

however, this past summer has seen significant delays and inconveniences to Amtrak's passengers across the country.

Amtrak's 5-year Strategic Plan, which was approved by its Board of Directors on June 10, 2004, specifies that approximately \$1.8 billion will be required for fiscal year 2006.

According to a recent report by the Congressional Research Service, both the now defunct Amtrak Reform Council and the DOT-IG acknowledge the need for at least \$1.5 billion in capital and operating support.

Seeking no funds for direct Amtrak expenses and ceding control of the railroad to a bankruptcy trustee, whose legal responsibility is to Amtrak's creditors, represents a drastic and unrealistic turnaround in the Administration's policy.

Since David Gunn's arrival, Amtrak Total Ridership has increased by 11.6 percent. The number of intercity trains operated have increased by 21.4 percent. The number of trains on the NEC has increased by 29.2 percent while others have increased by 17.3 percent.

Ridership on the NEC is 10 percent and other corridor trains, like the Pacific Surfliner, Capitals and San Juaquins in California and the Cascades in Oregon and Washington have increased by 27 percent driving a 12 percent increase in ticket revenue.

Americans have chosen it as their form of travel in record numbers. In the 3 years post September 11th, Amtrak has proven its value to the nation and has increased its ridership steadily.

Last year, Amtrak carried 25 million passengers, up from the previous year's record. When given the option, travelers choose Amtrak over other, less convenient forms of travel. In FY04 the air-rail market from DC to New York was split 50 percent to 50 percent, Los Angeles to San Diego was 30 percent to 70 percent and Portland to Seattle was 30 percent to 61 percent.

David Gunn has made real progress reforming the railroad since taking the helm in May of 2002. Over the last 30 months he has decreased the workforce by more than 22 percent, removing unnecessary layers on management, increased train service and operation, eliminated and realigned routes for greater efficiency and implemented more internal reforms than any of its previous CEOs.

In fact, Amtrak's core operating expenses are lower today than they were when he took over. David Gunn has made real reforms and has proven to be the right person to continue fixing the problems that have plagued Amtrak over the years.

HEALTH CARE

The SPEAKER pro tempore (Mr. INGELIS of South Carolina). Under the Speaker's announced policy of January 4, 2005, the gentleman from Georgia (Mr. GINGREY) is recognized for 60 minutes as the designee of the majority leader.

Mr. GINGREY. Mr. Speaker, tonight, as part of the Republican Health Care Public Affairs Team, my co-chair, the gentleman from Pennsylvania (Mr. MURPHY), and I are here with a couple of our colleagues to talk about, over

the next hour, one of the most important things to the people of this great country, and that is health care and our health care system.

We have a great system, without question, probably the greatest health care system on Earth. But we are not going to just stand up here during this next hour or as we go forward with our Health Care Public Affairs Team and on a monthly basis, talk about different health care issues that are so important to this Nation and pat ourselves on the back. We are not going to do that. We are going to talk about some problems that exist.

Tonight, we are going to focus primarily on the civil justice system and trying to solve a problem in regard to medical liability insurance and the lack of access to care. But there are so many other issues that we will be talking about as we go forward in this series of 1-hour discussions with our colleagues, Mr. Speaker. Things like Medicaid. Obviously, we have got a serious problem with Medicaid. We need to reform that system, and the President talked about many of these things in his State of the Union address. We addressed, of course, Medicare modernization and the prescription drug act last year. In fact, December of 2003 is when that bill was signed by President Bush.

But we will continue to focus on Medicare in realizing that it is not a perfect system. It is a good system. It has served our people well, but it is not perfect.

Then, of course, the issue of the uninsured, some 43 million in this country. Many of them, Mr. Speaker, have jobs. They work. They are not unemployed, but they are underemployed and, in many cases, are not insured at all. They do not have the opportunity to purchase health insurance. Maybe it is not even offered by their employer, or if it is, they cannot afford to purchase that insurance. And my colleague, the co-chairman of this Republican Health Care Public Affairs Team who is with us tonight, will be speaking in just a few minutes. We will be talking about, also, just the issue of electronic medical record keeping and how important that is to reduce the number of errors, medical errors that we know cause far too many injuries and, yes, in some cases, loss of life in this country. The gentleman from Pennsylvania (Mr. MURPHY) will talk about that.

The main emphasis tonight, of course, as I stated, Mr. Speaker, will be to talk about this issue of medical liability and why it is causing such anguish in our country and resulting in the lack of timely and necessary access to health care.

I am often asked, I am a physician Member, I think, Mr. Speaker, you know that, and my colleagues are aware of that. I came to this body after practicing OB-GYN medicine in my district, the 11th district of Georgia,

the City of Marietta, Cobb County of Georgia, where I delivered over 5,200 babies. And it was tough to give up that practice. But without question, I was beginning to feel a lot of stress, a lot of anxiety, frustration in my medical practice as I watched those medical liability insurance premiums just continue to skyrocket and get up to the point where it was awfully difficult to be able to afford that.

So this is really what a lot of my colleagues are going through. I have also had people back in the district say, now, I think you have a lot of doctors and a lot of health care providers in the Congress now. Did we not elect a few more? In fact, we did in this 109th Congress. We grew our numbers a little bit, Mr. Speaker. We went from a grand total of seven M.D.'s to ten in the House, and of course, we have a number of other health care providers, be they nurses or dentists or pharmacists or psychologists, but it is still a small number.

