

**Medical Misdiagnosis:
Challenging the Malpractice Claims
of the Doctors' Lobby**



**Congress Watch
January 2003**

Acknowledgments

This report was written by Public Citizen's Congress Watch Legislative Counsel Jackson Williams, based on extensive research provided by Civil Justice Fellow Gretchen Denk, Legislative Assistant Rebecca Romo, Special Counsel Barry Boughton, and Senior Researcher Andrew Benore. Congress Watch Director Frank Clemente provided significant editorial direction. State supplementary reports were written by Research Director Neal Pattison and Civil Justice Fellow Gretchen Denk.

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**Public Citizen's Congress Watch
215 Pennsylvania Ave S.E.
Washington, D.C. 20003**

P: 202-546-4996

F: 202-547-7392

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Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors' Lobby

Executive Summary

The major findings in this report are the following:

Doctors' Attacks on the Tort System Are a Misdiagnosis that Diverts Attention from an Epidemic of Medical Errors and Unsafe Practices

- **Between 44,000 to 98,000 Americans die in hospitals each year due to preventable medical errors, according to the Institute of Medicine (IOM).** By comparison, the annual death toll is 43,000 from automobile accidents, 42,000 from breast cancer, and 15,000 from AIDS.
- **The costs of doctor negligence and the medical liability system is much greater for patients than doctors.** The IOM estimates the annual costs to society for medical errors in hospitals at \$17 billion to \$29 billion. These costs include disability and health care costs, lost income, lost household production and the personal costs of care. They do not include medical malpractice occurring outside the hospital setting. By contrast, the National Association of Insurance Commissioners reports that the total amount spent on medical malpractice insurance in 2000 was \$6.4 billion – at least three to five times less than the costs of malpractice to society.

Rather than Facing “Runaway Litigation,” Doctors Benefit from a Claims Gap

- **The landmark Harvard Medical Practice Study and other studies have found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers found that only one in eight preventable medical errors committed in hospitals results in a malpractice claim. Researchers replicating this study made similar findings in Utah and Colorado. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. In other words, for every 6 medical errors only 1 claim is filed.
- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the Medicare Payment Advisory Commission (MedPAC), liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the past year. The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

Increases in Medical Malpractice Premiums and Payments Track — And Do Not Exceed — Increased Costs of Injuries

- **Malpractice insurance costs have risen at half the rate of medical inflation, debunking the myth of “out-of-control juries.”** While medical costs have increased by 113 percent since 1987, the total amount spent on medical malpractice insurance has increased by just 52 percent over that time—less than half of medical services inflation.
- **Government data shows that medical malpractice awards have increased at a much slower pace than claimed by Jury Verdict Research.** According to the federal government’s National Practitioner Data Bank (NPDB), the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2001, from \$100,000 to \$135,000. By contrast, data from Jury Verdict Research (JVR), a private research firm, shows that awards rose 100 percent from 1997 to 2000, from \$503,000 to \$1 million. The reasons for the huge difference: JVR only collects jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.
- **Government data shows that medical malpractice awards have increased at a slower pace than health insurance premiums.** According to the federal government’s National Practitioner Data Bank, the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2000, from \$100,000 to \$135,000. But during the same time, the average premium for single health insurance coverage has increased by 39 percent. [See Figure, “Growth in Health Insurance Costs and Malpractice Awards Compared.”] Payments for health care costs, which directly affect health insurance premiums, make up the lion’s share of most medical malpractice awards.

The Spike in Medical Liability Premiums Was Caused by the Insurance Cycle, Not By New Claims or “Skyrocketing” Jury Verdicts

- **There is no growth in the number of new medical malpractice claims.** According to the National Association of Insurance Commissioners (NAIC), the number of new medical malpractice claims declined by about four percent between 1995 and 2000. There were 90,212 claims filed in 1995; 84,741 in 1996; 85,613 in 1997; 86,211 in 1998; 89,311 in 1999; and 86,480 in 2000.
- **For much of the 1990s, doctors benefited from artificially lower premiums.** According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, “What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income.” IRMI also noted: “Clearly a business cannot continue operating in that fashion indefinitely.”

- **One major insurer appears to have triggered a “crisis” in at least four states studied.** Case studies on Mississippi, Nevada, Pennsylvania, and West Virginia in this briefing book show that the “crisis” in at least these four states was triggered after a leading company, The St. Paul Companies, Inc., withdrew from the medical liability marketplace in December 2001. That decision had more to do with St. Paul’s reckless cash flow policies than it did with malpractice claims or jury awards.
- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country’s most knowledgeable insurance actuaries and director of insurance for Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy is booming and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.

“Repeat Offender” Physicians Are Responsible for the Bulk of Medical Malpractice Costs

- **Five percent of doctors are responsible for 54 percent of malpractice in the U.S.** Public Citizen’s analysis of the federal government’s National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, found that 5.1 percent of doctors (35,009) have paid two or more malpractice awards to patients. These doctors are responsible for 54 percent of all payouts reported to the Data Bank. Of these, only 7.6 percent have ever been disciplined by state medical boards. Only 17 percent of doctors (1 out of 6) who have made 5 or more malpractice payouts have been disciplined.

Few, If Any, Malpractice Lawsuits Are “Frivolous”

- **Plaintiffs drop ten times more claims than they pursue.** Based on Physician Insurer Association of America (PIAA) figures, Public Citizen estimates that about 54 percent of claims are being abandoned by patients. Attorneys often may send a statutorily required notice of intent to claim or file a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim. We estimate that the number of cases withdrawn voluntarily by plaintiffs was 92,621, *ten times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent*.
- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files. The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, “These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care.”

So-called “Non-Economic” Damages Are Real and Not Awarded Randomly

- **“Non-economic” damages aren’t as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called “non-economic” damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) 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. According to PIAA, the average payment between 1985 and 2001 for a “grave injury,” which encompasses paralysis, was only \$454,454.
- **No evidence supports the claim that jury verdicts are random “jackpots.”** Studies conducted in California, Florida, North Carolina, New York, and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered. In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.

Empirical Evidence Does not Confirm the Existence of “Defensive Medicine” — Patient Injuries Refute It

- **The Congressional Budget Office has rejected the defensive medicine theory.** CBO was asked to quantify the savings from reduced “defensive medicine” if Congress passed H.R. 4600. This bill, which passed the House in 2002, contained very stringent restrictions on a patient’s ability to recover damages. CBO declined, saying that any such “estimates are speculative in nature, relying, for the most part, on surveys of physicians’ responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending. Using broader measures of spending, CBO’s initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending.”

Solutions to Reduce Medical Errors and Long-term Insurance Rates

- **Implement patient safety measures proposed by the Institute of Medicine.** The “systems approach” to patient safety advocated by the Institute of Medicine shows promise. Some three years after the release of its report little has been done to establish mandatory nationwide error reporting systems, identify unsafe practices, or raise performance standards. Although experts using the systems approach have identified a number of promising strategies to reduce malpractice, few have been implemented.
- **Open the National Practitioner Data Bank.** Information about doctor discipline, including state sanctions, hospital disciplinary actions and medical malpractice awards is now contained in the National Practitioner Data Bank. HMOs, hospitals and medical boards can look at the National Practitioner Data Bank but consumers cannot, because the names of

physicians in the database are kept secret from the public. Congress should lift the veil of secrecy and allow the people who have the most to lose from questionable doctors to get the information they need to protect themselves and their families.

- **Improve oversight of physicians.** Less than one-half of one percent of the nation's doctors face any serious state sanctions each year. 2,708 total serious disciplinary actions a year, the number state medical boards took in 2001, are a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by medical errors annually. State medical boards should be strengthened and more doctors should be disciplined for incompetence.
- **Limit physicians' workweek to reduce hazards created by fatigue.** American medical residents work among the highest—if not the highest—number of hours in the professional world. They work up to 120 hours a week, including 36-hour shifts for several weeks at a time. After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10% blood alcohol level. In other words, doctors who would be considered too unsafe to drive may still treat patients for 12 more hours. Residents should be limited to an 80-hour workweek.

Introduction

In November 1999, the Institute of Medicine released its report on patient safety in the U.S. The report's findings were shocking – that between 44,000 and 98,000 Americans die annually as a result of preventable medical errors. But the report raised hopes among consumer advocates that what we knew to be a major public health problem would finally be addressed by policymakers.

Unfortunately, the public's hopes were quickly dashed. The economic downturn that began the following year, and which in turn led to an insurance market decline, led to stiff but temporary increases in medical liability premiums. The medical community saw the rate hikes as a golden lobbying opportunity. Medical providers ceased negotiations on patient safety legislation, and for the third time in as many decades, they declared war on our legal system.

The tactics that have been employed in their war are deplorable. The first casualty was the truth. Doctors and their lobbyists claim that hard-working American citizens undergo a hideous transformation when they take a juror's oath: they become part of "out-of-control" juries and issue "skyrocketing" verdicts. Such verdicts, say the medical lobby, are the cause of increased liability premiums.

This report demonstrates the falsity of this charge. The facts are these: Insurance premiums are rising as a result of a business cycle wholly unrelated to tort claims. New claims filings are flat. Liability insurance expenditures and victim compensation are barely keeping pace with increases in health care costs. Only a fraction of patients harmed by malpractice ever seek compensation.

The doctors' message has been, "Give us what we want or we'll pull out of your community." Essentially we're blackmailed into suspending all manner of reasonable judgment – to believe that a sudden jump in premiums over the last two years is caused by anything other than investment company losses. In fact, it typically takes five years for a malpractice case to work its way through the system.

It would be a travesty of justice for Congress and state legislatures to take away patients' legal rights in the name of protecting insurance company profits and doctors' income. Caps on damages hurt those most seriously injured. The fact is that the legal system is all patients have to ensure just compensation for injury and to force improvements in patient safety. It's clear that the current regulatory system is not up to the task.

Our goal in issuing this briefing book is not just to refute the phony charges. The underlying problem of sloppy medical care urgently needs to be addressed. Doctors and hospitals have been able to shift the costs of their carelessness onto victims. This "compensation gap" has allowed the medical community to ignore the problem of medical errors.

It is very unfortunate that rather than reducing the real threats that current medical care poses to their patients, the doctor's lobby has proposed to shift the costs of injuries onto innocent individuals, their families, voluntary organizations and taxpayers. Doctors, patients and consumers should be allies on this issue – which fundamentally comes down to improving the quality of medical care in the U.S. – not be pitted against each other.

Doctors' Attacks on the Tort System Are a Misdiagnosis that Diverts Attention from an Epidemic of Medical Errors and Unsafe Practices

- **Between 44,000 to 98,000 Americans die in hospitals each year due to preventable medical errors, according to the Institute of Medicine.**¹ By comparison the annual death toll from automobile accidents is 43,000, 42,000 die from breast cancer and 15,000 die from AIDS. The IOM estimates the costs to society for these medical errors at \$17 billion to \$29 billion. These costs include disability and health care costs, lost income, lost household production and the personal costs of care. These figures do not take account of medical malpractice occurring outside the hospital setting.
- **Medical journals, state reporting systems and news accounts document continuing, widespread disregard for patient safety.**

Hospital infections. The *Chicago Tribune* reported that some 75,000 Americans die each year because of infections acquired in hospitals that “were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses.”²

Medication errors. Two recent studies have found numerous errors in administering medication to hospitalized patients. An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful.³ The authors said this amounts to about 40 potential adverse drug events per day in a typical 300-patient facility.

Wrong-patient surgery. According to a study published in the *Annals of Internal Medicine*, New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.⁴ (There were nine such instances in Florida in 2001.⁵) In trying to determine how such shocking errors could occur, the New York researchers analyzed one case in detail. The case study determined that medical personnel had ignored “many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure.”

- **The resources devoted to preventing medical errors are disproportionate to their toll in lives.** Deaths attributable to medical errors each year exceed those caused by breast cancer and AIDS. Yet while the federal government spends \$655 million on breast cancer prevention⁶ and \$3.5 billion on AIDS prevention,⁷ only about \$130 million has been committed this year, for the first time, for improving patient safety.⁸
- **Physicians' cavalier attitudes toward medical errors are out of step with public opinion.** The *New England Journal of Medicine* recently released a survey of physicians and the public on the issue of medical errors.⁹ The public understands this problem far better than do physicians. The public is more likely than physicians to agree with patient safety experts' assessments of how to reduce medical errors. The public understands the need for

better nurse staffing. The public understands the role of fatigue in causing injuries to patients. The public wants hospitals to develop patient safety systems. The public wants computerized prescriptions and medical records. The public wants mandatory reporting of medical errors. The public wants stronger disciplining of doctors. On each of these issues, doctors are in significant disagreement with the public and with the experts.

- **Doctors' views on accountability for medical errors are out of step with the public's.** The respondents to the (*New England Journal of Medicine*) survey were given a hypothetical case of a doctor ordering the use of an antibiotic for a patient whose medical record noted an allergy, and who subsequently died. The vast majority of the lay respondents to this survey thought that such a doctor should be held accountable, both through a malpractice lawsuit and through disciplinary proceedings. Significantly fewer doctors felt the same. Doctors are promoting an approach to public policy with which the general public simply does not agree with.

¹ Institute of Medicine, *To Err Is Human: Building a Safer Health System*, November, 1999.

² Berens, "Infection Epidemic Carves Deadly Path," *Chicago Tribune*, July 21, 2002. This number is attributed to the "Tribune's analysis, which adopted methods commonly used by epidemiologists."

³ Barker et al, "Medication Errors Observed in 36 Health Care Facilities," 162 *Arch Intern Med.* 1897 (2002).

⁴ Chassin & Becher, "The Wrong Patient," 136 *Ann Intern Med.* 826 (2002).

⁵ Agency for Health Care Administration, *Risk Management Reporting Summary*, March 2002.

⁶ "Fiscal Year 2003 Defense Appropriations Conference Summary Of Agreements," Committee on Appropriations, October 9, 2002. See also:

http://216.239.53.100/search?q=cache:azyKTgpXKNEC:www.house.gov/appropriations/news/107_2/03defconf.htm+%22breast+cancer%22+FY+2002+budget+&hl=en&ie=UTF-8

⁷ Kaiser Family Foundation, *Federal HIV/AIDS Spending: A Budget Chartbook*, 2001.

⁸ *HHS Announces \$50 Million Investment to Improve Patient Safety*. Press Release, October 11, 2001. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/news/press/pr2001/patsafpr.htm>; Phone conversation with Veterans Health Administration FOIA Officer, Clay Johnson, December 19, 2002; Phone conversation with Agency for Healthcare Research and Quality Public Inquiries Officer, Paula Hunt, December 19, 2002.

⁹ *Views of Practicing Physicians and the Public on Medical Errors*, *The New England Journal of Medicine*, 347:1933-1944 (Dec. 12, 2002).

Rather than Facing “Runaway Litigation,” Doctors Benefit from a Claims Gap

- **The landmark Harvard Medical Practice Study found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in eight medical errors committed in hospitals results in a malpractice claim.¹ Researchers replicating this study made similar findings in Colorado and Utah.² [See figure “Malpractice Claims Gap: Ratio of Medical Errors to Claims Filed.”]
- **Actual numbers collected by government agencies show a similar claims gap.** A Florida statute requires hospitals to report “adverse incidents,” defined as “an event over which health care personnel could exercise control” that results in death or injury. Tables prepared by Florida’s Agency for Health Care Administration have compared reports of adverse incidents to filing of new malpractice claims. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims.³ In other words, for every 6 medical errors only 1 claim is filed. [See figure “Florida Malpractice Claims Gap: 1996-1999 Ratio of Medical Errors to Claims Filed.”]
- **By any measure, it is clear that the number of medical errors far outstrips the number of lawsuits.** On hospital discharge forms, health information management specialists are asked to record an “external cause of injury,” or “E-code” for a patient. A number of codes correspond to “medical misadventures” during surgical and medical care.⁴ Public Citizen obtained E-Code information from those states that collect such data and will supply it either for free or for less than \$100. In each of the states for which we were able to obtain accurate data, medical injuries outnumbered compensation payments to injured patients by ratios similar to those found by academic researchers. [See figure “Malpractice Compensation Gap: Hospital E-Code Injuries vs. Malpractice Payments.”]
- **Overall tort expenditures are less than the cost of medical injuries.** Because so few medical injuries result in compensation to patients, the overall expenditures made for medical liability are far below the projected injury costs. The Institute of Medicine estimated the costs of preventable medical injuries in hospitals alone at between \$17 billion and \$29 billion.⁵ The Utah Colorado Medical Practice study estimated it at \$20 billion.⁶ By contrast, the National Association of Insurance Commissioners reports that the total amount spent on medical malpractice insurance in 2000 was \$6.4 billion.⁷ This is at least three to five times less than the cost of malpractice to society. [See figure “Malpractice Compensation Gap: Annual Costs of Medical Negligence vs. Medical Liability Expenditures.”]
- **Malpractice insurance costs amount to only 3.2 percent of the average physician’s revenues.** According to experts at the federal government’s Medicare Payment Advisory Commission (MedPAC), who have no axe to grind about medical liability, liability insurance premiums make up just a tiny part of a physician’s expenses and have increased by only 4.4 percent over the last year.⁸ The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

- **The compensation gap helps explain why, although medical injuries are costly, expenditures on medical liability comprise less than one percent of overall health care costs.** As the Congressional Budget Office reported, “Malpractice costs account for a very small fraction of total health care spending; even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums. In addition, some of the savings leading to lower medical malpractice premiums—those savings arising from changes in the treatment of collateral-source benefits—would represent a shift in costs from medical malpractice insurance to health insurance.”⁹

¹ Harvard Medical Practice Study Group, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990).

² Studdert et al, “Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado,” 33 Ind. L. Rev. 1643 (2000).

