendously underserved areas such as the Delta. One doctor in particular I know moved up to South Dakota and started practicing medicine. Others are retiring when they would not have retired if they believed they could make a decent living.

Even worse than that, doctors are getting out of certain practices. It has become a serious problem for health care delivery in my State. We have to act in this area, and soon, because the bleeding is growing in terms of losing doctors in these critical areas.

Mr. McCONNELL. Mr. President, I say to my friend from Mississippi, he is absolutely right. Not only does it affect decisionmaking at the end of one's career but at the beginning. The younger doctors taking a look at which speciality to choose are shying away from obstetrics because they believe they cannot afford to go into that specialty, thus creating a shortage at that end as well as on the other end where doctors who have been in the field a number of years are no longer able to afford it. This is truly a national problem that cries out for a national solution.

One modest estimate from CBO, in response to Senator LOTT's earlier question—this is from my staff—this bill would probably save the Federal Government at least $11 billion. Our suspicion is it is higher than that.

In conclusion, as this map shows, most of America is either nearing or facing a medical liability crisis. There are not many white States on this map. The white States are the ones that are currently OK. There are six of them. The rest are either in yellow, States showing problem signs, or red, States now in crisis, to which we have added a reasonable number just since this debate last year.

During the last 8 years, the House of Representatives has recognized this brewing storm and has passed meaningful medical liability reforms on multiple occasions. Unfortunately, during this same period, the Senate has served as a graveyard for meaningful legal reforms.

However, I believe the tide has begun to turn. The American people are beginning to understand this is not a battle about doctors, personal injuries, lawyers, and insurance companies; it is about ensuring their access, the patients of America, to needed medical care. Expectant mothers are worried that their obstetricians will have to discontinue practice before their baby is born. Parents are concerned that their local trauma center might not have a neurosurgeon on staff to treat a child injured in a car accident. Seniors worry that the double whammy of rising malpractice premiums and reduced Medicare payments will drive their doctors out of business.

I believe the Patients First Act encompasses the key reforms needed to address this crisis. This legislation allows patients to be fairly compensated—fairly compensated—while placing badly needed limits on often out-of-control damage awards. I believe it is time for the Senate to address this crisis, and I urge my colleagues to support the Patients First Act.

Mr. President, I yield the floor.

EXHIBIT 1

TESTIMONY—UNITED STATES SENATE COMMITTEE ON THE JUDICIARY: PATIENT ACCESS CRISIS: THE ROLE OF MEDICAL LITIGATION—FEBRUARY 11, 2003

Ms. Leanne Dyess. Chairman Hatch, Chairman Gregg, Senators Leahy and Kennedy, distinguished members of the Senate Judiciary and HELP committees, it's an honor for me to sit before you this afternoon—to open up my life, and the life of my family, in an attempt to demonstrate how medical liability costs are hurting people all across America. While others may talk in terms of economics and policy, I want to speak from the heart.

I want to share with you the life of my two children and I are now forced to live because of a crisis in health care that I believe can be fixed. And when I leave and the lights turn off and the television cameras go away, I want you—and all America—to know one thing, and that is that this crisis is not about insurance. It's not about doctors, or hospitals, or even personal injury lawyers. It's a crisis about individuals and their access to what I believe is, otherwise, the greatest health care in the world.

Our story began on July 5th of last year, when my husband Tony was returning from work in Gulfport, Mississippi. We had started a new business. Tony was working hard, as was I. We were doing our best to build a life for our children, and their futures were filled with promise. Everything looked bright. Then, in an instant, it changed. Tony was involved in a single car accident. They suspect he may have fallen asleep, though we'll never know.

What we do know is that after removing him from the car, they rushed Tony to Garden Park hospital in Gulfport. He had head injuries and required immediate attention. Shortly thereafter, I received the telephone call that I pray no other wife will ever have to receive. I was informed of the accident and told that the injuries were serious. But I cannot describe to you the panic that gave way to hopelessness when they somberly said, ''We don't have the specialist necessary to take care of him. We need to airlift him to another hospital.''

I couldn't understand this. Gulfport is one of the fastest growing and most prosperous regions of Mississippi. Garden Park is a good hospital. Where, I wondered, was the specialist—the specialist who could have taken care of my husband? Almost six hours passed before Tony was airlifted to the University Medical Center—six hours for the damage to his brain to continue before they had a specialist capable of putting a shunt into his brain to drain the swelling—six unforgettable hours that changed our life.

Today Tony is permanently brain damaged. He is mentally incompetent, unable to care for himself—unable to provide for his children—unable to live the vibrant, active and loving life he was living only moments before his accident.

I could share with you the panic of a woman suddenly forced into the role of both mother and father to her teenage children—of a woman whose life is suddenly caught in limbo, unable to move forward or backward. I could tell you about a woman who now had to worry about the constant care of her husband, who had to make concessions she thought she'd never have to make to be able to pay for his therapy and care. But to describe this would be to take us away from the most important point and the value of what I learned. Senator Hatch, I learned that there was no specialist on staff that night in Gulfport because rising medical liability costs had forced physicians in that community to abandon their practices. In that area, at that time, there was only one doctor who had the expertise to care for Tony and he was forced to cover multiple hospitals—stretched thin and unable to care for everyone. Another doctor had recently quit his practice because his insurance company terminated all of the medical liability policies nationwide. That doctor could not obtain affordable coverage. He could not practice. And on that hot night in July, my husband and our family drew the short straw.

I have also learned that Mississippi is not unique, that this crisis rages in states all across America. It rages in Nevada, where young expectant mothers cannot find ob/gyns. It rages in Florida, where children cannot find pediatric neurosurgeons. And it rages in Pennsylvania, where the elderly who have come to depend on their orthopedic surgeons are being told that those trusted doctors are moving to states where practicing medicine is affordable and less risky.

The real danger of this crisis is that it is not readily seen. It's insidious, like termites in the structure of a home. They get into the woodwork, but you cannot see the damage. The walls of the house remain beautiful. You don't know what's going on just beneath the surface. At least not for a season. Then, one day you go to hang a shelf and the whole wall comes down; everything is destroyed. Before July 5th, I was like most Americans, completely unaware that just below the surface of our nation's health care delivery system, serious damage was being done by excessive and frivolous litigation—litigation that was forcing liability costs beyond the ability of doctors to pay. I had heard about some of the frivolous cases and, of course, the awards that climbed into the hundreds of millions of dollars. And like most Americans I shook my head and said, ''Someone hit the lottery.''

But I never asked, ''At what cost?'' I never asked, ''Who has to pay for those incredible awards?'' It is a tragedy when a medical mistake results in serious injury. But when that injury—often an accident or oversight by an otherwise skilled physician—is compounded by a lottery-like award, and that award along with others make it too expensive to practice medicine, there is a cost. And believe me, it's a terrible cost to pay. Like

many Americans, I did not know the cost. I did not known the damage. You see, Senator Hatch, it's not until your spouse needs a specialist, or you're the expectant mother who needs an ob/gyn, or it's your child who needs a pediatric neurosurgeon, that you realize the damage beneath the surface.

From my perspective, sitting here today, this problem far exceeds any other challenge facing America's health care—even the challenge of the uninsured. My family had insurance when Tony was injured. We had good insurance. What we didn't have was a doctor. And now, no amount of money can relieve our pain and suffering. But knowing that others may not have to go through what we've gone through, could go a long way toward healing us heal.

Senator Hatch, I know of your efforts to see America through this crisis. I know this is important to you, and that it's important to the President. I know of the priority Congress and many in the Senate are placing upon doing something . . . and doing it now. Today, I pledge to you my complete support. It is my prayer that no woman—or anyone else—anywhere will ever have to go through what I've gone through, and what I continue to go through every day with my two beautiful children and a husband I dearly love.

The PRESIDING OFFICER. The distinguished Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, let me first commend my colleague, Senator MCCONNELL of Kentucky, for his presentation and his leadership on this issue. Though we disagree on some very fundamental parts of this issue, I have the highest regard and respect for his ability and I look forward to working with him.

What occurred about 45 minutes ago was that Senator FRIST, the majority leader, came to the Chamber and filed a motion to proceed, and I objected. What Senator FRIST was asking was that the Senate stop its business and move directly to S. 11 relative to the issue of medical malpractice. Because I have filed an objection, Senator FRIST indicated he would file a cloture motion. After collecting the necessary signatures from our colleagues, this will lead to a vote on cloture come Wednesday.

If Senator FRIST can gather some 60 votes, he will be in a position to then move to this bill and begin the debate and the amendment process. That is the ordinary course of the procedure.

An obvious question is why I objected. An issue clearly as important as medical malpractice should be considered by the Senate. There is no doubt in my mind. But I would object to the fact that this bill comes to the floor without any hearing before a Senate committee. Consider that. The most revolutionary and dramatic reform of tort law in America, in modern memory, will come to the floor without the normal hearings, witnesses, opportunities to amend, opportunity to work out compromises and negotiate, all part of the legislative process. So why then does a bill of this gravity and importance only come to us in this circumstance where there is no chance for us to work out ways to resolve our differences? Why, I cannot explain that to my colleagues. For a person like myself who served for some time in the House and the Senate, it seems to me that the Republican leadership in control of the committee structure would not object to taking this bill to one of their committees, having hearings, bringing in the doctors, the lawyers, the victims, the insurance companies, the pharmaceutical companies, and the companies that make medical devices. Let's hear about this problem in its entirety. But, no, they object to that. They do not want hearings. They do not want the people of this country to hear both sides of the story. They would rather come to the floor and present their side with a take-it-or-leave-it approach. I do not think that is fair. I think we can and we should do better.

Let me say at the outset that though I have objected and though most major medical associations, like the American Medical Association, support this bill, I want to make clear my high regard for the medical profession. Time and time again, in my life and the life of my family, I have turned to some of the best and most talented medical professionals in America. I have entrusted them with the most important things I have on Earth—my wife, my children, and the people whom I love.

Time and again I have found them to be selfless, extraordinarily talented, compassionate men and women who give the medical profession a good name every single day. Thank God they are there, and I want them to continue to be there. So I do not come to this Chamber as a doctor basher, as someone who thinks doctors are overpaid or frankly should be held to task for this, that, and the other. Not at all. Like most Americans, if I, my wife, or children are ever sick, I want to look up into the eyes of the best and brightest doctor in America helping a member of my family through a medical crisis. My family and I have been lucky in our lives. Many times I think we have had the best and the brightest, and I still continue to thank them as I take a position with which many of them will not agree.

I believe there is a fundamental unfairness in the current situation with medical malpractice. I have seen that unfairness in my State. Senator MCCONNELL has noted it in many other States. The largest medical malpractice insurance company in Illinois, the Illinois State Mutual Insurance Company, raised its rates last week 35 percent on doctors for medical malpractice insurance. Many lines of insurance are going up in cost, health insurance and other insurance, but this is an extraordinary increase.

Two neurosurgeons in Joliet, IL, have given up the practice of brain surgery because of malpractice premium increases. They have left the city's only two hospitals without a full-time coverage for head trauma cases. Senator MCCONNELL is right; Victims of automobile accidents and trauma need immediate help and immediate care.

Memorial Hospital in Belleville, IL, near the area where I grew up, has lost three OB/GYN physicians in the past 6 months due to increases in rising malpractice premiums. I met one of them. I met one during the course of the campaign last year. She came to me and said: Senator, I just cannot continue to pay these premiums and deliver babies. And I believe her.

Eduardo Barriuso of Humboldt Park, an obstetrician in my State of Illinois, pays $104,000 a year for malpractice insurance. He says he earns $175,000 a year treating mostly poor people, Medicaid patients. He pays $104,000 in malpractice, and has $175,000 in income. Like other doctors who treat patients who depend on Medicare or Medicaid or insurance through an HMO, Dr. Barriuso cannot pass on his higher insurance rates to his patients.

The Family Health Partnership Clinic in McHenry, IL, was almost forced to close after its insurer left my home State. They found new insurance at four times the cost. The clinic serves the uninsured and operates off the volunteer services of physicians. It now pays $28,000 a year for malpractice insurance, up from $7,000 last year, for a clinic serving poor people.

A Chicago area OB/GYN is studying to obtain his pharmacist license. He has decided he cannot continue as a doctor. He thinks he can make a better life as a pharmacist. He is now paying $115,000 for his liability insurance. I would readily concede the point made over and over by Senator MCCONNELL that these malpractice premiums are not fair. They are unfair particularly to certain specialties—neurosurgery, trauma care physicians, OB/GYN, and several others who have been hit hard by these increases. That is just not fair.

I suggest there is another unfairness involved in this discussion, an unfairness which my colleague from Kentucky never conceded. Frankly, there is an unfairness in this bill when it comes to the victims of medical malpractice. Of all the comments made by my colleague from Kentucky, little was said about whether it is fair to cap the recovery for a victim of medical malpractice at medical bills, lost wages, and pain and suffering of no more than $250,000.

Now, I do not come as an expert on anything. Some 20 years ago, in my legal practice in Springfield, IL, I handled medical malpractice cases. For a number of years I defended doctors through their insurance company. I had about 7 years with that experience. Another 2½ years I was a plaintiffs' attorney suing some doctors and hospitals for malpractice. So I have seen it from both sides of the table in a courtroom. I do understand the dynamics of a medical malpractice case, at least as they applied 20 years ago. I do not know how many others in this Chamber have had that experience. Some have but very few.

So we come to this discussion, frankly, listening to others who are experts

in the subject asking them for advice. What is the right thing to do to deal with this medical malpractice insurance crisis? I think, frankly, that this bill, which limits the compensation to be paid to an individual under a medical malpractice case to $250,000, is fundamentally unfair. It is as unfair to victims as the malpractice insurance rates are to doctors.

Is that the best the Senate can do, that we take the unfairness to doctors and then visit it on unsuspecting people who go to a doctor or to a hospital expecting professional care and come home with their lives changed or ruined?

I recall one case in Chicago. Let me give an illustration of what S. 11 would mean in this case. This woman, about 50 years old, had two moles on the side of her face. She said to her doctor: I think I would like to have those removed, doctor. He said: I will send you to one of the very best hospitals for this surgical procedure, and he did.

She went in for this surgical procedure to have two moles removed. She was given an anesthesia. They administered oxygen to her and they began to cauterize these moles. But there was a problem. Medical personnel were not supposed to use a cauterizing gun near oxygen.

As a consequence, there was an explosion and a fire on her face, burning off her nose, completely disfiguring and scarring her face. She is in her early fifties now and has gone through extensive reconstructive surgery. She is lucky to be able to breathe through what was once her nose. Her life will never, ever be the same.

She told the story herself in an article published in the newspaper in Chicago. Routine surgery went disastrously bad and her life was changed forever.