When we look at 435 Members, and maybe we have something less than 20 who have a background in health care, in the health care professions, and on the Senate side, we increased our number over there by 100 percent this time. We went from one to two. And, of course, I am speaking of the majority leader of the Senate, Dr. FRIST, and also, now, Senator COBURN from the great State of Oklahoma.

But we are determined to talk about this health care issue and make sure the American people know that, while we might not be large in numbers, we are going to discuss these issues. We are going to do it on a regular basis.

The Republican hour tonight, of which we are managing, we are going to get this issue in front of our colleagues, in front of the public and let them know that we care about this. It is a tremendously important issue, and it should not be partisan.

When you think about it, health care, when you have a patient, you never ask them if they are a Republican or a Democrat. And believe you me, they do not ask their doctor either. President Reagan joked about that when he was shot and went to the hospital and looked up just before they put him to sleep, looked up at the anesthesiologist and said, I sure hope we got some good Republicans in here. But truly, we have, as I say, there are ten M.D.'s in the House, three on the Democratic side, seven on the Republican side. But we are not going to let this be a partisan issue.

We are going to just talk to our colleagues and make sure that everybody understands that we need to do this for the good of the country and not for the good of a party or, in particular, not with our vision, our focus on the next election.

The issue of medical liability and the crisis that we are in, Mr. Speaker, I

would like to call attention to this first slide that we have that shows the United States of America and the number of States that are either in crisis in regard to this issue or they are getting darn close.

I know that my colleagues on the other side of the aisle do not like the word crisis. And we are talking about another issue, of course, in regard to that, but let us say a serious, a very serious problem. But I think indeed a crisis.

In my State of Georgia, along with about 13 others depicted here in red, indeed a State in crisis, and something like 25 other States depicted in yellow, showing serious problems in regard to this issue. In fact, there is just only a handful of States, maybe less than six or eight, that are not either in crisis or near crisis. And what do I mean by that?

If you think about the fact that, when people go to the emergency room with an injured child, and maybe it is a head injury, maybe that child is unconscious, they at that point do not need a family practitioner. They do not need an OB-GYN. They do not need an oral surgeon. They need a neurosurgeon. They need someone who can immediately assess the condition of that child and if there is a serious head injury. And certainly, if the child is unconscious, that is very likely.

If there is no neurosurgeon there that can act in a very timely manner and in some instances get that child to surgery, the damage that can be done is irreparable damage and it cannot be undone.

□ 1845

So we know that we have physicians like neurosurgeons, and I mentioned my specialty, OB-GYN. Doctors who are involved in high-risk specialties are the ones that are getting absolutely killed by runaway medical liability premiums and that constant threat. They are willing, through compassion and love of their profession and their patients, to take on those tough cases, those high-risk obstetrical cases.

I will use the word "toxemia." I am sure most of my colleagues, Mr. Speaker, do not know what that is, but all of the OB-GYNs certainly know what I am talking about, a life-threatening complication of pregnancy. If a doctor is not available to treat that condition, these people could not only lose their child but they could lose their lives. So we have some real serious problems, and I think it is just time to talk about it.

I am very thankful that my State, as I showed my colleagues on the first slide, is one of the 13 or so that is in crisis, did during this session of their General Assembly just pass a really good, a significant piece of tort reform legislation that I think is going to bring some relief. When I say bring

some relief, I am not hardly even talking about the doctor's income. I am talking about keeping them in practice, keeping them performing those cases, seeing those patients that are high risk, rather than hanging up that stethoscope and trading it in for a fishing rod or whatever, because they just no longer can stay in practice under that environment. So it is a huge, huge problem.

Let me just talk about why we at the Federal level, I said Georgia passed tort reform, Florida did, Texas did, California of course gave us the model of tort reform back in 1978, the bill called MICRA, which stabilized malpractice insurance premiums so that doctors did not leave California, did not stop their practices, continued to see those high-risk patients, without these premiums going just totally through the roof, and it worked and it worked because of one thing primarily and that is a cap, a cap of \$250,000 on noneconomic damages, so-called pain and suffering.

It has nothing to do whatsoever with economic damages. It is just to say that without a cap that number could be infinity. It could be tens of millions of dollars, and that is wrong and that is what is driving those rates up so high. That is the model that was passed in Georgia, and that is basically what we are trying to do here in the Congress.

My colleagues might say, well, just let the States take care of it; why worry about it at the Federal level. Well, many of the States, in fact most of the States, have not taken care of this.

There are a lot of reasons why you may think that we cannot get tort reform. The trial lawyer lobby is a very strong lobby. There is no question about it. We have passed tort reform legislation, the Health Act of 2003. We passed it again here in this body, Mr. Speaker, last year in 2004; and now we have reintroduced it in the 109th in 2005, and we will pass it again. We will pass it again in this body with bipartisan support; but when it gets to the other Chamber, it has been just almost impossible.

Again, I mean, it should not be a partisan issue, but for some reason it always seems to be, and I continue to have hopes. I am not going to give up on the other body. I think that, Mr. Speaker, we have got some different faces over there this year, and I have always said to my doctor friends that say, well, what can we do, and I say to them, if you cannot change their minds, you need to change their faces. Fortunately, Mr. Speaker, in this last election cycle we changed a few faces, and indeed, we elected another doctor to the United States Senate and I mentioned Dr. COBURN earlier.

So I continue, hope springs eternal, but we want to continue to make sure that we tell our colleagues about this

and make sure the American people understand how serious a problem this is.

At the Federal level, and let me just frame it just for a minute, the amount of money that is spent on health care, I just want to focus my colleagues on this particular chart.

