

**Oregon's Increased Number of Doctors:
*Government Data Refutes Medical
Lobby Claims***



August 2004

Acknowledgments

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Table of Contents

Executive Summary	1
The Number of Doctors in Oregon Has Increased Steadily Despite the Damages Cap Being Declared Unconstitutional	6
<i>Figure 1: Active Doctors in Oregon, 1995-2004</i>	6
The Number of Doctors Practicing "High-Risk" Specialties Has Increased Steadily	7
<i>Figure 2: Selected Specialties, Active Doctors in Oregon, 1995-2004</i>	7
The Number of Doctors in Rural Oregon Has Also Increased Steadily	9
<i>Figure 3: Active Doctors in Rural Oregon, 2000-2004</i>	9
The Number of Doctors Practicing "High-Risk" Specialties in Rural Oregon Has Increased Significantly.....	10
<i>Figure 4: Selected Specialties, Active Doctors in Rural Oregon, 2000-2004</i>	11
Insurance Costs for Oregon's Rural Doctors Recently Have Been Dramatically Reduced	12
Congressional Watchdog Agency Finds AMA Claim of Malpractice Insurance "Crisis" Unsubstantiated	13
Many Factors Contribute to a Continually Low Supply of Rural Physicians.....	15
2003 Oregon Medical Association Survey Is Unreliable and Inconclusive.....	18
2003 OHSU Survey of Obstetricians Provides No Evidence of a Malpractice "Crisis" as the Cause of Discontinuing Care	20
New York Study Found a Relation Between Age and Discontinuing Obstetrics Care but not Between Malpractice Premiums and Discontinuing Care	22
A Variety of Factors Have Led to a Nationwide Scarcity of Obstetrics Providers in Rural Areas	23
Why Doctors Practice Where They Do: Quality of Life, Not Caps on Damages	24
<i>Figure 5: States With Most Doctors Per Capita</i>	25
<i>Figure 6: States With Fewest Doctors Per Capita</i>	26
End Notes	27

Executive Summary

The American Medical Association (AMA) has declared that Oregon is one of 19 states experiencing a “liability crisis.”¹ According to Oregonians for Quality, Affordable and Reliable Health Care—a coalition associated with the Oregon Medical Association (OMA)—“Patients are watching helplessly as their doctors retire early, leave the state, or stop offering certain procedures, such as delivering babies, or complex surgery. Obstetrics, trauma centers, and rural health clinics are being forced to close, and many Oregon patients are losing access to their doctors and are forced to travel long distances for their care.”²

The medical lobby also argues that *rural* areas are hardest hit by rising insurance premiums and that, as a result, a disproportionately high percentage of rural doctors in high-risk specialties such as obstetrics are no longer providing services.

The medical lobby asserts this “crisis” is caused by a 1999 Oregon Supreme Court ruling declaring that a \$500,000 cap on non-economic damages was unconstitutional. Interest groups claim that lifting the cap has led to greatly increased medical liability premiums, and that these costs are having a devastating effect on access to health care.

Oregon’s cap on non-economic damages was in place from 1987 to 1999. Non-economic damages are awarded by juries for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, loss of sexual function, lost bowel and bladder control, loss of limb) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility.

Public Citizen and OSPIRG have a different point of view. While we are very concerned that a spike in insurance rates is occurring, we believe that it is temporary and due to the economics of the insurance industry—not a result of lawsuits and the legal system.

We also believe a close examination of the assertions made about a doctor exodus from Oregon is sorely needed. That is the purpose of this study, and its major findings show that:

- The number of active Oregon doctors has increased at the same rate from 2000-2004 as it did from 1995-1999.
- The number of key specialists in Oregon, such as those practicing emergency room medicine, obstetrics and gynecology, neurological surgery and general surgery, increased at a faster rate from 2000-2004 than from 1995-1999.
- From 2000-2004, the only years for which the data was available, the increase in the number of active rural doctors in Oregon was equal to the overall state increase in doctors, 11.9 percent.
- The most important factors determining where and whether doctors continue to practice are wages and quality of life issues (education, recreation, arts)—not caps on damages.

Specific findings of this report include:

- **The number of active doctors in Oregon increased at the same rate during the four years before and after damage caps were ruled unconstitutional, according to Oregon Board of Medical Examiners data.** The number of active doctors in Oregon rose 11.9 percent from 2000 to 2004, compared to 12 percent from 1995 to 1999. There were 8,388 physicians practicing in Oregon in 2000 and 9,382 in 2004—an increase of 994, or 11.9 percent. By comparison, the number of physicians practicing in Oregon grew from 7,517 in 1995 to 8,416 in 1999, an increase of 899, or 12 percent.
- **According to Oregon Board of Medical Examiners data, the number of active Oregon doctors specializing in:**
 - **Obstetrics and gynecology** rose 17.1 percent from 2000 to 2004, compared to 15 percent from 1995 to 1999;
 - **Emergency medicine** rose 25.8 percent from 2000 to 2004, compared to 15.4 percent from 1995 to 1999.
 - **Neurological surgery** increased 21.7 percent from 2000 to 2004, compared to 13.9 percent from 1995 to 1999; and
 - **General surgery** increased 34.4 percent from 2000 to 2004, compared to a 4.3 percent decrease from 1995 to 1999.
- **Trauma care is plentiful in Oregon.** Oregon has seven Level I and II trauma centers, or 2.05 per 1 million residents. According to a 2003 study published in the *Journal of the American Medical Association*, this is at the upper end of what is considered the optimal range (between one and two per 1 million residents).
- **The number of active doctors in rural Oregon rose 11.9 percent from 2000 to 2004, according to Oregon Office of Rural Health data—the same rate of increase in doctors as in all of Oregon.** In 2000, there were 1,484 physicians practicing in rural Oregon. In 2004, the number had risen to 1,660—an increase of 176, or 11.9 percent.
- **The number of doctors practicing obstetrics and gynecology in rural Oregon rose 26.7 percent from 2000 to 2004, according to Oregon Office of Rural Health data.** This rate of increase is 56 percent greater than the 17.1 percent increase in OB/GYNs in all of Oregon over the same period.
- **The number of doctors practicing emergency medicine in rural Oregon rose 27.5 percent from 2000 to 2004, according to Oregon Office of Rural Health data.** This rate of increase is 6.5 percent greater than the 25.8 percent increase in emergency room doctors in all of Oregon over the same period.
- **From 2000 to 2004, only one doctor performing neurological surgery in rural Oregon stopped providing this service.** While few neurosurgeons practice in rural Oregon, their numbers have not decreased significantly since the 1999 Oregon Supreme

Court decision. In 2000, only four doctors performed neurological surgery in rural areas, whereas in 2004 three doctors perform these high-risk surgeries, according to the Oregon Office of Rural Health. This is too small a sample to consider this change statistically significant.