According to those who have brought the bill to the Senate, they have decided how much it is worth to live 20 or 30 years with permanent disfigurement and scarring, what it is worth to go into the hospital for routine surgery and have something happen that completely changes your life. Do you know what it is worth under this bill? It is worth $250,000 for her pain and suffering. Not a penny more, not one penny more.

The decision will be made in the Senate that in her case, and thousands of others across America, we will decide the maximum amount to which she is entitled. I don't think that is fair. I don't think it is fair to victims.

Malpractice premiums are too high and that is unfair to doctors. But a $250,000 pain and suffering cap? That is unfair in many cases of which I am aware.

Let me talk about another case from my home State of Illinois, in the city of Urbana. David was born prematurely with a lot of problems. By the time he was 6 years old many of the problems were behind him, though he still had some problems with his lungs and asthma. When he was 6 he had a respiratory infection and started running a fever. The doctor who usually cared for him was out of town so his parents took him to a clinic for nighttime care. At the clinic, he was given an antibiotic and sent home. He got worse. His parents took him to an emergency room that same night where he remained overnight with a fever. The next day, concerned about David's continuing fever, David and his parents returned. The doctor admitted him to the hospital at 5 p.m. At the hospital, they took his temperature and admitted him to a regular hospital room. They did not refer him to the ICU, nor did they place a temperature monitor on him.

His mother was dozing in the chair in his room when a nurse observed he appeared to be lapsing into a seizure condition. The nurse did an emergency code. By the time the emergency team arrived, he was in full seizure. His temperature spiked to 107.7 degrees. He remained in a state of seizure for quite some time and eventually went into cardiac arrest.

As a result of this ordeal, this 6-year-old boy was rendered a quadriplegic and lost all expressive ability. Professionals believe he has what is called receptive language. He can understand spoken language at an age-appropriate level but he is unable to communicate. He breathes through a tracheotomy stoma and is fed through a gastrointestinal tube.

That was 11 years ago. He is now 17. David can never be left alone, not for 1 minute of 1 day. His mother says she can tell he is interested in girls by the way he perks up when a girl his age enters the room. But he cannot express himself. He cannot say a word. There is no chance of recovery and, of course, in his condition he is at a heightened risk prone to infection.

The very issue that brought David to the hospital in the first place was his elevated temperature. Despite that fact, no temperature monitor was ever placed on him. In light of his history and his delicate medical condition he should have been admitted to the ICU rather than simply sent to the regular hospital room and given periodic attention. His family reached a settlement with the doctors and the hospital for the negligence in the treatment of David.

It is not likely with all of the liability protections and extreme cap on damages under this bill that defendants would have felt compelled to reach a settlement with that family if the bill before the Senate would have been the law of the land.

The tragic malpractice of which David was a victim literally took away from him all that every one of us take for granted. He will never walk again. He will never have a normal relationship with other people. Though he remains alert and is apparently not intellectually impaired, he cannot express himself and he never will be able to. He requires constant care. His mother gave up her job at a local college to care for him full time.

For all of these losses with their child, for being denied a normal life, those who bring S. 11 today say they know what it is worth. They know what the pain and suffering of David is worth for the rest of his life. It is worth $250,000. Not a penny more. Is that fair? Is that fair to David, his mother, his father? I don't think it is.

What we have here is a response to a medical insurance crisis which I don't believe gets to the root cause of a problem.

What I am about to say now is not a statement made by trial lawyers or those friendly to them. I quote from Dr. Carolyn Clancy, director for the Agency for Health Care Research and Quality at the U.S. Department of Health and Human Services. What I am stating she said, under oath, before a committee I attended several weeks ago. This is what she said:

> As we all know, medical errors and patient safety issues represent a national problem of epidemic proportion.

This is a spokesman for the Department of Health and Human Services, a medical doctor herself.

When listening to the explanation of this bill, at any point in time did you hear any reference to the fact that we are facing an epidemic of medical errors on patient safety issues in America? No. What we heard was we have lawyers who want to make too much money in court and they are taking these cases to the courtroom.

Do you know, according to Harvard, what percentage of medical malpractice actually ends up in a lawsuit being filed? Two percent. One case out of 50 ends up with a lawsuit being filed. Think of that. In the universe of medical errors and patient safety, think of it in terms of this statement by Dr. Clancy that we have a national problem of epidemic proportions.

The response of S. 11 to this epidemic of malpractice and medical negligence is to do what? It is to say that David, who is now 17, who is now a quadriplegic, unable to respond or express himself, is going to pay the price. David and children like him in the future will never, ever be able to recover more than $250,000 regardless of medical malpractice that brings them to the court.

I understand my colleague from Oregon is here and I yield to him for the purpose of a question.

Mr. WYDEN. I thank my colleague. I had a couple of questions, having listened to the statement.

First, my sense is that many physicians in our country—I am seeing this across Oregon and rural Oregon—are having a real problem out there paying their malpractice premiums. We are seeing physicians leave the profession. This has resulted in patients not having the access to care they deserve.

My understanding is that the distinguished Senator from Illinois agrees

with that and that the Senator has already discussed that a bit this afternoon; is that correct?

Mr. DURBIN. That is correct. I say to my friend and colleague from Oregon, I think it is a disservice to the medical profession of America not to concede there is a medical malpractice insurance crisis affecting some specialties in some States. I do not argue that point. I have seen those doctors face to face. Maybe my colleague from Oregon has, too.

It is interesting, I might say to my friend from Oregon, as I listened carefully to the explanation on the other side as to how to deal with this crisis, I waited in vain to hear any suggestion that insurance companies should be brought in as part of this conversation. To the other side of the aisle it appears the only thing we need to do is to make sure the victims of medical malpractice have a limitation on what they can recover in court, no matter whether we are dealing with children or elderly people, no matter how serious the injuries. I do not think that is a complete and honest approach to an extremely complicated problem.

Mr. WYDEN. If my colleague will yield further, my understanding is you have already indicated you are open to working with others in the Senate, colleagues on the other side of the aisle, to try to find a bipartisan solution. I am particularly interested. Senator HATCH and I were able to do this a number of years ago for the community health centers that were being priced out of their malpractice coverage. We were able to come up with a solution that has made it possible for thousands and thousands of poor people across the country to get their care and have these clinics covered without extra cost to the taxpayers, simply by working in a bipartisan way. My sense is to get out beyond the blame game, saying it is this interest group's fault or that interest group's fault, and to try to find some common ground here between Democrats and Republicans so we can really deal with a problem that is affecting many of our physicians and affecting our vulnerable patients. My understanding is my colleague from Illinois is open to that kind of bipartisan approach and may even have some ideas he will offer this week.

I wanted to come to the floor because I think this is a real problem. I so often go to meetings and one group says it is the insurance companies' fault and the other group says it is the trial lawyers' fault. I have heard the distinguished Senator from Illinois say he wants to get beyond that and find a solution to a real problem. Perhaps he could address that in whatever time is remaining.

Mr. DURBIN. I thank the Senator. I did not have a chance to speak to Senator MCCONNELL, but I did speak to Senator FRIST, who was here earlier and made that same offer. I said to him, instead of bringing this bill to the floor, take it or leave it, with no committee hearings and no effort to try to work out our differences, wouldn't it be better for us to sit down at some point and try to engage all the elements that are necessary for success if we are going to deal with this true crisis in America?

He is open. I hope, if opportunity presents itself, we have that chance. I think we need to bring to the table, not only the legal profession but also the medical profession and the insurance companies. If you do not have all three of them at the table, as I will make clear in my statement, you are not going to get to the root cause of the problem.

The answer from the other side is strictly to limit for malpractice victims the amount they can recover in court. I am going to show in charts I will present that that has not worked. Caps really do not guarantee that malpractice premiums come down, for a variety of very complicated reasons.

I hope we can do that. I hope on a bipartisan basis we can stop this high-noon standoff and reach a point where we have real conversation and dialog.

Mr. WYDEN. If my colleague will yield for one last question——

The PRESIDING OFFICER (Mr. SUNUNU). Will the Senator suspend so the Presiding Officer may remind all Senators that yielding is only for purposes of asking a question in order for the Senator from Illinois to retain his recognition on the floor.

Mr. DURBIN. I yield for the purpose of a question.

Mr. WYDEN. I ask, is there any reason why we couldn't begin such a bipartisan effort immediately? That is something I would like to do. I cited a specific example with Senator HATCH where we were able to make a real difference by working in a bipartisan way. It is making a difference in community health centers for their liability coverage. Is there any reason why efforts to come up with creative solutions that are bipartisan could not begin right now, rather than going this route that is going to polarize the Senate once again?

Mr. DURBIN. I would say through the Presiding Officer, there is no reason why it should not start this evening and I hope it will. But it will require people of good will on both sides. It will require some of the special interest groups that have not even been brought into this conversation to be brought in and to accept their share of responsibility.

I think we can work this out. We must work this out so we do not have the denial of basic medical services that are needed across the State of Oregon and Illinois and New Hampshire and Kentucky and so many other States. But we have to do it in a bipartisan, constructive way.

Mr. WYDEN. I thank my colleague.

Mr. DURBIN. I thank the Senator from Oregon for coming to the floor.

The point I wanted to make with Dr. Clancy's quote is that medical malpractice in this country is a very serious problem. It is not just a matter of how many lawsuits are filed. As I indicated, only one out of 50 malpractice cases actually ends up in court, and fewer than half of them end up going to verdict or settlement. It is a serious problem. The source of my statement is none other than the Institute of Medicine, a well respected organization here in Washington. They say this epidemic of medical malpractice has caused more American deaths this year than breast cancer, AIDS, and car accidents combined. It is an equivalent of a jumbo jet liner crashing every 24 hours for a year.

More than 70 studies in the past decade have documented serious quality problems in medical treatment. One of the most well known studies published in 1991 by a team of Harvard researchers found adverse events occur in 3.7 percent of all hospital admissions and 58 percent of those events are due to error.

The Institute of Medicine later took that study and another similar study done in Colorado and Utah and extrapolated the results to all U.S. hospital admissions. The Institute of Medicine found that there are at least 44,000 adverse events every year and as many as 98,000.

They also found that each year drugs kill 14,000 hospital patients and injure another 750,000.

The group of Harvard researchers that published the 1991 study found only 47 malpractice claims in the 31,429 cases they discovered. Of the 280 identified patients who experienced adverse events as a result of medical negligence, only eight filed malpractice lawsuits. That is only 2 percent of the people who had a justifiable reason to file a claim. Those researchers concluded that we do not now have a problem of too many claims. If anything, they said they were surprised there were so few.

A similar study published in The Lancet found that although 17.7 percent of patients experienced an adverse event that led to longer hospital stays, only 1.2 percent filed a claim. Thirty patients filed a malpractice claim out of 1,047 who could have, under this study.

There are profound problems with the current system. Doctors are not being disciplined and errors are not being reported. How can we expect fewer errors in the future if we do not address the system as a whole? Despite the alarming incidence of malpractice, only about 2,000 doctors, one-third of 1 percent of the doctors in the United States, are disciplined each year by State medical boards. Let me repeat, one-third of 1 percent of all doctors are disciplined each year by State medical boards.

I was on a trip recently and picked up a book in a book store which I recommend to people on both sides of this issue because I think it is the best and most balanced story of what we are

facing and debating. It is entitled ''Complications.'' It is by a surgical resident from Boston, Atul Gawande, a National Book Award finalist for this book. It is subtitled ''A Surgeon's Notes On An Imperfect Science.''

If you read this book—some people won't want to because there are some parts that may make you squeamish. I think Dr. Gawande really talks to you about the difficulty of being a medical doctor. The first chapter talks about placing a central line. It was tough for me to read this chapter, let alone what it was like for him as a surgical resident after having seen this central line implanted in a person's chest to do it for the first time himself. He had to. Trial and error was the only way he would learn. Of course, some mistakes were made. In his case they were not fatal or serious. But it was part of the learning process.

I think we have to concede that medical practice is not perfect. But we also know some serious mistakes can be made with terrible consequences on an innocent patient.

Dr. Gawande refers in one part to this whole question of what to do or how to deal with the fact that many doctors practice with other doctors who they really are worried about.

Let me give you an example of what he refers to in a chapter entitled ''When Good Doctors Go Bad.'' He says:

> But the problem of bad doctors isn't the problem of these frightening aberrations. . . . In medicine, we all come to know such physicians: the illustrious cardiologist who has slowly gone senile and won't retire; the long-respected obstetrician with a drinking habit; the surgeon who has somehow lost his touch. On the one hand, strong evidence indicates that mistakes are not made primarily by this minority of doctors. Errors are too common and widespread to be explained so simply. On the other hand, problem doctors do exist. Even good doctors can go bad, and when they do, colleagues tend to be almost entirely unequipped to do anything about them.

He talks about situations that he has faced where doctors are taking drugs. Doctors continue to practice and make errors every day. Because of the tight-knit community of physicians, other doctors are even afraid to speak to them, let alone to governing boards. Those doctors continue to make serious mistakes.

Quoting again, he says:

> When a skilled, decent, ordinarily conscientious colleague, whom you've known and worked with for years, starts popping Percodans, or become preoccupied with personal problems and neglects the proper care of patients, you want to help, not destroy the doctor's career.

There is no easy way to help, though. In private practice, there are no sabbaticals to offer, no leaves of absence, only disciplinary proceedings of public reports and misdeeds. As a consequence, when people try to help, they do it quietly, privately. Their intentions are good; the result usually isn't.

This is a serious problem. If we are talking about malpractice claims, don't we owe it to the American people to be talking about medical errors and negligence and what we can responsibly do to make certain that the small minority of physicians who are guilty of malpractice are changed or removed from the practice?

It is estimated that 50 percent of the malpractice cases in America are filed against 5 percent of the doctors. Yet all of the doctors end up seeing their malpractice premiums increase.

When Congress set up a national practitioner database in 1986 to collect data on adverse medical practice, it was expected that at most it would report about 1,000 disciplinary actions a month. However, fewer than 1,000 a year are reported across the United States.

Let me address another issue. It is interesting, when I speak to groups of doctors, this is the focus of their attention, as it should be, because malpractice premiums have gone up so high. But 2 years ago, this wasn't what doctors were talking about. Malpractice premiums were lower. They weren't raising this issue as often.

They were raising another issue which is related. They were raising the issue of HMOs and managed care. Doctors across America told me that for years they were having difficulty being good doctors because insurance companies were telling them whether or not they could have tests performed, how long they could leave a patient in the hospital, and whether or not a surgery was indicated. They were beside themselves saying we were trained as medical professionals. We are being overruled by insurance companies.

Is it a great leap for us to take that concern of doctors over these many years and understand that perhaps one of the reasons why malpractice has increased is that HMOs and managed care companies are squeezing doctors away from the professional standards that they were taught to follow? That is part of the reality.

Another part of the reality is that not very long ago increased malpractice premiums were passed on to patients. Patients paid more in fees. Hospitals, of course, charged more for their services. Now, with HMOs and managed care and strict accounting and restrictions in compensation, the malpractice premiums can't be passed on. The doctor pays more of it personally.