Nearly 45 percent of all mandatory spending is on health care. Let me say that again: nearly 45 percent of all mandatory spending is spent on health care. This pie chart, this part over here, 55 percent is nonhealth care mandatory spending; but when you talk about those numbers and I can just throw out a few, \$176 billion, this is fiscal year 2004, and these numbers continue to grow. Medicaid spending, \$176 billion; State children's health insurance program, the CHIP program, \$5 billion; Social Security disability, \$73 billion, that is 6 percent; Medicare, \$297 billion, 24 percent of mandatory Federal health care spending. No small numbers.

The Federal outlay for health care continues to rise. Nearly one-third of all Federal spending goes toward health care, nearly one-third, and just look at this slide. I would like my colleagues to pay close attention to this.

Starting in 1965 going forward to 2004, the percent of total Federal outlays, this is total Federal outlays, not just mandatory but also discretionary, 1965, Federal health care spending as a percent of our budget, 2.6 percent; 2004, all the way to the right, 29 percent.

We have a problem, and we have to solve it at the Federal level.

I hope that my colleagues can appreciate the magnitude of this, and I am very, very pleased to be, as I said at the outset, co-chairing the Republican Health Care Public Affairs Committee as we bring these issues, like the need for medical liability reform, before my colleagues. My co-chairman on this committee is the gentleman from Pennsylvania (Mr. MURPHY).

We appreciate him being with us tonight, and at this time I would like to turn it over to him and let us hear about some of those issues of concern in regard to medical errors and what we can do about that.

Mr. MURPHY. Mr. Speaker, I thank the good doctor from Georgia for yielding.

What I would like to do is lay out a couple of issues here and also turn it over to a couple of other colleagues who are here tonight and review some of these issues of why it is so important, and I thank the gentleman for pointing out some of the issues of the Federal outlay of health care.

The Federal spending for health care, it is so important to note that it is growing immensely, that it has grown and continues to grow, that the numbers out there, about 45 percent of mandatory spending, is in the area of health care, and it is probably going to climb to 49. By "mandatory" we mean

spending and these are not necessarily the things we vote on and change every year but other outlays that take place.

I want to point out as we are going towards this that as we are talking about such things that are brought up about liability, and tort reform issues are so important, that part of what we also have to pay attention to is patient safety.

I would like to bring up a couple of points, and one of these is the issue, the Institute of Medicine in a landmark study in 1999 pointed out, this study was called "To Err is Human," stated that over 7,000 people die every year from medication errors alone with 44,000 to 98,000 deaths every year from medical errors in hospital practices. Now, this touched off a great concern across the Nation. The government and many efforts, President Bush and then-Secretary Tommy Thompson started investigations to see what happened, why this was so. A great deal of research and other efforts took place in hospitals and physician offices and medical schools across the country to find out what this is about.

What stood out, however, is even more alarming: that we really do not know how many of these deaths occur every year because they typically may not get reported. This has led to a situation where many health care providers simply do not talk about the problem because they fear legal retribution. In other words, hospitals, we should have them tracking all errors, all suspected errors, and in every case, lead to a program within that hospital and with health care practice in every level of that hospital to review what that was for. Many times the concerns could be if those records were kept there or if they were reviewed this will simply be another source of suits.

What we have to be moving for in this Nation is a goal of zero medical errors, zero patient errors. Anything beyond that I believe is too high. It is too high of a cost for our Nation's health care facilities, and we should not embrace a goal of 1 percent or 2 percent or 3 percent.

Imagine a situation here if a factory had a goal of perhaps reducing their safety errors and injuries to their workers down to this 3 percent or 1 percent of the workers, how many injuries that would be, how many lost work days, how many deaths that would be. Would you want to go to a hospital that had a goal of perhaps only 98 percent or 99 percent success? Certainly, every one of us in the health care field wants to aim towards 100 percent success, and given the chart that we saw before about the great increases in health care spending in the Federal Government, it is very important that we look at controlling health care spending, Mr. Speaker, not just from the idea of accounting moves to cut down on some of those rates but also

making some major changes in what we are paying for, not just who is paying.

Let me touch off on a couple of areas here before I turn it back over. One is the Pittsburgh Regional Health Care Initiative reported that the United States has the world's second highest methasone-resistant staphylococcus rates with more than 50 percent of these infections resistant to antibiotics. They also went on to say that the Pittsburgh Regional Health Care Initiative reported that these hospital-acquired infections affect 5 to 10 percent of all patients, or about 2 million, per year who are admitted to acute care facilities at a cost overall in this Nation of \$4.5 billion. Many of these infections could have been prevented by simply having physicians wash their hands, using anti-bacterial scrubs; and I will use other techniques here to make sure we had a system that was working better.

Now, the reason I bring these up, they seem almost too simple, but there are a couple of areas we recognize as we are moving towards the issue of medical liability reform. I want to make it clear here to our colleagues, we are not just excluding that, not just saying this is not just an issue of caps on punitive damages. This is not just a legal issue. This is one that we need to recognize as a Congress and as a Federal Government embracing truly changes in how we handle errors.

Many hospitals and doctors are concerned about this, but we also see that there are recommendations for open and meaningful communication with health professionals about medical errors. It should be open to discussions of what takes place. I believe the Federal Government can be a major factor in moving these forward; and as we continue on this evening, I will be coming up with more examples.