³ The Agency for Health Care Administration; Division of Health Quality Assurance. Reported malpractice claims by district compared to reported adverse incidents 1996, 1997, 1998, 1999.

⁴ Adverse events characterized as “misadventures” include accidental cuts during surgery, foreign objects left in a patient during surgery, infections caused by failure of sterile precautions, and performance of inappropriate operations. They do not include abnormal reactions and other complications that occur during medical care. A misadventure does not necessarily constitute “medical negligence,” which is a legal term of art. However, a “misadventure” would constitute malpractice if it was a deviation from the standard of care and resulted in more than momentary harm to a patient.

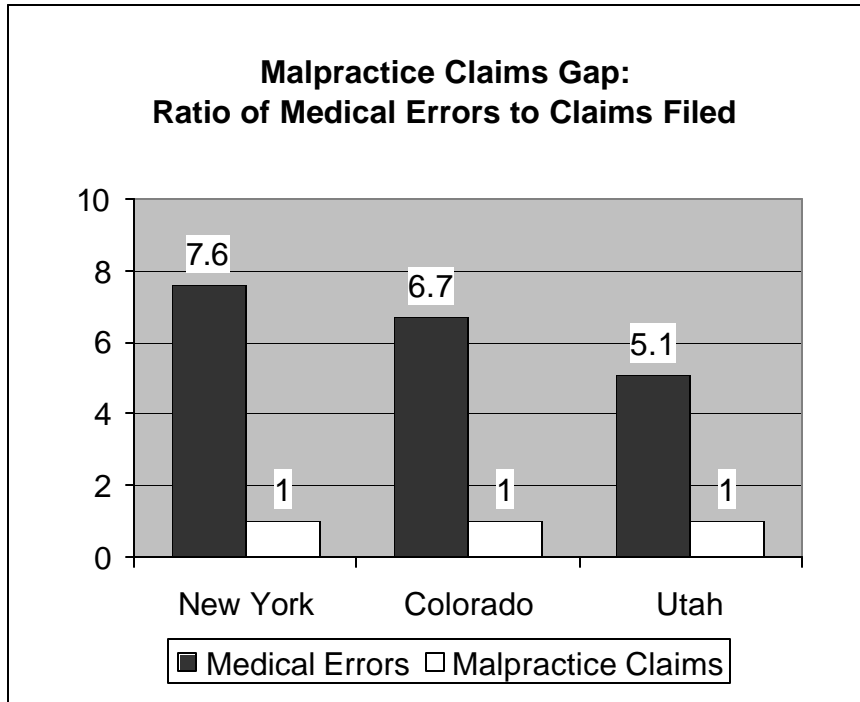
⁵ Institute of Medicine, To Err is Human (2000).

⁶ Studdert et al supra note 2.

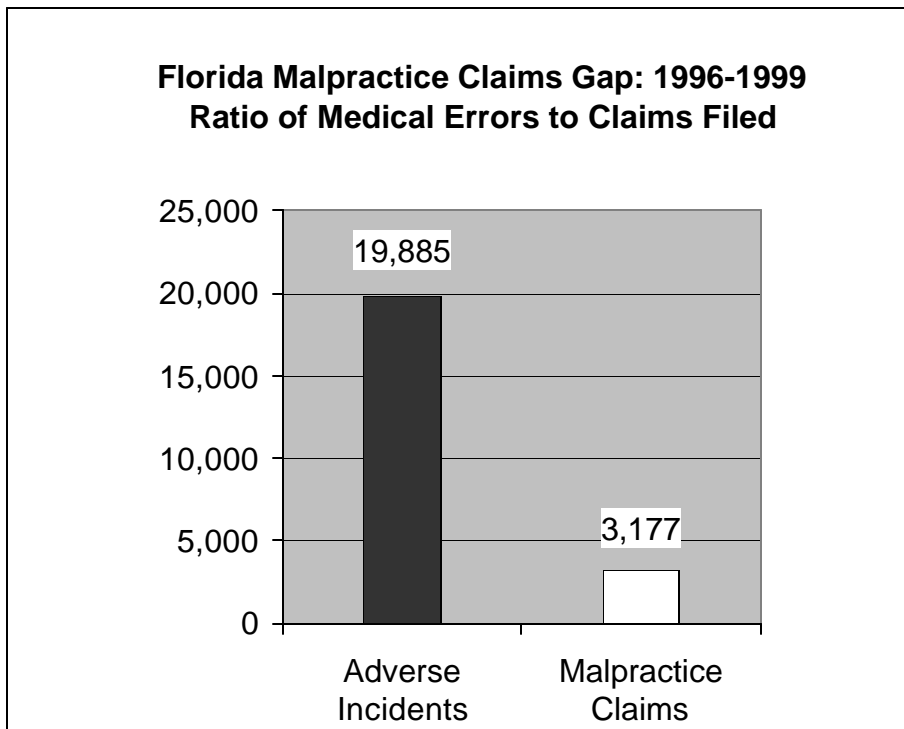
⁷ NAIC, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001).

⁸ Official Transcript, Medicare Payment Advisory Commission, Public Meeting, December 12, 2002.

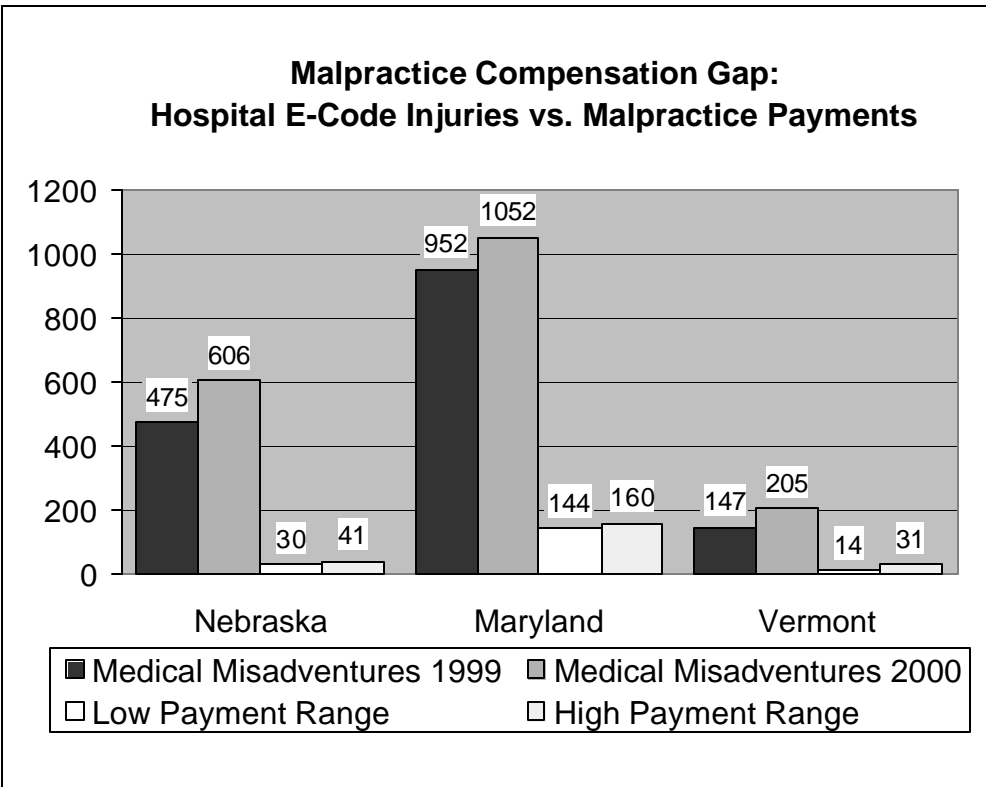
⁹ Congressional Budget Office Cost Estimate, H.R. 4600, September 24, 2002.



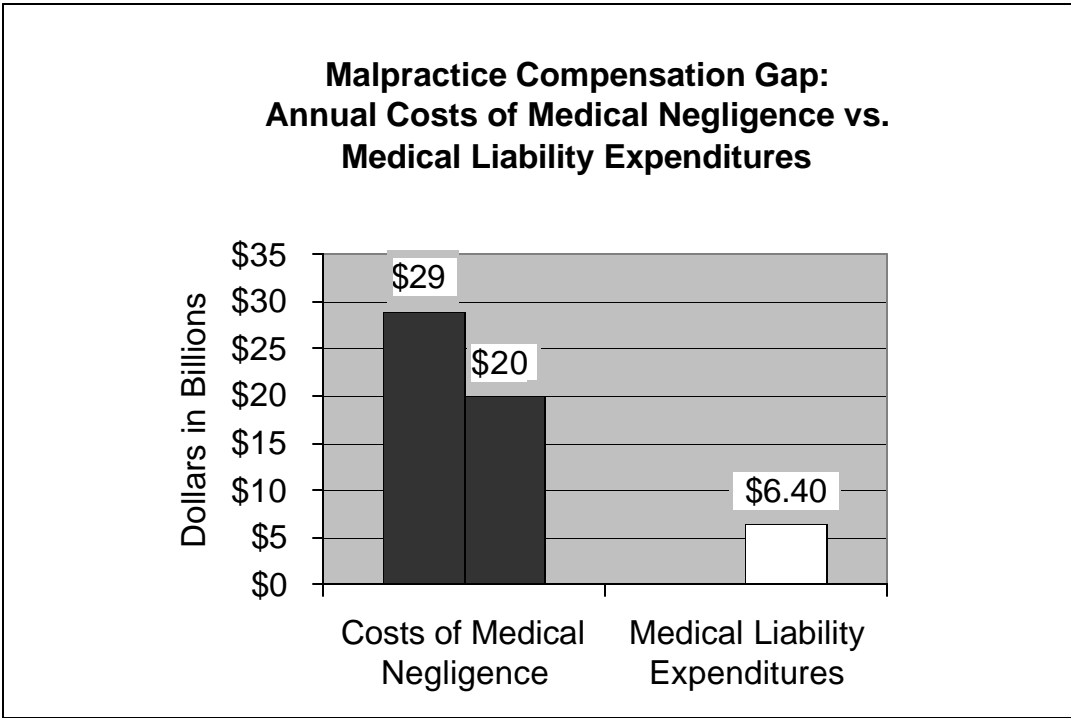
Source: Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990); Studdert et al, "Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," 33 *Ind. L. Rev.* 1643 (2000).



Source: The Agency for Health Care Administration; Division of Health Quality Assurance. Reported malpractice claims by district compared to reported adverse incidents 1996, 1997, 1998, 1999.



Source: Nebraska Department of Health and Human Services, Maryland Health Services Cost Review Commission, Vermont Department of Health Statistics, National Practitioner Data Bank.



Source: Institute of Medicine, *To Err is Human* (2000); Studdert et al, "Beyond Dead Reckoning Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," 33 *Ind. L. Rev.* 1643 (2000). NAIC, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001).

The Costs of Medical Malpractice to Patients and Consumers Versus the Cost to Doctors

The Institute of Medicine has estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors. The IOM also estimates that these errors cost society \$17 billion to \$29 billion per year. These costs include disability and health care costs, lost income, lost household production and the personal costs of care. They do not include the costs of medical malpractice that occurs outside the hospital setting. The table below compares these costs, prorated on a state-by-state basis, to the amount that physicians pay in medical malpractice premiums in those states. The costs of medical malpractice to society dwarf the costs to doctors.

State	Preventable Deaths Due to Medical Errors Each Year*	Costs Resulting from Preventable Medical Errors Each Year* (Millions)	Doctors' Medical Malpractice Premiums Paid in 2000** (Millions)
Alabama	695 – 1,549	\$269 – \$458	\$100.0
Alaska	98 – 218	\$38 – \$65	\$12.4
Arizona	802 – 1,787	\$310 – \$529	\$131.0
Arkansas	418 – 931	\$161 – \$275	\$35.9
California	5,296 – 11,795	\$2,046 – \$3,490	\$609.7
Colorado	672 – 1,498	\$260 – \$443	\$83.8
Connecticut	532 – 1,186	\$206 – \$351	\$106.1
Delaware	123 – 273	\$47 – \$81	\$17.8
District of Columbia	89 – 199	\$35 – \$59	\$36.0
Florida	2,499 – 5,566	\$965 – \$1,647	\$505.5
Georgia	1,280 – 2,851	\$495 – \$844	\$183.3
Hawaii	189 – 422	\$73 – \$125	\$29.9
Idaho	202 – 451	\$78 – \$133	\$20.1
Illinois	1,942 – 4,325	\$750 – \$1,280	\$393.0
Indiana	951 – 2,117	\$367 – \$627	\$51.6
Iowa	458 – 1,019	\$177 – \$302	\$54.6
Kansas	420 – 936	\$162 – \$277	\$43.2
Kentucky	632 – 1,407	\$244 – \$416	\$65.3
Louisiana	699 – 1,556	\$270 – \$461	\$76.0
Maine	199 – 444	\$77 – \$131	\$26.0
Maryland	828 – 1,844	\$320 – \$546	\$148.3
Massachusetts	993 – 2,211	\$384 – \$654	\$158.8
Michigan	1,554 – 3,461	\$600 – \$1,024	\$173.3
Minnesota	769 – 1,713	\$297 – \$507	\$50.0
Mississippi	445 – 991	\$172 – \$293	\$35.35
Missouri	875 – 1,948	\$338 – \$577	\$108.4

State	Preventable Deaths Due to Medical Errors Each Year*	Costs Resulting from Preventable Medical Errors Each Year* (Millions)	Doctors' Medical Malpractice Premiums Paid in 2000** (Millions)
Montana	141 – 314	\$54 – \$93	\$16.3
Nebraska	268 – 596	\$103 – \$176	\$24.6
Nevada	312 – 696	\$121 – \$206	\$50.8
New Hampshire	193 – 430	\$75 – \$127	\$17.3
New Jersey	1,316 – 2,930	\$508 – \$867	\$307.4
New Mexico	284 – 633	\$110 – \$187	\$27.1
New York	2,967 – 6,608	\$1,146 – \$1,955	\$857.1
North Carolina	1,259 – 2,803	\$486 – \$829	\$126.5
North Dakota	100 – 224	\$39 – \$66	\$12.8
Ohio	1,775 – 3,954	\$686 – \$1,170	\$239.8
Oklahoma	540 – 1,202	\$208 – \$356	\$57.7
Oregon	535 – 1,191	\$207 – \$353	\$40.9
Pennsylvania	1,920 – 4,277	\$742 – \$1,266	\$325.8
Rhode Island	164 – 365	\$63 – \$108	\$21.8
South Carolina	627 – 1,397	\$242 – \$413	\$18.8
South Dakota	118 – 263	\$46 – \$78	\$10.5
Tennessee	890 – 1,981	\$344 – \$586	\$179.3
Texas	3,260 – 7,261	\$1,260 – \$2,149	\$352.8
Utah	349 – 778	\$135 – \$230	\$36.1
Vermont	95 – 212	\$37 – \$63	\$9.1
Virginia	1,107 – 2,465	\$428 – \$729	\$120.8
Washington	922 – 2,053	\$356 – \$607	\$109.9
West Virginia	283 – 630	\$109 – \$186	\$62.7
Wisconsin	839 – 1,868	\$324 – \$553	\$59.5
Wyoming	77 – 172	\$30 – \$51	\$10.3
Total Premiums Paid			\$6,351.05

Sources:

* The range of preventable deaths and costs resulting from medical errors are prorated based on each state's share of overall U.S. population in 2000. Population statistics for 2000 from Census Bureau. Preventable deaths and costs data from, *To Err is Human: Building a Safer Health System*, Institute of Medicine, 1999.

** *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000*, National Association of Insurance Commissioners.

Increases in Medical Malpractice Premiums and Payments Track — and Do not Exceed Increased Costs of Injuries

- **Government data shows that medical malpractice awards have increased at a much slower pace than claimed by Jury Verdict Research.** According to the federal government's National Practitioner Data Bank (NPDB), the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2001, from \$100,000 to \$135,000.¹ By contrast, data from Jury Verdict Research (JVR), a private research firm, shows that awards rose 100 percent from 1997 to 2000, from \$503,000 to \$1 million.² The reasons for the huge difference: JVR only collects jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.
- **Malpractice insurance costs have risen at half the rate of medical inflation, debunking the myth of “out-of-control juries.”** At a July 2002 congressional hearing, Dr. Richard Anderson of The Doctors Company complained that “since 1990, [malpractice] claims costs have risen annually by 6.9 percent, nearly three times the rate of inflation.”³ The appropriate comparison is to health care inflation, because the bulk of damage awards go to pay medical bills.⁴ But while medical costs have increased by 113 percent since 1987, the total amount spent on medical malpractice insurance has increased by just 52 percent over that time—less than half of medical services inflation.⁵ [See figure “Medical Care Services Inflation vs. Growth in Malpractice Written Premiums.”]
- **Government data shows that medical malpractice awards have increased at a slower pace than health insurance premiums.** According to the federal government's National Practitioner Data Bank, the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2000, from \$100,000 to \$135,000.⁶ But during the same time, the average premium for single health insurance coverage has increased by 39 percent.⁷ [See Figure, “Growth in Health Insurance Costs and Malpractice Awards Compared.”] Payments for health care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice awards.
- **Medical malpractice awards are increasing in line with other general social trends.** In addition to medical costs, malpractice awards include two other main elements, lost wages and pain and suffering. These, like medical costs, are in turn multiplied by life expectancy. All of these factors are affected by upward social trends. Juries have not changed their behavior, but the numbers jurors take into account in making awards have changed.
- **Increases in our standard of living lead to higher awards.** Median household income has risen by an average of about \$1,000 each year, more than doubling over the past 20 years from \$17,710 in 1980 to \$42,151 in 2000.⁸ This increase reflects not only inflation but also real increases in our affluence. Higher expectations about quality of life affect the

valuation placed on a victim's pain and suffering. In years past, sickness and injury were viewed as an inevitable part of life. Today, health and safety are taken for granted, and most Americans expect to live a long, healthy life. Americans place a greater value on physical activity; the International Health, Racquet, and Sportsclub Association reports that health club memberships are increasing at a 9 percent annual rate.⁹ It is more likely today that a plaintiff will have regularly engaged in recreational or other physical activities, making a disabling injury all the more severe.