That is why this has become a dominant issue. But it also relates to insurance companies.

A special interest group that is so heavily favored here in the U.S. Senate, which was hardly mentioned in the opening statement about S. 11, is the insurance companies. We just do not talk about insurance companies in polite Senate company. It is considered inappropriate to think that perhaps they have gone too far.

Do you know what this bill does? I think this is a classic. When you get to section 13 of this bill, the sense of Congress—this is like sending a note to your sister, but it is a sense of Congress, not a law—that a health insurer should be liable for damages for harm caused when it makes a decision as to what care is medically necessary and appropriate.

We debated for months as to whether the HMO and managed care company would be held accountable for making the decision on what is medically necessary and appropriate. Those on the other side of the aisle stood with the insurance companies and said: No, we don't want to hold those insurance companies liable. If they say that somebody has to leave a hospital too soon or that surgery is not indicated, the best we can do in this bill on malpractice is a sense of Congress—note to your sister—that says we really think a health insurer should be liable for damages performed. No law, just that is what we think; that is what we sense.

Is that any way to address this serious problem that is part of the medical malpractice crisis facing our country? Doctors and nurses many times know who the problem doctors are, and they know the problems with insurance companies. But the culture we are creating in the medical profession and the political culture which we created on the floor of the Senate has led us to the point where we can't honestly speak to the American people about remedying this problem.

I think there is a better way to deal with this. We should enact legislation following the lead of Senator KENNEDY, who introduced a bill last year. It would establish a voluntary system to share medical error information among providers' and patients' safety organizations through the National Patients' Safety Database. Information shared in this manner would be privileged and not subject to legal discovery. But it would allow health care professionals to report accidents without fear that that information will put anyone in legal jeopardy. It would take a bad doctor out of the operating room when he should be out.

Health professionals who submit reports would also be protected from discrimination in the workplace for participating in reporting systems.

Also, consistent with the Institute of Medicine recommendation, this bill creates a new Center for Quality Improvement and Patient Safety and the Agency for Health Care Research and Quality. The center would conduct and support research on medical errors—something we need to face and face honestly.

We also have to concede another point. When the doctors from Illinois came in and said they favored this bill, I asked them: If we imposed a strict limitation of $250,000 on David and his family, a child who went to the doctor and hospital but unfortunately did not have his temperature monitored and became quadriplegic, if we said that child, no matter how long he lives, can never get more than $250,000 for pain

and suffering, no matter what the circumstances, if we did that, would it bring down your malpractice premiums? The doctors said: No, not right away, but maybe in 3 or 4 years we would start to see that turn around. In 3 or 4 years?

I listened to the Senator from Kentucky come before us and talk about an immediate national crisis. If his bill passes, it doesn't respond to this immediate national crisis. There is a better way to do this.

Over the past 2½ years with the Bush administration, we have been rather liberal—I guess I could use that word—in relation to their particular subject, tax cuts. We decided to use the tax cuts to reward and help certain people in our society. I believe we should construct legislation that allows a tax credit for those medical professionals and doctors who see their malpractice premiums going through the roof. To do that gives them immediate assistance, not something that may or may not help them 3 or 4 years from now.

The same could be true for hospitals and certainly for high-risk specialties. We need to allow doctors and hospitals to claim a tax credit for the percentage of malpractice premiums they are paying or will pay in the next number of years.

I also want to talk to you about the whole question of insurers and why we are in this dilemma. This has been analyzed by many groups, including the Government Accounting Office, the Wall Street Journal, and USA Today. How did we reach this point of a malpractice insurance crisis today? Why is it so much worse today than it was?

According to the Senator from Kentucky, one of the sponsors of S. 11, it is all about lawyers filing claims. That is not the whole story.

Insurance works in this fashion. If I am going to insure you for a loss, I collect the premium from you. The only way that I make a profit is if I collect more premiums from you than I have to pay back or I take those premiums and invest them in a way where I make money, and, coupling that together with excess premiums, make my profit.

It turned out that a few years ago, with the booming stock market and during the period of economic expansion in this country, a malpractice insurance company—a leading company in St. Paul, which is now out of business—had collected so much money in reserves and was making so much money in investments that they decided to declare a $1 billion dividend. Other companies saw this and said we need to get in the malpractice business; this is lucrative. So they did. They went in and made their investments. As the stock market started to crumble, they had no choice but to cut off their malpractice insurance or raise their premiums dramatically.

Did you hear any part of that explanation in the introduction of S. 11? You didn't. It was all about lawyers filing claims.

But there is another part of the story. The insurance companies are a part of the story. We are not supposed to talk about that on the floor of the U.S. Senate. Perhaps someone is entertaining a rule to prohibit reference to insurance companies. We just don't do that around here. That is not considered polite. But it is part of the problem, and it is also part of the solution. We need to deal with making certain that insurance companies treat doctors fairly—and reinsurance companies.

Now, this gets into the complexity of insurance policy, which I may not understand as well as I should, but I do know this part: There are five reinsurance companies in the world that reinsure for medical malpractice. Only one of them, the Hartford, is regulated in the United States and subject to State regulation; the other four are not. We have no idea whether the rates they are charging are fair. So before we say to David and his family, $250,000 and not a penny more, no matter how long you live, the obvious questions is, Are the insurance companies dealing with this challenge and dealing with it fairly?

Incidentally, the insurance companies are exempt from antitrust law. They can gather information and share that information without any penalty, through the Department of Justice, for violations of antitrust.

I think we understand what we are dealing with, but let me give you an idea of actual cases in States. The Senator from Kentucky talked about various States facing a malpractice insurance crisis, with which I do not quarrel. He suggested caps on recovery was the way to bring down malpractice insurance premiums.

The Weiss Ratings analysis took a look at the percentage increase in median medical malpractice premiums in the period between 1991 and 2002. They took a look at the States with caps, with limitations on how much a victim can recover, and those without caps.

You would assume, by the opening argument, that if the State has caps on how much a victim and his family can recover, the malpractice premiums must be low. But look at these States as examples of what happened during that 10- or 11-year period of time. The States without caps on recovery for malpractice victims such as this child David: Arizona had a 3 percent increase in median premiums for medical malpractice; New York, 6 percent; Georgia, 8 percent; the State of Washington, 27 percent.

When you go to the States with caps on recovery, let's see how their premiums reacted in the same period of time: California, up 50 percent; Kansas, up 60 percent; Utah, up 82 percent; and Louisiana, up 84 percent. So there is no direct correlation, no linear relation between caps and the premiums charged to doctors—exactly the opposite of what has been argued on the floor of the Senate on the motion to proceed to the bill.

In fact, if you look at it on a national basis—this, again, from the Weiss Ratings, Incorporated—the percentage increase in median medical malpractice premiums from 1991 to 2002: States with caps, with limitations on how much victims can recover, if they are the victims of medical negligence, a 48 percent increase in that period time; States without caps, 36 percent. So it is counterintuitive to argue that we are dealing with a linear relationship, direct relationship between caps and the premiums that are charged.

I would like to also add that I think we have to be honest about how we bring the groups together to deal with this. I think we also have to look to the legal profession. I do believe that if attorneys are guilty of filing frivolous medical malpractice lawsuits, we should put into law penalties to not only penalize them for costs and attorney's fees but ultimately to prohibit them from filing this kind of lawsuit if it is done with any repetition.

I do not believe doctors should be harassed. I want them to be doctors first and not sitting around in depositions and courtrooms for lawsuits that never should have been filed. But let me add very quickly, I have been there. I, as an attorney, had people walk into my office where they had husbands who had died, children who had died, and asked me to file medical malpractice lawsuits. I had to listen to those facts and make a decision. I will tell you, I thought long and hard before I considered taking on any of those cases.

Filing a medical malpractice case is not easy. It is not cheap. It is complicated and extremely expensive. If you do not start off with an understanding that you have a good chance of recovery, then, frankly, most attorneys will turn down those cases. That is why so few cases are filed relative to the number of malpractice claims that could be filed. Attorneys know that getting involved in those lawsuits in my State, now, requires an affidavit from a doctor which says, before you can file the complaint, that you do have a legitimate claim for medical malpractice.

We know the depositions will require expert witnesses, who are extremely expensive, in preparing your case to take it to the jury. All of these things are understood. We also know, at the end of the day, most plaintiffs lose their cases filed for medical malpractice, and that is after they have cleared all these hurdles. So to suggest that attorneys are just filing these cases frivolously, believing they are going to receive money for just filing a complaint, is certainly not my experience.

Let me say before I yield the floor—I notice my colleagues are in the Chamber and would like to speak—there is an element of this bill which the Senator from Kentucky made no mention of and no reference to whatsoever. He told us very good and important stories about doctors who could

not practice because of malpractice premiums. I think he should have also included the fact that this bill does not just provide a limitation on recovery for lawsuits brought against doctors; this bill provides a limitation on recovery for lawsuits brought against pharmaceutical companies and medical device manufacturers.

I did not read anywhere about a malpractice crisis involving pharmaceutical companies, but we learned 2 weeks ago, when we debated the prescription drug bill—and we have learned time and again—that hardly any major bill could go through the Senate unless it figured out a way to help drug companies. This bill is no exception. This bill has been designed to make certain there is a limitation on the amount of money that can be recovered from drug companies and medical device companies when they may be guilty of product liability, when they may have sold a product which injured someone.

I can recall a specific situation: heart catheters. I am a little bit familiar with this issue, and maybe some of those who have followed the debate are as well. These are tiny little lines which are passed through a vein of a person to their heart, and they actually film what is going on in the person's heart. It is an amazing diagnostic device.

The medical device itself had been cleared by the Food and Drug Administration, but it turned out that the manufacturer was guilty of shoddy practices in Massachusetts. This manufacturer was creating and producing catheters which, when inserted into a patient and sent up to the heart, would break, leaving portions within the heart, leading to the necessity for surgery to retrieve those pieces that were left behind.

Now, I ask you, is that truly what this debate is all about, that medical device manufacturers which negligently make a product that can endanger the lives of individuals should also be limited in terms of their liability? These are not individual doctors; these are medical device companies. The same thing can be said of pharmaceutical companies.

So I would just ask the sponsor of this legislation, the next time he comes to the floor to explain this bill—and does it in compassionate terms about doctors—why he does not tell us the rest of the story. I want to hear the rationale about drug companies and medical device companies, why they, too, need this protection when their products cause extremely excessive damage to individuals.

It is my understanding that tomorrow we are going to return to the motion to proceed to this bill, and I am sure many of my colleagues will be coming to the floor. But I will say this, as I did at the outset: It is unfair the way doctors are being treated with medical malpractice premiums. Something needs to be done in a responsible fashion, and involving doctors and lawyers as well as insurance companies. If we do it, and do it right, it will be a service to every family in America and every community in America.

But this bill, S. 11, is equally unfair to the victims of medical negligence. To put a limitation on the amount a person can recover—regardless of the permanent disfigurement, the incontinence, the blindness, the quadriplegia that these people will suffer for a lifetime—is fundamentally unfair and, as we have demonstrated, will not lead to lower premiums. There are better, more reasonable ways to approach this problem.

As I said before on the floor, and I repeat at this point, I stand ready to work with the majority and other Members of the Senate. Let's roll up our sleeves and do this the right way. Let's do it in a way that we can be proud of, and not do it in a take-it-or-leave-it fashion, as this bill has been brought to the floor.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. THOMAS. Mr. President, we are on this subject now. We are out of morning business; is that correct?

The PRESIDING OFFICER. The pending business is the motion to proceed on this bill.

Mr. THOMAS. I thank the Chairman.

I am very pleased to come to the floor this afternoon and join my colleagues to address an issue that has a crippling effect on the health care system. It has helped take out of control Medicare costs, malpractice costs. I guess specifically I am interested in it for my own State, of course, as well as everyone else's. Some providers have seen premiums jump as much as 81 percent in 2 years. Rural areas are disproportionately impacted. Often there is no other provider to fill in when a doctor is forced to close shop. That has been the case in my State.

Recent studies by HHS show that in States where they have enacted limits on noneconomic damages in lawsuits, there are about 12 percent more physicians per capita than there are where there is no such cap.

So we are beginning to not only test the costs but whether we have providers. That is a very important one. OB/GYN services have been especially impacted in my State, where 9 out of 54 recently surveyed have either stopped delivering babies or plan to do so because of rising liability costs.

I have listened to my friend from Illinois talk about this issue. Obviously it is going to be a controversial issue. There are different views, very different views, but it is not a new solution. It is one that has been in place and has proven to work in many of the States. It also is interesting that we have talked a lot—I happen to be involved with the rural health caucus. We have spent 2 weeks previous to this talking about Medicare. And we talk about, frankly, who is going to pay, but we seldom ever talk about what the costs are and what we could do about reducing some of the costs that put people out of touch with their own physician. This is one that is proven. This is one that does work. It is here to be acted upon.

As to the discussion on the other side of the aisle that maybe we are in too much of a hurry, this has been on our minds and on our floor and in our States for a very long time. This is not a new idea as a matter of fact.

I just wanted to show one little chart I think is interesting. That is to show that reforms do work as a matter of fact. This says, ''2003 Premium Survey Data Selected by Specialties, $1 million to $3 million limits.'' Here are the specialties. Los Angeles, CA; Denver which has the limitation versus similar to what is here; New York, Nevada, Illinois, Florida do not. Then take a look here at internal medicine. Here is an $11,000 premium, $9,000 premium. Over here where there is no control—$16,000, $19,000, $26,000, $56,000. Down here is the OB/GYN. In these cases where there is some limitation, $54,000, which is obviously too much anywhere, and $30,000. But look over here where there are none, none of the controls we are talking about here, $89,000, $107,000, $102,000, $200,000. It does work. It does work. Medical Liability Monitor is the source of these numbers.

It isn't as if we are talking about something that is untested, something that we don't know about. It is not as if we are talking about a new problem of which we were not aware. The fact is, we have physicians living in Cheyenne, WY, who drive to Colorado for this reason. Can you imagine Wyoming being one of the highest places to pay. You wouldn't think that, would you? I think this is something that has a good deal of merit, something that we need to talk about.

We have cited some of the things that are peculiar to our own States. We have a doctor in Wheatland, WY, who over the last several years has delivered more than 2,000 babies in about four different counties. He has been the major provider of services there. He has quit operating. He has quit delivering babies.

Sheridan, a little larger town, has one of two OB/GYNs in the area. His medical malpractice insurance costs over $60,000 a year. So we are in the position, then, when providers drop out of communities like this, where people are forced to drive 2 to 3 hours before they can get services. We have talked a lot, and we have a lot of concerns about rural health care. And it is difficult to keep providers in those areas. When you have one or two who leave, you have none. And so it is really quite different to be in our area.