At this point, I would like to turn it back to my colleague, the gentleman from Georgia (Mr. GINGREY), to proceed as we go through this evening and look at other ways that this liability crisis is affecting our Nation and how patient safety needs to work hand in hand with working to reduce some of these liability issues, and that will be something that not only keeps more doctors practicing but quite frankly will save a lot of money and save a lot of lives.

Mr. GINGREY. Mr. Speaker, I thank my colleague from Pennsylvania for bringing those points to us, because what is important for our colleagues to know is that while physicians in this country, health care providers are in a crisis situation, as we said at the outset, because of the need to practice defensive medicine, inability to pay for liability premiums that have gone through the roof, what Dr. MURPHY, my co-chair, has brought to us is to say physician, health care provider, heal thyself, heal thyself.

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And that is important. We cannot say that we are not going to do things to try to make sure that there are less errors and less accidents. People must know that we are determined to reduce those medical errors that the gentleman from Pennsylvania was talking about.

I am very pleased to introduce the next Member, my colleague from Georgia. We talked at the outset about the number of physicians in the House and the fact that we picked up a few. While it was indeed, Mr. Speaker, a great pleasure to me that one of those three new Members in this body is not only a colleague from Georgia but also a colleague from my own County of Cobb and represents the district that adjoins mine. We both have a part, a significant part of Cobb County.

The gentleman from Georgia (Mr. PRICE), Representative PRICE, Congressman PRICE is an orthopedic surgeon, one of my great mentors when I was a member of the Georgia Assembly, so I am very proud to introduce him tonight. He is going to talk about some of the unique problems in regard to physician workforce in our great State of Georgia.

Mr. PRICE of Georgia. Mr. Speaker, I thank my colleague, and it really is a pleasure to join him and the gentleman from Pennsylvania and others who are talking about something that is so incredibly important to every single American, and that is their health.

I know we are talking about patient safety, but I want to put a little different spin on patient safety. I want to put it in a little different light. Because I know, as my colleagues do, that if you cannot find a hospital that is open or if you cannot find a doctor's office, then you cannot be safe in your health care. So I want to talk a little bit about the access to health care and what is the dynamic going on that is limiting drastically, drastically, the access that so many individuals in our great State, but also our Nation as well, have to health care.

I want to point out some of this information just to start: Georgia is no different than the vast majority of States in this Nation, and this report came recently from the Georgia Board of Physician Workforce. What that workforce does is it reviews the entire State and looks at where doctors are practicing, where hospitals are open, how many beds they have and the like, and how capable they are of delivering the care that is needed by our citizens.

What they found recently is that 11 Georgia hospitals have closed since 1999. Eleven hospitals have closed. Ones does not think about that happening. If it is in your community, though, it is an incredibly important thing for not just the economic vitality of your community but for the health and well-being of your citizens.

Four percent of Georgia physicians will leave the State or quit medical practice in the coming year. This was asking, what is going to happen to your practice over this next year? Four percent. A remarkable number. And 11 percent of Georgia physicians will stop taking emergency room coverage.

Now, I believe that the crux of the liability crisis that has been talked about tonight and that, I think, is very real and incredibly important, but it is not important because of the amount of money that physicians have to pay for their malpractice insurance. It is important because, when that cost goes up, this is the consequence: Hospitals close; doctors quit doing certain procedures because they cannot afford the insurance to cover that, or they simply close their office. And when that happens, what is the real result? The real result is that patients cannot have access to the kind of quality care that they need and that they deserve.

So I want to touch on a few very specific issues that are certainly true in our State, and I know them to be true around the Nation because, as I mentioned, Georgia is not any different than any other State.

We have a number of different specialties that are more at risk than others, but any time you upset or kind of break that chain of quality care that is being delivered to a patient, any time a patient cannot get the specialists they need or the kind of doctor they need, then that individual, that patient's health care is compromised. They are not as safe in their health care. So I want to talk about a few specialists that I know who are having significant problems, and I will point out what they are no longer doing or are not able to do because of the liability crisis.

For example, in our State, nearly 40 percent, nearly 40 percent of the radiologists in our State are no longer performing high-risk procedures. So you say, well, what is a high-risk procedure? Must be something that endangers the patient's life; right, immediately? Well, in fact, that is not the case. For radiologists, mammograms are high-risk procedures. Mammograms are high-risk procedures. Something that is a preventive health care measure is a high-risk procedure.

Now, why is that? The reason is that the technology that goes into performing a mammogram and reading a mammogram is not perfect. There is about a 10 percent error rate. If you get the best radiologist in the world reading mammograms, that individual will only be correct in his or her interpretation about 90 percent of the time, which means there is about a 10 percent error rate because of the limitation of the test itself.

Now, that means if a radiologist is performing 25 or 30 mammograms in a given day, two or three of those inter-

pretations is not going to be correct. And so the radiologist, 40 percent of the radiologists nearly in our State, and I know it is true around the Nation as well, have said, look, I cannot expose my family to that liability, and the only thing I can do from a personal standpoint is say, I am sorry, I cannot do mammograms any longer.

Now, what does that mean? It does not necessarily limit that individual's livelihood significantly, but what it does mean for that community is that the women of that community no longer have access to appropriate preventive health care in the form of a mammogram. And it is not just true of radiologists, though I think you get the connection between when the cost of insurance goes up, that the important thing is not the cost of the insurance to the physician; the important thing is that we are limiting access to quality care for patients.