- **Increased life expectancy leads to higher awards.** According to the Center for Disease Control and Prevention, since 1980 the average life expectancy in the United States has increased by three years, from 73.7 to 76.7 years.¹⁰ The retirement age, set by Social Security, has also increased, resulting in longer expected years of employment. The full retirement age is 65 for persons born before 1938. The age gradually rises until it reaches 67 for persons born in 1960 or later.¹¹

¹ National Practitioner Data Bank Annual Reports, 1997 through 2001.

² Jury Verdict Research, "Medical Malpractice: Verdicts, Settlements and Statistical Analysis," 2002.

³ Statement of Richard Anderson Before House Energy and Commerce Committee, July 17, 2002.

⁴ Institute of Medicine, *To Err is Human* (2000).

⁵ Office of the West Virginia Insurance Commission, *Medical Malpractice: Report on Insurers with over 5% Market Share* (November 2002)

⁶ National Practitioner Data Bank Annual Reports, 1997 through 2001.

⁷ Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits Surveys, 1998-2002; National Practitioner Data Bank Annual Reports, 1997 through 2001.

⁸ Table H-7. Divisions—Households (All Races) by Median and Mean Income, 1976 to 2000. U.S. Census Bureau.

⁹ <http://www.ihrsa.org/industrystats/opbenchmarks.html>

¹⁰ Table 12. Estimated life expectancy at birth in years, by race and sex, National Vital Statistics Report, Vol. 50, No.6, March 21, 2002. www.cdc.gov

¹¹ www.ssa.gov

Medical Care Services Inflation vs. Growth in Malpractice Written Premiums

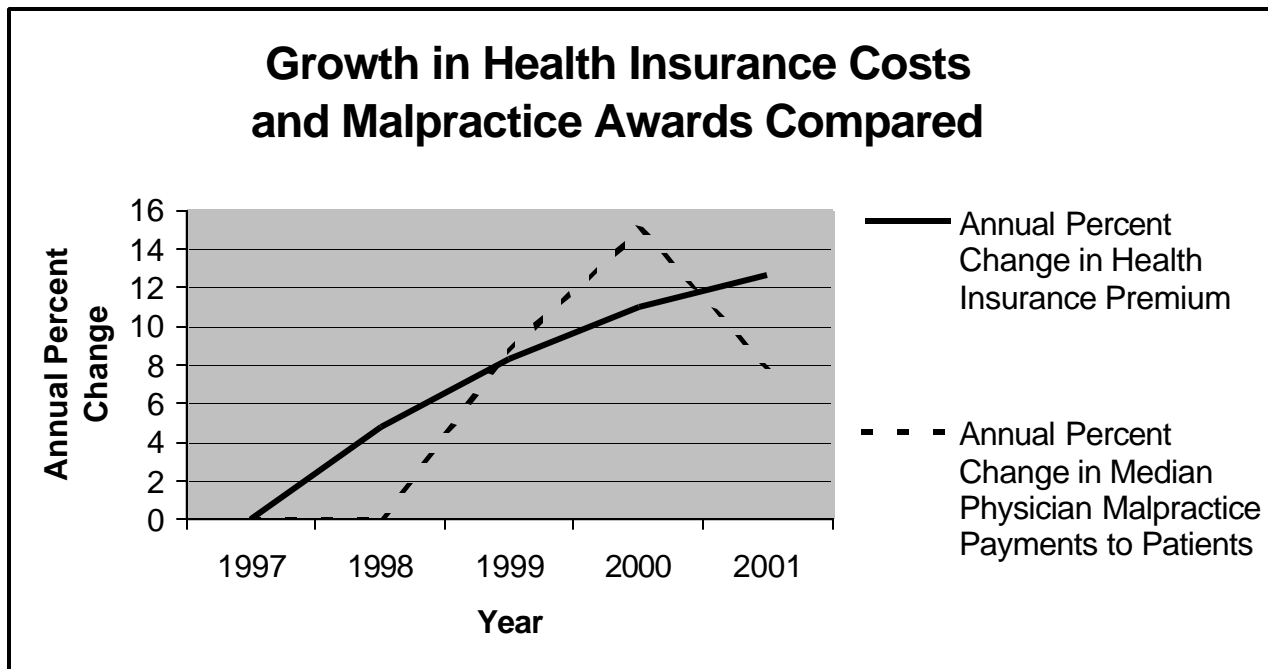
Year	CPI-U Index	Annual Percent Change	Cumulative Percent Change	Industry MedMal Net Written Premiums (000's)	Annual Percent Change	Cumulative Percent Change
1987	130.4	–	–	4,004,185	–	–
1988	139.0	6.6%	6.6%	4,027,825	0.6%	0.6%
1989	147.9	6.4%	13.4%	4,278,009	6.2%	6.8%
1990	161.5	9.2%	23.8%	4,014,622	-6.2%	0.3%
1991	176.1	9.0%	35.0%	4,067,803	1.3%	1.6%
1992	189.7	7.7%	45.5%	4,133,567	1.6%	3.2%
1993	202.6	6.8%	55.4%	4,370,812	5.7%	9.2%
1994	212.6	4.9%	63.0%	4,780,537	9.4%	19.4%
1995	223.5	5.1%	71.4%	4,800,552	0.4%	19.9%
1996	231.9	3.8%	77.8%	4,875,486	1.6%	21.8%
1997	238.7	2.9%	83.1%	4,892,496	0.3%	22.2%
1998	246.5	3.3%	89.0%	5,145,066	5.2%	28.5%
1999	254.6	3.3%	95.2%	5,104,093	-0.8%	27.5%
2000	265.6	4.3%	103.7%	5,586,584	9.5%	39.5%
2001	278.3	4.8%	113.4%	6,072,468	8.7%	51.7%
2002	291.7	4.8%	123.7%	–	–	–

Sources: Bureau of Labor Statistics – Medical Services CPI; Best's Aggregates and Averages.

Growth in Health Insurance Costs and Malpractice Awards Compared

Year	Cost of Health Insurance Premium	Annual Percent Change	Median Physician Malpractice Payment to Patient	Annual Percent Change
1997	\$2,196	***	\$100,000.00	***
1998	\$2,268	4.8	\$100,000.00	0
1999	\$2,424	8.3	\$108,675.00	8.7
2000	\$2,650	11.0	\$125,000.00	15.0
2001	\$3,060	12.7	\$135,000.00	8.0
Cumulative Change		39%	Cumulative Change	35%

Sources: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits Surveys, 1998-2002. National Practitioner Data Bank Annual Reports, 1997 through 2001.



The Spike in Medical Liability Premiums Was Caused by the Insurance Cycle, Not by “Skyrocketing” Jury Verdicts

- **For much of the 1990s, doctors benefited from artificially lower premiums.** According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, “What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income.” IRMI also noted: “Clearly a business cannot continue operating in that fashion indefinitely.”¹
- **West Virginia Insurance Commissioner blames the market.** According to the Office of the West Virginia Insurance Commission (one of the states in the throes of a medical malpractice “crisis”), “[T]he insurance industry is cyclical and necessarily competitive. We have witnessed these cycles in the Medical Malpractice line in the mid-'70's, the mid-80's and the present situation. This particular cycle is, perhaps, worse than previous cycles as it was delayed by a booming economy in the '90's and is now experiencing not just a shortfall in rates due to competition, but a subdued economy, lower interest rates and investment yields, the withdrawal of a major medical malpractice writer and a strong hardening of the reinsurance market. Rates will, at some point, reach an acceptable level to insurers and capital will once again flow into the Medical Malpractice market.”²
- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country’s most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums.³ He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy is booming and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.
- **The same trends are present in other lines of insurance.** Property/casualty refers to a large group of liability lines of insurance (30 in total) including medical malpractice, homeowners, commercial, and automobile. The property/casualty insurance industry has exhibited cyclical behavior for many years, as far back as the 1920s. These cycles are characterized by periods of rising rates leading to increased profitability. Following a period of solid but not spectacular rates of return, the industry enters a down phase where prices soften, supply of the insurance product becomes plentiful, and, eventually, profitability diminishes, or vanishes completely. In the down phase of the cycle, as results deteriorate, the basic ability of insurance companies to underwrite new business or, for some companies even to renew some existing policies, can be impaired. This is because the capital needed to support the underwriting of risk has been depleted through losses. The current market began

to harden in 2001, following an unusually prolonged period of soft market conditions in the property-casualty section in the 1990s. The current hard market is unusual in that many lines of insurance are affected at the same time, including medical malpractice. As a result, premiums are rising for most types of insurance. The increases have taken policyholders by surprise given that they came after several years of relatively flat to decreasing prices.⁴

- **Insurer mismanagement compounded the problems.** Compounding the impact of the cycle has been misleading accounting practices. As the *Wall Street Journal* found in a front page investigative story on June 24, 2002, “[A] price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims. Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly \$3 billion last year.”⁵ Moreover, “In at least one case, aggressive pricing allegedly crossed the line into fraud.” According to Donald J. Zuk, chief executive of SCPIE Holdings Inc., a leading malpractice insurer in California, “Regardless of the level of ... tort reform, the fact remains that if insurance policies are consistently under-priced, the insurer will lose money.”⁶
- **There is no growth in the number of new medical malpractice claims.** According to the National Association of Insurance Commissioners (NAIC), the number of new medical malpractice claims declined by about four percent between 1995 and 2000. There were 90,212 claims filed in 1995; 84,741 in 1996; 85,613 in 1997; 86,211 in 1998; 89,311 in 1999; and 86,480 in 2000.⁷

¹ Kolodkin, Charles, “Medical Malpractice Insurance Trends? Chaos!” International Risk Management Institute. <http://www.irmi.com/expert/articles/kolodkin001.asp>

² State of West Virginia Medical Malpractice Report on Insurers with over 5% Market Share, Provided by the Office of the West Virginia Insurance Commission, November 2002.

³ Americans for Insurance Reform, “Medical Malpractice Insurance: Stable Losses/Unstable Rates,” October 10, 2002. See also: <http://www.insurance-reform.org/StableLosses.pdf>.

⁴ Hot Topics & Insurance Issues, Insurance Information Institute, www.iii.org

⁵ Christopher Oster and Rachel Zimmerman, “Insurers’ Missteps”.

Helped Provoke Malpractice ‘Crisis,’” *Wall Street Journal*, June 24, 2002.

⁶ Charles Kolodkin, Gallagher Healthcare Insurance Services, “Medical Malpractice Insurance Trends? Chaos!” ((September 2001), found at <http://www.irmi.com/expert/articles/kolodkin001.asp>.

⁷ National Association of Insurance Commissioners, Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000 (2001).

“Repeat Offender” Physicians Are Responsible for the Bulk of Medical Malpractice Costs

- **Five percent of doctors are responsible for 54 percent of malpractice in the U.S.** Public Citizen’s analysis of the National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, found that 5.1 percent of doctors (35,009) have paid two or more malpractice awards to patients. These doctors are responsible for 54 percent of all payouts reported to the Data Bank. Of these, only 7.6% have ever been disciplined by state medical boards. Only 17 percent of doctors (1 out of 6) who have made 5 or more malpractice payouts have been disciplined.¹
- **A Vanderbilt University study found that doctors with past records of malpractice claims can be expected to have “appreciably worse claims experience” than other doctors in future years.**² Despite the fact that claims history predicts future claims, neither licensing boards nor the insurance market have been effective in reducing malpractice. There are over 6,000 doctors in the U.S. who have paid *four* or more malpractice claims, amounting to \$6.5 billion. These numbers can be expected to grow.
- **Redacted records from the National Practitioner Data Bank demonstrate that lax discipline by medical boards allows questionable doctors to inflict repeated injuries on patients:**

Physician Number 94358, licensed in New Jersey, settled or lost 33 medical malpractice suits involving improper diagnosis or treatment between 1988 and 1993, inflicting over \$400,000 in disability costs to his patients. This doctor has not been disciplined by authorities in New Jersey.

Physician Number 64625, licensed in Pennsylvania, paid 24 medical malpractice claims involving improper performance of surgery between 1989 and 2001. Damages to this doctor’s patients exceeded \$370,000. This doctor has never been disciplined by Pennsylvania authorities.

Physician Number 125457, while licensed in Nevada, paid five malpractice claims involving improper performance of surgery between 1995 and 1997, with damages totaling \$2.3 million. Recent news accounts have reported that doctors are fleeing from Las Vegas to other states to avoid high malpractice insurance premiums. Physician 125457 was ahead of the curve in moving his practice to California. There he paid another eight malpractice claims with damages exceeding \$7.5 million. This doctor has never been disciplined by authorities in either Nevada or California.

Physician Number 37949, licensed in Texas, settled or lost 13 medical malpractice suits involving improper treatment or improper performance of surgery between 1990 and 1997. Two of the suits involved the same allegation—a foreign body left in the patient during surgery. Damages to this doctor’s patients exceeded \$2 million. This doctor has never been disciplined by authorities in Texas.

¹ National Practitioner Data Bank, Sept. 1, 1990 – Sept. 30, 2002.

² Sloan et al, "Medical Malpractice Experience of Physicians: Predictable or Haphazard?" 262 JAMA 3291 (1989)

Few, If Any, Malpractice Lawsuits Are “Frivolous”

- **The contingency fee system discourages attorneys from bringing frivolous claims.** Medical malpractice cases are brought on a contingency fee basis, meaning the attorney receives payment only in the event there is a settlement or verdict. If the claim is closed without payment, the attorney does not receive a fee. Since attorneys must earn money to stay in business, it follows that they would not intentionally take on a non-meritorious case.
- **The high cost of preparing a medical malpractice case discourages frivolous claims—and meritorious claims as well.** Medical malpractice cases are very expensive for plaintiffs’ attorneys to bring, with out-of-pocket costs for cases settled at or near the time of trial (when most cases are settled) ranging from \$15,000 to \$25,000.¹ If the case goes to trial, the costs can easily be doubled.² These costs do not include the plaintiff’s attorney’s time, and an attorney pursuing a frivolous case incurs opportunity costs in not pursuing other cases. An attorney incurs expenses beginning with the determination of whether a case has merit. First, the attorney is required to obtain copies of the patient’s medical records from all the providers for analysis by a competent medically trained person. If that initial consultation reveals a likelihood of medical negligence, the records must then be submitted to medical specialists, qualified to testify in court, for final review. Typically, the records must be sent to experts outside of the plaintiff’s state, as physicians within the state will refuse to testify against local colleagues. As a result, the experts who agree to review records and testify can and do charge substantial fees. Fees from \$1,000 per hour to several thousand dollars are not uncommon.³ Discovery involves taking the sworn testimony of witnesses and experts. Such depositions cost \$300 and up, depending upon their length and complexity. If an expert witness is deposed, the plaintiff’s attorney is charged for the witness’ preparation time and time attending the deposition.
- **Plaintiffs drop 10 times more claims than they pursue.** The Physician Insurers Association of America (PIAA) reports that between 1985 and 2001 a total of 108,300 claims were “dropped, withdrawn or dismissed.” This is 63 percent of the total number of claims (172,474) closed during the study period.⁴ It is unclear what portion constitutes involuntarily dismissed cases (dismissed after a motion was filed by the defendant) rather than cases voluntarily dismissed by plaintiffs. According to researchers at the University of Washington School of Medicine, about nine percent of claims files are closed after the defendant wins a contested motion⁵ Based on this figure, Public Citizen estimates that about 54 percent of claims are being abandoned by patients.⁶ An attorney may send a statutorily-required notice of intent to claim or file a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim. We estimate that the number of cases withdrawn voluntarily by plaintiffs⁷ was 92,621, *10 times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent*.⁸

- The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files.⁹ The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, “These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care.” The percentage of all medical malpractice claims that go to trial is only 6.6 percent, according to PIAA, meaning that the parties and their attorneys ultimately reach agreement about liability five times more often than neutral doctors do. If truly frivolous lawsuits were being pursued, the proportion of claims going to trial would exceed the 38 percent of claims on which even doctors will disagree.
- The costs of defending claims that are ultimately dropped are not unreasonable.** Medical liability insurers have complained about the costs of defending cases that are ultimately dropped. But the professional obligation of lawyers to exercise due diligence is essentially identical to the duty of physicians. The lawyer must rule out the possibility of proving medical negligence before terminating a claim, just as doctors must rule out the possibility of illnesses suggested by their patients’ symptoms. The doctor performs his duty by administering tests; the lawyer performs hers by using discovery procedures. Both processes can lead to dead ends. But plaintiffs’ lawyers have no financial incentive to abuse the litigation process: they are using their own time and money to pursue discovery activities, and are only paid for work on behalf of clients whose cases are successful.

¹ Based on Public Citizen interviews with plaintiff attorneys.

² See Vidmar, *Medical Malpractice and the American Jury* (1995).

³ According to the Physician Insurers Association of America, expert witnesses in a medical malpractice case are paid on average over \$4,800.

⁴ *Trend Analysis Report*, 2001 Edition, 6b-4

⁵ Rosenblatt & Hurst, “An Analysis of Closed Obstetric Malpractice Claims,” 74 *Obstetrics & Gynecology* 710 (1989).