- **Insurance costs for Oregon’s rural doctors recently have been dramatically reduced.** Beginning in 2004, doctors in rural Oregon began receiving reductions of up to 80 percent in medical malpractice insurance costs. The program covers doctors of medicine and osteopaths who have active unrestricted licenses to practice medicine in Oregon, have rural medical practices amounting to at least 60 percent of their medical practices, and have current medical liability insurance with minimum limits of \$1 million per occurrence and \$1 million in aggregate to maximum limits of \$1 million per occurrence and \$3 million aggregate. The program provides premium reimbursements of up to 80 percent for rural obstetricians, 60 percent for family and general practice doctors who provide obstetric services, and 40 percent for all other doctors with qualifying rural practices. In 2004, 1,002 doctors are participating in the program.
- **The U.S. Government Accountability Office (GAO) essentially found that the AMA and allied groups manufactured a malpractice “crisis.”** A 2003 GAO study compared conditions in five AMA-designated “crisis states” and found that the AMA’s claims that medical services were unavailable in particular areas because of malpractice costs were not reliable.
- **Access to medical care has long been a problem throughout rural America.** The Council on Graduate Medical Education (COGME) has stated that, “The relative shortage of health professionals in rural areas of the United States is one of the few constants in any description of the United States medical care system.”
- **Attracting and retaining rural doctors is currently a problem throughout the country—not just in states that do not limit malpractice awards.** Although nearly 25 percent of the U.S. population resides in rural areas, only about ten percent of the nation’s doctors work in these areas.
- **A number of factors have been cited by doctors and researchers to explain the low supply of rural doctors.** For instance, wages are generally lower in rural areas; rural residents are more likely to be uninsured and depend on public health programs with lower reimbursement rates; rural doctors are more likely to report that they are overworked; rural doctors are more likely to report that they receive inadequate assistance and coverage from their colleagues; and rural are doctors more likely to suffer from burnout.
- **An Oregon Medical Association (OMA) Survey indicating that some physicians have stopped or planned to stop providing certain services as a result of high medical malpractice premiums is biased and fails to produce objective or reliable information.** According to the OMA, “Respondents were asked if the cost or

availability of professional liability insurance had caused or would cause them to make changes in their practices.” This question is leading and clearly indicates the desired answer. Results obtained from this survey should therefore be approached with caution. Also, the survey is limited by respondent bias. The survey does not demonstrate that 17 percent of doctors have quit or plan to quit providing certain services. Instead, it only shows that around 17 percent of respondents replied that they have quit or plan to quit. This percentage may be inflated since providers who have stopped or who are thinking about stopping certain services may be more likely to respond to a survey on this topic.

- **An Oregon Health and Science University (OHSU) study did not find any relationship between increased premiums and a doctor’s likelihood of ceasing obstetrical care.** The 2003 press release for the survey was highly misleading and resulted in news stories claiming that, “the most common reason offered [for physicians planning to quit] was the rising cost of malpractice insurance.” In actuality the survey did not even use insurance premium amount as a variable to predict discontinuation of care. Instead, it found that physicians’ age and workload factors are most likely to predict discontinuation of care.
- **Doctors commonly respond to such surveys by indicating a high likelihood of quitting.** Indeed, a higher percentage of all doctors in a California survey (43 percent)—a state with draconian limits on malpractice awards—than obstetricians in the OHSU survey (31 percent) said they plan to quit.
- **A University of California-San Francisco study of New York doctors found that the main reason doctors cease providing obstetrics care is advancing age.** The study, of New York State physicians during the mid-1980s insurance crisis, also found no association between malpractice premiums and doctors’ decisions to quit.
- **Obstetricians frequently cut back their practice as they advance in years.** As doctors become more financially secure, and as the child-bearing years of their patient population pass, many obstetricians give up the demands of delivering babies in favor of concentrating on the gynecological needs of their patients. For example, in 2000, 18.7 percent of Georgia’s OB/GYNs were between 40 and 44 years old, but only 11.1 percent of OB/GYNs were 50-54 years old—a decrease of about 40 percent.
- **When insurance premiums decline, rural areas often do not see an increase in providers willing to provide obstetrical services.** In many states, reducing malpractice rates did not bring obstetrics providers back to rural areas. One study of doctors in North Carolina found that tort limits and a malpractice insurance subsidy “did not seem to be extremely important in their decision-making process over whether to remain in obstetrics or to expand access to their practices.”
- **Throughout the country, few obstetricians practice in rural communities.** According to a nationwide study reported by COGME, in 1995, rural counties where the largest towns had fewer than 10,000 people had an average of less than three OB/GYNs.

- **There is a decreased demand for obstetrics services in rural Oregon.** The average age in many areas of rural Oregon is rapidly increasing as young families move away in search of better paying jobs. This has resulted in a decreased need for obstetricians. For example, according to an article in the *Oregonian*, the median age in Reedsport, Oregon in 1980 was 31. By 2003 it had increased to 47. In 1991 doctors in one Reedsport practice delivered about 100 babies a year, but in 2003 they delivered only about 40.
- **Liability laws do not correlate with where doctors' locate their practice.** While four of the states with the fewest per capita number of doctors in 2004 had enacted caps on non-economic damages, only three of the states with the most number of doctors per capita had enacted them. Similarly, while three of the states with the fewest number of doctors had enacted caps on punitive damages, only one of the states with the most number of doctors had capped punitive damages.
- **Doctors choose to reside in states with a higher quality of life, not because of state liability laws.** Like anyone else, doctors want to live in places where they can earn high incomes, enjoy cultural and leisure activities, and send their children to good schools. It is not surprising that doctors migrate to states on lists of "Best Places to Live."