A pathologist is another classic example. Pap smears that pathologists interpret, many of them, it is approaching again that same number, 30 to 40 percent of pathologists will no longer interpret Pap smears. Because, again, that error rate, that inherent error rate because of the limitation of the technology itself, does not allow them to interpret that with the reliability that is appropriate or that does not expose them to significant problems or significant liability.

So they say, well, the only option that I have is to no longer read Pap smears. Again, what is the consequence of that? It is that women no longer have somebody who is able to perform that preventive test for them.

I know that neurosurgeons were mentioned earlier, and I want to talk a bit about that because it is an extremely important issue. My district is all northern suburban Atlanta. I have a number of hospitals in my district. It is a grand place to live. It is a great place to work and play, and it has wonderful health care provided to it, except that there are hospitals within my district and very, very close to me in the center of Atlanta or around the environs of Atlanta, who no longer have the emergency room coverage 24 hours a day, 7 days a week of a neurosurgeon. Now, the consequences of that is not that it hurts the hospital; the consequence is that it harms patients.

I believe that the amount of safety for patients that is being compromised because of the liability crisis that we have is not even being measured because it is not recordable. I will use an example that I know to be true.

There was a gentleman in his mid-40s who fell and hit his head. So he went to the hospital. He drove himself to the emergency room. And when he was in the emergency room, his clinical course or his health status deteriorated, and he became unconscious. The hospital did not have a neurosurgeon

on call that night because of the liability crisis. So what is the hospital to do? They have to put him in an ambulance and move him to a hospital that has a neurosurgeon available.

The problem in this case is that that individual died on the way to the hospital. On the way to that second hospital. Now, this is a healthy gentleman who just had a fall. He had a significant injury, obviously, but the treatment for that injury is what is called a burr hole, which means you relieve the pressure on the brain where the bleeding is. And the vast majority of individuals not only survive; they recover 100 percent.

That individual's safety, health and life were compromised because of the liability crisis that we have in this Nation. That death will never be recorded as one that fits any of the statistics that people are talking about because it will be attributed to a traumatic fall. It will not be attributed to a liability crisis. Nowhere on that record will you find that the original hospital did not have a neurosurgeon available.

So these are the consequences of the incredible liability crisis that we have right now. Again, the problem is not that doctors are having to pay too much; the problem is that patients are losing their access to quality care.

Let me just review a couple of these slides, and then I would look forward to hearing some of the comments again from my colleagues. I mentioned this Georgia Board of Physician Workforce study that they did. This shows that 17.8 percent of Georgia physicians will stop providing high-risk procedures. You know what a high-risk procedure is for an OB doctor? Delivering a baby. Delivering a baby is a high-risk procedure. And so 17.8 percent of Georgia physicians will stop that, again, not because they forgot how to deliver a baby; not because they forgot how to perform the procedure or to read the tests, but because they cannot do it with the current liability crisis. We talked about the issue of radiologists as well.

The consequence of that is that more than 10 percent of the obstetricians in the State of Georgia, more than 10 percent, quit delivering babies over the last 18 months. That is a huge, huge consequence, which, again, is a decrease in the quality of care that is available to patients all across our State and, frankly, all across our Nation.

Let me close with just three very specific examples. A good friend of mine, and my colleague from Georgia knows him as well, Frank Kelly, an orthopedic surgeon who practiced for 25 years. He is in the prime of his career. He ought to be able to practice for another 10 or 15 year. A very, very highly-qualified orthopedic surgeon in the middle of our State who quit practice. Quit practice.

The reason was not that he did not have a passion for it any more. The reason was not that he had forgotten what he was supposed to do when he came to office. The reason was the liability crisis in our Nation.

Another example. Atlanta pediatric neurosurgeon, and we only have eight in the State, left the State last March, left the State because of the liability crisis.

Again, in Marietta, where my colleague and I, where we both share adjacent districts, a 52-year-old general surgeon we both know well, performed 80 surgeries a month. That is the level of his practice. That is how qualified he was and how much the patients and citizens of our districts love him. He, at 52 years old, again, this is somebody who ought to be in the prime of his career and providing excellent high-quality care to citizens in our districts, had to quit the practice of medicine because of the incredible liability crisis. And that is an individual who had no claims; had never been sued. But because of the increasing liability crisis and the increase in cost, he was no longer able to do that.

I simply want to close by just thanking the gentleman from Pennsylvania (Mr. MURPHY) and my colleague, the gentleman from Georgia (Mr. GINGREY), for their wonderful leadership on this issue, the patient safety issue, which encompasses so many things. I hope we continue to talk about it and make certain that we work with our colleagues and push them just as hard as we can on both sides of the aisle and on both sides of the Capitol to solve this problem.

Mr. MURPHY. Mr. Speaker, I thank the doctor from Georgia for his comments. It is very important, the point that he made, which is that the issue of health care, when you do not have health care providers practicing, is really something that leads to many problems and, quite sadly, deaths.

One of the statistics that I quoted before from the Institute of Medicine is a study done a few years ago that threw out some broadbased numbers; somewhere between 44,000 and 100,000 people die a year from medical errors. This study has come under some question, but it is one that is often quoted by attorneys when they bring up the concern for why one needs to focus on lawsuits in order to try and change these.

Some have said that no patient has ever been cured by a lawsuit. And certainly, even if it is just one, that is too many, but I would like to call upon our colleague now, the gentleman from Texas (Mr. BURGESS), who oftentimes refers to himself as a country doctor from Texas. He has delivered many babies in his OB-GYN practice, and so I wonder if he, as he begins to talk, whether he can talk about making sure we have more accurate approaches to tracking and understanding errors as a means of improving on patient safety.

