

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



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Acknowledgments

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About Public Citizen

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Executive Summary

The American Medical Association (AMA) recently declared North Carolina to be a “crisis” state when it comes to the malpractice liability system. Matching the AMA’s alarmist tone, the North Carolina Medical Society has issued warnings about the impact of a “deteriorating litigation climate” in the state, which it says threatens to limit patient access to care.

While we sympathize with doctors experiencing spikes in their insurance premiums, that is a temporary problem caused by the insurance cycle, not the legal system. The real malpractice “crisis” – and the greatest threat to care – faced by North Carolina residents 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 North Carolina every year.** Between 1,259 and 2,803 people die annually in North Carolina hospitals due to errors that are *preventable*. This does not count the many more thousands of injuries due to malpractice that occur each year or those deaths that occur outside the hospital setting.
- **The cost of malpractice to North Carolina patients and consumers is considerable.** The cost of preventable medical errors to patients, their families and society at large is between \$486 million and \$829 million a year. That is much more than the cost of malpractice premiums paid by North Carolina’s doctors, which amounts to \$159 million a year.
- **Doctors’ malpractice premiums are insignificant compared with North Carolina’s total health spending.** Total spending on health care in North Carolina was \$27.3 billion in 1998, the last year for which data is available from government sources. In 1998, North Carolina physicians paid \$120 million in malpractice insurance premiums – equivalent to only 0.44 percent of all the money spent on health care in North Carolina for that year.
- **The number of medical malpractice lawsuits filed in North Carolina has remained flat when adjusted for population increases.** The number of malpractice lawsuits filed in North Carolina courts increased only slightly between 1998 (the earliest year for which reliable data is available) and 2002, from 556 in 1998 to 608 in 2002, an increase of 2.3 percent a year. This rate of increase is only slightly greater than the 1.7 percent a year population growth for North Carolina from 1998 to 2001. If the increase in the number of doctors working in the state (2.8 percent a year) is factored in, the rate of lawsuits has probably remained flat.
- **Malpractice payouts per doctor have declined, when measured in constant dollars.** When inflation is taken into account, the amount of money paid out per North

Carolina doctor has declined over the past decade. Payouts per doctor in 1992 were the equivalent of \$4,694 (in 2002 dollars) compared with \$4,246 in 2001 (in 2002 dollars).

- **The number of doctors practicing in North Carolina has dramatically increased.** The number of doctors practicing in North Carolina has jumped by 4,760 in the last decade, from 11,632 in 1992 to 16,392 in 2001, an increase of 40.9 percent, or 4.5 percent a year. In comparison, the state's overall population experienced an annual average increase of 2.1 percent from 1992 to 2001 – less than half the rate of increase of the doctor population. And North Carolina's ratio of doctors per 10,000 population increased from 16.9 doctors per 10,000 in 1992 to 20 doctors per 10,000 in 2001, an 18.3 percent increase over nine years.
- **Doctors in Louisiana, a state with stringent caps, pay higher average premiums than their counterparts in North Carolina.** Louisiana has one of the most extreme caps in the country, limiting the *total* amount of recoverable medical malpractice damages to \$500,000, excluding future medical care and related benefits. Yet, malpractice insurance premiums charged by the largest malpractice provider in Louisiana are an average of 22 percent *higher* (between 2 and 51 percent for various specialties) than those of North Carolina's largest provider.
- **Medicare's local adjustment for the cost of malpractice insurance for North Carolina doctors is lower than for Louisiana doctors.** The federal government's Medicare actuary calculates that North Carolina's doctors spend an average of 1.9 percent of their practice incomes on malpractice insurance, compared with Louisiana's doctors who spend between 3.4 percent and 4.1 percent of their practice incomes on malpractice insurance.
- **A similar pattern in premium rates is apparent in comparisons between North Carolina and Virginia.** Virginia is the only other southern state that caps damages in medical malpractice cases. A comparison of two malpractice insurance companies that provide coverage in both states shows that North Carolina doctors are in the same general range with Virginia doctors when it comes to the premiums they pay. Moreover, injured North Carolina patients are much better off in North Carolina because there is no cap. According to the federal National Practitioner Data Bank, in 2001 the median malpractice payout in North Carolina was \$165,000, versus \$150,000 in Virginia – meaning that North Carolinians got 10 percent more in compensation.
- **Caps have not prevented a so-called malpractice "crisis" in Virginia.** Donald Palmisano, president-elect of the AMA, told a U.S. House committee in February that "physicians in Virginia are starting to see the warning signs of a full-blown medical liability crisis... Over the past two years physician premiums have increased on average over 30 percent. For some medical specialists, medical liability premiums in Virginia have increased upwards of 60 percent for this same recent two-year period." These increases are in spite of Virginia's stiff \$1.65 million cap on *all* damages.

- **A small portion of North Carolina’s doctors is responsible for the bulk of malpractice payouts.** According to the federal government’s National Practitioner Data Bank (NPDB), just 3.2 percent of North Carolina’s doctors, each of whom have made two or more payouts, are responsible for 42 percent of all medical malpractice payouts. Even more distressing, just 1 percent of North Carolina’s doctors, each of whom have made three or more payouts, are responsible for 20 percent of all medical malpractice payouts.
- **“Repeat-offender” doctors suffer few consequences in North Carolina.** The state agency that regulates North Carolina doctors is failing its citizens. Only 15 percent of North Carolina doctors who have made three or more malpractice payouts have been disciplined. And only 18 percent of North Carolina doctors who made five or more malpractice payouts have been disciplined.
- **The North Carolina Medical Board is among the nation’s least diligent when it comes to disciplining doctors.** In 2002, North Carolina ranked 45th among all states and the District of Columbia for the frequency at which it takes serious disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. In 2002, the Board levied serious sanctions against only 43 of its 20,851 doctors. Nationally in 2002, there were 3.6 serious actions taken for every 1,000 physicians. The rate of serious actions by the North Carolina Medical Board – 2.06 per 1,000 physicians – was roughly one-sixth of the rate in Wyoming, which is the top-ranked state with 11.9 serious actions per 1,000 physicians.
- **Caps on malpractice awards do not improve access to primary care.** There is no apparent relationship between caps on malpractice awards and access to primary medical care. Among the 15 states with the highest percentages of population lacking primary medical care, nine impose malpractice caps. In fact, three of the four states with the greatest underserved populations have malpractice caps. Conversely, among the 15 states with the smallest percentages of population lacking primary care, eight do *not* have malpractice caps.
- **Research shows that caps do not prevent doctors from leaving states.** During the last malpractice “crisis” in the late 1980s, researchers at the University of North Carolina studied the migration of doctors to and from rural counties, using data from the AMA Physician Masterfile. They found that the states with the greatest net inflow of rural doctors were North Carolina, Florida, Georgia, and South Carolina – none of which had caps on medical malpractice awards. The biggest losers included Louisiana, which had had caps for over a decade, and Missouri, which adopted a cap during the period of the study.
- **The AMA claims California’s caps attract doctors, but shortages continue to plague primary care.** In 1992, the state with the most medically underserved residents (6.4 million) was California, which has a \$250,000 cap on non-economic damages in malpractice cases. The American Medical Association has suggested that doctors leaving Nevada because of high insurance rates were flocking to California. Yet only two months ago, *Hospitals and Health Networks* magazine reported that 35 percent of primary care doctors in San Diego “plan to move, change professions or retire within five years.”