Caps on non-economic damages have not been proven to effectively lower medical malpractice insurance costs. More important, caps penalize only the most severely injured patients—those who most deserve full compensation—while reducing medical accountability, thereby lessening deterrence against errors and negligence.

Limiting medical malpractice awards for non-economic injury has a disproportionate impact on children, women, seniors and minorities. Children have no employment income, which is the basis for calculating most economic awards. One of the more significant medical injuries inflicted on women is harm to reproductive capacity, but that does not impact a woman's earning capacity, and thus does not entitle her to economic damages despite the devastating emotional impact of such a loss. Retired seniors who suffer often deplorable neglect and abuse in nursing homes and other long-term care facilities have no employment income. Capping awards also discriminates against minorities since they have lower incomes on average than whites.

People severely injured by medical negligence are already harmed once. It is cruel and unusual punishment to harm them a second time by capping their damages.

The Number of Doctors in Oregon Has Increased Steadily Despite the Damages Cap Being Declared Unconstitutional

The medical lobby claims that lifting the cap on non-economic damages has caused Oregon doctors to leave the state and to retire early. A website for a coalition affiliated with the OMA explains the results of rising malpractice premiums by stating, “Oregon is losing its doctors, and patient care is suffering.”³ Yet despite the 1999 Oregon Supreme Court decision finding a cap on non-economic damages to be unconstitutional, the number of doctors in Oregon has increased at the same rate in the four years before and after the court decision.

- **The number of active doctors in Oregon rose 11.9 percent from 2000 to 2004.** In 2000, there were 8,388 active doctors in Oregon. In 2004, the number had risen to 9,382—an increase of 994, or 11.9 percent. [See Figure 1] (Active doctors includes doctors licensed and living in Oregon, not working in another state. Virtually all are practicing.⁴)
- **The number of active doctors in Oregon rose as much from 2000-2004 as it did from 1995-1999.** In 1995, 7,517 physicians were practicing in Oregon, and by 1999 the number had risen to 8,416. This represents an increase of 899, or 12 percent, virtually the same amount that the number of doctors increased from 2000-2004. [See Figure 1]

Figure 1

Active Doctors in Oregon, 1995-2004

Year	Number of Licensed Physicians, Osteopaths and Podiatrists
1995	7,517
1996	7,559
1997	7,941
1998	7,935
1999	8,416
2000	8,388
2001	8,825
2002	8,929
2003	9,385
2004	9,382
Increase (1995 - 1999)	899 12%
Increase (2000 - 2004)	994 11.9%

Source: Licensed Physicians Totals by Status and Type, Oregon Board of Medical Examiners.

The Number of Oregon Doctors Practicing “High-Risk” Specialties Has Increased Steadily

The medical community argues that rising malpractice premiums are not only causing doctors to retire or leave the state, but they are also forcing Oregon doctors to quit practicing “high-risk” specialties, including obstetrics, emergency medicine, general surgery and neurological surgery. But not only are the numbers of doctors in Oregon increasing steadily, the numbers of doctors practicing these “high-risk” specialties are also increasing—often at a much higher rate than other much less risky specialties. Moreover, the number of doctors in each of these specialties increased by greater percentages from 2000-2004—after the cap on non-economic damages was lifted—than they did from 1995-1999.

- **The number of active Oregon doctors specializing in obstetrics and gynecology rose 17.1 percent from 2000 to 2004, compared to 15 percent from 1995 to 1999.** Obstetrics is considered a very “high-risk” specialty because a large percentage of malpractice claims are associated with obstetrics. But the number of doctors specializing in obstetrics and gynecology in Oregon has increased since the cap on non-economic damages was lifted. In 2000, there were 410 doctors specializing in obstetrics and gynecology in Oregon. In 2004, the number had risen to 480—an increase of 70, or 17.1 percent. By comparison, the number of doctors specializing in obstetrics and gynecology increased from 361 in 1995 to 415 in 1999, an increase of 54, or 15 percent. [See Figure 2]

Figure 2

Selected Specialties, Active Doctors in Oregon, 1995-2004

Specialty	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Change (1995 - 1999)	Change (2000 - 2004)
Emergency Medicine	351	360	370	386	405	431	474	502	540	542	54 15.4%	111 25.8%
Family Practice	1,057	1,089	1,186	1,199	1,293	1,267	1,403	1,415	1,517	1,517	236 22.3%	250 19.7%
General Surgery	349	332	343	323	334	311	402	396	454	418	-15 -4.3%	107 34.4%
Internal Medicine	1,112	1,120	1,198	1,210	1,291	1,280	1,476	1,503	1,610	1,578	179 16.1%	298 23.3%
Neurological Surgery	79	83	90	89	90	92	112	114	119	112	11 13.9%	20 21.7%
Obstetrics & Gynecology	361	364	393	395	415	410	475	478	516	480	54 15%	70 17.1%
Orthopedic Surgery	326	326	335	328	339	342	368	376	402	384	13 3.9%	42 12.3%

Source: Licensed Physician Totals by Specialty, Oregon Board of Medical Examiners.
Includes medical doctors, osteopathic physicians and surgeons, and podiatrists.

- **The number of active Oregon doctors specializing in neurological surgery increased 21.7 percent from 2000 to 2004, compared to 13.9 percent from 1995 to 1999.** Because injuries occurring during neurosurgery are often quite severe, malpractice awards in this field tend to be very high. Neurosurgery is therefore also considered to be very high-risk. In 2000, 92 Oregon doctors specialized in neurological surgery. In 2004, the number had risen to 112—an increase of 20, or 21.7 percent. By comparison, the number of active Oregon doctors specializing in neurological surgery increased from 79 in 1995 to 90 in 1999—an increase of 11, or 13.9 percent.
- **The number of active Oregon doctors specializing in general surgery increased 34.4 percent from 2000 to 2004, whereas it *decreased* 4.3 percent from 1995 to 1999.** In 2000, 311 Oregon doctors specialized in general surgery. In 2004 the number had risen to 418—an increase of 107, or 34.4 percent. By comparison, the number of doctors practicing general surgery decreased from 349 in 1995 to 334 in 1999, a decrease of 15, or 4.3 percent. [See Figure 2]
- **The number of active Oregon doctors specializing in emergency medicine rose 25.8 percent from 2000 to 2004, compared to 15.4 percent from 1995 to 1999.** In 2000, 431 doctors specialized in emergency medicine in Oregon. In 2004, the number had risen to 542—an increase of 111, or 25.8 percent. By comparison, the number of doctors specializing in emergency medicine increased from 351 in 1995 to 405 in 1999, an increase of 54 or 15.4 percent. [See Figure 2]
- **Trauma care is plentiful in Oregon.** Although the medical community claims that high medical malpractice premiums are creating a crisis in terms of patients access to trauma care, Oregon has seven Level I and II trauma centers, or 2.05 per 1 million residents. According to a 2003 study published in the *Journal of the American Medical Association*, this is at the upper end of what is considered the optimal range (between one and two per 1 million residents).⁵ Seven of the top ten states with the recommended number of level I and II trauma centers per million populations do not cap non-economic damages. Yet only two of the six states designated by the AMA as “currently okay” as far as medical liability is concerned have the required concentration of level I and II trauma centers per millions of populations.⁶