The Wyoming physician population ranks 47th out of 50 States. So every physician is very valuable to us. Forty percent of our family physicians are over the age of 50, and we are going to see more retirements. We are going to

see more movement, particularly if there are disincentives to serve such as this cost of malpractice insurance. So we need to deal with this.

As I said, this idea that is being promoted has been in place. We know that it works. Is it going to solve all the problems of cost? Of course not. But we know this one will solve some of the problems of cost, and we can move forward to find some other ones.

As I said, we talk all the time about health care and who is going to pay. But as all health care costs keep going up 12 or 13, 14 percent a year, we have to begin sometime to take a look at how we can contain some of the costs so that somebody will be able to pay for it.

One of our orthopedic surgeons in Teton County, Jackson Hole, WY, has seen a 300-percent increase in liability premiums in the last 12 months. Without trauma care in Jackson, these people have to go to Salt Lake City. This is the kind of additional difficulty we have.

We all pay for medical liability costs. All patients pay the escalating costs generated by the Nation's dysfunctional medical liability system. And these increased premiums are the result. It also reduces the access to care, especially specialty care. So every taxpayer pays the price.

We think we can reduce Federal spending in Medicare, Medicaid, the Federal Employees Benefits Plan. It is suggested we can reduce this by $14 billion in 10 years. This would be a savings to everyone. Local and State governments could save over $8 billion over that period of time. So it isn't just a focus on a few people. This is the kind of thing that would save us all money and I think would make our lives much better.

What we are doing—and I think there needs to be a little explanation of it, to talk about it—doesn't limit damages to $250,000. It limits noneconomic damages to $250,000. So if someone needs care, if somebody needs various things that are economic costs, those things are not there. We want to make sure we listen carefully to what is being said here.

So what we are seeking to do, of course—it seems to me reasonable—is to set reasonable limits on noneconomic damages, provide for a quicker review of liability claims, assure claims are filed within a reasonable limit of time, and educate folks that frivolous suits only add to the overall cost of care for everyone. We spend a lot of time talking about who should pay. I have already discussed that but rarely do we talk about the costs. They are becoming increasingly important to us.

This bill is modeled after California's liability reform bill. California's law stabilized the State's medical liability insurance market, increasing patient access to care, saving more than $1 billion a year in liability premiums. As I said, specifically it allows unlimited economic damages. Past and future medical expense, loss of past and future earnings, cost of domestic services, these things are not limited. It establishes a reasonable limit on noneconomic damages which is exactly what we are seeking to do. States, however, would have the flexibility to establish or maintain their own laws on damage awards. It establishes a fair share rule that allocates damages properly and fairly in proportion to the party's degree of fault. There is a sliding scale for attorney's contingency fees; therefore, maximizing recovery for patients, which this is really all about.

It authorizes periodic payments to injured parties rather than one lump payment.

It is interesting to me, it does seem to present kind of strange politics. We argue on the other side of the aisle all the time about health care and that we ought to pay and make sure everybody has health care and so we will do it with taxes so that they are appealing to those people who need help in terms of costs. But when we come up with something that will impact the costs, suddenly the sympathy shifts over to the trial lawyers. It is sort of interesting to try to argue both sides, when there is a certain amount of conflict here.

I think this is a real opportunity for us to do some things that will be helpful to everyone, whether they are taxpayers, patients, physicians, or whatever. We have a chance to do something with that. Now is our opportunity. It is not a new problem. I think it is time we act. I am pleased to be among the sponsors. I want to work to see that this moves forward.

The PRESIDING OFFICER. The Senator from Kentucky is recognized.

Mr. MCCONNELL. Mr. President, briefly, I thank the Senator from Wyoming for his contribution to this debate. We were discussing off the floor the fact that Wyoming got added to the crisis list—today, actually. Talk about a State in which the distances are great and the problems are compounded by it; Wyoming has to be at the top of the list. I thank the Senator.

I yield the floor.

The PRESIDING OFFICER. The Senator from Mississippi is recognized.

Mr. LOTT. Mr. President, I want to correct some of the perceptions that perhaps have been left about what this legislation would do, or what the situation is.

First, it is very interesting to me that it appears there is an effort to blame the medical profession, the doctors. I ask this question now of most Americans: Who do you have more confidence in, your local doctors, the drugs you have been taking, the medical devices that are keeping many alive, the type of medical care you are getting in home towns, or your local trial lawyer?

Well, that is an easy question to answer. I have had to deal with that myself on both sides of the issue. By the way, I do have a law degree and I do know a lot of lawyers on both sides of the issue for whom I have a great deal of respect. Nobody is saying you should not have an opportunity to bring a lawsuit when you have been wronged or damaged. That is clearly not the case. But the idea that we are going to say no, no, there is not a medical liability crisis, there is a medical malpractice crisis—in fact, when I go around and talk to people who have pacemakers and have drugs that make their lives somewhat acceptable, or they have had strokes but they are controlling their blood pressure, up or down, they feel pretty good about health care in America.

Health care in America is the goose that laid the golden egg. We are the most blessed people in the world when it comes to medical care. Is it perfect? No. Are mistakes made? Yes. Do we need better reporting or to keep records of this sort of thing? I will support that. The AMA may not like it that we keep closer track and deal with some of these mistakes that are made. But I am for that. I think we need to know where the problems are and we need to deal with them.

But to say the problem here is the medical profession or the insurance industry—by the way, I don't want to just dismiss their involvement either. I want to make sure we understand why these medical liability insurance rates are going through the ceiling like they are. It is a variety of issues, I believe. I don't believe it is just the lawsuits but I think that is a big contributor. I think defensive medicine is a big part of it. I think that some of their investments went south on them and that is causing some insurance companies to raise rates.

But to shift the burden over to the medical profession, when I know these men and women practicing medicine—the neurosurgeons, orthopedics, OB/GYNs—these general practitioners in the Mississippi Delta are already so terribly underserved and are just saying: We cannot continue. We are retiring or leaving and going to another State. This is the crisis. Maybe my State is worse than most but this is a huge problem, and it is all over the country now.

One of the things I want to correct is this: Senator DURBIN talked about David, referred to David's situation. The inference was that all he would get is $250,000. As a matter of fact, under this legislation, he would get all of his hospital bills paid for, all rehabilitation bills paid for, all physical therapy, all speech therapy, all occupational therapy; and if a home nurse is needed 24 hours a day, he could receive full compensation for that. He could get lost wages up to a lifetime of what he could have earned, which could be, obviously, millions of dollars. It could cover anything David's family would have to spend on his condition. Plus, the punitive damages in this legislation is not $250,000; it is the greater of

$250,000 or two times economic damages. Quite often, economic damages could easily be $10 million.

Mr. DURBIN. Will the Senator yield?

Mr. LOTT. Then it would be two times that—$20 million—that a victim could receive if the economic damages are $10 million.

So let me give an example, and then I will yield. I want to make this point. Under the California situation, with the $250,000 limit, what has happened? I ask unanimous consent to have this printed in the RECORD.

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

[From Californians Allied for Patient Protection]

SAMPLE RECENT MEDICAL MALPRACTICE AWARDS IN CALIFORNIA UNDER MICRA

December 2002; $84,250,000 total award; Alameda County.

5 year-old boy with cerebral palsy and quadriplegia because of delayed treatment of jaundice after birth.

The $750,000 award for non-economic damages was reduced to $250,000 under MICRA.

January 1999; $21,789,549 total award; Los Angeles County.

Newborn girl with cerebral palsy and mental retardation because of birth related injury.

October 1997; $25,000,000 total award; San Diego County.

Boy with severe brain damage, spastic quadriplegic and mental retardation because too much anesthesia was administered during a procedure.

November 2000; $27,573,922 total award; San Bernardino County.

25 year-old woman with quadriplegia because of a failure to diagnose a spinal injury.

July 2002; $12,558,852 total award; Los Angeles County.

30 year-old homemaker with brain damage because of a lack of oxygen during recovery from surgery.

The award included $250,000 in non-economic damages for the plaintiff's husband and $676,921 for past and future household services.

July 1999; $30,900,000 total award; Los Angeles County.

Newborn girl with cerebral palsy because of birth injuries.

October 2002; $59,317,500 total award; Contra Costa County.

3 year-old girl with cerebral palsy as a result of birth injury.

The award included $100,000 in non-economic damages for the child, $200,000 in non-economic damages for the mother and $200,000 in non-economic damages for the father.

April 1999; $6,885,000 total award; Orange County.

Premature newborn girl with permanent blindness because of delay in treatment.

February 2000; $1,384,685 total award; Riverside County.

39 year-old pregnant homemaker and mother who died because of misdiagnosis.

The $300,000 award for non-economic damages was reduced to $250,000 under MICRA.

December 1999; $50,239,557 total award; San Francisco County.

10 year-old boy with brain damage because of undiagnosed infection at birth.

The $324,000 non-economic damage verdict was reduced to $250,000 under MICRA.

Mr. LOTT. This shows that in December of 2002 there was an $84,250,000 total award in a case under the current California law; a $21 million in January of 1999; a $25 million award in October of 1997 for a boy with severe brain damage and mental retardation because of the anesthesia. It goes on. Here is one for a $59 million total award.

So the inference that all you could get under this legislation would be $250,000 is absolutely not the case. It would depend on the economic damages, the totality of the costs, and the verdict rendered. So I just wanted to make sure people are aware that there is flexibility here and that, depending on the severity and how long it would last, it could be a multimillion-dollar recovery.

I am glad to yield to Senator DURBIN for a comment or question.

Mr. DURBIN. I thank the Senator. I ask him this question: Is the Senator familiar with the provisions in this law relating to collateral sources? For example, health insurance?

Mr. LOTT. That you would get health insurance and that would be deducted, in effect, from the damage? I was not familiar with that particular provision but I understand that does happen all the time. I am not a cosponsor of the legislation but I am planning on being one. That is why I have been here listening to the debate and reading the legislation. I want to know all of the ramifications of it. There may be the collateral insurance provision that would allow the amount of money received to be reduced by that.

Mr. DURBIN. Is the Senator from Mississippi familiar with the fact that in all 50 States across the United States, including his State and mine, there is no similar provision about the deduction of collateral sources? There is only one other instance where we have passed a law where collateral sources would be credited, and that was for the victims of 9/11.

Mr. LOTT. I wasn't aware it doesn't apply to any other States. I would think the States would want to take that into consideration. I don't have a problem with that. You need to look at the totality of a situation—and you have judges and juries who will do that—to see what recovery they might be getting through their insurance, as you decide what the award may be in terms of what their economic needs are.

Mr. DURBIN. If the Senator will further yield, is he aware of the fact that in most States, if you go into a civil lawsuit and raise the issue of insurance coverage, it is an automatic mistrial?

Mr. LOTT. Absolutely. I have seen it happen. I was involved in a case one time and one of the lawyers accidentally mentioned insurance, and there was a mistrial on the spot. I always thought that was kind of ridiculous. But I also know that some juries, when they think an insurance company is involved and that actually the doctor might not himself be paying, that might affect the amount of the verdict they would give. So that is why that law is on the books.

Mr. DURBIN. If the Senator will further yield, this bill says that in any health care lawsuit any party may introduce evidence of collateral source benefits. I ask the Senator, does he consider it fair that if David's family had health insurance that paid for some or all of his medical bills, that those who were guilty of malpractice, in his case, should somehow be absolved from paying because his family had the foresight to have insurance?

Mr. LOTT. Are these lawsuits about punishment, or are they about helping the people who have been damaged? Sometimes both. By the way, there could be, I guess, under certain circumstances, a criminal act involved. While I am not an expert in this area—it has been a long time since I practiced law and defended anybody—I have always thought the admission of evidence about where the money would come from or how much should be admissible in court. I have to defer to others who have more experience and more expertise in this area than I do.

Mr. President, does Senator MCCONNELL wish to comment? I yield for a question.

Mr. MCCONNELL. Mr. President, I say to my friend, my understanding of the way this provision would work is the collateral rule would allow the jury to know but does not reduce the award and does not allow the insurer to subrogate. That is the way this provision is crafted in this legislation. It would allow a jury to know, but it would not reduce the award and would not allow the insurer to subrogate. That is my understanding of the way it is crafted in the underlying legislation.

Mr. DURBIN. Mr. President, I assume the Senator from Mississippi has the floor.

Mr. LOTT. I yield to Senator DURBIN for a further question or answer to the comments from Senator MCCONNELL.

Mr. DURBIN. I will do it in the nature of a question. Is it not true if the jury knows that the plaintiff's family, in David's case, has health insurance which is going to pay for some of his medical costs, which are obviously going to be extensive, that this is likely to diminish the amount that will have to be paid by the party responsible for David's condition?

I ask the Senator, he suggested earlier that this should not be about punishment. Is there not a question of accountability? If the doctor in this case did not monitor his temperature leading to quadriplegia and a lifetime of pain and suffering, is there not a question of holding that doctor accountable rather than his parents for having the foresight of buying insurance?

Mr. LOTT. To answer the question, I see no problem in a jury being able to consider the totality of the situation. I do not think we should ignore the fact a doctor—first of all, they are human beings. They do make mistakes. There are lawsuits based on very good cases and recoveries of a significant nature because of the extent of the damage or

the longtime life impact on that person.

When a doctor goes through this, don't you think it has an effect on his practice in that community? Do you think he is not adversely affected by it? I remember a case in my home area where a doctor left a sponge in a patient and it affected his career the rest of his life. He was punished. He was punished by the verdict, his insurance company had to pay, obviously—the patient got significant damages, both economic and punitive damages, and he suffered mightily.

The point is, I have watched this issue for pretty close to 34 years, both as a lawyer and then as a Member of Congress, and it has gotten worse and worse. It is leading to a serious problem. It is about the patients, and it is about the doctors' insurance companies. But what about the people now who are losing access to medical care, to expert doctors, to especially the trauma doctors we are about to lose in my own State, the women who have to drive literally hundreds of miles to get to an obstetrician when they are going to have a baby, what about their risks? Maybe they should be able to file a lawsuit against somebody because they do not get sufficient health care.

This is something we are going to talk about over the next 24 to 48 hours. I do think something has to be done.

I want to make this point, too, in terms of working something out: We saw last year prescription drug legislation was brought directly to the Senate floor. It did not go through the Finance Committee. Because of that, we were required to get 60 votes, and that is why we did not get prescription drug legislation last year. A couple of the alternatives that were voted on got over 50 votes, but we had to have 60. So there is nothing extraordinary about taking up a bill that comes over from the House or taking a bill directly to the floor for consideration.

I would prefer we have hearings. I think hearings would be a lot of fun. I would like to see the doctors, the nurses, and patients who are being denied care have a chance to say what this is doing to them. Maybe we could work out some of the disagreements.