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Mr. BURGESS. Mr. Speaker, I am pleased to comment on that. For a number of years, ever since the Institute of Medicine study came out, and I bought the book and read through it, I felt that their study methods were significantly flawed.

While I agree with their premise that if there is one death from medical errors, that is too many, the book is worth reading if only to look through the very tortured methods that they went through to come up with the number at the end of 98,000 deaths a year. They look at two hospital wards, one back in 1984, one in 1992; and from these two wards extrapolated the data that they have.

In fact, there was a significant reduction in medical errors between 1984 and 1992, and that never got really much in the way of any headlines, but they go through this very tortured analysis; and at the end they say since we are not sure that we are underestimating the figure, they doubled it. That gives Members some idea of the scientific rigor with which they approached the task.

Again I agree one death is too many, and we need to be moving toward a system that is a no-fault system. We strive for error-free medicine in a world that is sometimes all too human.

But I also feel compelled to talk about the good news. We have heard a lot of information and how serious the situation is across the country, and it is serious. I do not mean to diminish that, but there are some good news items out, and I would like to share them with this House. I am especially thankful to the Georgia medical delegation that has allowed me to appear on stage with them.

The State of Texas, which is so often a leader in so many areas across the country, 18 months ago dealt with the crisis in medical liability insurance by passing a State law that allowed for caps on noneconomic damages in medical liability suits. It was patterned after the Medical Injury Compensation Reform Act of 1975 done in California that we have all talked about here as a standard that we should aspire to. Our Texas law updated that for the 21st century.

There is a cap of \$250,000 on the doctor for noneconomic damages, not for real damages, but for noneconomic damages capped at \$250,000. The hospital is capped at \$250,000, and a third health care entity, a nursing home or hospital, is capped at \$250,000. That is a significant change from the California cap of only \$250,000 that was passed back in 1975.

What have the results been in the State of Texas since this constitutional amendment passed? The results are worthy of our study here. The first thing is when I was running for Congress in 2002, we had medical insurers

fleeing the State. We went from 17 to two in a very short period of time.

Just like the stories we heard earlier, as I was campaigning for this office, a young woman who is about 40 came up to me and said, I have lost my insurance coverage because my insurer left the State, and now I cannot practice my specialty of radiology. I cannot get insurance anywhere, so I am now a stay-at-home mom. What a travesty. She had gone to a State school, so the citizens of Texas essentially paid for her education. She came to her peak earning years, her peak power, and her profession is taken away from her, and not because as the gentleman from Georgia (Mr. PRICE) pointed out, not because she forgot how to read a chest X-ray, but because she could not get insurance coverage.

This system has changed with the passage of the Texas liability reform law. What the Texas Department of Insurance has seen since the law was passed in September 2003 is that we have now reacquired I believe it is up to 14 liability insurers. We have gone from 17 down to two, we are back up to 14, but the most important thing is those insurers have come back into the State without the type of rate increases that have occurred in neighboring States. Insurers have come back into the State of Texas, but they did not up their premiums like they did in Oklahoma, and that is a terribly significant event.

The other thing that we have seen is Texas Medical Liability Trust, my old insurer of record, immediately cut its rates by 12 percent after the constitutional amendment passed. There was some discussion as to whether or not this rate reduction would hold, but in fact this year they have put on top of that an additional 5 percent rate reduction for a total of 17 percent in rate reductions. Again, remember what we are talking about here is not cheaper insurance for doctors; what we are talking about is permitting doctors to stay in the practice of medicine because, after all, patients cannot have access to a health care system if they do not have access to a physician somewhere along the line.

The other unintended benefit from passing caps in the State of Texas has been what hospitals who self-insure, the benefits they have seen. The Christus health care system down in South Texas reported in the Dallas Morning News almost a year ago, so very shortly after these caps went into effect, that they had achieved savings of \$22 million in the 6 months after this law, this constitutional amendment was first passed. That means \$22 million going into nurses' salaries, capital expansion. The types of things you want your community hospital to be doing, they were allowed to participate in, again, because of the savings brought about by simply instituting a

series of caps on noneconomic damages, those awards that are for pain and suffering in medical liability suits.

The other thing that has happened which is pretty good news for Texas doctors is the number of suits have plummeted. That has been truly a significant breathing spell for the past 18 months for physicians of a State who were significantly beleaguered.

I am frequently asked, if Texas has done such a good job of solving the problem, why do you care about doing something on a national scale. I do care because it is important. As a Member of Congress, I have been privileged to travel around the country. Two years ago with the Committee on Transportation and the Infrastructure, I visited the Alaskan National Wildlife Refuge. On the way home, we stopped in Nome, Alaska. We had a chamber of commerce lunch there. When they found out there was a doctor who was a Congressman, all of the medical staff at their local hospital came out to talk with me.

What they wanted to talk about is are you going to be able to do anything about medical liability rates, because we cannot afford the insurance rates for an anesthesiologist at our hospital. I said, My gosh, how do you practice without an anesthesiologist?

And they said, We do the best we can. I asked what kind of doctor he is, and the doctor said, I am an OB/GYN just like you.

I said, Wait a minute, how do you practice obstetrics without an anesthesiologist? What do you do for a C-section?

He said, We arrange for an airplane and get the mother transferred to Anchorage.

Mr. Speaker, that is an hour and a half by air, assuming the weather is okay; and they sometimes have bad weather in Nome, Alaska. I fail to see how we are advancing the cause of patient safety by allowing this situation to continue.