The Number of Doctors in Rural Oregon Has Also Increased Steadily

One of the primary claims of the medical community—and the one that has attracted the most attention from the media—is that lifting the cap on non-economic damages has led to a crisis in access to health care in rural Oregon. However, examining the number of doctors practicing in rural Oregon reveals that their numbers have increased at the same rate since 2000 as doctors throughout Oregon. (Note: Rural doctor data was not available for earlier years.)

- **The number of active doctors in rural Oregon rose 11.9 percent from 2000 to 2004, the same rate of increase in doctors as in all of Oregon.** In 2000, there were 1,484 physicians practicing in rural Oregon. In 2004, the number had risen to 1,660—an increase of 176, or 11.9 percent. [See Figure 3]

Figure 3

Active Doctors in Rural Oregon, 2000-2004

Year	Number of Licensed Physicians and Osteopaths
2000	1,484
2001	1,620
2002	1,604
2003	1,651
2004	1,660
Increase (2000 - 2004)	176 11.9%

Source: Oregon Office of Rural Health determined rural areas and obtained the number of licensed physicians in those rural areas from the Oregon Board of Medical Examiners.⁷ (The Office did not collect this data prior to 2000,⁸ nor does it include podiatrists.)

The Number of Doctors Practicing “High-Risk” Specialties in Rural Oregon Has Increased Significantly

Leaders in the medical community argue that rural areas are most affected by the loss of doctors performing high-risk specialties such as obstetrics and emergency medicine. However, both specialties saw dramatic increases in the number of practicing doctors between 2000 and 2004, at rates that surprisingly exceeded low-risk specialties such as family practice and internal medicine.

- **The number of doctors specializing in obstetrics and gynecology in rural Oregon rose 26.7 percent from 2000 to 2004.** Obstetrics is considered a very “high-risk” specialty because a large percentage of malpractice claims are associated with obstetrics. In 2000, there were 60 doctors specializing in obstetrics in rural areas. In 2004, the number had risen to 76—an increase of 26.7 percent. [See Figure 4] This rate of increase is 56 percent greater than the 17.1 percent increase in OB/GYNs in all of Oregon over the same period.
- **The number of doctors specializing in emergency medicine in rural Oregon rose 27.5 percent from 2000 to 2004.** In 2000, 102 doctors specialized in emergency medicine in rural Oregon. In 2004, the number had risen to 130—an increase of 27.5 percent. [See Figure 4] This rate of increase is 6.5 percent greater than the 25.8 percent increase in emergency room doctors in all of Oregon over the same period.
- **From 2000 to 2004, only one doctor specializing in neurological surgery in rural Oregon has stopped providing this service.** The Oregon medical community has argued that due to high insurance premiums, neurosurgeons are no longer practicing in rural Oregon. It is true that few neurosurgeons practice in rural Oregon; however, their numbers have not decreased significantly since the 1999 Oregon Supreme Court decision. In 2000, four doctors specialized in neurological surgery, whereas in 2004 three doctors specialize in these high-risk surgeries.⁹ This is too small a sample to consider this change statistically significant.

It is not surprising that few neurosurgeons practice in rural Oregon. Indeed, few of such highly specialized doctors practice in any part of rural America. Statistics show that the more specialized the physician, the less likely she is to settle in a rural area. Specialists require a large population base, state-of-the-art hospitals and laboratories, and colleagues also practicing their specialty.¹⁰

Figure 4
Selected Specialties, Active Doctors in Rural Oregon,
2000-2004

Specialty Name	2000	2001	2002	2003	2004	Increase (2000 - 2004)
Emergency Medicine	102	116	114	123	130	28 27.5%
Family Practice	470	507	518	524	521	51 10.9%
General Surgery	72	83	80	78	79	7 9.7%
Internal Medicine	212	240	239	236	256	44 20.8%
Obstetrics and Gynecology	60	76	75	83	76	16 26.7%
Orthopedic Surgery	64	67	66	72	71	7 10.9%

Source: Oregon Office of Rural Health determined rural areas and obtained the number of licensed physicians, by specialty, in those rural areas from the Oregon Board of Medical Examiners.¹¹ (The Office did not collect this data prior to 2000.¹²)

Insurance Costs for Oregon's Rural Doctors Recently Have Been Dramatically Reduced

Since at least 1989, Oregon has recognized the need to provide incentives to its rural doctors. At that time the state legislature passed a law granting up to \$5,000 in tax credits to rural doctors.¹³ The legislature's newest attempt to recruit and retain rural physicians with a major liability insurance subsidy program has made it harder for the medical community to claim that limited access to health care in rural Oregon is caused by a spike in malpractice insurance premiums.

While there is no evidence that strong tort laws systematically drive doctors away from delivering babies, it is true that the higher premiums charged to obstetricians, coupled with declining birthrates in rural areas, can make it economically infeasible for some doctors to attend deliveries. Oregon's subsidy program targets this particular problem without reducing compensation to injured patients.

On January 1, 2004, doctors in rural Oregon began receiving reductions of up to 80 percent in medical malpractice insurance costs.¹⁴ Under the new program, the State Accident Insurance Fund (SAIF) will reimburse insurance companies covering rural doctors for a portion of the premium they charge. The reimbursement is then used to reduce doctors' premiums.