- **The temporary spike in medical liability premiums is 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.
- **Corporate mismanagement fueled malpractice problems.** Pressure on North Carolina’s physician premiums intensified after December 2001, when the St. Paul Insurance Companies quit the medical liability business. The company had covered about 50 percent of all doctors in North Carolina. St. Paul’s departure had much less to do with jury awards than with the company’s cash flow policies, its disastrous involvement with Enron, and its ill-fated acquisition of two companies that manufactured asbestos products. Even without these large setbacks, St. Paul had contributed to a catastrophic cycle of low prices and artificially high profits in the malpractice insurance industry.
- **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 for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control, loss of a limb) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to the PIAA, the average total payout between 1985 and 2001 for a “grave injury,” which encompasses paralysis, was only \$454,454.
- **Insurance companies and their lobbyists admit caps on damages won’t lower malpractice premiums.** Caps on “non-economic damages” effect the most catastrophically injured patients. But, because such truly severe cases comprise a small percentage of medical malpractice claims and because the portion that pays for defense lawyer fees dwarfs the portion of the insurance premiums that pay for compensation, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this, and have said so on numerous public occasions.
- **Caps on malpractice awards hurt women in particular.** 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 do. Additionally, 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.** 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.

- **Action could be taken on a national level to reduce medical errors.** The only way to reduce the cost of medical injuries is to reduce negligence and mistakes – and the best way to accomplish this is by reforming the regulatory oversight of the medical profession. Public Citizen recommends opening up the National Practitioner Data Bank to empower consumers with information about their doctors. It also recommends implementing the “systems approach” advocated by the Institute of Medicine to establish mandatory nationwide error reporting systems, identify unsafe practices and raise performance standards. And Public Citizen recommends that Congress encourage better oversight of physicians through grants to state medical boards, tied to the boards’ agreements to meet performance standards.
- **States should improve oversight of health-care providers.** When negligent doctors are disciplined, it is rarely for inferior care. Instead, state medical boards frequently respond to more easily documented things such as prescription drug violations, fraud convictions or disciplinary actions taken in other states. Governance of physicians would improve if medical and licensing boards were required to sever formal links with state medical societies. And legislatures could help ensure that medical boards have enough revenue to hire more investigators and legal staff to perform effective oversight. In addition, Rhode Island is demonstrating how medical errors can be addressed on the state level by considering two bills to reduce overwork among nurses. This is a constructive step, in light of studies that identify fatigue among nurses and medical residents as a significant contributing factor to patient injuries and deaths.
- **State regulators could make insurance rates more predictable.** J. Robert Hunter, Director of Insurance for the Consumer Federation of American, on behalf of Americans for Insurance Reform, has recommended a number of steps to state insurance regulators. These include thoroughly auditing insurance companies’ pricing and profitability data; regulating excessive prices; freezing “stressed rates” until prices and jumps in loss reserves can be analyzed; and requiring medical malpractice insurers to use claims history as a rating factor. He also advocates creating a standby public insurer to write risks during “hard markets,” and asking the National Association of Insurance Commissioners to stop the implementation of the deregulation of commercial rates and forms, which it is unwisely pushing.

Introduction

It is understandable that doctors are concerned by sharp rises in medical malpractice insurance costs reported in some parts of the country. Nobody wants to see physicians forced to pay more to insure themselves, even if they are highly paid specialists who earn hundreds of thousands of dollars a year. It is essential, however, that discussions of public policy and attempts to address the issue of medical liability insurance be based on solid facts, not a false sense of “crisis” generated to serve special interests.

Physician groups and their political allies are essentially blaming patients and their lawyers for the temporary spike in some insurance premiums. They have resorted to alarmist language and continued to advocate for a solution – a cap on damages – that is unrelated to the source of the problem.

A bill pending in the North Carolina Legislature mirrors proposals in numerous states and in the U.S. Congress, which would place a \$250,000 cap on medical malpractice payouts for pain and suffering.

While proponents of such legislation argue that litigation and payouts have caused a spike in malpractice insurance premiums – and while they suggest that insurance costs are forcing doctors out of business – this report demonstrates that these claims are not supported by reliable data. The insurance industry has experienced economic fluctuations – and it is these pricing and profitability problems, not patient lawsuits, that have triggered the recent increases in malpractice insurance premiums.

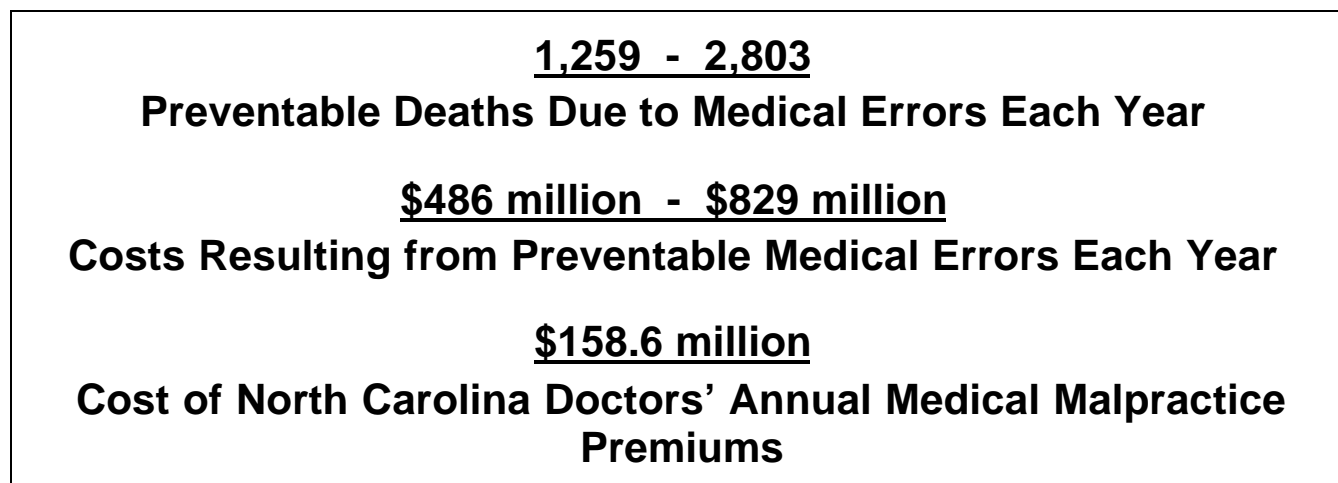
The real long-term threat to the quality of health care in North Carolina is the excessive number of preventable medical errors, the absence of regulations requiring their disclosure and the state medical board’s lax discipline of doctors who repeatedly cause harm to patients. This report provides suggestions for fixing those underlying flaws.

The Costs of Medical Malpractice to North Carolina's Patients & Consumers vs. North Carolina's Doctors

In 1999, the Institute of Medicine (IOM) estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors.¹ The IOM also estimated the costs to individuals, their families and society at large for these medical errors at \$17 billion to \$29 billion a year. These costs include disability and health-care costs, lost income, lost household production and the personal costs of care.