I wish to make this point: That effort has been made this year. Senator FRIST has been working with Senator FEINSTEIN to come up with a bipartisan bill basically along the lines of what is in this bill with the $250,000 limit on punitive damages or two times economic damages, whichever is greater. Senator MCCONNELL probably was involved in those negotiations, but it fell apart when there was pressure to raise it from $250,000 to $500,000, and they just basically quit working on it, I guess, because they could not get an agreement.

I would hope a committee would act—have hearings, report a bill, and let's make sure it is a good bill, but let's make sure it is not one written by just the plaintiffs' lawyers.

Mr. President, does Senator MCCONNELL wish to comment?

Mr. MCCONNELL. Mr. President, I want to make sure my friend from Mississippi is aware that, in fact, there was a joint hearing on February 11 between the Judiciary Committee and the Labor Committee on this subject. There has been a recent hearing. Of course, in previous Congresses, there have been numerous hearings on this subject for as long as the Senator from Mississippi and I have been Members of the Senate.

Mr. LOTT. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, to make sure we all understand what the provision is in the bill we have been discussing, let's put it this way, Mr. President: This provision only allows a jury to know the victim has received benefits from a third party, such as a health insurer. It allows the jury to know that, I say to my friend from Mississippi, but the jury is free to ignore that evidence if they like. It would allow them to know there was insurance coverage, but the jury is free to ignore that evidence if they like. The provision also prevents health insurers, a third party, from recovering payments it made to the victim. That is what this bill actually does.

I think it is important just to set the record straight on what is, in fact, contained in this legislation on that point.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank my colleagues for joining us in this floor debate, and I hope others will tomorrow, and I am sure they will. It is worth noting that the State of Mississippi, faced with the circumstances described by my colleague and friend, Senator LOTT, decided to do what each State has the right to do, and that is establish its own standards of recovering for noneconomic losses.

It is my understanding they have established a schedule that starts at half a million dollars and, over a period of 10 or 15 years, goes up as high as $1 million or $1.2 million. That has been done by the State of Mississippi, as it could be done by any other State. What we are considering here is what we will do on a national basis.

I was wondering if the Senator from Kentucky would help me understand the portion of the bill relative to what he described as flexibility in terms of States rights.

Would the Senator be kind enough to yield, without me yielding the floor, to engage him in a dialog about this State flexibility? Is that permissible under the rules of the Senate? I direct that request through the Chair.

The PRESIDING OFFICER. If the Senator from Illinois will make a unanimous consent request for the purpose of engaging in a colloquy, that will be acceptable.

Mr. DURBIN. If the Senator from Kentucky is kind enough to yield to this procedure, I ask unanimous consent—I do not yield the floor—that we be allowed to engage in a dialog about some aspects of this bill so there is a clear understanding on the record of his intention.

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

Mr. DURBIN. Mr. President, I thank the Senator from Kentucky. As I have said before, we get dangerously close to Senate debate on this floor from time to time. This just happens to be one of those moments. I am happy to be here to witness it.

I ask the Senator from Kentucky, what is the Senator's intention in the portion of the bill relative to State flexibility? I want to make certain I understand. If my State has any law relative to medical malpractice, relative to discovery or expert witnesses or, in my case, we do not have a limitation on noneconomic losses, what part of State laws would this new S. 11 preempt, and which portion would it not preempt?

Mr. MCCONNELL. Mr. President, I say to my friend from Illinois, reading from the bill, of which I hope he has a copy, section 11 says:

SEC. 11. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this Act preempt, subject to subsections (b) and (c)—

Which I will go through in a minute—

State law to the extent that State law prevents the application of any provisions of law established by or under this Act. The provisions governing health care lawsuits set forth in this Act supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment future damages,

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

Subsection (b) any issue that is not governed by any provision of law established by or under this Act . . . shall be governed by otherwise applicable State or Federal law.

Now, what the flexicaps are designed to do, as I understand it, is to allow a State to, in effect, opt out, consistent with the provisions that I read to my colleague from Illinois, within those parameters.

Mr. DURBIN. If I could ask my colleague from Kentucky, that paragraph (b) goes on to say:

This Act does not preempt or supersede any law that imposes greater protections (such as a shorter statute of limitations) for health care providers and health care organizations from liability, loss, or damages than those provided by this Act.

As I read that, though, I understand that if one's State law is more generous to doctors, hospitals, drug companies, medical device providers, HMO

insurance companies, then that State provision would be the applicable provision. Is that correct?

Mr. MCCONNELL. It is correct that this legislation allows states to provide greater protections to health care providers than are contained in this legislation.

Mr. DURBIN. So it is not a balanced playing field completely. We are not leaving it to the States to decide, for example, that wrongdoers of medical malpractice cases would be treated more strictly, more severely? If there is a stricter provision in the treatment of those individuals, it would be preempted by this act? Is that the way we have explained it?

Mr. MCCONNELL. Again, to ensure the availability of health care services, the states are allowed to provide greater or additional protections to health care providers than are contained in this bill.

Mr. DURBIN. Then if I might ask, the next section (c)—I am trying to get to the point of let's use an example of the State of Mississippi which has just decided on a cap of $500,000 on noneconomic losses effective January 1 of this year. Now, the underlying bill, S. 11, says that the cap on noneconomic losses will be $250,000. So in that instance, is it the position of the Senator that this bill would not preempt Mississippi law; that Mississippi's number would apply even though it is larger than S. 11?

Mr. MCCONNELL. Yes. This legislation does not preempt existing or future state laws on noneconomic damages.

Mr. DURBIN. May I ask the Senator to explain subsection 2(c)(2) in terms of defenses available to a party in a health care lawsuit under any other provision of State or Federal law that does not preempt it? I do not understand that particular section. If I have caught the Senator off guard on that particular section, we can return to it at a later time, but perhaps he could explain what that particular section means.

We can come back. I do not mean to catch the Senator off guard.

Mr. MCCONNELL. Let's come back to that.

Mr. DURBIN. We can come back to that at some point. I thank the Senator for yielding and providing that additional information.

As my colleagues can tell, during the course of this exchange we are doing what usually happens in a committee hearing where sections of the bill are explained and members of the committee have a chance to ask questions such as I have asked of one of the sponsors, Senator MCCONNELL. Then perhaps members of the committee say, perhaps, we need to change that language and we offer amendments. That is the committee process.

For this bill on medical malpractice, we have not done that. We are bringing it directly to the floor. As my colleagues can see, despite the fact that my colleague, the Senator from Kentucky, is certainly an able attorney, there are some complicated elements.

It is important, if we are going to consider a bill of this gravity, that we do take the time to do it and do it right.

I also note that a case which I mentioned earlier is a clear illustration of why this bill is fundamentally unfair to victims. I mentioned this case earlier because it involves a woman who lives in the city of Chicago. As I said in my opening statement, this lady, who has written an article in a leading newspaper in our town, says that she is literally the face of tort reform.

Three years ago, she went to a prestigious hospital in Chicago for a routine surgery to have two moles removed from the side of her head. During the surgery, the oxygen which was being administered to her ignited. In her words, it set her face on fire. It ended with her face in flames.

In her words:

> My entire upper lip was burned off and much of my nose is gone. For two years, I couldn't breathe on my own, and I now wear a face mask with nasal tubes in what's left of my nose, 23 hours a day. I have endured eight surgeries, with more to follow. The doctors who are trying to reconstruct my face and teeth say the whole process could take up to seven years.

That is 10 years of surgery from that tragic accident.

> Even then, the scars and burn marks will still be visible and the emotional cost will be with me forever.

She says:

> I'm 50 years old, and the mistakes made at the hospital have damaged every part of my life—from my career to my personal life to my sense of self. . . .
>
> But today's proponents of medical malpractice reform don't want to consider each case individually. They want to put a cap on damages—regardless of how old a person was when they were injured, how serious the injury, how an individual's life has been affected by the negligence of others.

Let me interject for a moment. What is at stake in this debate is not just this important issue of medical malpractice but several other important issues. We are now talking about changing, at least in some respects, the right of States to make individual decisions about the lawsuits filed in their States.

As the Senator from Kentucky said earlier, there are some parts where the States will still have the last word but in other parts they will not. So we will preempt a State's right to establish standards for lawsuits in its State. Now that is an important issue which we consider from time to time, and depending on one's prejudice on the issue before them, they either ignore or honor States' rights. In this case, we clearly do not honor States' rights. The sponsors of S. 11 have decided that on a national basis we will preempt States' rights.

The other thing that S. 11 preempts that is critically important is the jury system. It is interesting that the men and women in the Senate who came here because of the votes of the people they represent, who trust the decision of the people they represent, would say that when 12 of them are gathered together in a jury box we cannot trust them; they are just not reasonable. They get carried away. And because they get carried away, according to those supporting S. 11, we have to restrain them. The only way to restrain them is to put limits in the law, say to them no matter how much they think this poor lady's case is worth they cannot give her more than $250,000. This bill says we just do not trust that jury.

Put the good lawyers in the room representing the doctor and the hospital, as well as those representing her, and the fear is, from those who bring S. 11 to the floor today, that they are just going to see this situation and say this is not fair, it is not right, and this poor lady deserves more than $250,000. Because of that fear that the jury may go too far, this bill says: We will stop them. We will stop them in every State in the Union.

Is it not interesting that when it comes to juries in medical malpractice cases we have so little regard for their ability to find the truth and do what is fair? And yet when it comes to so many other areas of the law, such as criminal justice and the imposition of the death penalty, the jury is sacrosanct; the jury has the final word. When it comes to deciding what this is worth for this lady, we do not trust them.

She goes on to say:

> Some claim that $250,000 compensates people who are injured.

I refer to this photograph of this poor lady and what she has been through, and she asks: ''Would any healthy person allow their face to be set on fire, or worse, to receive that sum of money?''

She says:

> Not in the worst type of reality television show.
>
> Some claim that caps are necessary to protect insurance companies and HMOs. With documented medical mistakes soaring, it is astonishing that federally proposed legislation would first target the victims of medical error, before addressing the errors themselves.

Now the Senator from Mississippi earlier suggested that I went too far in suggesting we ought to look at the whole issue of medical malpractice. Well, I do not think that is an issue foreign to this debate. I think it is an issue central to this debate. If we are going to reduce exposure to lawsuits, if we are going to reduce the size of premiums, then we certainly have to look to the root cause of the problem. If we do not deal with medical malpractice and the fact that only 1 out of every 50 cases of malpractice ends up in a lawsuit being filed, then frankly no matter how much we lower the noneconomic losses per case, there is still a universe of liability, a universe of exposure, for doctors and hospitals which goes untouched.

If this is going to be an honest discussion about reducing malpractice insurance premiums and the crisis that

they have created among some specialities in some States, then I think frankly, as is said by this poor lady who was a victim, what is wrong with asking how we make our hospitals safer? How do we get our doctors to reach a point where they are making better informed decisions? That is a reasonable inquiry. It is one from which we should not shy away. It is certainly one that applies directly to what we are discussing.

She goes on to say:

Some claim that juries are the problem. I trust a jury of my peers to competently determine a fair judgment in cases like mine.

The proponents of this legislation want to rein in juries in medical malpractice cases, but never question the legitimacy of the jury in cases of the death penalty or other cases of wrongdoing. It appears that their concerns focus more on satisfying specific constituencies than protecting citizens from harm.

Like many people, I have been injured by poor care at a hospital. More than anything in my life, I wish I could take that day back, to make myself the way I was before the fire exploded all around me. But I can't have that day back. All I can have now is the right to be treated as an individual, to have others understand how this event has changed my life.

Caps on damages seek to treat all injured people in the same way. No victim is exactly like any other. Devastating injuries affect each life differently and deserve to be treated individually.

In short, my injuries are personal—though part of a national epidemic of negligence in hospitals. A recent study showed that 98,000 people were killed in hospitals, through neglect, in a single year.

I'm hoping that Congress and the public will see that each victim of medical malpractice is worth considering on his own and not put arbitrary caps on the personal suffering of so many people.

That is what it comes down to, a question of individual worth. The question is whether or not we have reached such a point in our society where we have to step away from the rights of this individual who was clearly a victim—as much a victim as someone who would be shot by a gun on the street or hit by a drunk driver on the road—whether we have to say in her circumstance we cannot trust a jury of her neighbors and people in her community to decide what that injury was worth.

Have we reached that point? I hope we have not. I hope, instead, we will do something which would be a breakthrough in the Senate—that we will bring together the parties who are clearly responsible for where we are today. Those include insurance companies.

The Senator from Mississippi conceded the point. He said: I will concede that the investments of insurance companies have something to do with the premiums, of how high they are.

Well, though the Senator from Mississippi conceded the point, this bill doesn't have anything to do with it. It does not bring to task the insurance companies for the premiums they are charging or hold them accountable for premiums they will charge in the future.

We can keep noneconomic losses, limit the amount of money the victims like this can recover, find premiums still rising through the roof as they have in many States that already have these caps, and be powerless to respond. Our friends in the medical profession who are rightly asking us to do something should be enraged at that point, as well. Having been promised this so-called tort reform—though I don't believe it is real reform—that this limitation on the amount that can be recovered on individuals is going to be the answer to their prayers, it may fail. That is not fair to them.

Bringing together in one place the medical profession to deal with lessening medical malpractice, which according to the Bush administration spokesman, Dr. Clancy, has reached epidemic proportions, bringing together the insurance companies, which because of bad investments have seen their premiums skyrocket to try to make up the difference, bringing together the attorneys to make sure frivolous lawsuits are not filed, can bring a solution. If that solution is to be immediate—and it should be—it should necessarily involve some help in the Tax Code for doctors who are currently facing these problems, as well as hospitals.

I would like to know if the Senator from Kentucky would engage me, if he would explain why he has included in this medical malpractice bill, that was originally designed for doctors and hospitals, protection against lawsuits relative to medical device manufacturers and drug manufacturers. Why were these two additional groups included in S. 11 to limit their exposure to lawsuits? I don't recall any reports of a crisis when it comes to insurance for pharmaceutical companies.

I ask unanimous consent that the Senator from Kentucky be allowed to respond and I still retain the floor.

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

Mr. MCCONNELL. I want to respond to some of the other suggestions my friend from Illinois has made, so if he completes his comments, I will be happy to respond.

Mr. DURBIN. Fair enough. I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, with regard to medical errors, were we not debating a motion to proceed, and if we were on the bill, I am sure my friend from Illinois or other Members of the Senate would offer amendments with regard to medical errors. A medical errors bill has passed the House of Representatives.

I don't think anyone is suggesting—certainly not I—that the underlying bill which we are seeking consent to get before the Senate should not be amended or improved in a variety of different ways. However, it is pretty hard to offer an amendment when we are on a motion to proceed.

With regard to the lady who was horribly disfigured—this picture displayed by my friend from Illinois—it is important to remember that her damages would not be capped at $250,000. She would get all of her economic damages—all of them—plus $250,000 noneconomic damages, plus, in all likelihood, punitive damages on top of that equal to twice economic damages or a quarter of a million, whichever is greater.