⁶ Another study, Sloan et al, *Suing for Medical Malpractice*, (1993) found the number was 5.9 percent, not nine percent. According to our queries to the database of Federal District Court Civil Cases, maintained by Professors Theodore Eisenberg and Kevin Clermont, about 4.7 percent of 10,075 medical malpractice cases between 1987 and 1992 were disposed of by pre-trial motion. To make a conservative estimate, however, we are going to use the nine percent figure.y

⁷ .09 times 172,474 equals 15,679; subtracted from 108,300 equals 92,621 claims voluntarily withdrawn.

⁸ 9,293/172,474=.054

⁹ Posner et al, “Variation in expert opinion in medical malpractice review,” 85 *Anesthesiology* 1049 (1996).

So-Called “Non-Economic” Damages Are Real and Not Awarded Randomly

- **“Non-economic” damages are not as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called “non-economic” damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) 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. According to PIAA, the average payment between 1985 and 2001 for a “grave injury,” which encompasses paralysis, was only \$454,454.
- **No evidence supports the claim that jury verdicts are random “jackpots.”** Studies conducted in California, Florida, North Carolina, New York, and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered.¹ In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.
- **The insurance industry’s own numbers demonstrate that awards are proportionate to injuries.** PIAA’s Data Sharing Report also demonstrates the relationship between the severity of the injury and the size of the settlement or verdict.² PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners’ classifications.³ The average indemnity paid per file was \$49,947 for the least severe category of injury and increased with severity, to \$454,454 for grave injuries. All researchers found that the amount of jury verdicts fell off in cases of death, for which the average indemnity was \$195,723. This is not surprising, as the costs of medical treatment for a grave injury are likely to be greater and pain and suffering would be experienced over a longer time period than in the case of death.⁴

¹ Kelso & Kelso, *Jury Verdicts in Medical Malpractice Cases and the MICRA Cap*, Institute for Legislative Practice (1999). Vidmar N, Gross F, Rose M, “Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards,” 48 *DePaul Law Review* 265 (1998). Merritt & Barry, “Is the Tort System In Crisis? New Empirical Evidence,” 60 *Ohio State Law Journal* 315 (1999).

² PIAA *Data Sharing Report*, Report 7, Part 10.

³ The NAIC scale grades injury severity as follows:

Emotional damage only (fright; no physical injury);

Temporary insignificant (lacerations, contusions, minor scars);

Temporary minor (infections, fall in hospital, recovery delayed);

Temporary major (burns, surgical material left, drug side-effects);

Permanent minor (loss of fingers, loss or damage to organs);

Permanent significant (deafness, loss of limb, loss of eye, kidney or lung);

Permanent major (paraplegia, blindness, loss of two limbs, brain damage);

Permanent grave (quadriplegia, severe brain damage, lifelong care or fatal prognosis);

Death

⁴ Vidmar, Gross, Rose, *supra* at 284

Insurance Companies and Their Lobbyists Admit It: Caps on Damages Won't Lower Insurance Premiums

Caps on damages for pain and suffering will significantly lower awards to catastrophically injured patients. But because those truly severe cases make up a small percentage of medical malpractice claims, and because the portion of the medical liability premium dollar that pays for compensation is dwarfed by the portion that pays for defense lawyer fees, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this – so don't take our word for it, take theirs.

A Premium on the Truth

“Insurers never promised that tort reform would achieve specific savings.” – American Insurance Association¹

“We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.” – Sherman Joyce, president of the American Tort Reform Association²

“Many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years.” – Victor Schwartz, general counsel to the American Tort Reform Association³

Florida

“No responsible insurer can cut its rates after a bill (that caps damages at \$250,000) passes.” – Bob White, president of First Professionals Insurance Co.⁴

Mississippi

“Regardless of what may result from the ongoing tort reform debate, please remember that such proposed public policy changes are critical for the long-term, but do not provide a magical ‘silver-bullet’ that will immediately affect medical malpractice insurance rates ... The 2003 rate change [a 45 percent increase] would happen regardless of the special session outcome.” – Medical Assurance Company of Mississippi⁵

Nevada

“The primary insurer for Las Vegas obstetricians, American Physicians Assurance, has no plans to lower premiums for several years, if ever, said broker Dennis Coffin.” – The Las Vegas Review-Journal⁶

“[John Cotton of the Nevada Physicians' Task Force] noted that even if the bill reflected a cap of \$5, there would not be an immediate impact on premiums.” – Minutes of the Nevada Assembly Committee on Medical Malpractice Issues⁷

New Jersey

During a hearing on medical malpractice issues, New Jersey Assemblyman Paul D'Amato asked Patricia Costante, Chairwoman and CEO of MIIX Group of Companies, “[A]re you telling the insured physicians in New Jersey that if this State Legislature passes caps that you'll guarantee that you won't raise your premiums, in fact, you'll reduce them?” Costante replied: “No, I'm not telling you [or them] that.”⁸

The New Jersey Medical Society commissioned Tillinghast-Towers Perrin, a leading actuarial firm, to analyze the effects of a \$250,000 cap on pain and suffering damages. The findings: “We would expect that a \$250,000 cap on non-economic damages will produce some savings, perhaps in the 5 percent to 7 percent range for physicians.” – Letter from Tillinghast-Towers analysts James Hurley and Gail Tverberg⁹

Ohio

“In the short run, we may even see prices go up another 20 percent, and people will say, ‘Gee, what happened, I thought we addressed this.’” – Ray Mazzotta, president of Columbus-based Ohio Hospital Insurance Co.¹⁰

“The stroke of the governor’s pen [enacting caps on damages] will not result in immediate lowering of rates by responsible companies.” – Frank O’Neil, spokesman for Birmingham, Ala.-based Medical Assurance¹¹

Wyoming

During a hearing on medical malpractice insurance issues, Bruce Crile of the Doctors’ Company and Melissa Dennison of OHIC Insurance Company testified that insurance rates would not drop if caps on damages were imposed. “Both the Doctors’ Company and OHIC’s actuaries say a cap of \$500,000 is meaningless for purposes of ratemaking. Even with caps enacted premiums will still increase, but with predictability of the risk there will be a moderating of rate increases.” – Minutes of the Wyoming Legislature’s Joint Labor, Health and Social Services Interim Committee¹²

Endnotes

¹ “AIA Cites Fatal Flaws In Critic’s Report On Tort Reform,” American Insurance Association press release, March 13, 2002.

² “Study Finds No Link Between Tort Reforms And Insurance Rates,” *Liability Week*, July 19, 1999.

³ Michael Prince, “Tort Reforms Don’t Cut Liability Rates, Study Says,” *Business Insurance*, July 19, 1999

⁴ Phil Galewitz, “Underwriter Gives Doctors Dose of Reality,” *The Palm Beach Post*, January 29, 2003.

⁵ Julie Goodman, “Premiums Rise by 45 Percent; Insurance Group’s Hike Comes as Doctors Seek Relief,” *Clarion-Ledger* (Jackson, Miss.), September 22, 2002.

⁶ Joelle Babula, “Obstetricians Say Problems Remain,” *The Las Vegas Review-Journal*, October 1, 2002.

⁷ “Testimony on Assembly Bill 1: To Make Various Changes Related to Medical and Dental Malpractice,” Nevada Assembly Committee on Medical Malpractice Issues, July 30, 2002.

⁸ “Testimony Concerning the Affordability of Medical Malpractice Insurance for Physicians Practicing in New Jersey,” Public Hearing Before the Assembly Health and Human Services Committee and Banking and Insurance Committee, June 3, 2002.

⁹ Letter to Ray Cantor, Director of Governmental Affairs for the State Medical Society of New Jersey, from Tillinghast-Towers analysts James Hurley and Gail Tverberg, January 7, 2003.

¹⁰ “No Drop in Malpractice Rates Pending,” *The Associated Press*, January 10, 2003.

¹¹ “No Drop in Malpractice Rates Pending,” *The Associated Press*, January 10, 2003.

¹² Testimony at the Wyoming Legislature’s Joint Labor, Health and Social Services Interim Committee, December 4-6, 2002.

Empirical Evidence Does not Confirm the Existence of “Defensive Medicine” — Patient Injuries Refute It

- **A search of the scholarly literature on medicine will turn up dozens of studies documenting the incidence of medical errors, but not one peer-reviewed study documenting purely defensive medicine.** One might laugh at the spectacle of a lobbying campaign constructed around a flimsy theory unsupported by any empirical evidence. Unfortunately, the evidence *disproving* the theory is so overwhelming and compelling as to be truly frightening. Several recent studies demonstrate that current disincentives to unsafe and sloppy practices are inadequate, and show how much more dangerous medical care would be if deterrents were further weakened.
- **The Congressional Budget Office has rejected the defensive medicine theory.** The Congressional Budget Office (CBO) was asked to quantify the savings from reduced “defensive medicine” if Congress passed H.R. 4600. This bill, which contained very stringent restrictions on patients’ ability to recover damages, passed the U.S. House in 2002. CBO declined, saying:

Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians’ responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.

A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments that are disproportionately likely to experience malpractice claims. Using broader measures of spending, CBO’s initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending. Although the provisions of H.R. 4600 could result in the initiation of fewer lawsuits, the economic incentives for individual physicians or hospitals to practice defensive medicine would appear to be little changed.¹

- **Defensive medicine hasn’t prevented wrong-patient surgery.** New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.² There were nine such instances in Florida in 2001.³ In trying to determine how such shocking errors could occur, researchers analyzed one case in detail. The case study determined that medical personnel had ignored “many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure.” In this case, “defensive medicine” measures would have included follow-up questioning or record-checking when the patient told personnel she had not been admitted for cardiac treatment. Surely if the medical providers were frightened of lawsuits they would have made such minimal inquiries.

- **Defensive medicine hasn't prevented medication errors.** An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful.⁴ The authors said this amounts to about 40 potential adverse drug events per day in a typical 300-patient facility. The errors were made in spite of the presence of observers from the research team—who could easily have been called as witnesses in a medical liability lawsuit. An earlier study by Boston researchers estimated that there are some 500 preventable adverse drug events in the average hospital each year, in spite of the fact that “drug injuries frequently result in malpractice claims, and in a large study of closed claims... accounted for the highest total expenditure of any type of procedure-related injury.”⁵
- **Defensive medicine hasn't prevented mammography errors.** The *New York Times* reported in June 2002 some very disturbing facts about errors committed by radiologists in reading mammograms.⁶ The theory of defensive medicine predicts that radiologists would err on the side of caution, and detect more false positives than false negatives. Unfortunately the opposite is true, with studies indicating that some doctors and clinics miss as many as one in three cancers. Despite the possibility of lawsuits, doctors with no aptitude for mammography continue to read mammograms. Clinics continue to employ doctors who read too few mammograms to keep their skills sharp. It appears that only reviews by regulators spur doctors and clinics to meet minimum standards.
- **Defensive medicine hasn't prevented hospital infections.** The *Chicago Tribune* reported on July 21, 2002 that some 75,000 Americans die each year because of infections acquired in hospitals that “were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses.”⁷ If medical providers fear being sued over the slightest lapse, why would doctors and nurses neglect to take the most elementary precautions of washing their hands and changing scrub uniforms? Why would American hospitals “have collectively pared cleaning staffs by 25 percent since 1995”?⁸ Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.⁹
- **Defensive medicine hasn't caused hospitals to keep nursing staffs up-to-strength.** Two reports published in the past six months concluded that patients in hospitals where nurses had heavier workloads had a higher risk of dying.¹⁰ One report found specifically that each additional patient per nurse corresponded to a seven percent increase in both patient mortality and deaths following complications.¹¹ Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts over-staffing.

¹ CBO supra note 22.

² Chassin & Becher, "The Wrong Patient," 136 *Ann Intern Med.* 826 (2002).

³ Agency for Health Care Administration, *Risk Management Reporting Summary*, March 2002.

⁴ Barker et al, "Medication Errors Observed in 36 Health Care Facilities," 162 *Arch Intern Med.* 1897 (2002).

⁵ Bates et al, "The Costs of Adverse Drug Events in Hospitalized Patients," 277 *JAMA* 307 (1997).

⁶ Moss, "Spotting Breast Cancer: Doctors Are Weak Link," *New York Times*, June 27, 2002.

⁷ Berens, "Infection epidemic carves deadly path," *Chicago Tribune*, July 21, 2002. This number is attributed to the "Tribune's analysis, which adopted methods commonly used by epidemiologists."

⁸ *Id.*

⁹ U.S. Department of Health and Human Services, *Confronting the New Health Care Crisis* (July 24, 2002)

¹⁰ Needleman J., Buerhaus P., Mattke S., Stewart M., Zelevinsky K, *Nurse-Staffing Levels and the Quality of Care in Hospitals*, *N Engl J Med* (2002); 346:1715-1722, May 30, 2002. *See also*: Aiken LH, Clarke SP, Sloane DM, et al., *Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction*, *JAMA*, 2002;288:1987-1993, October 23/30, 2002.

¹¹ Aiken LH, Clarke SP, Sloane DM, et al., *Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction*, *JAMA*, 2002;288:1987-1993, October 23/30, 2002.

Doctors' Aversion to Settlements May Increase Malpractice Insurance Costs

- **Medical malpractice insurers market their product based on aggressive defenses, not on low costs.** The Doctors Company, a leading doctor-owned insurer, states on its website: “When litigation is necessary, we dedicate more resources than our competitors to defend your good name. Our claims representatives and defense attorneys combine their knowledge of regional laws and jury experience to develop *aggressive, successful, defense strategies... We will not consent to settle without your written permission.*” (emphasis theirs)¹ In other lines of insurance coverage, claims managers dispassionately evaluate the insured’s exposure and make an objective decision as to whether to settle the claim. This rational calculation takes a back seat to pride and other emotional considerations when medical malpractice insurance is involved.
- **The result is that defense attorney fees are higher and verdicts are higher, pushing malpractice premiums higher.** According to A.M. Best figures cited on The Doctors Company website, the average doctor-owned medical malpractice insurer spends 32 percent of premiums on defense costs. The Doctors Company entices customers by boasting that 49 percent of its premiums are spent on defense costs.² A study by the West Virginia Insurance Commissioner found that one company spends 88 cents of each premium dollar on defense lawyers.
- **Malpractice insurance defense costs far exceed defense costs in other lines of insurance.** According to NAIC figures, defense costs incurred as a portion of direct premiums written amount to 4.8 percent for passenger auto liability, 7.1 percent for commercial auto liability, 16.5 for commercial general liability, and 28.9 percent for product liability.³ Malpractice insurers seldom settle a case before the eve of trial, waiting until discovery is complete. They also take three times more cases to trial than other civil defendants. In 2000, the overall percentage of federal civil cases going to trial was 2.2, but 6.8 percent of medical malpractice cases went to trial.⁴
- **In reality, the liability insurance purchased by doctors is not just for risk management; it is also a public relations tool.** The Doctors Company and Medical Assurance both use the motto “Defending your reputation” in marketing themselves.⁵ Kansas Medical Mutual Insurance Company (KaMMCO) cites “the existence of the National Practitioner Data Bank” as a reason that it is “more important than ever for health care professionals... to defend themselves against allegations of wrongdoing.”⁶ Doctors’ complaints about high premiums must be viewed skeptically when much of the price quoted may pay for services entirely unrelated to managing risks of patient care.⁷
- **Evidence indicates that the negotiation process in medical malpractice cases fails, directly leading to the high verdicts that doctors complain about.** Pursuing a hardball defense strategy guided by emotion rather than reason will also affect the parties’ ability to negotiate rational settlements. An Ohio State study compared medical and product liability negotiations. It found that product liability defense attorneys “correctly” predicted

jury outcomes (i.e. rejected plaintiff demands that were higher than the jury's eventual verdict) in 12 of the 14 cases studied. By contrast, defense attorneys made the correct settlement decision in only eight of 17 medical malpractice cases in the study. In one case, the defendant rejected a demand of \$2 million only to be hit with a judgment for more than \$8 million. The authors concluded that, "In malpractice cases, plaintiffs gained more than defendants from rejecting settlement offers and proceeding to trial. In product liability cases, defendants gained more than plaintiffs from eschewing settlement and defending claims in court... It appears that malpractice defendants—rather than plaintiffs—may be somewhat too inclined to resist settlement and push cases to trial."⁸

¹ <http://www.thedoctors.com/resources/I-27/DocBrochure/Protectdoc4-5.html>

² Id.

³ National Association of Insurance Commissioners, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001).

⁴ Query to database of Federal District Court Civil Cases, maintained by Professors Theodore Eisenberg and Kevin Clermont of Cornell University. <http://teddy.law.cornell.edu:8090/questata.htm>

⁵ See <http://www.thedoctors.com/resources/I-27/DocBrochure/Protectdoc4-5.html>, <http://www.medicalassurance.com>

⁶ <http://www.kammco-msc.com>

⁷ Other "extras" that may be included in the price of malpractice insurance include Defendant Reimbursement Coverage, that pays a doctor \$500 per day to attend a trial, offered by ISMIE; and "defense coverage associated with the investigation of Medicare and Medicaid billing errors, regulatory agency actions, and... an initial consultation with an attorney to discuss potential countersuits," offered by KaMMCO.

⁸ Merritt and Barry, "Is the Tort System in Crisis? New Empirical Evidence," 60 Ohio St. L. J. 315 (1999).

Solutions to Reduce Medical Errors and Long-term Insurance Rates

Implement Patient Safety Measures Proposed by the Institute of Medicine

Public Citizen believes in personal responsibility and accountability for negligence as one of the principal methods for deterring medical errors. Nevertheless, we acknowledge that the “systems approach” to patient safety advocated by the Institute of Medicine shows considerable promise. We are disappointed that some three years after the release of its report, almost nothing has been done to establish mandatory nationwide error reporting systems, identify unsafe practices, or raise performance standards.