The true impact of medical malpractice in North Carolina should be measured by the cost to patients and consumers, not the premiums paid by doctors to their insurance companies. Extrapolating from the IOM findings, we estimate that there are 1,259 to 2,803 preventable deaths in North Carolina each year that are due to preventable medical errors. The costs resulting from preventable medical errors to North Carolina's residents, families and communities is estimated at \$486 million to \$829 million each year. But the cost of medical malpractice insurance to North Carolina's doctors is only \$158.6 million a year.² [See Figure 1]

Figure 1



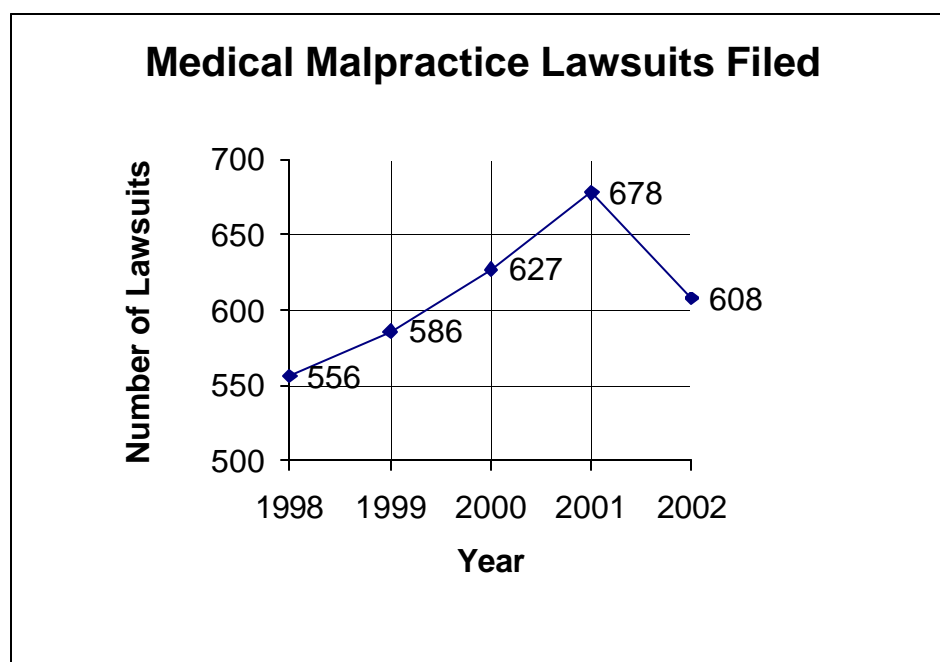
Sources: Preventable deaths and costs are prorated based on population and based on estimates in *To Err Is Human*, Institute of Medicine, November 2000. Malpractice premiums are based on "Medical Malpractice Net Premium and Incurred Loss Summary," National Association of Insurance Commissioners, July 18, 2001.

The Number of Medical Malpractice Lawsuits Filed in North Carolina Has Remained Flat

Proponents of caps on malpractice awards claim that there has been a rise in the number of medical malpractice suits. However, official state statistics show that the number of North Carolina lawsuits has remained flat when you account for population and physician increases.

- The number of malpractice lawsuits filed in North Carolina courts increased only slightly between 1998 (the earliest year for which reliable data is available) and 2002, from 556 in 1998 to 608 in 2002, an increase of 2.3 percent a year.³ [See Figure 2] This rate of increase is only slightly greater than the 1.7 percent annual rate of population growth for North Carolina from 1998 to 2001.⁴ And if the increase in the number of doctors working in the state is factored in – 2.8 percent a year over the same period⁵ – the rate of lawsuits probably has remained flat.

Figure 2



Source: North Carolina Administrative Office of the Courts.

N.C. Doctors' Malpractice Premiums Are Insignificant Compared with Total State Health Spending

Malpractice insurance premiums paid by physicians in North Carolina are insignificant when compared with the state's overall healthcare expenditures. Total spending on health care in North Carolina was \$27.3 billion in 1998, the last year for which data is available from government sources.⁶

In 1998, North Carolina physicians paid \$120 million in malpractice insurance premiums⁷ – equivalent to only 0.44 percent of all the money spent on health care in North Carolina for that year.

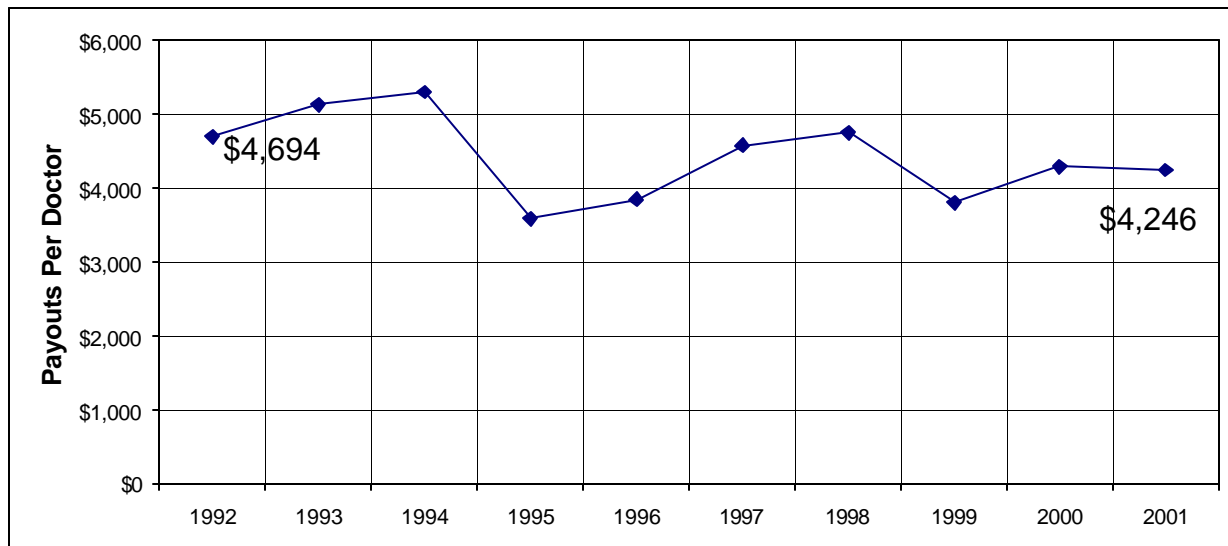
Malpractice Payouts Per Doctor Have Declined

Proponents of caps on malpractice damages have claimed that the amounts paid out to injured patients are rising and that is the principal cause for increases in malpractice insurance premiums. When inflation is taken into account, however, the amount of money paid out per North Carolina doctor has declined over the past decade.

- Payouts per doctor in 1992 were the equivalent of \$4,694 (in 2002 dollars) compared with \$4,246 in 2001 (in 2002 dollars). [See Figure 3]
- There were fewer payouts per North Carolina doctor in 2001 than in all but three of the past 10 years (1995, 1996 and 1999).

Figure 3

Value of Medical Malpractice Payouts Per Doctor
(Adjusted for Inflation)



Sources: Payouts are based on the National Practitioner Data Bank Sept. 1, 1990 – Sept. 30, 2002. Number of doctors are from North Carolina Health Professionals Data System, Cecil G. Sheps Center for Health Service Research – UNC Chapel Hill.

No Evidence of Doctors Abandoning North Carolina

The North Carolina Medical Society has called attention to a number of physicians who it claims have decided to abandon their practices or leave the state in response increasing medical malpractice insurance premiums.⁸ Statistics reveal that – far from an “exodus” of doctors – North Carolina has experienced a steady and significant increase in the number of doctors.