The program covers doctors of medicine and osteopaths who have active unrestricted licenses to practice medicine in Oregon, have rural medical practices amounting to at least 60 percent of their medical practices, and have current medical liability insurance with minimum limits of \$1 million per occurrence and \$1 million in aggregate to maximum limits of \$1 million per occurrence and \$3 million aggregate.

The program provides premium reimbursements of up to:

- 80 percent for rural obstetricians;
- 60 percent for family and general practice doctors who provide obstetric services; and
- 40 percent for all other doctors with qualifying rural practices

Total reimbursement for all policy holders is capped at \$10 million per year for 2004-2007. In 2004, 1,002 doctors are participating in the program. At this level, doctors will be reimbursed at the full level permitted (80, 60, or 40 percent, depending upon the doctor's practice).¹⁵

Congressional Watchdog Agency Finds AMA Claim of Malpractice Insurance “Crisis” Unsubstantiated

The AMA and state medical associations in all the so-called “malpractice crisis” states claim that rising malpractice premiums are limiting consumers’ access to health care by driving doctors in these states either out of practice, or out of the state. The non-partisan watchdog, the U.S. Government Accountability Office (GAO), formerly named the General Accounting Office, performed a detailed examination of five of the AMA’s “crisis” states to determine whether evidence supported the claim that rising malpractice premiums affected consumers’ access to health care. Based on the GAO’s findings of August 2003, Oregonians should take heed when listening to the medical associations’ claims that rising premiums are limiting access to healthcare.

The GAO made the following findings:

- **Many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis.** The GAO study examined in-depth five states on the AMA’s crisis list: Florida, Mississippi, Nevada, Pennsylvania and West Virginia. The study failed to reveal convincing evidence that increased malpractice insurance premium costs had caused a significant number of physicians to move, retire or reduce high-risk services.¹⁶
- The GAO report said: *“In the five states with reported problems ... we determined that many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to health care. For example, some reports of physicians relocating to other states, retiring, or closing practices were not accurate or involved relatively few physicians.”*¹⁷ (emphasis supplied)
- Although the GAO confirmed instances in which “actions taken by physicians [in response to malpractice insurance rates] have reduced access to services...these were not concentrated in any one geographic area and often occurred in rural locations, where maintaining an adequate number of physicians may have been a long standing problem.”¹⁸ The GAO further reported that “the problems we confirmed were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services.”¹⁹
- **The GAO found no decreases in three of the services frequently cited by the AMA as being reduced.** After analyzing utilization rates among Medicare beneficiaries in the five states, the GAO found that spinal surgeries actually increased during the so-called “crisis” period. Moreover, the rate of spinal surgeries in the five “crisis” states was higher than the national average. Similarly, the GAO found that utilization rates of mammograms increased during the “crisis” period and were higher in the five states studied than the national average. Utilization of joint revision and repair services (hip, knee and shoulder repairs) in the five states studied was slightly below the national average but had not recently declined.²⁰

- **The GAO said its findings are relevant to other states.** In response to questions by the AMA regarding the application of its findings to states other than the five crisis states studied, the GAO said: “While we did not attempt to generalize our findings beyond these five states, we believe that – because they are among the most visible and often-cited examples of ‘crisis’ states – the experiences of these five states provide important insight into the overall problem.”²¹

Regarding three of the specific states covered in its study, the GAO reported:

- **Florida:** In Florida, where doctors’ successfully lobbied for the passage of a cap on damages, “[r]eports of physician departures ... were anecdotal, not extensive, and in some cases ... inaccurate. For example, state medical society officials told us that Collier and Lee counties lost all of their neurosurgeons due to malpractice concerns; however, we found at least five neurosurgeons currently practicing in each county as of April 2003. ... [O]ver the past two years the number of new medical licenses issued has increased and physicians per capita has remained unchanged.”²²
- **Nevada:** “In Nevada, 34 OB/GYNs reported leaving, closing practices, or retiring due to malpractice concerns; however, confirmatory surveys conducted by the Nevada State Board of Medical Examiners found nearly one-third of these reports were inaccurate. ... Random calls [GAO] made to 30 OB/GYN practices in Clark County found that 28 were accepting new patients. ... Similarly, of the 11 surgeons reported to have moved or discontinued practicing, the board found four were still practicing.”²³
- **Pennsylvania:** “In Pennsylvania, despite reports of physician departures, the number of physicians per capita in the state has increased slightly during the past six years. The Pennsylvania Medical Society reported that between 2002 and 2003, 24 OB/GYNs left the state due to malpractice concerns; however, the state’s population of women age 18 to 40 fell by 18,000 during the same time period.”²⁴

Many Factors Contribute to a Continually Low Supply of Rural Physicians

Leaders of the medical community have raised alarm that due to unlimited medical malpractice awards, doctors in rural Oregon are being forced to leave their practices and some specialties are no longer available throughout the state.²⁵ As demonstrated above, Public Citizen found that the numbers of physicians in rural Oregon are actually increasing—even in “high-risk” fields such as obstetrics. But to the extent that doctors practicing certain specialties are not available in some parts of the state, it is not at all likely that it is caused by a spike in malpractice insurance rates or a result of unlimited non-economic damages. For 25-30 years many rural communities have not had the number of medical professionals that most experts consider adequate.²⁶

- **Access to medical care has long been a problem throughout rural America.** According to the Council on Graduate Medical Education (COGME), “Geographic maldistribution of health care providers and services [the tendency for physicians to practice in affluent urban and suburban areas] is one of the most persistent characteristics of the American health care system. Even as an oversupply of some physician specialties is apparent in many urban health care service areas across the country, many inner-city and rural communities still struggle to attract an adequate number of health professionals to provide high-quality care to local people. This is the central paradox of the American health care system: shortages amid surplus.”²⁷

COGME also notes that, “The relative shortage of health professionals in rural areas of the United States is one of the few constants in any description of the United States medical care system.”²⁸