- **Medication errors are among the most common preventable mistakes, but safety systems have been put in place in very few hospitals.** Although experts using the systems approach have identified a number of promising strategies to reduce malpractice, few have been implemented. Experts have estimated that more than 950,000 serious drug errors occur annually in hospitals alone.¹ Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,² CPOE is an electronic prescribing system that intercepts errors where they most commonly occur – at the time medications are ordered. Physicians enter orders into a computer, rather than on paper. Orders are automatically checked for potential problems, such as drug interactions or allergies. CPOE also resolves problems associated with deciphering doctors’ notoriously bad handwriting. But in spite of these benefits, fewer than three percent of hospitals have fully implemented CPOE.³
- **Evidence-based hospital referral could save 4,000 lives every year, but has not been implemented.** Evidence-based hospital referral means directing patients with high-risk conditions to hospitals with characteristics shown to be associated with better outcomes. Dr. Adams Dudley, a researcher at the University of San Francisco at California, identified 10 surgical procedures for which outcomes were strongly related to hospital volume. Using data from California hospitals, he estimated that using evidence-based hospital referral for those 10 procedures would prevent over 4,000 deaths across the U.S. each year.⁴
- **Surgery performed on the wrong part of the body, to the wrong patient, and performing the wrong procedure on a patient are all completely preventable, yet continue to occur.** Such mistakes should *never* happen, according to a special alert reissued December 5, 2001 by the Joint Commission on Accreditation of Healthcare Organizations.⁵ To prevent these accidents, the JCAHO recommends the surgical site be marked with a permanent marker. Sometimes referred to as “signing your site,” doctors place their initials on the surgical site with a permanent marking pen in a way that cannot be overlooked and then actually operate through or next to the initials. JCAHO also recommends orally verifying the surgery in the operating room just before starting the operation.⁶ Nevertheless, during 2001 in Florida hospitals alone there were 54 surgeries on the wrong part of the body, 16 wrong procedures performed and nine wrong patient

surgeries.⁷ Had Florida mandated the JCAHO recommendations in 2000, these 79 incidents would not have occurred.

Open the National Practitioner Data Bank to Empower Consumers with Information About Their Doctors

Information about doctor discipline, including state sanctions, hospital disciplinary actions and medical malpractice awards is now contained in the National Practitioner Data Bank. HMOs, hospitals and medical boards can look at the National Practitioner Data Bank. Unfortunately, consumers cannot because the names of physicians in the database are kept secret from the public. Congress should lift the veil of secrecy and allow the people who have the most to lose from questionable doctors to get the information they need to protect themselves and their families.

Limit Physicians' Workweek to Reduce Hazards Created by Fatigue

American medical residents work among the highest—if not the highest—number of hours in the professional world. They work up to 120 hours a week, including 36-hour shifts for several weeks at a time.⁸ After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10 percent blood alcohol level.⁹ In other words, doctors who would be considered too unsafe to drive may still treat patients for 12 more hours. 41 percent of resident-physicians attribute their most serious mistake in the previous year to fatigue.¹⁰ 45 percent of residents who sleep less than four hours per night report committing medical errors.¹¹ Working these extreme hours for years at a time also has ill-effects on doctors' own personal health and safety. Multiple studies in the medical literature demonstrate that sleep-deprived and overworked residents are at increased risk of being involved in motor vehicle collisions, suffering from depressed mood and depression, and giving birth to growth-retarded and/or premature infants.¹² If the maximum workweek for residents was limited to 80 hours it could considerably reduce mistakes due to fatigue and lack of supervision.

Refine the Malpractice Insurance System

The number of classifications of doctor specialties for insurance rating purposes should be reduced to more broadly spread the risk. Risk pools for some are too small and thus overly influenced by a few losses and the concentration in a few specialties of doctors handling the highest risk patients. Often the high-risk patients are “referred up” from general practitioners who do not bear any of the risk.

Improve Oversight of Physicians

Public Citizen has long sought greater consumer access to information about doctors, and there have been recent improvements in making that information available. Most state medical boards now provide some physician information on the Internet, but the information about disciplinary actions varies greatly, is often inadequate and can be difficult for people to access.¹³

For more than a decade, Public Citizen's Health Research Group has been carefully scrutinizing the performance of state medical boards. As reported in our *Questionable Doctors* publication,¹⁴ too little discipline is being done. Too many state medical boards, despite their duty to protect the public, still believe their first responsibility is to rehabilitate "impaired physicians" and shield them from the public's prying eyes. Fewer than one-half of one percent of the nation's doctors face any serious state sanctions each year. 2,708 total serious disciplinary actions a year, the number state medical boards took in 2001, are a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by medical errors annually.

State discipline rates ranged from 10.52 serious actions per 1,000 doctors (Arizona) to 0.73 actions per 1,000 physicians (District of Columbia), a 14.4-fold difference between the best and worst states. If all the boards did as good a job as the lowest of the top five boards, Kentucky's rate of 6.32 serious disciplinary actions per 1,000 physicians, it would amount to a total of 5,089 serious actions a year. That would be 2,381 more serious actions than the 2,708 that actually occurred in 2001. It is likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top performances.

Negligent doctors are rarely disciplined with loss or suspension of their license for inferior care. Instead, state medical boards focus on more easily documentable offenses such as prescription drug violations and fraud convictions or disciplinary action in another state as potential indicators of substandard care. Congress could encourage better oversight through grants to state medical boards, tied to the boards' agreements to meet performance standards. The following state reforms would help protect patients:

- **Reform medical board governance.** States should sever any remaining formal, debilitating links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees. At least 50 percent of the members of each state medical board and disciplinary board should be well-informed and well-trained public members who have no ties to health care providers and who, preferably, have a history of advocacy on behalf of patients. The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians who are trying to evade disciplinary actions.
- **Beef up medical board funding and staffing.** State legislatures should permit medical boards to spend all the revenue from medical licensing fees, rather than being forced to give part to the state treasury. The medical boards should raise their fees to \$500 a year. All boards could benefit from hiring new investigators and legal staff. Boards should employ adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements. They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care.

- **Require risk prevention.** States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk prevention program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.
- **Require periodic recertification of doctors based on a written exam and audit of their patients' medical care records.**

¹ Birkmeyer JD, Birkmeyer CM, Wennberg, DE Young MP, *Leapfrog Safety Standards: potential benefits of universal adoption*. The Leapfrog Group. Washington, DC: 2000. Available at: http://www.leapfroggroup.org/PressEvent/Birkmeyer_ExecSum.PDF.

² Bates DW, Leape LL, Cullen DJ, Laird N, et al. *Effect of computerized physician order entry and a team intervention on prevention of serious medical errors*. JAMA. 1998;280:1311-6.

³ Sandra G. Boodman, "No End to Errors," *Washington Post*, December 3, 2002.

⁴ Birkmeyer JD. *High-risk surgery—follow the crowd*. JAMA. 2000; 283:1191-3; See also Dudley RA, Johansen, KL, Brand R, Rennie DJ, Milstein A. *Selective Referral to High Volume Hospitals: Estimating Potentially Avoidable Deaths*. JAMA. 2000; 283: 1159-66.

⁵ *A follow-up review of wrong site surgery*, JCAHO, Sentinel Event Alert, Issue 24, Dec. 5, 2001.

⁶ *Joint Commission Issues Alert: Simple Steps By Patients, Health Care Practitioners Can Prevent Surgical Mistakes*. See JCAHO web site: <http://www.jcaho.org/news+room/press+kits/joint+commission+issues+alert+simple+steps+by+patients.++health+care+practitioners+can+prevent+surg.htm>

⁷ Florida Agency for Health Care Administration, *Risk Management Reporting Summary, 24 Hour Reports and Code 15 Reports, 2001*, March 2002.

⁸ American Medical Student Association, *Fact Sheet, Support H.R. 3236 limiting resident-physician work hours*; See also: <http://www.amsa.org/hp/rwhfact.cfm>.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² Public Citizen, *Petition to the Occupational Safety and Health Administration requesting that limits be placed on hours worked by medical residents (HRG Publication #1570)*, April 30, 2001; See also: <http://www.citizen.org/publications/release.cfm?ID=6771>.

¹³ See <http://www.citizen.org/publications/release.cfm?ID=7168>

¹⁴ www.questionabledoctors.org

Politicians Should Reject Proposals that Reduce Accountability for Negligence

There are three main critiques of the legal system that have been offered to justify changes to medical liability laws.

The first is that the system sometimes reaches erroneous results. Nobody would contend that any institution relying on fallible human beings is perfect. Fortunately, the legal system provides far more back-ups than other institutions in our society, through its transparency and its extensive appellate process. Judges can, and do, reverse decisions of juries when they act with passion or prejudice, as well as review decisions of lower courts. In recent years, the U.S. Supreme Court has expanded protections to defendants in civil cases much as it expanded protections to criminal defendants in the 1960s. We are confident that few, if any, unreasonable results survive the review process.

The second critique is that the transaction costs (court administrative and attorneys' fees) of the civil justice system are too high. We believe that the tort system is worth its transaction costs. Unlike a bare-bones no-fault system, the tort system marshals lawyers' investigations, experts' opinions, and jurors' determinations to answer complex safety questions and set minimum standards for consumer protection. Within the category of "transaction costs" are attorneys uncovering the Ford/Firestone scandal; Erin Brockovich's investigation of the poisonings in Hinkley, California; and the work that exposed tobacco company fraud in manufacturing and marketing cigarettes.

Nevertheless, both consumers and corporations agree that unnecessary transaction costs should be cut when possible. Defense lawyers have favored reduction of document discovery, and plaintiffs' lawyers have favored limits on the length of depositions. But care must be taken to ensure that the "cost-cutting" label is not used to disguise measures that advantage one side. Just as defendants are skeptical of reducing the size of juries from twelve to six, consumers and patients are skeptical of measures such as mandatory arbitration.

The third critique of the tort system is that it awards too much compensation. It is with this argument that we fully and vehemently disagree. As we have noted earlier, there is overwhelming evidence that most injuries are not being compensated.

The medical community needs to say explicitly why it thinks a 6-to-1 disparity in injuries to claims is not favorable enough. Do they think it should be a 12-to-1 disparity? 20-to-1? What is their justification? The Health Care Liability Alliance has on its website a comparison of American tort expenditures to those in Japan and Denmark. Are doctors suggesting that Americans should mimic the conflict-aversion of Japanese culture or the stoicism of Scandinavian culture? Is there something wrong with us Americans? Is our individualism excessive? Debate is being driven by anecdotes, slogans, and hyperbole, without an acknowledgment or discussion of the values underlying the system.

We deplore the efforts to place arbitrary caps on so-called “non-economic damages.” This Orwellian term has been applied to damages for pain and suffering (for injuries resulting in paralysis, loss of limb, etc.), disfigurement, and loss of fertility in an effort to demean their importance. The tremendous amount of money spent on such things as pain relief medication, grief counseling, cosmetic surgery, and fertility treatments belies the absurd notion that such damages could be “non-economic.” To make matters worse, caps by definition apply only to the most catastrophically injured victims.

Every reputable economist says that paid damages need to be equal to injury costs in order to force an industry to exercise safety precautions. The conservative appointees to the President’s Council of Economic Advisors phrased it very well in their recent report on the tort system:

[A] patient purchasing a medical procedure, for example, may be unlikely to fully understand the complex risks, costs and benefits of that procedure relative to others...In such a case, the ability of the individual to pursue a liability lawsuit in the event of an improper treatment, for example, provides an additional incentive for the physician to follow good medical practice. Indeed, from a broad social perspective, this may be the least costly way to proceed – less costly than trying to educate every consumer fully. In a textbook example, recognition of the expected costs from the liability system causes the provider to undertake the extra effort or care that matches the customer’s desire to avoid the risk of harm. This process is what economists refer to as “internalizing externalities.” In other words, the liability system makes persons who injure others aware of their actions, and provides incentives for them to act appropriately.¹

Measures that reduce compensation will reduce patient safety. Reducing tort system expenditures does not reduce the cost of injuries but shifts them, and ultimately increases them. While it is unfortunate that doctors have had to cope with large spikes in liability premiums, the silver lining is the message that the tort system is sending about medical errors. Publicly, doctors are saying that the tort system is out of control and needs to be fixed. But privately, we are certain, doctors are saying that they need to get their house in order, and ramp up new patient safety systems and risk management efforts.

¹ Council of Economic Advisors, *Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System* (April 2002).

Analysis of the Medical Malpractice “Crisis” in several States

Medical Misdiagnosis in Arkansas: Challenging the Medical Malpractice Claims of the Doctors' Lobby

Executive Summary from the Public Citizen's Congress Watch Report *Full Report available at www.citizen.org*

The Arkansas Medical Society and its allies have made a number of sensational allegations about what they call a malpractice “crisis.” We agree that there is a *temporary* “crisis” and malpractice insurance costs have spiked over the last two years. But claims that it has been caused by “many frivolous lawsuits,” an “out-of-control legal system,” “an irrational lottery,” or “astronomic jury verdicts” have no basis in fact.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

- 1) The medical malpractice “crisis” in Arkansas, as in the rest of the country, is not a long-term problem nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country’s economic slowdown.
- 2) A more significant, longer-term malpractice “crisis” faced by Arkansas is the unreliable quality of medical care being delivered – a problem that health care providers have not adequately addressed. Taking away people’s legal rights, as is proposed under a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Highlights of this report include:

- **The cost of medical negligence to Arkansas’ patients and consumers is considerable, especially when measured against the cost of malpractice insurance to Arkansas’ doctors.** Extrapolating from Institute of Medicine findings, we estimate that medical errors cause 418 to 931 preventable deaths in Arkansas each year. The cost resulting from preventable medical errors to Arkansas’ residents, families, and communities is estimated at \$161 million to \$275 million each year. But the cost of medical malpractice insurance to Arkansas’ doctors is less than \$40 million a year.
- **Arkansas doctor’s liability premiums are among the lowest in the nation.** Malpractice insurance premiums in Arkansas are some of the lowest in all 50 states and the District of Columbia, according to data collected by *Medical Liability Monitor*. The median premium for a general surgeon practicing in Arkansas in 2002 was \$16,400 – about the same amount paid by general surgeons in North Dakota or South Dakota, and higher than those in only four other states.

- **Government data shows that large malpractice award payments have been the rare exception in Arkansas.** According to the federal government’s National Practitioner Data Bank (NPDB), Arkansas physicians made only two multi-million dollar award payments between 1998 and 2001. The largest was only \$2,550,000. The number of large (more than \$100,000) malpractice payments in Arkansas remained constant over the past four years, and so has the total amount of malpractice payments – declining from \$15.8 million in 1998 to \$15.1 million in 2001. Adjusting for inflation, this steady level of awards represents a significant decline in dollar value.
- **Government data show that malpractice payments in Arkansas have increased at a slower pace than national medical costs.** According to the National Practitioner Data Bank, the median medical malpractice payment by an Arkansas physician to a patient rose 48.6 percent between 1992 and 2002, or less than 5 percent a year. However, during those same years, medical costs increased by 53.7 percent nationally, or 5.4 percent a year. (Medical costs typically represent the lion’s share of most malpractice awards.) Moreover, between 1999 and 2002, the median malpractice payment by an Arkansas physician actually dropped by more than 10 percent.
- **Arkansas’ cumulative median malpractice payment has remained less than the national average.** Among the 50 states and the District of Columbia, Arkansas historically has ranked below the national average for the median malpractice payment by a physician to a patient. According to the NPDB, the cumulative median malpractice payment from 1991 to 2001 was \$90,000 in Arkansas – compared with \$100,000 nationally for the same period.
- **The number of Arkansas malpractice lawsuits filed in 2002 was less than in the preceding years.** In each of the past two years, which was the height of the insurance “crisis,” the number of malpractice lawsuits filed in the state decreased. In 2002, 371 malpractice cases were filed in Arkansas, compared with 383 in 2001, and 413 in 2000. Overall, this represented a 10 percent decrease in lawsuits filed.
- **Doctors diagnose a crisis where the Chamber of Commerce sees none.** The American Medical Association added to a false sense of crisis when it included Arkansas on a list of states showing “problem signs” with their medical liability systems. On the same list, however, the AMA included Delaware and Virginia – states that the U.S. Chamber of Commerce ranks first and second among states with the *best* liability systems.
- **The number of doctors in Arkansas has been increasing.** Despite gloomy forecasts issued by those declaring a malpractice “crisis” in the state, the Arkansas State Medical Board reports that from 1998 to 2002 the state experienced an increase of 209 doctors, an average of 52 additional doctors each year. In 1995, Arkansas had 192 doctors for each 100,000 citizens. By 2001, the ratio was 212 per 100,000, an improvement of 10.4 percent.
- **“Repeat offender” physicians are responsible for the bulk of malpractice costs.** According to the federal government’s National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 2.6 percent of Arkansas’ doctors have made two or more malpractice payments to patients. These repeat offender doctors are responsible for 43.7 percent of all payments. Overall, they have paid out

\$48.9 million in damages. Even more surprising, less than 1 percent of Arkansas' doctors, each of whom has paid three or more malpractice claims, are responsible for 20.3 percent of all payments.