- The number of in-state practicing doctors in North Carolina has jumped by 4,760 in the last decade, from 11,632 in 1992 to 16,392 in 2001. This is an overall increase of 40.9 percent, or 4.5 percent a year. [See Figure 4]
- In comparison, North Carolina’s overall population experienced an annual average increase of 2.1 percent from 1992 to 2001.⁹ This rate was less than half the annual rate of increase of the doctor population during the same period.
- North Carolina had 16.9 doctors per 10,000 population in 1992, and 20.0 doctors per 10,000 in 2001, an 18.3 percent increase over nine years.¹⁰

Figure 4

Licensed Physicians and Osteopaths in North Carolina

Year	Number of Licensed Doctors
1992	11,632
1993	12,704
1994	12,870
1995	12,949
1996	13,782
1997	14,366
1998	15,135
1999	15,470
2000	15,925
2001	16,392

Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research – UNC Chapel Hill

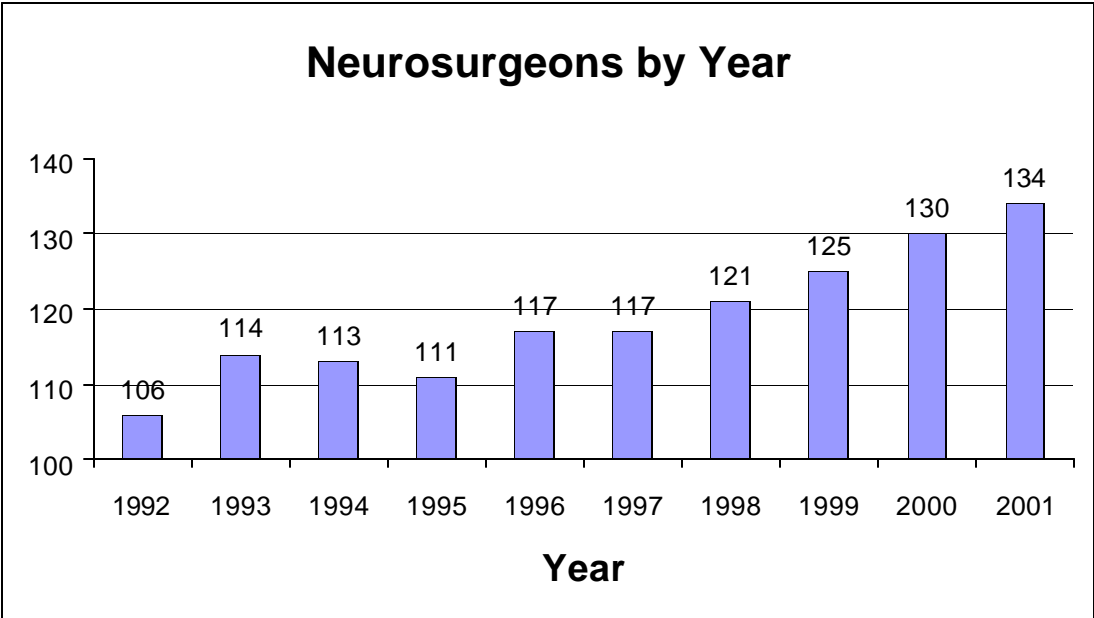
Numbers of Doctors in Higher-Risk Specialties

When the North Carolina Medical Society raises the issue of doctors leaving the state, it calls particular attention to physicians whose specialties often pay high malpractice premiums.¹¹ But, an examination of data for three higher-risk specialties – neurosurgeons, ob/gyns and general surgeons – makes it clear that North Carolina has gained, not lost many doctors in these areas.

While North Carolina’s overall population grew at an average of 2.1 percent from 1992 to 2001:

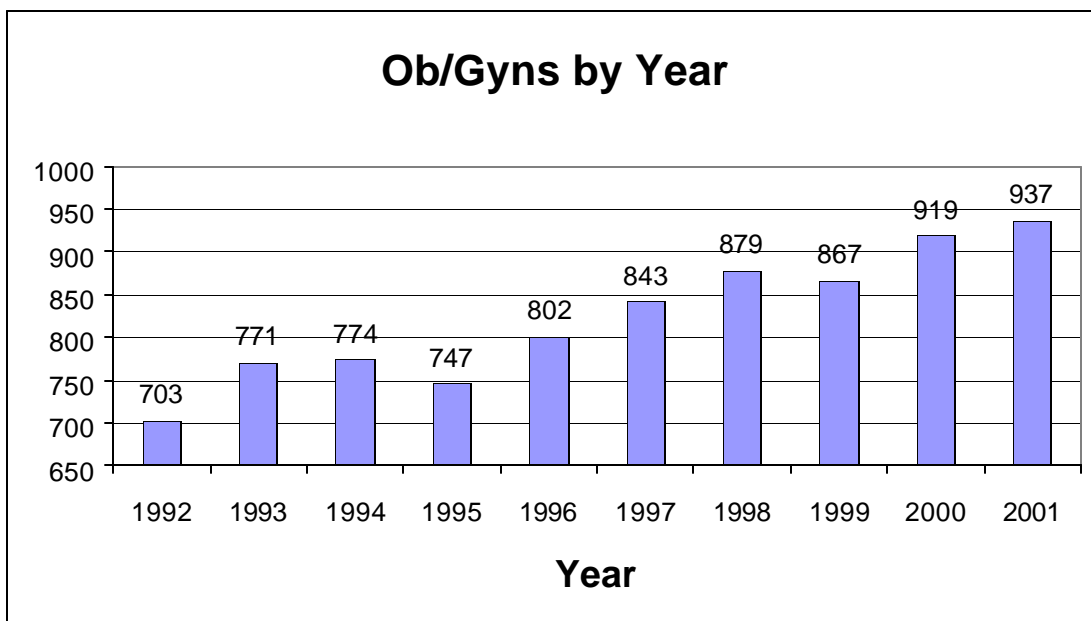
- The number of neurosurgeons in North Carolina increased from 106 in 1992 to 134 in 2001, a 26.4 percent increase over nine years – or 2.9 percent a year. [See Figure 5]
- The number of Ob/Gyns in North Carolina increased from 703 in 1992 to 937 in 2001, a 33.3 percent increase over nine years – or 3.7 percent a year. [See Figure 6]
- The number of general surgeons in North Carolina increased from 564 in 1992 to 654 in 2001, a 16 percent increase over nine years – or 1.8 percent a year. [See Figure 7]

Figure 5



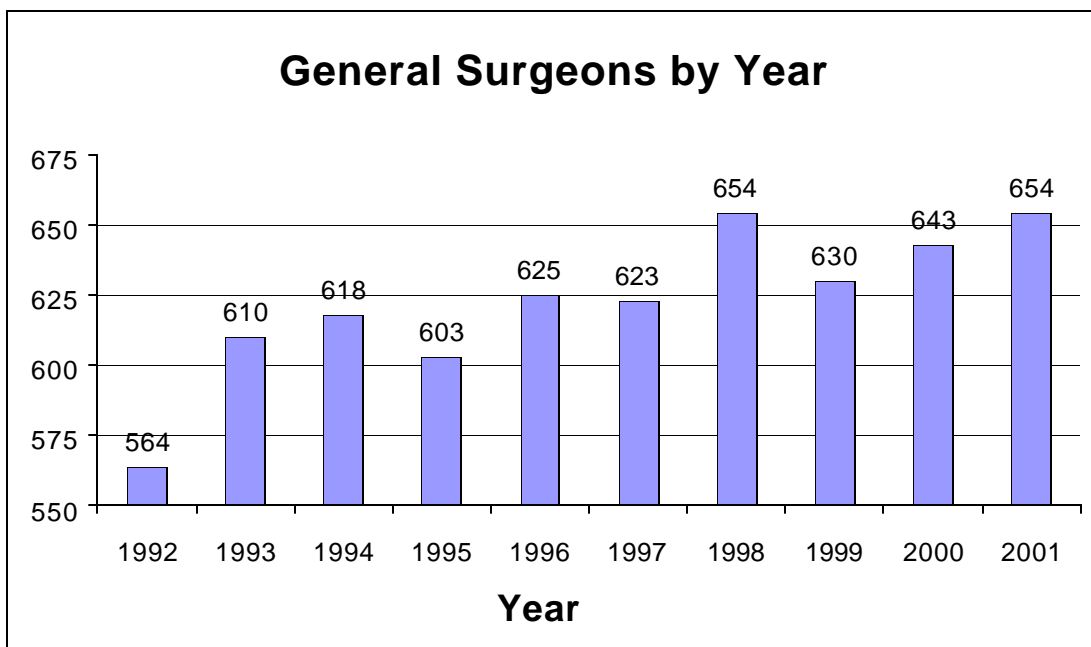
Source: North Carolina Professions Data System, Cecil G. Sheps Center for Health Services Research – UNC Chapel Hill.