- **Attracting and retaining rural doctors is currently a problem throughout the country—not just in states that do not limit malpractice awards.**
 - Rural doctors around the country find it difficult to recruit colleagues, and community groups in rural areas have similar troubles in recruiting doctors to work in their communities.²⁹
 - Although nearly 25 percent of the U.S. population resides in rural areas, only about ten percent of the nation’s doctors work in these areas.³⁰
- **A number of factors have been cited by doctors and researchers to explain the low supply of rural doctors.**
 - People who live in rural areas are more likely to be uninsured than are those who live in urban areas, meaning that they see a doctor less often or are often a financial liability for doctors who care for them.³¹

- The percentage of public health recipients is also greater in rural areas.³² Low Medicare and Medicaid reimbursement rates can be crippling for these doctors.
- Rural doctors have a lower volume of patients, while costs for things such as equipment remain the same.³³
- Rural doctors report that they are overworked.³⁴ According to surveys conducted by the Oregon Medical Association, doctors in rural Oregon report that they work more hours per week than those in urban areas of the state.³⁵
- Rural doctors are more likely to report that they receive inadequate assistance and coverage. One study of obstetricians and gynecologists in North Carolina investigated these doctors' perceptions of the adequacy of consultation and coverage and found that 13 percent of rural physicians but only 1.5 percent of urban physicians in North Carolina indicated that assistance (opportunities for colleagues to see patients and review charts) in high-risk delivery situations was "inadequate" or "very inadequate." In terms of coverage (opportunities for colleagues to assist in the primary doctor's absence), 16.7 percent of rural physicians and only 2.5 percent of urban physicians indicated that coverage was "inadequate" or "very inadequate."³⁶
- Studies indicate that women are much less likely to settle in rural areas than are men. As the percent of doctors who are women increases, it has been suggested that women's preferences for urban practice may be contributing to the problem of recruiting and retaining rural doctors.³⁷
- **Numerous additional factors explain the limited numbers of rural doctors.** According to the Association of Maternal and Child Health Programs, the Oregon Health Department, as well as health departments in Alaska, Idaho, and Washington, cite the following barriers to attracting doctors to rural areas of their states:³⁸
 - **"Burnout** is one reason it is so difficult to retain qualified primary care providers. Physicians note that as the only doctor in a small, isolated community they are on-duty 24-7 and can expect to be asked for medical opinions at the post office, grocery store or a 2:00 a.m. call at home from a worried family member. Taking time off for vacation or professional training means complicated arrangements for a substitute doctor."
 - **"Isolation** is a factor in rural practice, not just for the physician but also for their families. Physicians note that while they may find rural practice challenging and engaging, their families may be less enthusiastic. Rural areas offer limited employment opportunities for spouses and limited educational, recreational and social opportunities for children. Physicians are also isolated from colleagues. Rural physicians are not able to enjoy the day-to-day personal contact with peers for consultations, quality assurance and feedback."

- “**Wages** are generally lower for non-urban practitioners. Higher rates of unemployment and poverty, uninsured residents and fewer patients mean rural communities are less able to match the financial incentives and job benefits offered in urban areas.”
- “**Community and cultural connections** are important for both the physician and the patients they serve, but are not easily made. Physicians and health care providers are usually recruited from larger urban areas or from out-of-state and usually have limited knowledge of the health needs, culture or history of the people in their care. At the same time the physician is feeling disconnected, community members are reluctant to accept or support a new physician unless they have proven their commitment to the community over time.”
- “**The health care infrastructure** — such as a hospital, clinic and laboratory facilities — supports primary health care providers. Physicians are reluctant to locate in a community without a hospital or other supporting facilities.”

2003 Oregon Medical Association Survey is Unreliable and Inconclusive

The medical community has supported its argument that a limit on malpractice awards is needed by citing a 2003 Oregon Medical Association (OMA) Survey.³⁹ The OMA mailed questionnaires to all physicians listed as practicing with an active Oregon license. About half of these physicians, 48 percent, responded. Of these, 17.5 percent indicated that the cost or availability of liability insurance had caused or would cause them to stop providing certain services. Physicians outside of the Portland metropolitan area were more likely to have made or planned to make changes in their practices.

- **The survey is biased and fails to produce objective or reliable information concerning physician supply.** Respondents were asked “to complete a table by indicating if the cost or availability of professional liability insurance had caused or would cause them to make changes in their practices.”⁴⁰

Results obtained from these surveys should be approached with caution. Asking doctors to “Indicate if the cost or availability of professional liability insurance caused or will it cause you to make changes in your practice?” is leading and clearly indicates the desired answer. This phrasing of the question does not distinguish between situations in which physicians limit certain practices or procedures for reasons other than malpractice, such as age, health, lateral moves, lifestyle or a desire to move to other, more attractive locations.

Had the questions been presented in two parts, “Have you changed your practice?” and, “If so, why?,” respondents would have been more likely to separate malpractice insurance costs from non-malpractice reasons.

Asking a physician whether he plans to limit his practice at a time when large increases in medical liability insurance are being contemplated and widely discussed is like asking a prison inmate requesting early release if he will be good once he is set free. The response is a foregone conclusion.

- **The survey is also limited by respondent bias.** Some news stories have indicated that the survey demonstrated that 17 percent of doctors have quit or plan to quit providing certain services. But this is inaccurate. The study actually only shows that around 17 percent of respondents replied that they have quit or plan to quit. The percentage of respondents indicating that they have stopped or plan to stop may be inflated due to respondent bias. Providers who have stopped or who are thinking about stopping certain services may be more likely to respond to a survey on this topic. Therefore, the overall percentage of providers who have stopped or plan to stop providing services is likely less than the percentage of respondents who have stopped or plan to stop providing certain services.

- **The survey responses do not indicate either how many providers have stopped or how many will stop providing certain services.** Research will need to be done to determine if the doctors who replied that they planned to quit do indeed quit providing these services. Responding to a survey by stating that you plan to stop providing certain services is much different than actually stopping. It is not known how many of those who say they plan to quit performing services will act on this intention. Moreover, the survey results only provide one number representing both those doctors who have already quit and those who plan to quit providing certain services. The percentage of respondents who have already adapted their practices is therefore unknown.

2003 OHSU Survey of Obstetricians Provides No Evidence of a Malpractice “Crisis” as the Cause of Discontinuing Care

Oregon medical leaders have relied upon a 2003 study by Oregon Health and Science University (OHSU)⁴¹ to argue that due to rising liability insurance costs, many Oregon clinicians—especially those practicing in rural areas—have quit delivering babies and many more plan to quit within the next five years.