- **Repeat offender doctors suffer few consequences in Arkansas.** The Arkansas state government and the state's health-care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions have been few and far between for Arkansas physicians. Of the 153 physicians in Arkansas who have made two or more payments to patients for malpractice since 1990, only 15 have been disciplined by the Arkansas State Board of Medicine – that is fewer than one out of 10. Moreover, only 14 percent of those doctors who made three or more malpractice payments were disciplined by the Board. A brief description of eight repeat offender doctors is contained in the body of this report.
- **Where's the doctor watchdog?** The Arkansas State Board of Medicine is dangerously lenient with doctors, repeatedly letting serious and sometimes repeat offenders off the hook. In 2001, only 24 doctors in Arkansas had serious sanctions levied against them. Arkansas took 4.18 serious actions per 1,000 doctors – slightly better than the national average, but only half as good as the best performing states and not nearly high enough to prevent bad doctors from practicing. Further, Arkansas is one of 10 states that provides no public information about doctors disciplined by their licensing boards.
- **The spike in medical liability premiums was caused by the insurance cycle, not by “skyrocketing” malpractice awards.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.
- **Insurer mismanagement compounded the problems.** Underpriced premiums, reckless cash-flow policies, and ill-fated involvement with Enron and asbestos subsidiaries forced one major carrier, the St. Paul Companies, to stop offering malpractice insurance. The company had covered more than 40 percent of Arkansas' doctors. According to a *Wall Street Journal* analysis, St. Paul generated large cash reserves by raising rates during the 1980s, and then released \$1.1 billion from reserves between 1992 and 1997 – dramatically boosting its bottom line. This artificial profitability attracted numerous, smaller competitors into the malpractice insurance market and led to widespread price-cutting. By the end of the 1990s, revenue from premiums no longer could cover malpractice claims, causing some companies to collapse and others, like St. Paul, to drop coverage.

Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies Not the Legal System

Executive Summary from the Public Citizen's Congress Watch Report *Full Report available at www.citizen.org*

The American Medical Association, the Florida Medical Association and their allies in the business community have made a number of sensational allegations about what they call a "malpractice crisis." Their allegations about the current state of medical malpractice litigation include: "many frivolous lawsuits," "out-of-control legal system," "explosions in costs," "astronomic jury verdicts," "an irrational lottery," to cite a few.

This new Public Citizen study challenges these assertions by examining statistics from two sources that have not yet been considered in the debate about medical liability – injury data reported by hospitals to Florida's Agency for Health Care Administration and the "public use" file of the National Practitioner Data Bank, which reports on doctors who commit malpractice.

According to the Institute of Medicine (IOM), which completed a comprehensive report on the medical malpractice issue in 1999, medical errors "are a leading cause of death in the United States... At least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors. Deaths due to preventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516). Costs attributable to medical errors are estimated at between \$17 billion and \$29 billion, according to the IOM. Given these shocking numbers, it can be no surprise that medical liability premiums are too high for some specialties.

But the spike in some medical malpractice premiums is an insurance industry pricing and profitability problem – not a legal system problem. As this study shows, the assertions made about the medical liability system in Florida are, at best, highly exaggerated, and, at worst, totally false.

Rather than reducing the real threats that medical care poses to their patients, the doctor's lobby has proposed to shift the costs of injuries onto individuals, their families, voluntary organizations and taxpayers. This is unfortunate because doctors and patients and consumers should be allies on this issue – not be pitted against each other. Doctors should join together with patients and consumers and work hard to reform the poor business practices of the insurance industry, rather than blame the victims and their lawyers, and to better police the very small number of their profession who commit most of the state's malpractice.

The following are the major findings of this report:

- **The number of medical errors reported by Florida hospitals exceeds the number of medical malpractice *claims* filed each year by 6 to 1.** About two-thirds of malpractice claims arise during hospitalization. Reports prepared by Florida's Agency for Health Care Administration have compared reports of adverse incidents in hospitals to the filing of new malpractice claims. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. This means that for every 6 adverse incidents in the hospital only 1 malpractice claim is ever filed. The agency's 2001 report contains these astonishing figures on medical errors in Florida hospitals: 9 incidents of surgery performed on the wrong patient; 16 incidents where the wrong procedure was performed; 54 incidents where the procedure was performed on the wrong site; and 122 incidents where a foreign object was left in a patient after surgery. See Section I.
- **Six percent of the doctors in Florida are responsible for half the malpractice.** Public Citizen's analysis of the federal government's National Practitioner Data Bank information, which records malpractice judgments and settlements since September 1990, found that 2,674 of the state's 44,747 doctors have paid two or more malpractice awards to patients. These doctors are responsible for 51 percent of all payments. Overall, these doctors have paid \$1.2 billion in damages. Despite the fact that claims history predicts future claims, neither the state medical licensing boards nor the insurance market have been effective in reducing malpractice. See Section II, which includes examples of the most egregious repeat offenders.
- **Many of Florida's most dangerous doctors continue to practice and the state watchdog is asleep on the job.** There are 1,555 physicians who have been disciplined by Florida's state medical and osteopathic boards for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses and other offenses. Many were not required to stop practicing, even temporarily. In fact, only 36 percent of Florida's disciplinary actions in 2001 were serious – meaning license revocation, suspension, surrender or probation. When compared to the rest of the country, only two states were worse in that regard, Wisconsin (22 percent) and North Carolina (32 percent). Overall, Public Citizen ranks Florida 26th among the states in terms of the performance of its state medical board, which is charged with policing the medical profession. See Section III.
- **Rate increases are up for many other types of insurance in Florida.** Doctors like to blame lawyers and the legal system for rising malpractice insurance rates. But these rate increases are largely the result of the economics of the insurance industry – major stock market losses mean insurers cannot continue to offer artificially low rates in the hope of attracting more customers. The resulting cycle of insurance rate hikes is today propelling the costs of all insurance products upward. Types of insurance and rate increases in Florida during 2002 include: medical malpractice (26 percent), health insurance (20 to 28 percent); auto (10.6 percent); and homeowners (15.7 percent). See Section IV.

Medical Misdiagnosis in Mississippi

Introduction

In Mississippi, changes in medical malpractice were lumped into a broad, pro-business agenda that sought to make it harder for consumers to collect damages from everyone—from manufacturers and small-business owners to auto dealers and doctors. A statewide coalition, representing 40 different associations, derisively mocked the Mississippi tort system as “jackpot justice” and put forth 42 different bills during the 2002 legislative session.

When the session ended in April, tort “reform” had gone 0-for-42.¹ It was only when legislators were called back in September for an 83-day special session that changes were enacted to the Mississippi civil-justice system. The changes in malpractice law included placing caps on non-economic damages, holding physicians responsible only for their portions of non-economic damages, and requiring that lawsuits be filed in the county where the medical malpractice occurred.

The new laws took effect on Jan. 1, 2003. Although physicians had described the increase in malpractice rates in desperate terms, the president-elect of the Mississippi State Medical Association expressed only modest ambition for the new system. It may help to stabilize the market, Dr. George McGee told the *Sun Herald* newspaper in August. “It may not translate into premium reductions.”²

Assumptions vs. realities

As it did in many states, the December 2001 decision by the St. Paul Companies, Inc. to cease offering liability coverage to doctors triggered the immediate talk of a malpractice insurance “crisis” in Mississippi. St. Paul was one of the top three malpractice insurance carriers in the state and covered 427 doctors.³

Pointing to this development, the president of the Mississippi Medical Association reported that doctors statewide alleged that lawsuits were making it difficult for them to obtain insurance coverage.⁴ Lawsuits, however, had little to do with the departure of the St. Paul Companies from the marketplace. An analysis by the Wall Street Journal made these points about the decline in the medical liability insurance market:

- Some insurance carriers “rushed into malpractice coverage because an accounting practice widely used in the industry made the areas seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly \$3 billion last year.”
- When malpractice claims increased in the 1980s, St. Paul and its competitors sharply raised rates. But, as the frequency and size of claims leveled off, St. Paul realized it had set too much money aside for malpractice payments. The company then released \$1.1 billion from its reserves between 1992 and 1997, which dramatically boosted its bottom line.

- St. Paul's apparent profitability attracted numerous, smaller carriers into the malpractice insurance market, which led to widespread, competitive price-cutting.
- By the end of the 1990s, the revenue from premiums decreased to the point that insurers no longer could cover malpractice claims. Some collapsed and others, like St. Paul, withdrew from the market.⁵

The centerpiece in the malpractice liability package passed by Mississippi's Legislature was a \$500,000 cap on non-economic damages – a limit scheduled to increase to \$750,000 in 2011 and to \$1 million after 2017. But an examination of malpractice awards and current malpractice insurance rate problems in Mississippi shows almost no direct linkage between the two.

In August 2002, the *Sun Herald* newspaper published an in-depth report on the malpractice insurance showdown, relying on data available from the Board of Medical Licensure, the state Medical Association and other sources. Its findings included:⁶

- Although premiums had increased dramatically for some medical specialists, across the board, Mississippi's malpractice rates increased about 15 percent during 2002 – not higher than many other states, including those with caps on awards.
- In 2001, Medical Assurance Co. of Mississippi had 397 lawsuits, but paid out on only 73, according to the company's records. It paid out an average of \$261,194 per claim – well below the state's new cap.
- Since lawsuits reportedly began escalating in 1995, there has been only one mega-award against a medical provider in Mississippi – a \$23 million award against a medical center where a baby was dropped at childbirth and suffered permanent brain damage.

Rates that are being requested and approved for other forms of insurance in Mississippi indicate that malpractice insurance is part of a broader trend of rising insurance costs.

- In January 2003, the Mississippi Insurance commissioner approved a 19.9 percent increase statewide for State Farm homeowner policy premiums – with a 25 percent hike approved for homeowners in the coastal regions. A month earlier, the insurance company had requested a 42.5 percent statewide increase.⁷
- In September 2002, Aetna proposed rate increases of about 25 percent for one group of policyholders in Hinds County, Ms. A year earlier, Aetna had sought a 41 percent increase in premium rates.⁸

The costs of medical malpractice in Mississippi

The true impact of medical malpractice in Mississippi should be measured by the cost to consumers, not the premiums paid by doctors to their insurance companies. Consider these facts:

Estimated preventable deaths annually in Mississippi due to medical errors: 445-991

Estimated annual costs in Mississippi resulting from preventable medical errors:

\$172-293 million

Cost of Mississippi doctors' medical malpractice premiums paid in 2000: \$35.4 million.⁹

A questionable accomplishment

- The public relations and advertising campaigns that pushed for changes in Mississippi's malpractice laws made it clear that businesses and physicians placed a high priority on this accomplishment. What is not clear, however, is what other – if any – tangible results they achieved.
- Early last year, 474 Mississippi physicians published full-page newspaper ads in which they labeled the state “Litigation Central,” and melodramatically claimed, “Our legal climate has a disease no physician can cure. The cure is in the hands of the Mississippi Legislature.”¹⁰
- In May 2002, the U.S. Chamber of Commerce joined in the criticism of Mississippi's lack of tort-reform, claiming it had created a bad business climate. During this same time, studies were showing the state was scoring great successes in industrial recruitment and retention.¹¹
- When doctors took their malpractice pleas public, doctors from Gulfport Memorial Hospital bought newspaper ads to warn patients that they might be unable to remain in business without insurance coverage. Within weeks, however, all but one of the physicians had been able to replace their malpractice policies.¹²
- While Mississippi still ranks nearly last among states in the number of doctors per capita,¹³ it has made dramatic gains since 1995. In fact, only four states have had faster increases in their number of physicians.¹⁴

In the end, it appears Mississippi political and medical leaders pursued a central tactic: limiting the amount of money patients can collect after they have been injured by medical errors. This narrowly focused change, however, did nothing to address the central challenge of reducing liability payments by reducing medical errors.

¹ Joey Bunch, “Crisis or PR campaign,” *The Sun Herald*, Biloxi, Ms., Aug. 11, 2002

² Id.

³ Patrice Sawyer, “Tort reform: Where’s the crisis?” *Clarion-Ledger*, Jackson, Ms., Jan. 31, 2002.

⁴ Id.

⁵ Rachel Zimmerman and Christopher Oster, “Insurers’ Missteps Helped Provoke Malpractice ‘Crisis,’” *Wall Street Journal*, June 24, 2002.

⁶ Joey Bunch, “Crisis or PR campaign,” *The Sun Herald*, Biloxi, Ms., Aug. 11, 2002

⁷ Timothy Boone, “State Farm granted smaller rate hike,” *The Sun Herald*, Biloxi, Ms., Jan. 4, 2003.

⁸ Thyrie Bland, “Aetna proposal could reduce county staffers’ bottom line,” *Clarion-Ledger*, Jackson, Ms., Sept. 4, 2002.

⁹ Preventable deaths and costs data from, To Err is Human. Building a Safer Health System, Institute of Medicine, 1999. The range of preventable deaths and costs resulting from medical errors are prorated based on each state’s share of overall U.S. population in 2000. Population statistics for 2000 from the Census Bureau. *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000*, National Association of Insurance Commissioners.

¹⁰ Jerry Mitchell, “Doctors taking fight over suits to Capitol,” *Clarion-Ledger*, Jackson, Ms., Jan. 16, 2002.

¹¹ Joey Bunch, “Crisis or PR campaign,” *The Sun Herald*, Biloxi, Ms., Aug. 11, 2002.

¹² Id.

¹³ Kaiser Family Fund, St Kaiser Family Foundation, available at www.statehealthfacts.kff.org/

¹⁴ Id.

Medical Misdiagnosis in Nevada

Introduction

Nevada began 2002 with political and medical leaders proclaiming a “malpractice crisis” in the state – especially in Southern Nevada, where Las Vegas is located. By October, an emergency session of the Legislature enacted several changes in Nevada’s tort laws, placing limits on the amount injured patients can receive for pain and suffering and creating a \$50,000 cap on damages against hospitals and physicians who treat trauma patients. None of the changes, however, effectively addressed the need to reduce the rate at which patients are harmed by substandard medical care in Nevada.

Nevada ended 2002 with little good to show for the changes it had rushed into place. Malpractice premiums remained high, numerous physicians – especially those in high-risk specialties – were still threatening to leave the state, and a doctor-led referendum movement had pronounced Nevada’s tort reform efforts a failure.

Assumptions vs. realities

Doctors and politicians in Nevada adopted their crisis mentality shortly after the state’s leading provider of malpractice insurance, the St. Paul Companies, Inc. announced in December 2001 that it would no longer make liability coverage available to doctors. Health professionals and insurance industry representatives were quick to assign blame for the problem, as the *Las Vegas Review-Journal* reported, claiming that “insurance rates are rising because there are too many frivolous medical malpractice lawsuits and there is no cap on the amount of money juries can award.”¹

In fact, the decision by the St. Paul Companies had more to do with its reckless cash flow policies than it did with jury awards. A *Wall Street Journal* analysis of the decline in the medical liability insurance market made these points²:

- Some insurance carriers “rushed into malpractice coverage because an accounting practice widely used in the industry made the areas seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly \$3 billion last year.”
- When malpractice claims increased in the 1980s, St. Paul and its competitors sharply raised rates. But, as the frequency and size of claims leveled off, St. Paul realized it had set too much money aside for malpractice payments. The company then released \$1.1 billion from its reserves between 1992 and 1997, which dramatically boosted its bottom line.
- St. Paul’s apparent profitability attracted numerous, smaller carriers into the malpractice insurance market, which led to widespread, competitive price-cutting.
- By the end of the 1990s, the revenue from premiums decreased to the point that insurers no longer could cover malpractice claims. Some collapsed and others, like St. Paul, withdrew from the market.

Within six weeks of the announcement by the St. Paul Companies, Nevada Gov. Kenny Guinn, met behind closed doors with a small group of physicians and reached the swift conclusion that the state should impose caps on malpractice awards.³

But a detailed look at malpractice insurance problems in Nevada shows that claims by patients were singled out inappropriately.

- From 1997 through 2001, the mean number of payments made annually to cover malpractice claims in Nevada was 89 – exactly the number reported for 2001. In other words, state declared its crisis following a year in which the annual number of malpractice payments was not extreme. (In fact, there was a decline in this annual number between 2000 and 2001.)⁴
- In Clark County, which includes the fast-growing Las Vegas area, there had been no extreme escalation of malpractice lawsuits filed. According to District Court records, 133 suits were filed in 1998, 148 were filed in 1999 and 158 were filed in 2000. Of the cases filed in 2000, only 17 went to a jury trial and the remainder were dismissed or settled out of court.⁵
- Although physicians in Las Vegas experienced the same kinds of rate increases as doctors in many metropolitan areas, they were paying substantially less than the highest rates within their specialties⁶:

Sample of annual 2002 premiums paid by general surgeons:

Miami (Dade County), Fla. - \$174,268
Detroit, Mich. - \$107,139
Las Vegas (Clark County), Nev. - \$85,056
Chicago (Cook County), Ill. - \$75,630
Cleveland, Ohio - \$74,554
New York (Nassau/Suffolk counties), N.Y. - \$65,870

Sample of annual premiums paid by obstetricians-gynecologists:

Miami (Dade County), Fla. - \$210,576
Cleveland, Ohio - \$152,496
Las Vegas (Clark County), Nev. - \$141,760
Detroit, Mich. - \$140,917
New York (Nassau/Suffolk counties), N.Y. - \$115,431
Chicago (Cook County), Ill. - \$110,091
Brownsville, Laredo, El Paso (Rio Grande Valley), Texas - \$97,830

The costs of medical malpractice in Nevada

The true impact of medical malpractice in Nevada should be measured by the cost to consumers, not the premiums paid by doctors to their insurance companies. Consider these facts:

Estimated preventable deaths annually in Nevada due to medical errors: 312-696

Estimated annual costs in Nevada resulting from preventable medical errors:

\$121-206 million

Cost of Nevada doctors' medical malpractice premiums paid in 2000: \$50.8 million.⁷

- Medical negligence was not the only form of insurance for which rates have been rising dramatically in Nevada. Sierra Health Service, which has 55 percent of the statewide market for health insurance, forecasts double-digit increases for most of its client groups this year – and increases as high as 20 percent for some.⁸

Pressure for a misdirected solution

Physicians in Nevada took drastic, overt steps to pressure the state’s political leaders to respond to the malpractice insurance crisis by emphasizing caps on jury awards.