Figure 6



Source: North Carolina Professions Data System, Cecil G. Sheps Center for Health Services Research – UNC Chapel Hill.

Figure 7



Source: North Carolina Professions Data System, Cecil G. Sheps Center for Health Services Research – UNC Chapel Hill.

Damage Caps Don't Guarantee Lower Medical Malpractice Insurance Premiums

Doctors have argued that caps on non-economic damages will lower medical malpractice liability premiums. That is not necessarily the case, as demonstrated by the comparison of the premiums charged by the leading malpractice insurance providers in North Carolina, which does not cap damages, and Louisiana, which has one of the most extreme caps in the country. [See Figure 8] Louisiana caps the *total* amount of recoverable damages to \$500,000, excluding future medical care and related benefits.

Figure 8

North Carolina vs. Louisiana: Comparison of Malpractice Insurance Premiums

Specialty	North Carolina Medical Mutual Insurance Co. 2002 Premiums	North Carolina Medical Mutual Insurance Co. % increase since July 2001	Louisiana Medical Mutual Insurance Co. 2002 Premiums	Louisiana Medical Mutual Insurance Co. % increase since July 2001
Internal Medicine	\$7,334	14 percent	\$11,080	15 percent
General Surgery	\$32,801	14 percent	\$36,914	15 percent
Obstetrics & Gynecology	\$57,145	15 percent	\$58,061	15 percent

Source: "Trends in 2002 Rates for Physicians' Medical Professional Liability Insurance," Medical Liability Monitor, October 2002; Louisiana Department of Insurance; and North Carolina Department of Insurance.

- On average, doctors in Louisiana pay higher premiums than their counterparts in North Carolina.** Malpractice insurance premiums charged by the largest malpractice provider in Louisiana, Louisiana Medical Mutual Insurance Co., were an average of 22 percent *higher* (between 2 and 51 percent) in 2002 than those of North Carolina's largest provider, Medical Mutual Insurance Co. of North Carolina.¹² Premiums for Louisiana's

internists were 51 percent higher than North Carolina's (\$11,080 vs. \$7,334). Premiums for Louisiana's surgeons were 13 percent higher than North Carolina's (\$36,914 vs. \$32,801). Premiums for Louisiana's obstetricians were 2 percent higher than North Carolina's (\$58,061 vs. \$57,145).

- **Increases seem more connected to the insurance cycle than to award caps.** Louisiana's cap seems to have no bearing on how much premiums have increased between 2001 and 2002 compared to North Carolina. This suggests that premium increases are more related to the insurance cycle than the liability system. Louisiana Medical Mutual Insurance Co. raised insurance premiums 15 percent last year during the peak of the insurance "crisis." Medical Mutual Insurance Co. of North Carolina raised premiums the same amount – between 14 and 15 percent.
- **Despite its cap, Louisiana is losing doctors to other states, including North Carolina, at the expense of the medically underserved.** During the last malpractice "crisis" in the late 1980s, researchers at the University of North Carolina studied the migration of doctors to and from rural counties, using data from the AMA Physician Masterfile. They found that the states with the greatest net inflow of rural doctors were North Carolina, Florida, Georgia, and South Carolina – none of which had caps on medical malpractice awards. The biggest losers included Louisiana, which had had caps for over a decade, and Missouri, which adopted a cap during the period of the study.¹³ Louisiana is one of nine states with damage caps that have greater percentages of medically underserved residents than North Carolina.¹⁴
- **Medicare's local adjustment for the cost of malpractice insurance is lower for North Carolina doctors than Louisiana doctors.** The federal government's Medicare actuary calculates that North Carolina's doctors spend an average of 1.9 percent of their practice incomes on malpractice insurance, compared with Louisiana's doctors who spend between 3.4 percent and 4.1 percent of their practice incomes on malpractice insurance.¹⁵
- **A similar premium rate pattern is apparent in comparisons between North Carolina and Virginia.** Virginia is the only other southern state that caps medical malpractice damages – at \$1.65 million overall. But a comparison of the two malpractice insurance companies¹⁶ that provide coverage in both Virginia and North Carolina (which does not cap damages) and that reported their rates to *Medical Liability Monitor*, also undercuts the argument that caps result in lower premiums for doctors.¹⁷ [See Figure 9]
- **But North Carolina patients are much better off than Virginians.** While North Carolina doctors are in the same general range as Virginia doctors when it comes to the premiums they pay, patients fare much better in North Carolina because there is no cap. According to the federal National Practitioner Data Bank, in 2001 the median malpractice payout in North Carolina was \$165,000, versus \$150,000 in Virginia – or 10 percent *more* in compensation.¹⁸

Figure 9

North Carolina vs. Virginia:
Comparison of Malpractice Insurance Premiums

Specialty	North Carolina Doctors' Company 2002 Premiums	Virginia Doctors' Company 2002 Premiums	North Carolina Professionals Advocate 2002 Premiums	Virginia Professionals Advocate 2002 Premiums
General Surgery	\$31,687	\$21,343 - \$34,083	\$23,394	\$25,775 – 40,912
Obstetrics & Gynecology	\$38,024	\$25,712 - 41,464	\$44,207	\$48,005 – 76,199
Internal Medicine	\$8,564	\$5,878 - 9,264	\$5,378	\$6,444 – 10,228

Source: "Trends in 2002 Rates for Physicians' Medical Professional Liability Insurance," *Medical Liability Monitor*, October 2002. MLM reports one premium statewide for each North Carolina insurer, but four different, regional premiums for each Virginia insurer. The range of those four premiums is shown.

- **Caps have not prevented a so-called malpractice “crisis” in Virginia.** Donald Palmisano, president-elect of the AMA, admitted in testimony before a U.S. House committee in February 2003 that “physicians in Virginia are starting to see the warning signs of a full-blown medical liability crisis... Over the past two years physician premiums have increased on average over 30 percent. For some medical specialists, medical liability premiums in Virginia have increased upwards of 60 percent for this same recent two-year period.” These increases are in spite of Virginia’s stiff \$1.65 million cap on *all* damages.

Repeat Offender Doctors Are Responsible for 42% of Medical Malpractice Payouts

The insurance and medical communities have argued that medical liability litigation constitutes a giant “lottery,” in which lawsuits are purely random events bearing no relationship to the care given by a physician. If the tort system is a lottery, it is clearly a rigged one, because some numbers come up more often than others. A small percentage of doctors have attracted multiple claims, and it is these doctors who are responsible for much of the malpractice in North Carolina.

- According to the federal government’s National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, just 3.2 percent of North Carolina’s doctors have been responsible for 41.6 percent of all malpractice payouts to patients. [See Figure 10] Overall, these 458 doctors, all of whom have made two or more payouts, have paid \$223.9 million in damages.
- Even more surprising, just 1.1 percent of North Carolina doctors (158), each of whom has paid three or more malpractice claims, were responsible for 20.4 percent of all payouts.
- The 22 doctors with five or more payouts, just 0.2 percent of all North Carolina doctors, account for almost 5 percent of all payouts.

Figure 10

Number of Medical Malpractice Payouts to Patients and Amounts Paid by North Carolina Doctors, 1990 – 2002

Number of Payout Reports	Number of Doctors that Made Payouts	Percent/Total Doctors (14,366)	Total Number of Payouts	Total Amount of Payouts	Percent of Total Number of Payouts
All	2,113	14.7%	2,834	\$641,263,100	100.0%
1	1,655	11.5%	1,655	\$417,389,750	58.4%
2 or More	458	3.2%	1,179	\$223,873,350	41.6%
3 or More	158	1.1%	579	\$106,727,300	20.4%
4 or More	56	0.4%	273	\$44,778,250	9.6%
5 or More	22	0.2%	137	\$17,483,750	4.8%

Source: National Practitioner Data Bank Annual Reports, Sept. 1, 1990 – Sept. 30, 2002
 (For these calculations, Public Citizen used the number of in state practicing doctors in North Carolina from 1997, the mid-year of the NPDB time period.)