So the notion that there is simply no other compensation, that there is a $250,000 cap, is not accurate, I say with all due respect to my friend from Illinois.

Senator LOTT read off a few moments ago a list of awards under the California system—which is the underlying bill, the one we are seeking to get before the Senate, which this bill mirrors—of multimillions of dollars for compensatory damages; and punitive damages in a case of truly egregious events could be twice the economic damages. Then there is a pain and suffering award potential of $250,000 on top of that.

The people who do not get a penny are the ones who cannot find a doctor because the doctor is no longer there. One of the examples I used in my remarks earlier, Leanne Dyess from Mississippi, did not get a penny. Nor did the women who give birth by the side of the road. They don't get any money when their doctors have been driven out of business.

So the point I make in response to my friend from Illinois: This is not nearly as draconian as he suggests. On the economic side, there are no limits at all. Under punitive damages, there could be twice what compensatory damages are, and there is a $250,000 possibility on pain and suffering already. We think that clearly the victims are not denied adequate compensation.

As we have already pointed out with several speeches, the States that have tried this kind of approach have lower malpractice insurance premiums and do not have the crisis that we have in most of America today without that kind of legislation.

Mr. DURBIN. Will the Senator yield?

Mr. MCCONNELL. I will not yield at the moment.

With regard to an earlier reference to the FDA, if a product is found to be appropriate by the FDA, the companies should not have punitive damages assessed when they follow the FDA approval process. Punitive damages are for illegal conduct, and if the Federal Government blesses that conduct, it can't be illegal. However, there is no cap on economic or noneconomic damages against the drug companies in that situation.

The other part of the FDA section prevents doctors from being sued on product liability cases just because they prescribed a drug that the FDA has approved.

That is the answer to the question the Senator asked earlier.

Mr. DURBIN. Will the Senator yield?

Mr. MCCONNELL. I yield the floor.

Mr. DURBIN. Let me go on to say that in this case the question I was going to ask the Senator from Kentucky is this: This poor lady was a victim in my home State of Illinois which does not allow punitive damages in medical malpractice cases. My question for him, which I will save for a time when he has a chance to answer—whether or not, under those circumstances, this victim of medical malpractice has been allowed to recover punitive damages under his bill.

The reason I ask that question is I think that the section relative to State flexibility and protection of State rights is not altogether clear. If he is saying that this lady who was a victim of this explosion in her face, which led to multiple surgeries over a projected 10-year period of time, might have recovered punitive damages under S. 11, then in my home State you cannot turn to punitive damages. Your recourse, in her case, is for noneconomic losses, which are limited.

I might also add the Senator should note his punitive damage section includes a phrase which is a very restrictive phrase. In my home State, when punitive damages were allowed they were allowed for reckless misconduct or willful and wanton misconduct, which is a higher level of negligence.

Under the specific language of S. 11, in order to recover for punitive damages, you must show a malicious intent to injure. So to have cases of gross negligence is not enough. There must be ''malicious intent to injure.''

Another question which I am going to ask the Senator from Kentucky to consider, and perhaps respond to at another time, is whether or not a situation where a doctor is either on drugs, addicted to drugs, or intoxicated, is a case of malicious intent as opposed to gross negligence or willful and wanton misconduct. Because if the doctor is clearly addicted or intoxicated and as a consequence someone is severely injured, the question in my mind is, Is that plaintiff, that victim, then strictly limited to $250,000? Is that a question of negligence or is that a malicious intentional act?

The reason I raise that is because though we come to the floor and have these phrases go back and forth in debate, in a courtroom it makes all the difference in the world, as in this case or similar cases where States allow punitive damages.

From my point of view, I think this bill is certainly deserving of a committee hearing where many of these questions could be asked and answered before taken up on the floor. We should have an amendment process. At the end of that process, we should decide whether or not this is the only way to deal with the malpractice insurance premium crisis, which we are facing in this country.

I will also add at this point, the Senator made reference earlier to some of the challenges facing my home State of Illinois as part of the crisis which he has referred to in his opening remarks. I might also note it was just a couple of weeks ago in his home State of Kentucky that a report that became very controversial was put together by the Program Review and Investigations Committee on the cost of medical malpractice insurance and its effect on health care. It turned out when this report was filed there were those who tried to suppress it so it would not be made public because it addressed the question of why malpractice insurance premiums were high in the State of Kentucky. They raised, I think, some important points that deserve being part of our debate, since the Senator from Kentucky has been kind enough to bring in my home State of Illinois.

This report talked about the impact of medical malpractice costs and access in Kentucky, and I quote:

> The total number of physicians in Kentucky has increased in every year for which data was available—1981 through 2000—suggesting that the cost of medical malpractice has not reduced the overall availability of physicians for the State.

It goes on to say:

> The difference of premiums in states with joint and several liability [another provision in S. 11] and other states was generally not statistically significant.

Then it went on to say:

> Premiums in states with caps on non-economic damages were not statistically different than in other states.

This is a report from the State of Kentucky written as it considered capping its own noneconomic losses. They concluded:

> Premiums in States with caps on non-economic damages were not significantly different than in other states.

It said:

> Premiums for internists and general surgeons were higher in States that capped the amount of punitive damages that may be awarded than in other states.
>
> . . . There was no evidence that limiting the amount that attorneys may charge for fees resulted in lower premiums.

That is from the State of Kentucky, this controversial report, which many people did not want released to the public.

I think it raises questions as to whether or not the premise of S. 11 is a sound premise. Certainly in the State of Kentucky, people who looked at it came to the opposite conclusion.

Let me say a word about attorneys' fees. There has been a lot said here about attorneys and contingency fees. The contingency fee is the way a poor person comes to court. Unless you are independently wealthy and can finance a lawsuit and pay a lawyer by the hour, your only recourse is to say to the lawyer, You recover your fee if I recover a settlement or a verdict. That is what a contingency fee is.

In this bill, S. 11, the authors go to great lengths to limit the amount of fees that can be recovered by attorneys filing medical malpractice cases.

I will tell you in my experience as a down-State Illinois attorney—I don't speak for any other part of the State or for current practitioners—it was not uncommon to say to someone coming in: I am going to charge you a 25 percent fee if we can settle this before court; a third if we have to go through a trial; and up to 40 percent if there is an appeal. You will also have to pay costs, but I will try to hold onto those in the hopes that ultimately you recover and we can take that out of the ultimate settlement.

Many people would say, What is my recourse? I can't pay for this lawsuit. I know it is expensive to hire experts, it is expensive to have attorneys prepare the case—for this lady who was a victim of malpractice and many others.

In this particular law that is before us today, we try to put, at least it is suggested that we put, limits on the amount attorneys can be paid. We take away from the individuals the right to make that decision with their own attorney.

Undoubtedly there have been abuses on attorneys' fees. I am sure that is the case, as there have been abuses on medical fees and abuses on fees charged by hospitals. But to say we are going to have a one-size-fits-all, one single approach nationwide as to the amount you can recover is in fact to work a disservice as to whether or not attorneys will be able to take these cases.

I spoke to an attorney today who took an extremely complicated case in Chicago who said before he finally reached a settlement his firm had incurred $250,000 in costs alone and there was no way that a 70-year-old plaintiff could pay them. So this attorney and his firm decided they would put the money on the table, believing the case was meritorious, hoping ultimately they could recover it if there were settlement or verdict. And there was in this case.

But in this approach here, there is an attempt to try to limit the amount attorneys can receive. I think people like the woman I showed here, this lady here, who is a victim and certainly one deserving of any compensation coming back—but she may never have her day in court, may never have an attorney, may never get a chance to submit her case to a jury of her peers if some attorney doesn't offer a contingency fee arrangement. I have serious concerns about where this will take us in terms of limiting these contingency fee contracts. That, to me, is a concern which should be I think debated and debated openly here.

I also want to raise a question—I hope if the Senator from Kentucky does not want to address the issue at this point; he will at a later point—as to his qualifications of experts in medical malpractice cases. I want to understand the limitations he is putting on the experts who come before the court.

In each trial I have been involved in, it was a decision to be made by the judge initially, and ultimately by the

jury, as to the credibility of an expert witness. The difficulty which a plaintiff has in a medical malpractice lawsuit, in any city—whether it's in Illinois or Kentucky or New Hampshire—is most doctors are not anxious to testify against their colleagues. So if you are a person who has been injured in a malpractice case, you have to look hard, far, and wide to find an expert who will come to the courtroom and say the doctor did something wrong.

In this particular legislation there is a limitation on the types of doctors who can testify in medical malpractice cases. I hope tomorrow when we return to this bill the Senator from Kentucky will consider addressing that particular issue as well—what kind of limitations he puts in place. Usually it is a case for the judge to decide initially and the jury to weigh. If they take a look at the doctor who is brought in and say, This doctor doesn't even have a specialty that relates to this lawsuit, or has no experience or really no testimony, then they discount this and perhaps even reject it and maybe even use it against the party who called this doctor. But to establish standards of evidence in this law—I think at least during the course of debating this motion to proceed, we should have an opportunity to discuss the matter.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, the Senator from Illinois mentioned the Legislative Research Service's study in Kentucky, which has been quite controversial and discredited by some. I think a more interesting study was released today by HHS here in Washington which revealed that the States' that enacted limits on noneconomic damages and medical losses have been about 12 percent more for physicians per capita than States without such a cap.

As was pointed out earlier by a number of speakers on this side of the issue, California and Colorado tend to prove the point. This legislation is modeled after the California legislation. They enjoy lower malpractice insurance premiums in California. Widely believed by everyone is that the reason for that is a sensible system of caps on noneconomic damages.

With regard to the limitation of lawyer's fees, I would remind everyone that is for the benefit of the victim because every penny the lawyer doesn't get, the victim does. The notion that somehow there would not be lawyers available to pursue worthy litigation if there were some kind of reasonable cap on lawyer's fees, it seems to me, is not substantiated by the facts. Under the Federal Tort Claims Act, there has been a 25-percent cap for many years. I never heard of any crisis created by the absence of lawyers willing to bring litigation under the Federal Tort Claims Act. Certainly there should be a reasonable limitation on fees. We want to make it possible for lawyers to be adequately compensated. But to protect the victim from his own lawyer, it seems to me that some reasonable limitation is appropriate. This bill includes what we believe to be a reasonable limitation.

The Senator from Illinois also suggested the bill only allows punitive damages in case of malicious intent. It is not just malicious intent; the bill also allows punitive damages when the doctor deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. Interpreted, that means that would apply to the situation of the drunk doctor Senator DURBIN refers to, or a doctor who was on drugs or somehow incapacitated through this kind of behavior. This would clearly mean that punitive damages would be allowed in this case.

We are making a careful list of all the questions which the Senator from Illinois asked. All of them are good questions. They deserve a response and further argument for getting past the motion to proceed and getting onto the bill. So if there are improvements that the Senator from Illinois and others think should be made to the bill, offer those amendments, debate them, vote on them. It could well be that by the time we get to the end of this bill it would be in such a form that the Senator from Illinois might applaud and want to clear the Senate. Who knows.

But at the moment, what we are left with is a cloture motion which the leader will later file on the motion to proceed in order to even get into a position to do anything beyond having an interesting back and forth conversation between the Senator from Illinois and myself and get beyond that and actually begin to offer amendments to the bill and have debate on them and see where the votes may lie.

I think that pretty well covers my observations for today. We look forward to continuing the discussion tomorrow.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Senator from Kentucky for his invitation to improve the bill. I believe it would be a better exercise done in a committee setting with experts and witnesses and Senators having the opportunity to debate it openly and amend it and to include not just changes to the rights of malpractice victims to recover, but also the insurance industry and the medical profession. I think all of those would make for a very constructive and important and timely undertaking which, unfortunately, we are not doing here.

This is a vote to bring this bill to the floor immediately, and to literally debate it and pass it in a span of 3 or 4 weeks that we have left before the August recess.

I might also add that California is often referred to in this debate. It is true that in 1975 California passed a malpractice law which put caps on the amount that individuals could recover from malpractice lawsuits. They have not changed that $250,000 cap in the interim. The actual value has been calculated. Because there has been some 28 years since California put that in place, inflation has really taken its toll on $250,000. Its value today is about $38,877.

Mr. MCCONNELL. Mr. President, will the Senator yield for a question on that point?

Mr. DURBIN. I am happy to yield.

Mr. MCCONNELL. If we indexed that amount under this bill, would the Senator then support the bill?

Mr. DURBIN. I would be open to the Senator bringing that in as an option, as long as we are dealing with honest figures and fair compensation. But I would also say that in most States which have caps, there are exceptions. For instance, in the State of Mississippi, there were exceptions where judges could see extraordinary cases like the one I mentioned earlier and say that should not be subject to the caps. My problem with California is it is a blanket cap.

Mr. MCCONNELL. I agree with the Senator from Illinois that some kind of inflation adjustment is an appropriate suggestion.

Mr. DURBIN. I hope the Senator also agrees with me that we ought to allow some exceptions to the cap. I don't want to put words in his mouth. But that is what I think. I think those exceptions should be allowed.

I would also say it is important to remember if there has been any containment of malpractice premiums in California, they also followed Proposition 103 which is insurance reform. It is not just the limitation on malpractice law that California has, but they passed insurance reform. After that reform, we saw some changes in the amount that was charged to physicians.

The last point I want to make is this: There has been talk that if we don't do something about malpractice insurance, some doctors are forced to leave the State in which they are practicing. I don't doubt that is a fact. I have spoken to doctors in Illinois in specialties in certain areas who are seriously considering leaving. I hope they don't have to. I hope we can do something here to avoid it.

But the fact is, in California there are indicators of significant physician dissatisfaction with medical malpractice, and they have the caps. There appears to be widespread problems recruiting physicians. Only a third of California physicians would still choose to practice in California, if they had to do it over today.

To suggest that this is all about malpractice premiums and whether you have a cap on how much victims of malpractice can recover, the California experience does not necessarily prove that.

Let me also say I would take exception—and we can debate this, I am

sure—to my colleague's interpretations of the punitive damage section. It is true there are two elements here for punitive damages. They are both possibilities.

One is that the person who is being charged with malpractice has acted with ''malicious intent to injure the claimant.''

So that is an intentional act.

Then it goes on to say, ''or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.''

I would say to my colleague from Kentucky and those who drafted this bill that is unusual wording, and wording I am not familiar with. I would have to study that. But I think to talk about the deliberate act rises to intentional conduct again. The example I used was not a deliberate act but the act of a doctor who was under the influence of alcohol or drugs who may have imbibed or taken drugs, and then in that state of mind did a careless thing which resulted in medical malpractice. Whether that is included in the phrase ''deliberately failed to avoid unnecessary injury,'' I think is arguable. It should be clarified.