- Southern Nevada’s only trauma center shut down for 10 days, July 3 through July 13, when dozens of doctors resigned over liability concerns. These physicians objected when politicians described them as “striking workers,” but most had not stopped working at other hospitals during the trauma center’s closure.⁹
- Threats by physicians to close their practices or leave the state in reaction to insurance costs are particularly potent in Nevada, which gained population at a rate of 66 percent between 1990 and 2000, but ranks only 46th in the nation for its number of doctors per 100,000 population.¹⁰
- In April, the executive director of the Nevada State Medical Association told a legislative committee that 100 physicians were poised to leave the state in coming months in reaction to increasing insurance premiums.¹¹
- Doctors sponsored a \$1 million campaign of newspaper ads encouraging public support for tort reform.¹²
- In a related matter, the District Attorney’s office opened an investigation into possible legal violations associated with a paid political advertisement supporting tort “reform,” published by the top administrator at the publicly funded University Medical Center in Las Vegas.¹³

Tort “reform” gets a failing grade

The Nevada Legislature met in a four-day special session at the end of July and enacted changes in its tort system that¹⁴:

- Placed a \$350,000 cap on non-economic damages in most cases.
- Placed a \$50,000 limit on damages for hospitals and physicians treating trauma patients.
- Holds doctors financially liable only for the damages for which they are responsible.
- Allows judgments to be paid over time.

By most measurements, however, these responses to Nevada’s malpractice insurance problems have been ineffective.

- One month after the new medical liability laws took effect, at least 20 Las Vegas obstetricians still were making plans to leave the state or abandon their practices. Doctors complained that tort reform had not succeeded in reducing their malpractice premiums.¹⁵
- The new medical liability laws will not halt the exodus of physicians from the state or ensure consumer's access to medical care, according to a report by a legislative analyst hired by a physician-led group, "Keep Our Doctors in Nevada." The organization is circulating initiative petitions to dump the recent changes and try again.¹⁶
- In the process of proposing solutions to the malpractice problems, Gov. Kenny Guinn rejected suggestions that Nevada make it easier to weed out bad doctors. The governor and lawmakers did not support efforts to allow consumers to see complaints filed against doctors or to learn of disciplinary actions taken by hospitals against staff physicians.¹⁷

Missed opportunity

The decision to allow only voluntary and confidential reporting of medical errors and complaints against doctors reflects Nevada's determination to reduce payments to injured patients – but not to reduce the likelihood that patients will be harmed by substandard care.

- In the words of Dr. Bernard Feldman, member of a legislative subcommittee established to study a system for reporting medical errors, "There is no evidence this kind of voluntary system will reduce medical errors." He also questioned whether hospitals would voluntarily comply with a request to report medical errors to a public registry.¹⁸
- An opportunity exists in Nevada to reduce medical liability payments through better policing of the state's worst doctors. As a case in point, one of Nevada's worst doctors surrendered his license and moved to California at the end of June 2001. Orthopedic surgeon Francis G. D'Ambrosio was sued five times during 2001 – a rate that a local newspaper called a "record" for Clark County. In two of the cases, he was accused of turning older patients into paraplegics.¹⁹

CBSNews reported that by the time D'Ambrosio arrived in California, he had amassed a record of 39 lawsuits, 21 settlements and "was already building his reputation as the most sued surgeon in Nevada." And to make matters worse, "Nevada's medical board didn't post D'Ambrosio's record until June of this year [2002] after its investigation was done. More than a year after he'd surrendered his Nevada license."²⁰

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- ¹ Joelle Babula, "Insurance costs driving doctors away," *Review-Journal*, Jan. 23, 2002.
 - ² Rachel Zimmerman and Christopher Oster, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.
 - ³ Joelle Babula, "Guinn eyes cap on jury awards to avert crisis," *Review-Journal*, Jan. 24, 2002.
 - ⁴ National Practitioner Data Bank, 2001.
 - ⁵ Joelle Babula, "Insurance costs driving doctors away," *Review-Journal*, Jan. 24, 2002.
 - ⁶ *AMNews*, Oct. 28, 2002.
 - ⁷ Preventable deaths and costs data from, To Err is Human. Building a Safer Health System, Institute of Medicine, 1999. The range of preventable deaths and costs resulting from medical errors are prorated based on each state's share of overall U.S. population in 2000. Population statistics for 2000 from the Census Bureau. *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000*, National Association of Insurance Commissioners.
 - ⁸ John G. Edwards, "Handcuffed by health-care costs," *Review-Journal*, Jan. 2, 2003
 - ⁹ Joelle Babula, "Trauma center closes; ERS gear up," *Review-Journal*, July 4, 2002; and "Trauma center to reopen today," *Review-Journal*, July 13, 2002.
 - ¹⁰ Kaiser Family Foundation, available at www.statehealthfacts.kff.org/
 - ¹¹ Sean Whaley, "Lawmakers told crisis to get worse," *Review-Journal*, April 24, 2002.
 - ¹² Joelle Babula, "Doctors to launch ad campaign to fight rising malpractice rates," *Review-Journal*, June 14, 2002.
 - ¹³ Frank Geary, "UMC ad supporting tort reform investigated," *Review-Journal*, Jan. 24, 2002.
 - ¹⁴ *AMNews*, Oct. 28, 2002
 - ¹⁵ Joelle Babula, "20 obstetricians poised to leave LV," *Review-Journal*, Oct. 30, 2002.
 - ¹⁶ Joelle Babula, "Analysis finds laws won't keep doctors in state," *Review-Journal*, Oct. 16, 20, 2002.
 - ¹⁷ Ed Vogel, "Bill does not allow public to see complaints against doctors," *Review-Journal*, July 31, 2002.
 - ¹⁸ Ed Vogel, "Bill does not allow public to see complaints against doctors," *Review-Journal*, July 31, 2002.
 - ¹⁹ Chris Di Edoardo, "Las Vegas surgeon subject of multiple lawsuits," *Review-Journal*, March 4, 2002.
 - ²⁰ CBSNews.com, Nov. 19, 2002

Medical Misdiagnosis in New Jersey: Challenging the Medical Malpractice Claims of the Doctors' Lobby

Executive Summary from the Public Citizen's Congress Watch Report *Full Report available at www.citizen.org*

The Medical Society of New Jersey and its political allies have made a number of sensational allegations about what they call a malpractice “crisis.” We agree that there is a *temporary* “crisis” and malpractice insurance costs have spiked over the last two years. But claims that it has been caused by “frivolous malpractice claims,” “unbridled lawsuits,” or a legal system that is “running amok” have no basis in fact.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

- 3) The medical malpractice “crisis” in New Jersey, as in the rest of the country, is not a long-term problem nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country’s economic slowdown.
- 4) A more significant, longer-term malpractice “crisis” faced by New Jersey residents is the unreliable quality of medical care being delivered – a problem that health care providers have not adequately addressed. Taking away people’s legal rights, as is proposed under a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Highlights of this report include:

- **The cost of medical negligence to New Jersey’s patients and consumers is considerable, especially when measured against the cost of malpractice insurance to New Jersey’s doctors.** Extrapolating from Institute of Medicine (IOM) findings, we estimate that medical errors cause 1,316 to 2,930 preventable deaths in New Jersey each year. The cost resulting from preventable medical errors to New Jersey’s residents, families and communities is estimated at \$508 million to \$867 million each year. But the cost of medical malpractice insurance to New Jersey’s doctors is less than \$290 million a year.
- **The annual amount of medical malpractice insurance premiums paid in New Jersey has barely increased since 1992.** The amount New Jersey health-care providers paid in premiums for malpractice insurance in 2001 was \$290 million – compared with \$256 million in 1992. This is an overall increase of only 13 percent, or 1.4 percent a year. During that same time period, health care costs increased by 46.7 percent nationwide or 5.2 percent a year. Adjusting for inflation and a growing number of doctors in the state, this increase in malpractice premiums represents a significant decline in dollar values.

- **Annual malpractice payments to patients by New Jersey insurers have barely increased since 1992.** The amount of malpractice payments made by insurers to New Jersey patients in 2001 was \$235 million – compared with \$231 million in 1992. This is an overall increase of only 2 percent, far below the medical inflation index over that period of time.
- **There has been no “explosion” in malpractice litigation in New Jersey.** Physicians and their lobbyists justify efforts to restrict patients’ legal rights by describing “unbridled lawsuits,” and a legal system that is “running amok” – but official state statistics show that the number of malpractice lawsuits filed over the past two years has dropped significantly from previous years. Malpractice cases filed in 1998 numbered 1,776 but declined to 1,656 in 2002 – a drop of 7 percent.
- **“Repeat offender” doctors are responsible for the bulk of malpractice payments.** According to the federal government’s National Practitioner Data Bank (NPDB), which covers malpractice judgments and settlements since September 1990, 5.5 percent of New Jersey’s doctors have made two or more malpractice payments to patients. These repeat offender doctors are responsible for 61.1 percent of all payments. Overall, they have paid out \$939.4 million. Even more surprising, 2.1 percent of New Jersey’s doctors (636), each of whom has paid three or more malpractice claims, are responsible for 36.9 percent of all payments.
- **Repeat offender doctors suffer few consequences in New Jersey.** The New Jersey state government and the state’s health care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen’s analysis of NPDB data, disciplinary actions have been few and far between for New Jersey physicians. Only 10.8 percent of those doctors who made four or more malpractice payments have been disciplined by the New Jersey Board of Medical Examiners. And only 20 percent of those doctors who made five or more malpractice payments have been disciplined.
- **Where’s the doctor watchdog?** In 2001, only 105 doctors in New Jersey had serious sanctions levied against them by the state’s Board of Medical Examiners for incompetence, misconduct, ethical lapses or other offenses. Most of these doctors were not required to stop practicing even temporarily. New Jersey ranks 23rd among the states when its diligence in taking disciplinary actions is measured. But it is important to emphasize that New Jersey has a great deal of room for improvement – it disciplines doctors at only one-third the rate of the top state (Arizona).
- **The spike in medical liability premiums was caused by the insurance cycle, not by “skyrocketing” malpractice awards.** J. Robert Hunter, one of the country’s most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.

- **Poor business strategies by a leading insurance company compounded New Jersey's problems.** Pressure on physician premiums intensified after May 2002, when one of New Jersey's biggest carriers, Medical Inter-Insurance Exchange (MIIX), announced it would stop renewing policies. The company had covered 37 percent of all the doctors in New Jersey. The state's Department of Banking and Insurance attributed the company's problems to its ill-fated decisions to expand into other states and to increase its stock market investments.
- **Malpractice insurance has remained affordable for the vast majority of New Jersey physicians.** The Commissioner of Banking and Insurance has reported to the Legislature that "relatively few" – approximately 7.4 percent – of the state's doctors have experienced large premium increases, even in high-risk specialties.
- **No exodus of physicians from New Jersey is evident.** Despite gloomy rhetorical descriptions of "doctors leaving the profession in droves," there is no shortage of doctors in New Jersey. Statistics from American Medical Association show that New Jersey ranks 8th best among all 50 states and the District of Columbia for its ratio of doctors to residents – and this ratio has improved significantly in recent years. In 1990, New Jersey had 267 doctors per 100,000 residents. By 2001, that ratio had climbed to 328 doctors per 100,000 residents. This places the state well ahead of the national average, which in 2001 was 286 doctors per 100,000 residents.
- **Rather than facing "runaway litigation," doctors benefit from a claims gap.** A landmark Harvard Medical Practice Study and other studies have found that only a small percentage of medical errors result in lawsuits. Twelve years ago, Harvard researchers found that only one in eight preventable medical errors committed in hospitals results in a malpractice claim. Researchers replicating this study made similar findings in Utah and Colorado. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. In other words, for every six medical errors only one claim is filed.
- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the Medicare Payment Advisory Commission (MedPAC), liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the past year. The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.
- **Plaintiffs drop 10 times more claims than they pursue.** Based on Physician Insurer Association of America (PIAA) figures, Public Citizen estimates that about 54 percent of claims are being abandoned by patients. Attorneys often may send a statutorily required notice of intent to claim or file a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim. We estimate that the number of cases withdrawn voluntarily by plaintiffs was 92,621, *10 times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent*.

- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files. The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, “These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care.”
- **So-called “non-economic” damages are real and not awarded randomly.** “Non-economic” damages aren’t as easy to quantify as lost wages or medical bills, but they compensate the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) 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. According to PIAA, the average payment between 1985 and 2001 for a “grave injury,” which encompasses paralysis, was only \$454,454.
- **No evidence supports the claim that jury verdicts are random “jackpots.”** Studies conducted in California, Florida, North Carolina, New York and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered. In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.
- **Empirical evidence does not confirm the existence of “defensive medicine” – and patient injuries refute it.** The Congressional Budget Office was asked to quantify the savings from reduced “defensive medicine” if Congress passed H.R. 4600. This bill, which passed the House in 2002, contained very stringent restrictions on a patient’s ability to recover damages. CBO declined, saying that any such “estimates are speculative in nature, relying, for the most part, on surveys of physicians’ responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health-care spending. Using broader measures of spending, CBO’s initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending.” In addition, numerous studies continue to document preventable medical errors ranging from invasive procedures performed on the wrong patients, medication errors, misreading of test results and unsanitary conditions – all mistakes that any widespread practice of “defensive” medicine could have been expected to reduce.

New York’s Dangerous – and Undisciplined – Doctors

Executive Summary from the Public Citizen’s Congress Watch Report Full Report available at www.citizen.org

The American Medical Association – and its counterpart, the Medical Society of the State of New York – have declared New York to be a “crisis” state when it comes to the malpractice liability system. Their concern: “skyrocketing liability exposure,” which threatens to limit patient access to care.

The real malpractice “crisis” – and the greatest threat to care – faced by New Yorkers is the negligent medical care being delivered by a relatively small proportion of doctors – a problem that health-care providers and state officials have not adequately addressed. This Public Citizen report, which relies on government statistics and other reputable sources, has found:

- **Preventable medical errors cost thousands of lives in New York every year.** Between 2,967 and 6,608 people die annually in New York State hospitals due to errors that are preventable. This doesn’t count the many more thousands of injuries due to malpractice that occur each year or those deaths that occur outside the hospital setting. By comparison, 3,800 people in New York die annually from AIDs (2,299) and auto accidents (1,501) combined.
- **The cost of malpractice to New York patients and consumers is considerable.** The cost of preventable medical errors to patients, their families and society at large is between \$1.1 and \$1.9 billion a year. That is much more than the costs of malpractice premiums paid by New York’s doctors, which amount to \$873 million a year.
- **As a group, New York doctors’ malpractice premiums have effectively declined since 1992.** According to the National Association of Insurance Commissioners (NAIC), the total amount that New York doctors paid in malpractice insurance premiums in 2001 was \$873 million, compared with \$821 million in 1992. This is an increase of only 6 percent over nine years. Adjusting for medical inflation and the growing number of physicians in the state, the amounts of premiums paid have declined significantly when measured in actual dollars.
- **A small portion of New York doctors are responsible for the bulk of malpractice payouts.** According to the federal government’s National Practitioner Data Bank (NPDB), just 7 percent of New York’s doctors are responsible for two-thirds (68 percent) of all medical malpractice payouts. Even more distressing, just 1 percent of New York’s doctors are responsible for 22 percent of all medical malpractice payouts.
- **“Repeat-offender” doctors suffer few consequences in New York.** The state agency that regulates New York doctors is failing its citizens. Only 10 percent of New York doctors who made three or more malpractice payouts have ever been disciplined. And only 28 percent of New York doctors who made 10 or more malpractice payouts have ever been disciplined.

- **New York has 5 of the country’s 10 most dangerous – and undisciplined – doctors, based on the number of malpractice payouts listed in the data bank.** These doctors have made at least 17 medical malpractice payments worth at least \$2.75 million. One doctor has made 33 payments totaling \$4.9 million as a result of lawsuits alleging improper performance of surgery. Another surgeon made 18 payments totaling \$3.8 million as a result of lawsuits alleging improper performance of surgery, foreign objects left in patients and a failure to properly monitor patients. Their names are not available to the public because Congress has refused to authorize public access to the data bank.
- **Strong discipline against repeat offender doctors could dramatically reduce malpractice payouts.** By disciplining doctors with two or more malpractice payouts and preventing them from becoming “repeat offenders” with three or more payouts, the state board could eliminate 45 percent of the total number of medical malpractice payouts. If the state board could prevent doctors with three payments from having to pay a fourth one, nearly one third of malpractice payouts would be eliminated.

Medical Misdiagnosis in Pennsylvania: Challenging the Medical Malpractice Claims of the Doctors' Lobby

Executive Summary from the Public Citizen's Congress Watch Report *Full Report available at www.citizen.org*

The Pennsylvania Medical Society (PMS) and its medical industry allies have made a number of sensational allegations about what they call a malpractice “crisis.” We agree that there is a *temporary* “crisis” in that malpractice insurance costs have spiked over the last two years. But the PMS’s allegations that it is caused by “many frivolous lawsuits,” an “out-of-control legal system,” “an irrational lottery” and “astronomic jury verdicts” has no factual basis.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

- 5) The medical malpractice “crisis” in Pennsylvania, as in the rest of the country, is not a long-term problem nor is it caused by the legal system. It is a short-term problem caused by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and declining investments caused by the country’s economic slowdown.
- 6) The more significant longer-term malpractice “crisis” faced by Pennsylvanians is the quality of medical care being delivered, which health care providers have not adequately addressed. Taking away people’s legal rights, such as is proposed with a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Highlights of the report include:

- **The costs of medical negligence to Pennsylvania’s patients and consumers is considerable, especially when compared to the cost of malpractice insurance to Pennsylvania’s doctors.** Extrapolating from Institute of Medicine findings, we estimate that there are 1,920 to 4,277 preventable deaths in Pennsylvania each year that are due to medical errors. The costs resulting from preventable medical errors to Pennsylvania’s residents, families and communities is estimated at \$742 million to \$1.3 billion each year. But the cost of medical malpractice insurance to Pennsylvania’s doctors is less than \$731 million a year.
- **Government data show that medical malpractice awards have increased at a much slower pace in Pennsylvania than claimed by the Pennsylvania Medical Society.** According to the federal government’s National Practitioner Data Bank (NPDB), the median medical malpractice payment by a Pennsylvania physician to a patient rose 33 percent from 1997 to 2001, from \$150,000 to \$200,000, or eight percent a year. By contrast, medical organizations in Pennsylvania quote data from Jury Verdict Research (JVR), a private research firm, indicating that verdicts rose almost 43 percent from 1997 to 2000, from \$700,000 to \$1 million, or 14 percent a year. The reason for the difference: JVR collects only

jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.