Repeat Offenders Suffer Few Consequences

The North Carolina Medical Board and the state’s healthcare providers have done little to rein in those doctors who repeatedly commit medical errors and medical negligence. According to the National Practitioner Data Bank and Public Citizen’s analysis of NPDB data, disciplinary actions (license suspension or revocation, or a limit on clinical privileges) have been few and far between for North Carolina physicians. [See Figure 11]

- Only 8.1 percent (37 of 458) of North Carolina doctors who made two or more malpractice payouts were disciplined by the Board.¹⁹
- Only 15.2 percent (24 of 158) of North Carolina doctors who made three or more malpractice payouts were disciplined by the Board.
- Only 19.6 percent (11 of 56) of North Carolina doctors who made four or more malpractice payouts were disciplined by the Board.
- Only 18.2 percent (4 of 22) of North Carolina doctors who made five or more malpractice payouts were disciplined by the Board.
- The one North Carolina doctor who made 10 or more malpractice payouts was not disciplined by the Board.

Figure 11

Number of North Carolina Doctors with Two or More Medical Malpractice Payouts Who Have Been Disciplined (Reportable Licensure Actions), 1990 – 2002

Number of Payout Reports	Number of Doctors that Made Payouts	Number of Doctors with One or More Reportable Licensure Actions	Percent of Doctors with One or More Reportable Licensure Actions
2 or More	458	37	8.1%
3 or More	158	24	15.2%
4 or More	56	11	19.6%
5 or More	22	4	18.2%
10 or More	1	0	0.0%

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

Examples of Repeat Offenders Who Have Gone Undisciplined

The extent to which North Carolina doctors make multiple payouts to patients for medical malpractice claims and are not disciplined is illustrated by the following NPDB descriptions of 11 physicians practicing in North Carolina who have made between four and 10 malpractice payouts, *none* of whom have been disciplined by the state:²⁰

- **Physician Number 28985** made 10 malpractice payments between 1991 and 2000 involving four obstetrics related problems, delay in delivery, two incidents of improper management of course of treatment, five incidents of improper performance of surgery, two incidents of failure to diagnose, and delay in diagnosis. The damages add up to \$2,285,250.
- **Physician Number 28838** made four malpractice payments between 1993 and 1998 involving failure to diagnose, wrong diagnosis, performing two unnecessary surgeries, improperly performing a surgery, and failure to order appropriate medication. The damages add up to \$5,665,000.
- **Physician Number 29204** made five malpractice payments between 1991 and 2002 involving three incidents of failure to identify or treat fetal distress, two incidents of delay in treatment of identified fetal distress, an improperly performed vaginal delivery, improper choice of delivery method, and failure to diagnose a patient. The damages add up to \$4,185,000.
- **Physician Number 65196** made four malpractice payments and lost one malpractice judgment between 1994 and 2001 involving a surgery related problem, improperly performing surgery on a patient, performing surgery on the wrong body part of a patient, improperly positioning a surgical patient, and a delay in diagnosing a patient. The damages add up to \$2,283,750.
- **Physician Number 84891** made four malpractice payments between 1995 and 1999 involving improperly managing two surgical patients, ordering the wrong dosage of a medication, two incidents of improperly performed surgery, and failure to perform surgery. The damages add up to \$1,812,500.
- **Physician Number 28923** made four malpractice payments between 1993 and 2002 involving two improperly performed surgeries, improperly positioning a surgical patient, failure to obtain consent for surgery, and administering the wrong medication. The damages add up to \$1,801,250.
- **Physician Number 141714** made four malpractice payments between 1999 and 2001 involving three surgery related problems, improper performance of surgery, a diagnosis related problem, and delay in diagnosis. The damages add up to \$995,000.

- **Physician Number 28980** lost four malpractice judgments between 1993 and 1994 involving three incidents of improperly performing tests and a wrong diagnosis. The damages add up to \$950,000.
- **Physician Number 66632** made four malpractice payments between 1995 and 1997 involving delay in diagnosis, performing surgery on the wrong body part, improperly performing a surgery, improperly managing a surgical patient, and two incidents of delay in treatment. The damages add up to \$767,500.
- **Physician Number 68327** made five malpractice payments between 1995 and 2002 involving two incidents of performing unnecessary surgery, three incidents of improperly performing surgery on a patient, and failure to diagnose a patient. The damages add up to \$793,750.
- **Physician Number 28846** made six malpractice payments between 1991 and 2001 involving two surgery related problems, two incidents of improperly managing a surgical patient, improperly performing surgery, and leaving a foreign body in a surgical patient. The damages add up to \$750,000.

Where's the Doctor Watchdog?

Chances that North Carolina could reduce its rate of malpractice claims by cutting the frequency of medical errors and negligence are weakened by the state's failure to provide patients and consumers with information about doctors' records and by the North Carolina Medical Board's failure to diligently discipline doctors who commit repeated malpractice.

- **The North Carolina Medical Board is among the nation's least diligent when it comes to disciplining doctors.** In 2002, North Carolina ranked 45th among all states and the District of Columbia for the frequency at which it takes serious disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. In 2002, the North Carolina Medical Board levied serious sanctions against only 43 of its 20,851 doctors, according to Public Citizen's Health Research Group ranking of the rate of state medical boards' serious disciplinary actions in 2002.²¹

Nationally in 2002, there were 3.6 serious actions taken for every 1,000 physicians. The rate of serious actions by the North Carolina Medical Board – 2.06 per 1,000 physicians – was roughly one-sixth of the rate in Wyoming, which is the top-ranked state with 11.9 serious actions per 1,000 physicians.²²

Over the last decade, North Carolina has consistently ranked in the bottom half of states for rate of doctor discipline, from its best rating of 26th out of 51 to its worst rating of 48th. In four of the last 10 years, North Carolina has been ranked 40th or worse.

Caps on Malpractice Awards Do Not Improve Access to Primary Care

There is no apparent relationship between caps on malpractice awards and access to primary medical care. Among the 15 states with the highest percentages of population lacking primary medical care, nine impose malpractice caps. [See Figure 12] In fact, three of the four states with the greatest underserved populations have malpractice caps. Conversely, among the 15 states with the smallest percentages of population lacking primary care, eight do *not* have malpractice caps.²³

The Health Professional Shortage Area database maintained by the U.S. Department of Health and Human Services²⁴ shows that urbanization and affluence are the most frequent predictors of access to medical care.

- **Mississippi had the nation's worst access to medical care years before the current malpractice "crisis."** Mississippi, with just 149 physicians per 100,000 residents, ranks worst in the nation for the percentage of its population that lacks medical primary care. And Mississippi also ranked worst among states in terms of its medically underserved population in 1992 (33.3%),²⁵ long *before* a so-called "malpractice crisis" was proclaimed in that state.
- **Caps and low payouts to patients haven't made primary care accessible in Utah.** The third worst state for the percentage of its population lacking primary medical care is Utah, which has a \$400,000 cap on damages and very low malpractice payouts to patients – ranking 49th nationally for the average size of payouts.²⁶ "Rural communities in Utah have long had a hard time attracting and retaining specialty physicians," according to a Utah Medical Association spokesman.²⁷
- **Idaho also has malpractice caps – as well as a medically underserved population.** Idaho, another state that has a \$400,000 cap on non-economic damages, ranks fourth worst in the nation for the percentage of its population that lacks primary care.²⁸
- **The AMA claims California's caps attract doctors, but shortages continue to plague primary care.** In 1992, the state with the most medically underserved residents (6.4 million) was California, which has a \$250,000 cap on non-economic damages in malpractice cases.²⁹ The American Medical Association has suggested that doctors leaving Nevada because of high insurance rates were flocking to California.³⁰ Yet only two months ago, *Hospitals and Health Networks* magazine reported that 35 percent of primary care doctors in San Diego "plan to move, change professions or retire within five years." In the San Diego Medical Society survey, cited by the magazine, "64% of the physician respondents say there's already a doctor shortage in the county; and 71% percent say they have difficulty recruiting doctors."