I also want to say in fairness to my friend from Kentucky, since Kentucky and Illinois have been part of this debate, that a report of Wednesday, August 9, 2000, in the Courier Journal noted that 329 physicians had been disciplined in Kentucky for alcohol or drug abuse, incompetence, and other offenses from 1990–1999 according to a report issued on questionable doctors.

I might also say, Kentucky was ranked as one of the 10 best States in 1999 in responding to this problem. I only raise that because, as painful as it is to concede by anyone, including those on the Senate floor, and certainly those in the medical profession, there are, in fact, cases where individuals have been involved in alcohol and drug abuse and then involved in malpractice.

What I am hoping we can do, if we seriously want to deal with the malpractice issue, is to go beyond limiting the amount that victims can recover and bringing this conversation to how we police the ranks, so doctors who are not doing the right thing are not going to continue to commit malpractice. That isn't fair to the patients, and it certainly isn't fair to other members of their profession who end up paying higher premiums as a result of it. I think that should be part of any legitimate discussion that deals with this malpractice crisis.

Mr. President, I know my colleague from Kentucky has yielded the floor for the evening, and I am prepared now, for my side, to close the debate on this matter and perhaps return to it tomorrow. At this point, until the Senate business is clear, 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. DASCHLE. 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. DASCHLE. Mr. President, I did not come to the floor to talk specifically about this debate but I commend the distinguished Senator from Illinois for his excellent presentation today and for the work he has already committed to with our colleague, Senator GRAHAM, and others in an effort to try to resolve this matter and provide some meaningful direction and leadership.

I am disappointed we find ourselves in the position we are in, both procedurally as well as substantively—procedurally because this bill, obviously, has not had the benefit of committee consideration. The majority leader, as is his right, brought it directly to the floor.

We have a model we used last year to resolve issues of controversy of this nature, in particular the terrorism insurance bill. That bill was brought to the floor after a significant degree of consultation and cooperation and, ultimately, negotiation. As a result of that negotiation, even though the whole question of jury awards and issues involving tort reform were brought up—because there were some who argued that was the only way to resolve this issue involving terrorism and the problems of insurance related to terrorism—we passed the legislation on a bipartisan basis.

If you ask anybody today in the industry, they will tell you that insurance premiums have gone down dramatically. The terrorism insurance bill has worked. I would only hope that we could use a model such as that with this issue as well. We can find legitimate, bipartisan, constructive, substantive ways to deal with this issue.

There is no question this is a problem. There is no question that unless we address the problem successfully, it will become even more of a problem, exacerbated by the month. So clearly we have to address it. The question is how to address it.

If you look at independent analysis done over and over by studies—the most recent, the Weiss study, issued about 3 weeks ago—those studies have shown conclusively, and I would say almost unanimously, that there is no connection between caps and reduced insurance premiums, none.

So we know we have to find a way to deal with the very legitimate problem being faced today by physicians across the country. The question is how.

I give great credit to the Senator from Illinois and the Senator from South Carolina and others who have tried to find a way to address this issue in a meaningful, effective, and, ultimately, bipartisan manner. I hope we can continue to work.

There is a problem on the other side as well. We want to relieve the problem, financially, that doctors are facing but let us not forget that we had reported by Health and Human Services that there were approximately 100,000 deaths due to malpractice last year. Mr. President, 100,000 people died due to mistakes made in the operating room, in the hospital, in the clinic. I will talk more about this at a later date but there are cases in South Dakota that are troubling.

So while we ought to be concerned with one side of this ledger, let us not forget the real problem that exists, as the Senator from Illinois has said so powerfully this afternoon, on the other side of the ledger. Let's find that balance. I hope we can do that.

But the reason I oppose the motion to proceed is because we have not really allowed the same opportunity that worked with terrorism insurance to work here. If Senator DURBIN and Senator GRAHAM can work together to find some solution, you would think there could be other ways with which we could use that terrorism model and truly find a constructive, bipartisan solution to this issue.

Jamming this in the Senate, overriding the committee, and filing cloture on the motion to proceed is not the way to achieve some bipartisan consensus on a very legitimate issue. So we will vote in opposition to the motion to proceed, not because we do not want to address the issue but because there is a better model if we are ultimately going to find a solution. That is what it is we are trying to do. Let's use the model we established last year. I would hope we could do that.

But we are spinning our wheels. We have 4 weeks in July, 4 weeks in September, maybe a week or two in October—roughly 10 weeks to deal with all the appropriations bills, all of the other issues that have come before the Senate so far, a prescription drug bill, the child tax credit legislation that is still languishing here, and an education bill that falls far short of even what the President said he would commit with regard to resources.

We have a homeland security situation now, we are told by a report by Senators Rudman and Hart, that falls $98 billion short of where we need to be. One of the most stunning comments in that most recent report is that there isn't a first responder in the country that will survive today a chemical, biological, or nuclear attack to respond in the first place. That is right out of the report. So if we are serious about dealing with the Nation's issues, I hope we will not look at the ideological agenda. I hope we will look at the real agenda.

I understand the President is going to be spending some time traveling the country over the course of the next several days talking about jobs. I hope he does. When we look at all the administrations, from the very first time we started looking at whether jobs were created or lost in any administration, you cannot find one—you cannot find one—where in the first term of an

administration that administration was actually responsible for the loss of jobs, not the gain of jobs. We gained them in the Eisenhower administration, the Kennedy administration, the Johnson administration, all through the 1980s and 1990s. This will be the first administration since Herbert Hoover that has actually seen a net loss of jobs—so far 3 million of those jobs in the first 2½ years.

So my point in raising these other issues is simply to say we have a lot of work to do. The more we spend time on ideological agendas and issues for which there has not been adequate committee consideration, much less an effort made by people on both sides of the aisle to address them in a substantive way rather than in a political way, we are going to lose time and lose an opportunity to address these issues.

Mr. President, I know the majority leader came to the Senate floor earlier to talk about how unprecedented it is to consider the possibility of a filibuster on a judge. I go back to our record and I will say we have broken all records with regard to the speedy confirmation of judges. The New York Times again addressed it over the weekend.

Out of 134 judges considered so far under this administration, 132 have been confirmed; 132 confirmed and 2 have not so far. But for the record I want to make sure people understand. Michael Gerhardt is one of the most respected analysts and experts with regard to the constitutionality of advice and consent. I want to read one segment of a speech he gave a few weeks ago. He talks about the historical practices of the constitutional right of advice and consent, especially as it applies to the rules of the Senate.

Obviously, we talk about rule XXII, and we are very cognizant of the importance of Senate rules in this regard. Senate historical practice, according to Mr. Gerhardt, goes back to the first recorded filibuster of a judge in 1881, to block President Hayes's nomination of Stanley Matthews to the Supreme Court. Numerous nominees before him were denied votes by delay—in other words, they didn't come to the floor—which has been a common practice for the 215 years the Senate has been meeting. But on the very first occasion of a recorded filibuster, in 1881, President Hayes's nomination was defeated; that being of Stanley Matthews.

From 1949 to the year 2002, 35 nominations were filibustered, 3 fatally, including Abe Fortas's nomination as Chief Justice. Seventeen of those thirty-five filibusters were of judicial nominations. From 1968 to 2002, Republicans filibustered against 19 Presidential nominations. So these historical practices weigh heavily in support, of course, of the constitutionality in addition to the language itself.

That really doesn't tell the whole story: Thirty-five nominations, seventeen filibustered against judicial nominations by Republicans since 1968. But the other story is the 65 nominations filibustered by 1 person in the committee, not on the floor. Sixty-five nominations failed to come out of the Judiciary Committee because of a hold respected by the majority leader at the time or by a committee chairman. Ten had hearings. Fifty-five did not. Sixty-five nominations died before they could even be considered by the Senate on the Senate floor.

You have 35 nominations which came to the floor, 17 of which were judicial, all of which were filibustered, the 17 by Republicans, but 65 didn't even have the opportunity to come to the Senate floor for even a vote on cloture.

I want to make sure the record, as the majority leader discussed the issue earlier today, is complete with regard to judicial nominations as well.

Again, I go back to my hope that we can look back on those occasions when we actually succeeded at addressing a real problem and how it was we did so. We succeeded with terrorism insurance because people such as DICK DURBIN and MITCH MCCONNELL and others sat down and negotiated and ultimately came to a resolution that solved a problem, solved it almost, I would say today, by acclamation. Nobody would differ with that assertion that we have solved, at least for now, the issue on terrorism insurance, even though it had many of the same questions involving it that we are dealing with today regarding malpractice.

We have a lot of work to do. I hope we can address education and jobs and prescription drugs and the child tax credit and homeland security, not to mention energy and a lot of other issues that have to be addressed in the month before we leave. We can spend our time more productively. I hope that realization will be one that will be accepted by our Republican colleagues sooner rather than later.

I yield the floor.

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

Mr. MCCONNELL. Mr. President, let me make a few observations about the record of the Senate this year. This year, the Senate had to complete 11 of last year's appropriations bills. There were only 13 that were supposed to pass the basic work of the Government. This Senate had to come back and approve last year's work that was never done, 11 of the 13 appropriation bills. Last year, for the first time since the Budget Act was enacted in the early 1970s, there was no budget. The Senate never passed a budget. This year, the Senate enacted a budget.

It is important to note that this year's Senate has also enacted the President's growth package which included the third largest tax cut in American history. And just before the recently completed recess, the Senate completed a bill modernizing and preserving Medicare and adding a prescription drug benefit for our seniors, an issue that had languished over the last three or four Congresses with no action.

This has been an extraordinarily productive first part of the first session of the 108th Congress, one of which we all have a right to be proud. We are moving forward to complete the agenda for the American people.

The measure we are considering today, or hoping to consider in the course of the week, the medical liability crisis, is a major part of trying to do what we need to do to make life better for the American people.

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

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

Mr. FRIST. Mr. President, I rise to continue the discussion on the health care crisis that exists because of our medical liability system. It is an issue we began talking about 4 hours ago, and it is an issue that does affect every single American. I have been very pleased in listening to the debate with the wide range of issues that have been discussed. For those who have listened, I think the debate today provides a very effective beginning of a debate the American people deserve and the American people expect.

Much of the discussion today has been about procedure and the fact that we are moving to proceed with a discussion of this bill on the Senate floor. Although we can argue procedure back and forth, what we are trying to do is respond to a health care crisis that is real. The crisis affects not just doctors and providers in health care today but does, in effect, have an impact on every American, whether it is through being beneficiaries of our Government program, Medicare, Medicaid, the Federal Employees Health Benefit Plan, or through the private sector, or even for those who have no insurance today.

I will outline a little bit about how every American is affected and why it is a bill that is important to every State and every citizen in every State.

Medical malpractice premiums, as we reviewed over the course of the day, have skyrocketed in recent years. So it is a problem we have been able to identify for a period of time. A lot of people will date the debate back to the mid-1970s when MICRA, or the health care medical liability refrom that was put forth in California, was first passed and then implemented. It is an issue that in States which have not addressed the problem that is growing and is growing rapidly. We see access to doctors being threatened, especially for women, and I will come back to that particular point. Especially in rural areas, we see this access to care being threatened, and this is why it is a crisis. Access to care is being totally taken away in certain regions of the country. The AMA has a chart to be brought out, I am sure, in the next day or so that depicts

those States which are in crisis. Since we last talked about some of these issues on the Senate floor, the number of States in crisis, where access to health care is threatened, has grown and grown dramatically.

Every American should participate in this debate. We hear the anecdotes. We see the trauma centers closing down. If one talks to their doctor or if my colleagues would talk to their doctors, or if the people who are listening talk to their doctors, they know it is a real problem and challenge that is increasing every day.

The situation is grave now. The crisis is there. It is getting worse and thus we bring the bill to the floor of the Senate for open debate. Once we get to the bill, it will be open for amendment where we can discuss these issues before the American people.

The horror stories are there. The headlines are there. Hospitals are closing labor wards, delivery units, obstetric units. We see the trauma centers that have either threatened to close or have actually closed. We hear the stories of the expectant mothers who are unable to find obstetricians. Doctors, especially orthopedic doctors, bone doctors, who often are in a high-risk specialty, are the ones who are involved most often in trauma centers. We see the specialties, neurosurgeons, as well as orthopedists and obstetricians, all high-risk specialities, treating the very sick in many cases, leaving their States. If they are in a high-risk State with skyrocketing premiums, they are often moving to a low-risk State. In the case of obstetricians, they are leaving the practice of specializing in the delivery of children and stopping the delivery of children totally. There are neurosurgeons who are no longer signing up to take trauma calls or work in trauma centers because of the risk of being sued. The headlines go on.

What I really want to stress as a physician, because I talk to my colleagues on a regular basis about this issue, the problem is getting worse, and getting worse by the day.

Time Magazine, June 9, the cover article—actually, I did not see Time when it came out but have gone back to look at that particular front page cover and then the articles behind it. They talk about this problem in very real terms.

I do encourage people, if they are unfamiliar with the debate, to go back and read the stories, the anecdotes, about what is happening around the country.

A year ago last July, when we talked about a particular amendment my distinguished colleague from Kentucky had offered and we debated the issue, there were 12 States that were in crisis according to criteria used by the American Medical Association. That number went from 12 States to 13, to 14, to 16, and 19. Now it is 19 States. Seven additional States have reached that threshold of being in crisis level.

Crisis level means that premiums are skyrocketing. There are increasing numbers of frivolous lawsuits, but that translates now to worse access, greater barriers to access, to everybody. All the citizens of that crisis State are harmed in the event there is a trauma accident, in the event somebody needs to see a neurosurgeon or somebody needs to see an orthopedic surgeon or somebody is going to have a baby delivered. That is really the simple reason why we need to bring this legislation to the floor now. We should not be blocking proceeding to this very important bill.

As a physician, this crisis is something I am close to because I watch what it is doing to my colleagues. These colleagues have chosen to go into this profession which is very special. I have a bias, but it is very special because they can go in and can heal, prevent disease, and people can live a better quality of life, day in, day out. That is why people go into the profession of medicine.

Yet as we talk to doctors today, many will say—and this is very different than 15 or 20 years ago—that the greatest threat to their being able to continue in this healing profession is this skyrocketing escalation of malpractice premiums. They are being forced to pay for what ends up being a lot of frivolous lawsuits. These lawsuits are engendered or occur because the current system, which needs to be reformed, gives incentives to those trial lawyers—not all trial lawyers—to go out and stir up business. I think that is what is most offensive to the American people, that a component of our liability system is unnecessarily driving up the numbers of lawsuits which in turn is diminishing access to health care. Driving up the cost of health care, which we all know, makes it more difficult for people to receive the care they deserve.

The fact that highly qualified and committed health care providers are being literally driven from the field they entered so they would have that opportunity to heal and to make others' lives better, is tragic. These individuals do not want to drop these vital services. They do not want to leave the specialities they spent years to develop, whether it is obstetrics, neurosurgery, or trauma surgery. They do not want to have to walk away from these fields. They do not want to have to leave underserved areas where this problem can be particularly bad.