- **Government data show that medical malpractice awards in Pennsylvania have increased at a slower pace than national health insurance premiums.** While NPDB data show that the median medical malpractice payment in Pennsylvania rose 33 percent from 1997 to 2001 (an average of 8.3 percent a year). The national average premium for single health insurance coverage increased 39 percent over that time period (9.5 percent a year). Payments for health care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice awards.
- **Government data reveals little growth in medical malpractice claims paid in Pennsylvania.** According to the NPDB, there has been only a modest increase in the total number of malpractice claims paid in Pennsylvania from 1995 through 2001. The difference between the 957 claims paid in 1995 and the 1,049 claims reported in 2001 is less than ten percent over six years, or 1.6 percent a year.
- **Large verdicts in Pennsylvania have dramatically declined.** The number of large jury verdicts in Pennsylvania and the amount paid in medical malpractice in these large verdicts decreased dramatically in recent years. From 2000 to 2002, the number of jury awards of \$1 million or more dropped by 50 percent (from 44 to 22) while the overall amount of these awards decreased by over 75 percent (from \$415 million to \$93 million).
- **At the height of the medical malpractice "crisis," the number of licensed physicians in Pennsylvania actually *increased* by 7.5 percent.** According to data provided by the Pennsylvania State Medical Board, the government agency charged with issuing medical licenses to qualified doctors, 34,330 physicians were licensed and practicing medicine in Pennsylvania during 2001. In 2002, the Board issued 36,921 licenses—a 7.5 percent increase over 2001. This increase in physician population is not isolated. Over the past seven years, the number of doctors licensed and residing in Pennsylvania increased by 14 percent. The theory that skyrocketing medical malpractice insurance premiums are forcing doctors to flee the state is not borne out by the facts.
- **Pennsylvania ranks 5th in doctor population.** According to the American Medical Association (AMA), Pennsylvania is home to five percent of the nation's doctors, a distinction that ranked the state's physician population the 5th highest in the nation. Further, the AMA reports that Pennsylvania has one of the largest physician populations under the age of 35, with 5.5 percent of the nation's younger doctors practicing in Pennsylvania.
- **Repeat offender physicians are responsible for the bulk of medical malpractice costs.** According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 10.6 percent of the state's doctors, have paid two or more malpractice awards to patients. These repeat offender doctors are responsible for 84 percent of all payments. Even more surprising, only 4.7 percent of Pennsylvania's doctors (1,838), each of whom has paid three or more malpractice claims, are responsible for 51.4 percent of all payments. This ranks Pennsylvania

worst among all fifty states in terms of the number of repeat offender doctors (three or more malpractice payments) as a percent of all doctors.

- **Repeat offender doctors suffer few consequences in Pennsylvania.** Public Citizen’s analysis of the federal government’s NPDB found that only 5.1 percent of those doctors who made five or more malpractice payments were disciplined by Pennsylvania’s State Board of Medicine. Only 6.8 percent of those doctors who made 10 or more malpractice payments were disciplined.
- **Where’s the doctor watchdog?** Pennsylvania’s State Board of Medicine is dangerously lenient with doctors, regularly letting serious and sometimes repeat offenders off the hook. In Public Citizen’s ranking of state medical boards, Pennsylvania ranked 36th out of 50 states and the District of Columbia. The ranking is based on the number of serious disciplinary actions per 1,000 doctors in each state. In 2001, nationally there were 3.36 serious actions taken for every 1,000 physicians. Pennsylvania is among the bottom third of U.S. states when its diligence in taking disciplinary actions is measured – 2.18 serious actions per 1,000 doctors.
- **The spike in medical liability premiums was caused by the insurance cycle, not by “skyrocketing” malpractice awards.** J. Robert Hunter, one of the country’s most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.
- **Insurer mismanagement compounded the problems.** Artificially low premiums in the 1990s, market competition, and accounting irregularities forced the Phico and St. Paul insurance companies to stop offering medical malpractice insurance in Pennsylvania. Phico Insurance Co. was the third-largest malpractice insurer in the state, and the St. Paul Companies, Inc. was the seventh largest. Together they carried about 18 percent of the state’s physicians. In each case, the departure of the insurance company from the market had little to do with malpractice award payments than with the mismanagement of the company itself. Phico had been placed under the supervision of insurance regulators and was later sued by the state’s Insurance Department. The lawsuit alleged that Phico directors ignored signs of financial trouble at the company and pressured the board to pay dividends at a time when the insurer’s surplus “was declining drastically and significant strengthening of loss reserves was required.” As the *Wall Street Journal* found in a front page investigative story on June 24, 2002, when malpractice claims increased in the 1980s, St. Paul and its competitors sharply raised rates. But, as the frequency and size of claims leveled off, St. Paul realized it had set too much money aside for malpractice payments. The company then released \$1.1 billion from its reserves between 1992 and 1997, which dramatically boosted its bottom line. St. Paul’s apparent profitability attracted numerous, smaller carriers into the malpractice insurance market, which led to widespread, competitive price-cutting. By the end of the 1990s, the revenue from premiums decreased to the point that insurers no longer could cover malpractice claims. Some collapsed and others, like St. Paul, withdrew from the market.

Medical Misdiagnosis in Texas: Challenging the Medical Malpractice Claims of the Doctors' Lobby

Executive Summary from the Public Citizen's Congress Watch Report *Full Report available at www.citizen.org*

The Texas Medical Association and its political allies have made a number of sensational allegations about what they call a malpractice “crisis.” We agree that there is a *temporary* “crisis” and malpractice insurance premium costs have spiked over the last two years. But arguments that it has been caused by “frivolous malpractice claims,” or “abusive” lawsuits by consumers have no basis in fact.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

- 1) The most significant, long-term malpractice “crisis” faced by Texans is the unreliable quality of medical care being delivered by a relatively small proportion of doctors – a problem that health-care providers have not adequately addressed. Taking away people’s legal rights, as is proposed under a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.
- 2) Any medical malpractice premium “crisis” in Texas, as in the rest of the country, is not a long-term problem nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country’s economic slowdown.

Highlights of this report include:

- **The cost of medical negligence to Texas patients and consumers is considerable, especially when measured against the cost of malpractice insurance to Texas doctors.** Extrapolating from Institute of Medicine (IOM) findings, we estimate that there are 3,260 to 7,261 preventable deaths in Texas each year that are due to medical errors. The costs resulting from preventable medical errors to Texas residents, families and communities are estimated at \$1.3 billion to \$2.2 billion each year. But the cost of medical malpractice insurance to Texas doctors is only \$421.2 million a year.
- **The total number of Texas malpractice claims has dropped for two consecutive years.** Over the past 10 years for which statistics are available from the State Board of Medical Examiners, Texas saw its greatest number of malpractice claims in 1993 – almost a decade ago. This number fluctuated in subsequent years, reaching its second highest point in 1999, but the number of claims decreased in both 2000 and 2001.
- **“Repeat offender” doctors are responsible for the bulk of malpractice payments.** According to the federal government’s National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 6.5 percent of Texas

doctors have made two or more malpractice payments to patients. These repeat offender doctors are responsible for 51.3 percent of all payments. Overall, they have paid out more than \$1 billion in damages. Even more disturbing, just 2.2 percent of Texas doctors (845), each of whom has paid three or more malpractice claims, are responsible for 24.9 percent of all payments.

- **Repeat offender doctors suffer few consequences in Texas.** The Texas state government and the state’s health-care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen’s analysis of NPDB data, disciplinary actions have been few and far between for Texas physicians. Only 15.5 percent of those doctors who made four or more malpractice payments have been disciplined by the Texas State Board of Medical Examiners. Only 25.4 percent of those doctors who made six or more malpractice payments were disciplined.
- **Where’s the doctor watchdog?** Texas ranks 32nd among all 50 states and the District of Columbia when its diligence in taking disciplinary action against doctors is measured. The rate of serious actions by the Texas State Board of Medical Examiners in 2001 – 2.5 per 1,000 physicians – is barely one-quarter of the rate in Arizona, the top-ranked state with 10.5 serious actions per 1,000 physicians.
- **Texas provides incomplete reports about doctor mistakes and offenses.** The Texas State Board of Medical Examiners provides only limited information about doctors who have committed offenses or medical errors. This shortcoming is highlighted when the information it provides is compared with reports developed for Public Citizen’s own website, www.questionabledoctors.org.
- **No exodus of physicians from Texas is evident.** Although the Texas Medical Association has circulated an unsubstantiated estimate that more than half of the state’s doctors plan to quit practicing in response to rising malpractice premiums, official state statistics show that the number of doctors in Texas has been increasing steadily. Between 1997 and 2002, the number of physicians and osteopaths practicing in Texas increased from 31,459 to 37,188 – an increase of 18.2 percent.
- **The spike in medical liability premiums was caused by the insurance cycle, not by “skyrocketing” malpractice awards.** J. Robert Hunter, one of the country’s most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.
- **Financial management problems at major insurers compounded Texas’ malpractice worries.** Pressure on physicians’ premiums intensified during 2001 and 2002 as the number of malpractice insurers in Texas dropped from 17 to four. In at least three noteworthy cases, the departing companies had severe cash-flow problems that went beyond their medical liability businesses.

- **Insurance companies and their lobbyists admit caps on damages won't lower malpractice premiums.** Caps on damages for pain and suffering will significantly lower awards paid to catastrophically injured patients. But because such truly severe cases comprise a small percentage of medical malpractice claims, and because the portion of the insurance premiums that pay for compensation is dwarfed by the portion that pays for defense lawyer fees, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this, and have said so on numerous public occasions.
- **Rather than facing “runaway litigation,” doctors benefit from a claims gap.** A landmark Harvard Medical Practice Study and other studies have found that only a small percentage of medical errors result in lawsuits. Twelve years ago, Harvard researchers found that only one in 7.6 preventable medical errors committed in hospitals resulted in a malpractice claim. Researchers replicating this study made similar findings in Utah and Colorado. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. In other words, for every six medical errors only one claim is filed.
- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the Medicare Payment Advisory Commission (MedPAC), liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the past year. The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.
- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files. The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, “These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care.”
- **So-called “non-economic” damages are real and not awarded randomly.** “Non-economic” damages aren't as easy to quantify as lost wages or medical bills, but they compensate the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) 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. According to the PIAA, the average total payment between 1985 and 2001 for a “grave injury,” which encompasses paralysis, was only \$454,454.
- **Capping damages hurts women the most.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on women. The largest part of economic damages in many tort claims is lost wages, and women earn on average less money than men. Second, the most significant effect of many medical injuries inflicted on women is harm to

reproductive capacity, which does not entitle them to receive economic damages, according to a study by the director of the Insurance Law Center at the University of Connecticut School of Law.

- **No evidence supports the claim that jury verdicts are random “jackpots.”** Studies conducted in California, Florida, North Carolina, New York and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered. In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.
- **Empirical evidence does not confirm the existence of “defensive medicine” – and patient injuries refute it.** The Congressional Budget Office was asked to quantify the savings from reduced “defensive medicine” if Congress passed H.R. 4600. This bill, which passed the House in 2002, contained very stringent restrictions on a patient’s ability to recover damages. CBO declined, saying that any such “estimates are speculative in nature, relying, for the most part, on surveys of physicians’ responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health-care spending. Using broader measures of spending, CBO’s initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending.” In addition, numerous studies continue to document preventable medical errors ranging from invasive procedures performed on the wrong patients, medication errors, misreading of test results and unsanitary conditions – all mistakes that any widespread practice of “defensive” medicine could have been expected to reduce.

Medical Misdiagnosis in West Virginia: Challenging the Medical Malpractice Claims of the Doctors' Lobby

Executive Summary from the Public Citizen's Congress Watch Report *Full Report available at www.citizen.org*

The West Virginia State Medical Association and its allies have made a number of sensational allegations about what they call a malpractice “crisis.” We agree that there is a *temporary* “crisis” and malpractice insurance costs have spiked over the last two years. But claims that it has been caused by “many frivolous lawsuits,” an “out-of-control legal system,” “an irrational lottery,” or “astronomic jury verdicts” have no basis in fact.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

- 1) The medical malpractice “crisis” in West Virginia, as in the rest of the country, is not a long-term problem nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country’s economic slowdown.
- 2) A more significant, longer-term malpractice “crisis” faced by West Virginians is the unreliable quality of medical care being delivered – a problem that health care providers have not adequately addressed. Taking away people’s legal rights, as is proposed under a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Highlights of this report include:

- **The cost of medical negligence to West Virginia’s patients and consumers is considerable, especially when measured against the cost of malpractice insurance to West Virginia’s doctors.** Extrapolating from Institute of Medicine findings, we estimate that medical errors cause 283 to 630 preventable deaths in West Virginia each year. The cost resulting from preventable medical errors to West Virginia’s residents, families, and communities is estimated at \$109 million to \$186 million each year. But the cost of medical malpractice insurance to West Virginia’s doctors is less than \$77 million a year.
- **Government data show that the median amount of medical malpractice awards in West Virginia has decreased, even as the cost of health insurance has increased.** Statistics from the federal government’s National Practitioner Data Bank (NPDB) show the median medical malpractice payment in West Virginia through the first nine months of 2002 was \$145,000. This is the same amount that it was in 1997. During that same time period, the national average premium for single health insurance coverage

increased 39 percent (9.5 percent a year). Payments for health care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice awards. In spite of this, payments to malpractice claimants in West Virginia have remained steady.

- **Large malpractice verdicts in West Virginia are decreasing.** The number of large jury verdicts in West Virginia medical malpractice cases is steadily decreasing. There were only two verdicts for more than \$1 million in 2000 and 2001 – and none reported for 2002.
- **At the height of the purported malpractice "crisis," the number of licensed physicians in West Virginia actually *increased slightly*.** The claim that skyrocketing malpractice insurance premiums are driving doctors from the state is contradicted by the facts. According to the West Virginia State Medical Board and the Board of Osteopathy, 4,069 physicians/osteopaths were practicing in West Virginia during 2001, and the number increased to 4,077 in 2002. Over the past five years, the number of doctors licensed and residing in West Virginia increased by 9.6 percent, a trend mirrored nationwide.
- **"Repeat offender" physicians are responsible for the bulk of malpractice costs.** The NPDB shows that 9.3 percent of doctors who have paid multiple (two or more) malpractice claims are responsible for 62.2 percent of all payments. Even more surprising, only 3.5 percent of West Virginia's doctors – those who have made three or more payments – are responsible for 36.5 percent of all payments. West Virginia ranks third worst among all 50 states and the District of Columbia in terms of its percentage of repeat offender doctors – those with three or more malpractice payments.
- **Repeat offender doctors suffer few consequences in West Virginia.** Public Citizen's analysis of NPDB data found that only 25.5 percent of those doctors who made five or more malpractice payments were disciplined by West Virginia's State Board of Medicine. And only 14.3 percent of doctors – one out of seven – who made 10 or more malpractice payments were disciplined.
- **Where's the doctor watchdog?** West Virginia's State Board of Medicine is lenient with doctors, as are most state medical boards, regularly letting serious and sometimes repeat offenders off the hook. Nationally in 2001, there were 3.36 serious actions taken for every 1,000 physicians. West Virginia took 4.89 serious actions per 1,000 doctors – slightly greater than the national average, but still half as good as the best performing states and not nearly high enough to prevent bad doctors from practicing.
- **Insurance costs are increasing overall, not just for malpractice.** The same cyclical economic forces that pushed up malpractice premiums in West Virginia also influenced the costs of other categories of insurance. In 2001-2002, increases for medical malpractice insurers ranged from 17.9 percent to 26.4 percent in West Virginia. Rate increases for health insurance in the state varied between 20.7 and 23 percent in 2002. And increases in homeowners insurance premiums ranged from 5.8 percent to 27.5 percent.

- **The spike in medical liability premiums was caused by the insurance cycle, not by “skyrocketing” malpractice awards.** J. Robert Hunter, one of the country’s most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.
- **Insurer mismanagement compounded the problems.** Underpriced premiums, reckless cash-flow policies, and ill-fated involvement with Enron and asbestos subsidiaries forced one major carrier, the St. Paul Companies, to stop offering malpractice insurance. The company had covered nearly 29 percent of West Virginia’s doctors. According to a *Wall Street Journal* analysis, St. Paul had generated large cash reserves by raising rates during the 1980s, and then released \$1.1 billion from reserves between 1992 and 1997 – dramatically boosting its bottom line. This artificial profitability attracted numerous, smaller competitors into the malpractice insurance market and led to widespread price-cutting. By the end of the 1990s, revenue from premiums no longer could cover malpractice claims, causing some companies to collapse and others, like St. Paul, to drop coverage.