Figure 12

**Percent of Population Lacking Access to Primary Care,
States With “Caps” and Without “Caps” – 2000**

THE FIFTEEN WORST			
Rank	State	Malpractice Caps?	Population w/o Access
1	Mississippi	No *	26.9%
2	Alabama	Yes	22.7%
3	Utah	Yes	21.0%
4	Idaho	Yes	20.3%
5	District of Columbia	No	19.5%
6	South Dakota	Yes	19.2%
7	Louisiana	Yes	18.3%
8	Wyoming	No	17.9%
9	Missouri	Yes	17.8%
10	Georgia	No	16.3%
11	South Carolina	No	16.0%
12	New Mexico	Yes	15.9%
13	North Dakota	Yes	15.5%
14	Alaska	Yes	14.2%
14	Kentucky	No	14.2%
(24	North Carolina	No	9.5%)
THE FIFTEEN BEST			
1	Hawaii	Yes	2.9%
2	New Jersey	No	3.5%
3	Vermont	No	3.7%
4	Massachusetts	Yes	4.0%
5	New Hampshire	No	4.3%
6	Delaware	No	4.5%
7	California	Yes	4.9%
8	Pennsylvania	No	5.5%
9	Connecticut	No	5.7%
10	Kansas	Yes	6.0%
11	Maryland	Yes	6.2%
12	Nebraska	No	6.6%
13	Illinois	No	6.7%
14	Ohio	No	7.0%
15	Virginia	Yes	7.2%

Source: *Health Care State Rankings 2001*, Morgan Quitno Press.

* Note: Mississippi did not have malpractice award caps during the year covered in this report.

- **Research shows that caps do not prevent doctors from leaving states.** During the last malpractice “crisis” in the late 1980s, researchers at the University of North Carolina studied the migration of doctors to and from rural communities, using data from the AMA Physician Masterfile. They found that the states with the greatest net inflow of rural doctors were North Carolina, Florida, Georgia, and South Carolina – none of which had caps on medical malpractice awards. The biggest losers included Louisiana, which had caps for over a decade, and Missouri, which adopted a cap during the period of the study.³¹

Caps on Damages Are a False “Solution”

There is convincing evidence that limits on awards for “non-economic” pain and suffering damages penalize severely injured patients the most, without cutting the frequency of medical errors or reducing the rates doctors pay for liability insurance.

- **“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, loss of limb) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to Physician Insurers Association of America (PIAA), the average total payment (including both economic and non-economic damages) 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.** Studies conducted in California, Florida, North Carolina, New York, and Ohio found that jury verdicts bear a reasonable relationship to the severity of the harm suffered.³² These studies examined more than 3,500 malpractice jury verdicts and found a consistent relationship between the severity of injuries and the sizes of verdict. Uniformly the authors concluded that their findings did not support the criticism that jury verdicts are frequently unpredictable and irrational.
- **The insurance industry’s own statistics demonstrate that awards are proportionate to injuries.** The PIAA Data Sharing Report also demonstrates the relationship between the severity of an injury and the size of the settlement or verdict.³³ PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners’ classifications.³⁴ 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.³⁵
- **Capping awards hurts women in particular.** Limiting awards for non-economic injury has a disproportionate impact on women – especially as it relates to their ability to have children, according to the director of the Insurance Law Center at the University of Connecticut School of Law. “This is so for two main reasons,” reported Tom Baker, Connecticut Mutual Professor of Law. “First, the largest part of the 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 and other injuries inflicted on women is harm to reproductive capacity. Although this may be hard to believe, harm to reproductive capacity does not entitle women to receive significant economic damages ... [and] lowering the price of making a women infertile cannot be sound policy.”³⁶

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

Caps on pain and suffering damages will significantly lower the 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 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.

- **Premium on the Truth:**

“Insurers never promised that tort reform would achieve specific savings.” – American Insurance Association³⁷

“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 Association³⁸

“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 Association³⁹

- **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.⁴⁰

- **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 Mississippi⁴¹

- **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-Journal⁴²

“[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 Issues⁴³

- **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.”⁴⁴

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 Tverberg⁴⁵

- **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.⁴⁶

“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 Assurance⁴⁷

- **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 Committee⁴⁸

Medical Liability Premium Spike Is Caused by the Insurance Cycle and Mismanagement, Not the Legal System

For much of the 1990s, doctors benefited from artificially lower insurance 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.”⁴⁹

- **The American Medical Association (AMA) acknowledges that spikes in malpractice premiums are caused by insurance cycles.** In a report by the AMA’s Board of Trustees to its House of Delegates, the following statements acknowledged that increasing malpractice insurance premiums were linked to the insurance underwriting cycle:
 - “The insurance underwriting cycle is now at a point where insurers have both pricing power and a need to increase revenues through premiums as returns on investments are no longer able to subsidize underwriting losses [sic] and as insurers have suffered large claims losses in other areas.”⁵⁰
 - “For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market surged, investments by these historically conservative insurers rose to 10.6% in 1999, up from a more typical 3% in 1992. With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates. The industry reported realized capital gains of \$381 million last year, down 30% from the high point in 1998, according to the A. M. Best Company, one of the most comprehensive sources of insurance industry data.”⁵¹

Other authoritative insurance analysts and studies indicate that this is a temporary “crisis” spurred by insurers’ pricing and cash-flow policies, not patient litigation:

- **West Virginia regulators emphasize the impact that the economic downturn has had on the malpractice insurance market.** In West Virginia, a state that the AMA has declared to be in a medical malpractice “crisis,” the Insurance Commission reported, “[T]he insurance industry is cyclical and necessarily competitive. We have witnessed these cycles in the Medical Malpractice line in the mid-’70s, the mid-80s and the present situation. This particular cycle is, perhaps, worse than previous cycles as it was delayed by a booming economy in the ’90s 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.”⁵²

- **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. 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 booms 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.⁵³
- **Corporate mismanagement fueled malpractice problems.** Pressure on North Carolina’s physician premiums intensified after December 2001, when a major carrier, the St. Paul Insurance Companies, quit the medical liability business. The company had covered about 50 percent of all doctors in North Carolina.⁵⁴ St. Paul’s departure had much less to do with jury awards than with the company’s cash flow policies, its disastrous involvement with Enron, and its ill-fated acquisition of two companies that manufactured asbestos products.