The gentleman from Georgia (Mr. GINGREY) eloquently pointed out how much of our Federal budget goes for health care, and this is a key point on why we need to involve ourselves with a national solution to this problem.

A 1996 study done out in Stanford, California, estimated that the cost of defensive medicine within the Medicare system is in excess of \$30 billion a year. That is in 1996, almost 10 years ago. I bet those numbers are higher today if someone were to rerun those numbers. That is the crux of the problem. We are talking about an amount of money that would almost pay for our prescription drug benefit that we are squandering on the practice of defensive medicine because our doctors are afraid that they are going to be pulled into court and they want to be sure their cases look good when presented on the stand. That is why this is so critical for us on a national level.

Mr. Speaker, I thank the doctors for putting this together. I certainly want to thank Georgia for their indulgence in allowing a non-Georgia physician to appear out here tonight. It has been a pleasure to be here. I thank you for doing this.

Mr. GINGREY. Mr. Speaker, we thank the gentleman from Texas (Mr. BURGESS) for the doctor's timely remarks, and appreciate the gentleman being here with us.

Again, I point out the fact that even though they have some relief in Texas and now we have a little relief, good legislation in Georgia, why are we so concerned. He said it so well, and that is as I had pointed out earlier in the hour that the total percentage of non-mandatory spending in this country that goes to health care, Federal dollars is like 45 percent.

I remember during the most recent Presidential campaign, I do not know which one of the three debates, I think maybe the last one, the President talked about this, talked about the issue of needing to do something about medical liability insurance rates and his opponent, Senator KERRY, said the insurance premiums for physicians so they can continue to practice is a minuscule amount. President Bush was so correct when he said, yes, that is a big cost per individual physician; but in the overall picture it is not a big cost, but the cost, of course, as the gentleman from Texas pointed out, is all of the tests and procedures, the defensive medicine that is being practiced. That is why we cannot sustain that and we need to do something about it. It is not just the cost, as my co-chair talked about during his time, and I want to have further discussion about that. It is a safety issue. It is very definitely a safety issue.

Mr. Speaker, I would like to ask the gentleman from Pennsylvania (Mr. MURPHY) if he would continue to discuss that with us a little bit.

Mr. MURPHY. Mr. Speaker, I thank the gentleman from Georgia (Mr. GINGREY) for continuing to bring up these points. I want to talk about a couple of things and have you comment as a member of the medical profession.

First, I want to point out that this is an issue that the Federal Government should be driving. The Federal Government is the largest purchaser of health care in our Nation, even among very large companies that may have hundreds of thousands of employees and retirees spending billions of dollars on health care. Looking at our chart again, 45 percent of mandatory spending that the Federal Government spent on health care, it is expected to climb to 49 percent, and this chart here shows the Federal outlays are climbing over time.

That being the case, if we are dealing with liability issues, it is inseparable from patient safety. There are a couple

of issues that President Bush has offered to be moving forward, and they are ones which I am hoping all of us can embrace. The President has included \$125 million in this year's budget to help meet the goal of ensuring that most Americans have electronic medical records within the next 10 years.

Patient records are usually kept on record on paper. I know when I worked in hospitals, if we needed to call upon a patient's file, sometimes that would take a good deal of time. Whether it was half an hour or hours, that could have an effect on some of the decisions. I ask the gentleman to describe the cumbersome system in terms of what we are trying to move away from.

Mr. GINGREY. Mr. Speaker, the gentleman is so correct. I would hope, and I think that some of my colleagues probably did a little bit better job in keeping accurate records and neat charts, even though I learned to write and my penmanship was developed by the Catholic nuns at a very strict parochial school, but what the gentleman from Pennsylvania (Mr. MURPHY) is talking about is you have a chart, it is in the office. The doctor sees a patient maybe a couple of times a year over a long period of time. The chart gets thicker and thicker. Sheets are put in, not tabbed, they are out of order. The doctor may not know even when the patient was last seen if they are not a good historian.

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The gentleman from Pennsylvania talked about this earlier, about medical errors. The gentleman from Texas mentioned it, and I think the gentleman from Georgia, too; that the Institute of Medicine statistics, hopefully they are not accurate, because that is an astronomical number of deaths and injuries that they say occur each year because of medical errors. But as the gentleman pointed out, even one is too many. A lot of it is because of this sloppy medical recordkeeping. So, yes, it is definitely a problem and needs some immediate attention.

Mr. MURPHY. What the President has proposed here is to make some changes to entice hospitals throughout the Nation and from medical practice to go towards electronic medical records. Let me try and describe that for our colleagues. This is a system which could be kept in place within the hospital itself, so that, any time a physician needed to access, or any medical provider within that hospital network, needed to access the patient's file, they could call upon this. Think about all the times you have been to see the doctor and you have to fill in the history sheet all over again and your address. You hope you remember all the places you have gone and all of the medication you have been on and all the illnesses you have had, but chances are,

for the most part, a person cannot. In fact, some studies have looked at that, just looking at some of the paper charts that occur, that there are omissions and doctors acknowledge that because there are omissions in there, if they had further information, they would have made some different recommendations for tests, for diagnoses and that, in turns, saves money. Electronic medical records are a way of keeping this. Some have even proposed having either on a card or a patient may have some other device which could be plugged into a computer when they go to visit the doctor or the hospital, they can update those records. But the whole thing is really keeping these secure and confidential.