In 2002, researchers at OHSU sent a survey to all licensed obstetrics providers in Oregon. Around 60 percent – or 511 – of all clinicians delivering babies in Oregon in 2002 responded. Of these 511 doctors, 157, or 31 percent, indicated that they planned to quit delivering babies in the next five years. Rural clinicians were more likely to respond that they planned to quit than doctors in the Portland area.

The press release for the survey was highly misleading and resulted in news stories claiming that, “the most common reason offered was the rising cost of malpractice insurance.”⁴² This statement gives a very inaccurate view of the study’s findings. In actuality, the study finds that a doctor’s age, workload, and geographical location—not *insurance costs*—are predictors of quitting.

- **Physicians’ age and workload factors are most likely to predict discontinuation of care.** The study’s write-up in *Family Medicine* states, “Logistic regression analysis...found that being in the oldest tercile [one-third] of age, in the highest tercile of work volume, and practicing outside of the Portland metropolitan area predicted quitting the next year to five years.”⁴³ These findings are no surprise. As they age, physicians retire from or reduce their practices. Physicians who work long hours, who practice on their own, or who practice in rural areas without back-ups can be expected to find obstetrical practice more of an interference with family and personal life—the main reason doctors avoid this specialty.
- **The study did not find any relationship between increased premiums and a doctor’s likelihood of ceasing obstetrical care.** Indeed, the survey did not even use premium amount as a variable to predict discontinuation of care. Unlike a previous study of New York State obstetricians described in the next section, the researchers did not collect data on liability premiums, but instead only asked disgruntled doctors to give reasons why they would discontinue deliveries.

The study finds merely that since medical societies made damage caps their public relations and lobbying priority, more physicians list lawsuits as a cause of dissatisfaction with their practices. The study did not find that proportionately more doctors will leave their practices when liability premiums spike.

- **Doctors commonly respond to such surveys by indicating a high likelihood of quitting.** Indeed, a higher percentage of all doctors in California (43 percent)—a state with draconian limits on malpractice awards—than obstetricians in Oregon (31 percent) said they plan to quit. The 43 percent of physicians surveyed by the California Medical Society in 2001 said they planned to leave medical practice in the next three years in spite of the California law limiting non-economic damages to \$250,000, among other severe tort restrictions. Another 12 percent of California doctors said they would reduce their time spent in patient care.⁴⁴

New York Study Found a Relation Between Age and Discontinuing Obstetrics Care but not Between Malpractice Premiums and Discontinuing Care

The conclusions drawn from the OHSU survey are also undercut by the fact that doctors often choose to quit obstetrics as they get older—for lifestyle reasons and not because of high liability premiums.

- **A University of California-San Francisco study of New York doctors found that the main reason doctors cease providing obstetrics care is advancing age.** While the OHSU researchers did not measure the effect of liability premiums on doctors' behavior, the UCSF researchers did collect such data. The study, of New York State physicians during the mid-1980s insurance crisis, found no association between malpractice premiums and doctors' decisions to quit.⁴⁵ The study did find that the decrease in doctors practicing obstetrics was associated with the *length of time* since receiving a medical license in New York. This relationship “very likely represents the phenomenon of physicians retiring from practice or curtailing obstetrics as they age.”⁴⁶
- **Obstetricians frequently cut back their practice as they advance in years.** As doctors become more financially secure, and as the child-bearing years of their patient population pass, many obstetricians give up the demands of delivering babies in favor of concentrating on the gynecological needs of their patients. For example, in 2000, 18.7 percent of Georgia's OB/GYNs were between 40 and 44 years old, but only 11.1 percent of OB/GYNs were 50-54 years old—a decrease of about 40 percent.⁴⁷
- **A North Carolina survey found that the main reasons doctors decreased their obstetrics patients were unrelated to fear of lawsuits.** The authors note that while some providers whose obstetrical patient volume had decreased cited fear of lawsuits as a factor, “[T]his was not the overwhelming reason for stopping or planning to stop deliveries. The strain and inconvenience of the practice and problems with burnout also were issues.”⁴⁸

A Variety of Factors Have Led to a Nationwide Scarcity of Obstetrics Providers in Rural Areas

The lack of obstetrics care in rural areas is a problem throughout the United States. To the extent that certain areas of rural Oregon lack doctors who perform deliveries, many factors other than high liability premiums contribute to this scarcity.

- **When insurance premiums decline, rural areas often do not see an increase in providers willing to provide obstetrical services.** In many states, reducing malpractice rates did not bring obstetrics providers back to rural areas.⁴⁹ One study of doctors in North Carolina found that tort limits and a malpractice insurance subsidy “did not seem to be extremely important in their decision-making process over whether to remain in obstetrics or to expand access to their practices.” Instead the authors state that, “The data suggest that the clinical network supporting rural obstetrics might be more of a key to the problems of access to care in rural areas than tort reform...”⁵⁰
- **Throughout the country, few obstetricians practice in rural communities.** According to a nationwide study reported by COGME, in 1995, rural counties where the largest towns had fewer than 10,000 people had an average of less than three OB/GYNs.⁵¹
- **There is a decreased demand for obstetrics services in rural Oregon.** The average age in many areas of rural Oregon is rapidly increasing as young families move away in search of better paying jobs. This has resulted in a decreased need for obstetricians. For example, according to an article in the *Oregonian*, the median age in Reedsport, Oregon in 1980 was 31. By 2003 it had increased to 47. In 1991 doctors in one Reedsport practice delivered about 100 babies a year, but in 2003 they delivered only about 40.⁵²

Why Doctors Practice Where They Do: Quality of Life, Not Caps on Damages

The AMA and OMA claim that doctors will leave Oregon and other states with high malpractice premiums, to settle in states where damages are capped. If this were true there would be more doctors in the states that already have enacted caps on damages. In reality, the existence of damage caps has no statistically significant relationship to the number of doctors in a state. Public Citizen conducted a multiple regression analysis of the number of doctors in each state. We found that 82 percent of the variation in doctors' state of residence is explained by two factors: a state's *income* and *population density*.