Only days before St. Paul discontinued its malpractice business, it reported to the Securities and Exchange Commission (SEC) that it had \$84 million of exposure from the Enron collapse and held another \$23 million in unsecured Enron debt. In that disclosure to the SEC, St. Paul also listed “a series of actions intended to improve profitability” – foremost of which was the insurance company’s plan to “exit its medical malpractice business.”⁵⁵ In August 2001, St. Paul’s quarterly earnings report also warned that it faced liability for incalculable asbestos claims resulting from its ownership of two subsidiaries, Western MacArthur and USF&G.⁵⁶ Within the year, St. Paul had agreed to pay \$988 million to settle those claims.⁵⁷

Even without these large setbacks, St. Paul had contributed to a catastrophic cycle of low prices and artificially high profits in the malpractice insurance industry. Only a few months before St. Paul withdrew from the market, one industry expert warned that these business practices would inflict “chaos” on the market. “The end result is that premiums must increase, losses must decrease, or the insurer will eventually cease operating,” predicted Charles Kolodkin of Gallagher Healthcare Insurance Services.⁵⁸ In fact, as St. Paul announced its withdrawal from the Arkansas market, a corporate spokesman told journalists the company had allowed its premiums to remain too low for too long.⁵⁹

And a *Wall Street Journal* investigation into the decline in the medical liability insurance market made these points:

“[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.”⁶⁰

- **The same trends are present in other lines of insurance.** Property/casualty refers to a large group of liability lines of insurance (a total of 30) 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.⁶¹

Solutions to Reduce Medical Errors and Long-term Insurance Rates

Physician groups and their political allies are essentially blaming patients and their lawyers for the temporary spike in some insurance premiums. They have resorted to alarmist language and continued to advocate for a solution – a cap on damages – that is unrelated to the source of the problem.

They are demanding that North Carolina’s congressional delegation and the North Carolina Legislature support, among other things, a \$250,000 cap on so-called “non-economic” damages. This refers to awards for pain and suffering, lost childbearing ability, or disfigurement. Such damages exceed \$250,000 only in cases of permanent significant injuries. Thus, the cap will not affect patients with minor injuries nor reduce so-called “frivolous” lawsuits. Instead, it targets only victims of catastrophic injuries such as deafness, blindness, loss of limb or organ, paraplegia, or severe brain damage.

Such measures will only result in more medical malpractice and more lives ruined by the physical and emotional scars that result from medical negligence. Instead, the focus of North Carolina’s elected representatives should be on improving patient safety. Public Citizen recommends the following patient safety reforms:

Federal Patient Safety Reforms

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

New York State is ahead of most states in that it provides consumers with on-line access to important information about their physicians – including a history of medical malpractice, a criminal history and a disciplinary record. Information about doctor discipline, including state sanctions, hospital disciplinary actions and medical malpractice awards is also contained in the National Practitioner Data Bank. HMOs, hospitals and medical boards can look at the National Practitioner Data Bank. Unfortunately, consumers cannot access the information 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.

State Patient Safety Reforms

- **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.⁶²

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,⁶³ 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. In 2002, state medical boards took 2,868 serious disciplinary actions, a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by preventable medical errors annually.

State discipline rates ranged from 11.87 serious actions per 1,000 doctors (Wyoming) to 1.07 actions per 1,000 physicians (Hawaii), a tenfold difference between the best and worst states. North Carolina is ranked 45th among the 50 states and the District of Columbia for the number of serious actions taken per 1,000 physicians. (Note: Most of these actions are unrelated to medical malpractice and instead involve sanctions for substance abuse, sexual and criminal offenses.)

If all the boards did as good a job as the lowest of the top five boards, Oklahoma's rate of 7.56 serious disciplinary actions per 1,000 physicians, it would amount to a total of 6,089 serious actions a year. That would be 3,225 more serious actions than the 2,864 that actually occurred in 2002. 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 improve medical board performance:

- **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.**

Federal and State Patient Safety Reforms

- **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.⁶⁴ Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,⁶⁵ 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.⁶⁶

- **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.⁶⁷

- **Prevent Wrong Procedure Surgery and Surgery Performed on the Wrong Body Part or to the Wrong Patient.**

Such mistakes should *never* happen, according to a special alert reissued December 5, 2001 by the Joint Commission on Accreditation of Healthcare Organizations.⁶⁸ 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.⁶⁹ 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.⁷⁰ Had Florida mandated the JCAHO recommendations in 2000, these 79 incidents would not have occurred.

- **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.⁷¹ After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10 percent blood alcohol level.⁷² 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.⁷³ 45 percent of residents who sleep less than four hours per night report committing medical errors.⁷⁴ 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.⁷⁵ If the maximum workweek for residents was limited to 80 hours it could considerably reduce mistakes due to fatigue and lack of supervision.

Solutions to Make Insurance Rates More Predictable

The following recommendations for state insurance regulators to implement have been made by J. Robert Hunter, Director of Insurance for the Consumer Federation of American, on behalf of Americans for Insurance Reform:⁷⁶

Investigations and Audits

There must be a full and thorough investigation of the insurance companies' data to determine if there are errors and over-reserving in the data. An investigation should determine:

- 1) The extent to which the extraordinarily high profitability of the insurance industry during much of the 1990s, and its lower profitability today, is related to the performance of interest rates and the stock market during those periods;
- 2) The extent to which today's rate increases are an attempt to recoup money that insurers lost in the stock market or in other poorly-performing assets;
- 3) The extent to which insurers are adversely affected by today's low interest rates;
- 4) Whether insurers' estimates of their future claims payments, which are the basis for rate increases, are unreasonably high today; and
- 5) Whether it is proper, or lawful, for insurers to seek substantial rate increases despite having hugely increased their surplus – the money they have “in the bank,” with policyholder-supplied funds, particularly if the insurer is overcapitalized.

In addition, state insurance commissioners are urged to institute, or seek statutory authority to institute, annual, rather than the typical once-every-three-years, audits of insurance companies operating in their state. These annual audits should ascertain whether the companies are engaging in questionable accounting practices and whether their business and investment practices, by failing to take into account cyclical economic downturns, present unacceptable financial risks for insurance consumers and shareholders.

Specific Reforms

- **Regulate excessive pricing.** One cause of the cycle is the lack of regulatory action to end excessive and inadequate rates during the different phases of the cycle. Insurance Commissioners should start now by regulating the excessive prices being charged by insurers. They should, at least, hold the necessary hearings to determine if the prices are not excessive.
- **Freeze particularly stressed rates until the examination of the prices and remarkable jumps in loss reserves can be fully analyzed.** For instance, medical malpractice and homeowner rates should be frozen. A rollback of unjustified rate increases

that have already taken effect should then be in order. (The manner in which insurance rate rollbacks can be written and implemented to comply with all Constitutional requirements is explained in *Calfarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989), and *20th Century Ins. Co. v. Garamendi*, 8 Cal.4th 216 (1994). These cases substantially upheld Prop 103, the California insurance reform initiative that rolled back auto insurance rates by 20 percent.)

- **Require that risks with poorer experience pay more than good risks in lines of insurance where such methods are not in use today.** For example, require medical malpractice insurers to use claims history as a rating factor, and to give that factor significant weight. Auto insurers use an individual’s driving record as a rating factor; workers compensation insurers use the employer’s loss experience as a rating factor – so-called “experience mod.” Malpractice insurers should do the same. In addition, insurance commissioners should require all medical malpractice insurers to offer all “good” doctors – *i.e.*, all doctors meeting an objective definition of eligibility based on their claims history, their amount of experience and perhaps other factors – the lowest rate.
- **Reduce the percentage of assets that insurers can invest in stocks or other risky assets.** Insurers should not be permitted to raise their rates in order to recoup losses on stocks or other risky assets. The less risky their investments, the more secure policyholders are, and the more stable are rates.
- **Create a standby public insurer to write risks when the periodic cycle bottoms and hard markets occur, such as a medical malpractice insurer funded by a start-up loan from the state to compete with the existing malpractice carriers.** Several states have created such carriers to write workers’ compensation, and in many states such carriers have helped bring down workers’ comp rates. Similarly structured medical malpractice insurers should have similar success.
- **Ask the National Association of Insurance Commissioners to stop implementation of the deregulation of commercial rates and forms, which it is unwisely pushing.**

Endnotes

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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

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