Tomorrow or once we get on the bill, I will bring letters to the Senate from physicians writing if they worked in, say, the Appalachian Mountains. In underserved areas or rural areas, they are being hit particularly hard because they are having to pay these skyrocketing premiums, going from $20,000 to $40,000 to 60,000 to $80,000. They simply cannot stay in business. They cannot afford paying an $80,000 or $100,000 premium for malpractice insurance. Without the insurance, they cannot ''go bare'' because then if they do get sued, it destroys their livelihood and any chance of practicing medicine in the future.

The crisis is made real by the victims themselves. I hope the opponents of the underlying reform measure, or even those people who are saying, now is not the time to be addressing this in the Senate—I hope they look at those anecdotes, those individual stories now which, when accumulated in the aggregate, have reached crisis proportion. I hope they will agree that there is a crisis and now is the time to respond.

The medical liability system is the root cause of this crisis. It is the perverse incentives we need to address and that this underlying bill, when we are allowed to go to the bill, does address. The current system, with the inefficiencies, with the perverse incentives, hurts every American. In addition, it hurts the negligently injured patients it is supposed to help.

The good news is there is something to be done about the problem to make the system more fair, more just, to get rid of the waste and frivolous lawsuits. That is what the underlying bill does.

Our system encourages lawsuit abuse in lots of different ways, in part, by rewarding personal injury lawyers who file huge claims in friendly venues, looking for that big payday. These lawyers often keep up to 40 percent—I think the least is probably around 30 percent or 33 percent. They keep up to 40 percent of many of the settlements or verdicts of those injured. If there is a million-dollar verdict, for example, in some States the personal injury lawyer, the trial lawyer, pockets 40 percent, or $400,000, and the injured patient gets only $600,000.

At the same time, negligently injured patient many times don't receive any compensation at all. They are never addressed because the personal injury lawyers go after the big bucks, the big pockets, the large lawsuits. When one is negligently injured and should be appropriately compensated, the personal injury lawyers are not there to address their particular needs. Again, they are going after the big pockets, the big sum. We have a system that compensates the few all too often at the expense of the many.

The effect of these suits is staggering. Between 1996 and 2002, the average jury award in medical liability cases jumped 83 percent. Between 1997 and 2002, over that 5-year period, the percentage of medical malpractice payments of more than $1 million more than doubled. Again, this illustrates that the problem we have in this system is getting worse by the day.

The mere threat of these huge, multimillion-dollar awards forces many doctors and many insurance companies to settle cases for large amounts even if that individual physician is not guilty. The incentive is to settle, simply to avoid the exorbitant suit, even if there is no guilt involved.

We will show charts in the Senate that most of the cases filed in the U.S.

courts are without merit. The most recent statistics showed that two out of three, or 67 percent, of those cases filed in U.S. courts are being dismissed or being dropped—not being settled and not actually going to trial. In addition, only 7 percent of cases actually go to trial, and a staggering 85 percent of those cases are won by the defendant.

So these numbers are clear evidence of the abuse of the current system, of the inefficiencies, of the number of lawsuits that are frivolous. It is that waste, those inefficiencies, those disincentives, those perverse incentives that this legislation addresses.

Frivolous lawsuits are unnecessarily driving up the premiums to physicians. For the most part, for the physician to stay in business with those premiums, skyrocketing premiums, increasing 10, 15, 20, 30, 40 percent a year, if that physician is to stay in business, those costs must be passed on to those patients directly.

It should be no surprise that the excessive litigation and frivolous lawsuits are forcing these malpractice premiums up. In 2002, physicians in many States did see their rates rise by 30 percent or more. In some States, and in some specialties, malpractice insurance premiums are rising by as much as 300 percent a year.

In New York and Florida, obstetricians, gynecologists, and surgeons pay more than $100,000 for every $1 million in coverage. Soon the annual premium these doctors pay could reach more than $200,000.

I mentioned earlier that the sky-high premiums uniquely affect women. This will be heard again and again in the Chamber. One of the three high-risk specialties is obstetrics. Many obstetricians are leaving the practice, leaving obstetrics, and are involved just in the practice of gynecology or family practice because they cannot afford the premiums. Right now, nearly 1 out of 11 obstetricians no longer deliver babies. Who can blame them? If you ask why, again and again it comes back to this threat of these frivolous lawsuits.

It is a tax that affects women in many ways disproportionately. If an obstetrician today pays $100,000 for premiums—and that is not unusual—say they deliver 100 babies. That is a $1,000 tax that has nothing to do with the health care that is actually delivered or the delivery itself, but it is a $1,000 tax that, in effect, is placed right on top of the delivery of that baby. Thus, if you are a woman and you have a family, you need to realize that the doctor is having to pay that $1,000 tax on each baby delivered. This cost is ultimately passed on to the patient.

This is clearly unacceptable because it reflects the waste, the perverse incentives in the system, all of which, again, can be fixed.

Again, women living in rural areas are disproportionately affected and are even more threatened by the current system.

In a June 9 front-page issue of Time magazine, there is one tragic story of an expectant mother in rural Arizona having to drive more than 2 hours on a desolate desert highway just to see a doctor. That is not the sort of story that should be happening in America, especially when we have physicians who want to stay in obstetrics, who want to practice in rural areas. However, they are being discouraged from doing so by the current system of medical liability.

If anything, the incentives should be just the opposite. We should be encouraging physicians to deliver this care to women. We ought to encourage them to go to these underserved areas which are being disproportionately affected.

It should be no surprise that the American College of Obstetrics and Gynecology is one of the strongest supporters of meaningful medical liability reform. They are uniquely positioned to understand the threat that the current system places on women. They are demanding action by Congress. I do urge my colleagues to listen to their unique concerns.

The broken liability system does more than just raise the liability premiums on individual physicians. It adds tremendous costs, both direct and indirect, throughout the health care system. We have all heard of what is called defensive medicine and the increase in defensive medicine that is, indeed, practiced because of the fear, the legitimate fear, of these outrageous and skyrocketing lawsuits. To avoid lawsuits or to make sure that they are protected as a physician if there happens to be one of these lawsuits, physicians will simply order more tests, establish more of a paper trail.

You think of the case of a simple headache. With defensive medicine, for a headache coming into the emergency room, a physician might just order, instead of a good physical exam and maybe some medicine, simple diagnostic tests. With defensive medicine we might go to the extreme of a CAT scan that might cost $800 or magnetic resonance imaging, an MRI of the head, which might cost $1,000. Why? Because people are at risk if they are in emergency rooms, treating somebody who comes to the door, even for something as simple as a headache. You do that, not just once or twice but hundreds of times, indeed thousands of times all across the United States of America—again, driven by the incentive of frivolous lawsuits being directed against you—and all of a sudden you can understand why these defensive medicine costs tens of billions every year.

Recent surveys show that 75 percent or more of doctors acknowledge practicing defensive medicine. The exact cost is hard to calculate, but we do know it is tens of billions of dollars per year. When we realize that three out of four doctors are practicing defensive medicine, those numbers seem to be very realistic.

In an authoritative study out of Stanford, two researchers there estimated that reasonable liability reform could save the country anywhere from $70 billion a year to $126 billion a year in defensive medicine expenditures; that is overall defensive medicine. If you look just at what the Federal Government could save by comprehensive medical liability reform, the Congressional Budget Office estimates about $18 billion a year could be saved over 10 years with such reform. They are looking at just the Medicare Program and the Medicaid Program and the Federal Employees Health Benefits Program.

Often in the Chamber today, a lot of people have talked about this issue of medical errors and patient safety. I think a lot of good points have been brought up in the Chamber. It is absolutely critical that we do address the issue of reporting of medical errors.

I will have to say, just listening to physicians and having been in the field of medicine myself, the current system where you know that anything you say, in terms of even a possible medical error or mistake could result in a lawsuit is unacceptable. If they are there, you need to shine a light on them, you need to elevate them, you need to talk among your peers and talk among others; that is the only way you are going to fix and reduce these medical errors.

But when above your health care system you do have some predatory lawyers who are sitting there looking for the big bucks, recognizing they are going to take home 30 percent or 40 percent of a settlement it discourages that light that we all know is critically important to allow a discussion, to allow a self-examination so you can have a system of ongoing, continuous quality improvement in health care.

In the Chamber, people have referred and will continue to refer to the report of 3 years ago by the Institute of Medicine, ''To Err Is Human.'' A lot of these issues are talked about there. That is why I am a strong supporter of the patient safety legislation that has been developed by Senators GREGG and JEFFORDS and many others in a bipartisan way, the Patient Safety and Quality Improvement Act. That needs to be done. That needs to be addressed. But at the same time, by improving in a comprehensive way our medical liability system, we will actually improve the system itself. That will allow light to shine openly with, I believe, a lot more discussion and self-reporting by the provider system in order to have that quality improvement.

It is an inefficient system that we have today. It does waste tens of billions of dollars. It does drive underground, I believe, our ability to improve patient safety. Thus, comprehensive reform of our medical liability system is, I believe, demanded. This bill, the Patients First Act, is a commonsense measure. It does restore a balance to the system itself. It protects the right of the negligently injured patient to sue for just compensation while at the same time curtailing the abuses that we know currently exist in our system—today. It has a number of

critical components. I will look forward, once we get on the bill itself, to talking about a number of those components.

I am delighted with the debate thus far. I look forward to continued participation on this important bill. We have seen at the State level that liability reform can work. This particular bill we are trying to bring to the floor is a bill based on the MICRA system, Medical Injury and Compensation Reform Act that was passed in California in the mid-1970s. We know that is a big State. It has a high cost of living. Yet the overall premiums paid by physicians there have been much more controlled than in other parts of the country. MICRA works. We have that track record. We have that to look back to. That is why I feel so good about the legislation we will hopefully bring to the floor.

There will be lots of blame passed around in terms of why the system today is not working. Some people say it is the doctors. Some people say it is hospitals. Others will say it is the insurance companies. Some people say the stock market and the bond market. We will have this crisis blamed on lots of different things as we go forward. I would argue that at the heart of the crisis is the current liability system which promotes these excessive lawsuits, and that it can be fixed. It can be fixed. That is what I look forward to doing with my colleagues on the floor of the Senate.

Passage of this measure will help on both the access issues in health care as well as the expense issues for all Americans. If we do it, and we do it right, it will improve health care for all Americans.

EXECUTIVE SESSION

NOMINATION OF BRUCE E. KASOLD, OF VIRGINIA, TO BE A JUDGE OF THE UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

Mr. FRIST. Pursuant to the order of June 27, I ask that the Senate proceed to executive session for the consideration of Calendar No. 132.

The PRESIDING OFFICER. The clerk will report the nomination.

The legislative clerk read the nomination of Bruce E. Kasold, of Virginia, to be judge for the United States Court of Appeals for Veterans Claims for the term prescribed by law.

RESOLUTIONS PLACED ON EXECUTIVE CALENDAR

Mr. FRIST. I now send a resolution to the desk to discharge from the Judiciary Committee the nomination of David W. McKeague, of Michigan, to be a United States Circuit Judge for the Sixth Circuit. I ask for its immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. Mr. President, reserving the right to object, this nomination for the Sixth Circuit, and the others that will be made by the majority leader, have not had the benefit of any hearing before the Senate Judiciary Committee. I believe that hearing should take place before a lifetime appointment is given to any person to the Circuit Court. So, on behalf of Senators CARL LEVIN and DEBBIE STABENOW of Michigan, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. FRIST. Mr. President, I now send a resolution to discharge from the Judiciary Committee the nomination of Susan Bieke Nielson of Michigan to be a U.S. circuit judge for the Sixth Circuit, and I ask for its immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. Mr. President, for the same reasons, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. FRIST. I now send a resolution to discharge from the Judiciary Committee the nomination of Henry W. Saad of Michigan to be a U.S. circuit judge for the Sixth Circuit, and I ask for its immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. Mr. President, for the same reasons, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. FRIST. Mr. President, I now send a resolution to discharge from the Judiciary Committee the nomination of Richard Griffin of Michigan to be a U.S. circuit judge for the Sixth Circuit, and I ask for its immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. For the same reasons, I object.

The PRESIDING OFFICER. Objection is heard.

The foregoing resolutions will be placed on the Executive Calendar.

LEGISLATIVE SESSION

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate resume legislative session, and the motion to proceed.

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

PATIENTS FIRST ACT OF 2003—MOTION TO PROCEED—Continued

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, at the outset, I thank my colleagues and the clerical staff awaiting my arrival from the customary Monday travel day from Philadelphia to Scranton to Harrisburg to Washington. For those who may be about to venture onto the Baltimore Washington Parkway, the traffic is very heavy indeed. Although when I arrived in the Senate Chamber and I saw active debate, I am not quite sure my late arrival has caused too much inconvenience.

I support legislation which would address the serious problems faced today by doctors, hospitals and other medical professionals and at the same time provide balance to treat fairly people who are injured in the course of medical treatment.

While most of the attention has been directed to medical malpractice verdicts, the issues are much broader, involving medical errors, insurance company investments and administrative practices.

I support caps on noneconomic damages so long as they do not apply to situations like the paperwork mix-up leading to the erroneous double mastectomy of a woman or the recent death of a 17-year-old woman on a North Carolina transplant case where there was a faulty blood test.

An appropriate standard for cases not covered could be analogous provisions in Pennsylvania law which limit actions against governmental entities or in the limited tort context which exclude death, serious impairment of bodily function, and permanent disfigurement or dismemberment.

Beyond the issue of caps, I believe there could be savings on the cost of medical malpractice insurance by eliminating frivolous cases by requiring plaintiffs to file with the court a certification by a doctor in the field that it is an appropriate case to bring to court. This proposal, which is now part of Pennsylvania State procedure, would be expanded federally, thus reducing claims and saving costs. While most malpractice cases are won by defendants, the high cost of litigation drives up malpractice premiums. The proposed certification would reduce plaintiff's joinder of peripheral defendants and cut defense costs.

Further savings could be accomplished through patient safety initiatives identified in the report of the Institute of Medicine.

On November 29, 1999, the Institute of Medicine—IOM—issued a report entitled: To Err is Human: Building a Safer Health System. The IOM Report estimated that anywhere between 44,000 and 98,000 hospitalized Americans die each year due to avoidable medical mistakes. However, only a fraction of these deaths and injuries are due to negligence; most errors are caused by system failures. The IOM issued a comprehensive set of recommendations, including the establishment of a nationwide, mandatory reporting system; incorporation of patient safety standards in regulatory and accreditation programs; and the development of a nonpunitive culture of safety in health care organizations. The report called for a 50 percent reduction in medical errors over 5 years.

The Appropriations Subcommittee on Labor, Health and Human Services and Education, which I chair, held three