- **Liability laws do not correlate with where doctors' locate their practice.** Figures 5 and 6 compare the ten states with the most per capita number of doctors in 2001 to the ten states with the fewest per capita number of doctors.⁵³
 - While four of the states with the fewest per capita number of doctors had enacted caps on non-economic damages, only three of the states with the most number of doctors per capita had enacted them. Similarly, while three of the states with the fewest number of doctors had enacted caps on punitive damages, only one of the states with the most number of doctors had capped punitive damages.
 - According to the U.S. Chamber of Commerce, Iowa, Utah, and South Dakota rank 5th, 8th and 9th for "reasonable litigation environment,"⁵⁴ yet those states rank 47th, 42nd, and 44th, respectively, in number of doctors. Only one state in the Chamber's legal climate top ten, Connecticut, also ranks in the top ten for doctors.
- **Doctors choose to reside in states with a higher quality of life, not because of state liability laws.** Like anyone else, doctors want to live in places where they can earn high incomes, enjoy cultural and leisure activities, and send their children to good schools. Doctors migrate to states on lists of "Best Places to Live":
 - 40 of the top 100 cities with "strong arts, cultural programs, and higher education" were in the ten states with the most per capita number of doctors, while there were none in the ten states with the fewest per capita number of doctors.⁵⁵
 - 33 of the top 100 cities rated for plentiful leisure activities were in the ten states with the most per capita number of doctors, while there were none in the ten states with the fewest per capita number of doctors.⁵⁶
 - 48 of the top 100 cities rated for having good schools were in the ten states with the most per capita number of doctors, while there were only seven in the ten states with the fewest per capita number of doctors.⁵⁷

Figure 5

States With Most Doctors Per Capita

		Non-Economic Damage Cap?	Punitive Damage Cap?	Income Rank	Have Cities Placed in the Top 100 for		
					Arts	Recreation	Education
DC	1			43	X		X
MA	2	Yes		12	X	X	X
NY	3			28	X	X	X
MD	4	Yes		2	X	X	X
CT	5			7	X	X	X
RI	6			18			X
VT	7			22			X
NJ	8		Yes	3	X	X	X
PA	9			24	X	X	X
HI	10	Yes		17			

Sources: US Census Bureau, Money Magazine, Sperling’s Best Places to Live

- The average median income for the ten states with the fewest per capita number of doctors for 2000 was \$54,552, versus \$70,360 for the ten states with the most per capita number of doctors.⁵⁸ Not surprisingly, doctors want to live in more prosperous states—even though damage awards are higher in high-income states. The District of Columbia has the highest median damage award and the most doctors. Idaho, with the fewest doctors, has the third lowest median damage award.⁵⁹
- Seven of the top ten states for doctors also rank in the top ten states in percentage of households earning \$200,000 or more in 2000.⁶⁰ Doctors want to live in areas with lots of affluent people—such areas are more likely to have the leafy suburbs, premium housing, clubs, and other amenities that doctors want.
- Six of the top ten states for doctors also rank in the top ten states in percentage of professionals in the population.⁶¹ Six of the bottom ten states for doctors are in the ten states with the fewest professionals. Doctors want to live in areas where they may socialize with other educated people.
- Finally, the average population density of the states with the fewest per capita amount of doctors is 29 persons per square mile, versus 1,444 in the states with the most per capita number of doctors.⁶² Doctors’ decisions on where to practice are largely in line with other Americans’ decisions on where to live and work.

Figure 6

States With Fewest Doctors Per Capita

		Non-Economic Damage Cap?	Punitive Damage Cap?	Income Rank	Have Cities Placed in the Top 100 for		
					Arts	Recreation	Education
ID	51	Yes		32			
MS	50			50			
OK	49		Yes	42			
AK	48	Yes	Yes	1			X
IA	47			30			X
WY	46			39			X
NV	45		Yes	20			
SD	44	Yes		45			
AR	43			51			
UT	42	Yes		9			

Sources: US Census Bureau, Money Magazine, Sperling's Best Places to Live.

- **Nearly all of *Modern Physician* magazine's top 75 places to run a medical practice are in the AMA's malpractice "crisis" states and "states showing problem signs"—only 8 are in states with the strictest caps.** *Modern Physician* included malpractice premiums in its criteria for picking the best places to practice medicine. Nevertheless, the strength of other criteria dictated that 17 of the top 30 cities picked were in AMA "crisis" states such as Georgia, North Carolina, and Washington.⁶³ While doctors insist that they will pack their bags and leave when malpractice premiums are too high, they in fact place many other criteria ahead of premiums, including low labor costs for support personnel, low state taxes, high Medicare reimbursement levels, and the educational attainment of their neighbors.

End Notes

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- ² Oregonians for Quality, Affordable, and Reliable Health Care, <http://www.endfrivolouslawsuits.com>.
- ³ Oregonians for Quality, Affordable, and Reliable Health Care, <http://www.endfrivolouslawsuits.com>.
- ⁴ Telephone conversation with Tess Borgnino, Registration Assistant, Oregon Board of Medical Examiners, August 4, 2004. In theory an active doctor might not be practicing, for instance if they are between jobs.
- ⁵ Ellen MacKenzie, et al, “National Inventory of Hospital Trauma Centers,” *Journal of the American Medical Association*, March 26, 2003, Vol. 289, No. 12.
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- ¹⁹ GAO Study at p. 13.
- ²⁰ GAO Study at p. 20.
- ²¹ GAO Study at p. 7.
- ²² GAO Study at p. 17.
- ²³ GAO Study at p. 18.
- ²⁴ GAO Study at p. 18.
- ²⁵ Oregon Medical Association, Slide Show, May 2004; American Medical Association, Statement to the Subcommittee on Wellness and Human Rights, Committee on Government Reform, U.S. House of Representatives, “Dying for Help: Are Patients Needlessly Suffering Due to the High Cost of Medical Liability Insurance?,” Oct. 1, 2003 at 31-33, available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_house_hearings&docid=f:91840.pdf.
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- ²⁷ COGME at p. xiii.
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- ³⁸ The Association of Maternal Child Health Programs, *From Rural to Remote: Family Health Care in Alaska, Idaho, Oregon, and Washington* (March, 2004) at 11, available at: <http://www.amchp.org/aboutamchp/Rural%20Health.pdf>
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