I know the University of Pittsburgh Medical Center, for example, is investing literally hundreds of millions of dollars in this. Information Weekly magazine rated them as the top medical center in the Nation in terms of making this move into electronic medical records. I am not sure if the gentleman from Georgia has seen one of these at work, but I am wondering perhaps if he could describe what happens and changing from that paper-dependent system which is very time consuming, requires a great deal of time for the doctor to keep track of what is in there as well as research those, what happens when you move towards an electronic medical records system and what that does for patient safety.

Mr. GINGREY. The point of all of that is that you know with that electronic medical recordkeeping, you can be anywhere in the world literally, a patient, if we have a way with a swipe card or maybe a radio frequency identification card which would look very much like a typical credit card, about the same size and thickness, but an individual would have a particular code that was unique to him or her and would have access through a very secure fire wall system to their medical records anywhere in the world, so that if you were in another country, on vacation, and this happens a lot, far too often, when a person gets sick, has a heart attack, in an automobile accident, in a remote place, the language is not the same, the communication is poor and the treatment is just not adequate. So when we get to that point, and we are there. I know the gentleman has talked about some systems. I have talked to a lot of people who are developing these cards. The President has talked about the need to go to a system like that. We have talked tonight about medical liability reform and needing to give our healthcare providers some relief so they can continue to practice medicine and our patients have access to that great health care system, but we have also spent a good bit of time tonight saying that we understand that, as I pointed out earlier in my statement, physician, heal thy-

self. We know there are some problems. I think one of the biggest problems in regard to the error rate is this issue, as the gentleman from Pennsylvania points out, of poor medical recordkeeping, the traditional system, the 20th century recordkeeping, if you will. It is time to make these changes. The technology is there. We need to incentivize. My colleague from Pennsylvania asked the question, what can we do in our individual office, how can we get doctors, either individuals or groups, to go to that kind of a system? It is going to be costly. That is going to be a disincentive, I think, for a lot of them to do that. But we need to move toward a system of reimbursement, maybe under the Medicare or Medicaid program, Federal match and 100 percent pay on Medicare. We need to be able to incentivize individual doctors and groups to go to this system.

Mr. MURPHY. The gentleman also well knows that doing these kinds of things saves money. The Center For Information Technology leadership estimated that, if we move towards electronic health records, it could save about \$78 billion a year, or 5 percent of the Nation's total annual healthcare cost. And in a time when so many businesses have seen their health care costs climbing, sometimes up into the double-digit amounts per year, it can do a great deal.

I know we only have a few minutes left, but one other thing just to whet the appetite with which we will need to come back to at another time is electronic prescribing. No offense to the good doctor, but very often, it is tough for someone to read a physician's handwriting. This can also lead to errors. Pharmacists estimate about 140 million times a year they will have to call back the physician because they may not understand the medication; they may question the dose. The pharmacist may be aware of other medication that patient is on, but the physician may not be aware. They may be aware of other allergies or reactions. Electronic prescribing, however, is another tool where doctors, at the moment they write the prescription, they can access that prescribing information. I wonder if the gentleman could comment on the importance of that.

Mr. GINGREY. There is no question about how important that is, because, as the gentleman from Pennsylvania pointed out, when you cannot even read the prescription, it is bad enough, but in many instances, a doctor is not going to know. Maybe the particular patient is sick in the emergency room, high fever, not at their best mentally, they are not going to be able to relate that information. That is why these cards are going to be so important so that, when you write that prescription, even if your penmanship is absolutely perfect, you need to make sure that you are not giving them a medication

that would react with maybe two or three other things that they are on and could cause a serious problem.

Tonight, as we wrap up, and I am so thankful to be doing this with my co-chair, the gentleman from Pennsylvania, and we will continue to bring subjects, healthcare issues, probably do an hour like this on a monthly basis, this team of Members, Republican Members, who are either healthcare providers or extremely interested in this issue for the good of the Nation.

In closing, I want to make sure that my colleagues understand that most healthcare providers, if a patient is injured because of someone practicing below the standard of care, then we want them to recover. It is not about taking away anybody's right to a redress of grievances. I look forward to the discussion with my colleagues next month.

THE NATIONAL ECONOMY

The SPEAKER pro tempore (Mr. DENT). Under a previous order of the House, the gentleman from California (Mr. DREIER) is recognized for 5 minutes.

Mr. DREIER. Mr. Speaker, I want to begin by congratulating the gentleman from Georgia (Mr. GINGREY) and the gentleman from Pennsylvania (Mr. MURPHY) for their fine work focusing on the very important health care needs that exist and the challenges that the American people have in obtaining quality health care.

I want to take just a few minutes to talk about an issue which was very critical and important in last fall's campaign, and I want to talk about some of the wild inaccuracies that came to the forefront during that campaign. That is, the claims that were made about the U.S. economy. Our supposedly Depression-like economy that was not producing any new jobs was the most prevalent issue that came to the fore during last fall's campaign. We all heard it over and over and over again, the charge that President Bush was the first President since Herbert Hoover to preside over a net job loss. It became something of a mantra for our friends on the other side of the aisle throughout the campaign, the first President since Herbert Hoover to preside over a net job loss.

Now that the frenzy of the campaign season is behind us, I hope that we can take a calm and very rational look at the actual facts. The basis for the Herbert Hoover comparison, Mr. Speaker, was the Bureau of Labor Statistics payroll job survey, a fitting association since it is a Depression-era survey. That payroll job survey was established at the time of the Depression, and it was based on a Depression-era economy.