

**Medical Malpractice Briefing Book:
Challenging the Misleading Claims
of the Doctors' Lobby**



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Acknowledgments

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Table of Contents

Executive Summary.....	i
Section I: Lawsuits Are not Responsible for Rising Medical Malpractice Insurance Premiums	
Malpractice Payouts per Doctor Have Declined	1
Average Physician Medical Malpractice Payouts Have Increased Only 1 Percent a Year After Adjusting for Medical Services Inflation	4
Jury Verdicts Are not Rising.....	5
Malpractice Insurance Costs Have Risen at Three-fifths the Rate of Medical Inflation.....	6
Increases in Medical Malpractice Premiums and Payments Track — and Do not Exceed — Increased Costs of Injuries	8
Medical Malpractice Expenditures Comprise Less than 1 Percent of Overall Health Care Costs.....	9
Malpractice Insurance Costs Comprise 3.9 Percent of a Physician's Practice Income.....	10
Doctor's Bottom Line not Affected by Malpractice Awards, According to New Earnings Data.....	11
Reduced Fees – Not Insurance Rates – Are the Biggest Financial Burden on Doctors	13
Rather than Facing “Runaway Litigation,” Doctors Benefit from a Claims Gap.....	14
Empirical Evidence Does not Confirm the Existence of “Defensive Medicine” – Patient Injuries Refute It	16
Doctors' Aversion to Settlements May Increase Malpractice Insurance Costs	19
Few Malpractice Lawsuits Are “Frivolous”.....	21
 Section II: The Insurance Cycle Is the Real Cause of Medical Malpractice Premium Spikes	
Medical Liability Premium Spike Was Caused by the Insurance Cycle and Mismanagement, not the Legal System	24
The End of the “Hard” Insurance Market Is in Sight	28
Insurance Companies and Their Lobbyists Admit It: Caps on Damages Won't Lower Insurance Premiums.....	29
Solutions to Make Insurance Rates More Predictable	32
 Section III: The Real Medical Malpractice Crisis Is Inadequate Patient Safety	
Patients Need Protection from an Epidemic of Medical Errors and Unsafe Practices in Medicine	35
Patients and Consumers Suffer the Real Costs of Medical Malpractice	38
State-by-State "Costs" of Medical Malpractice to Patients and Consumers vs. Health Care Providers.....	39
5.4 Percent of Doctors Are Responsible for 56.2 Percent of Medical Malpractice Payouts	41
Doctors with Repeated Malpractice Payouts Suffer Few Consequences	42
Examples of Repeat Offender Doctors Who Have Gone Undisciplined.....	43
Anesthesiologists' Experience Shows Patient Safety Efforts Do More than Caps to Reduce Lawsuits and Insurance Premiums.....	45
Health-Care Providers and Legislators Should Focus on Patient Safety Reforms	48
Federal and State Patient Safety Reforms	50

Section IV: Malpractice Insurance Crisis Is not Threatening Access to Patient Care

Congressional Watchdog Agency Finds Claims of Malpractice Insurance “Crisis” Unsubstantiated ..54
A Case Study in Deception: The Phony “Doctor Exodus” in Pennsylvania57
Stories of Reduced Access to Trauma Care Are Exaggerated60
Why Doctors Practice Where They Do: Quality of Life, not Caps on Damages.....61
Most Complaints of Doctor Shortages are Attributable to the Chronically Low Supply
of Rural Physicians.....64

Section V: Caps on Damages Are Unjust and Offer No Solution to Rising Premiums Caused by the Insurance Cycle

Caps on Damages Are Unjust.....68
The Inequitable Impact Of Non-Economic Damage Caps: Three Academic Studies
Demonstrate Severely Handicapped and Female Patients Are Hurt the Most.....70
California's Lower Malpractice Insurance Premiums Are Due to Insurance Reform, not
Damage Caps74
Non-Economic Damage Awards Paid by Doctors in Texas Have
Declined Dramatically.....77
Caps on Malpractice Awards Do not Improve Access to Primary Care.....80
Percent of Population Lacking Access to Primary Care,
States With “Caps” and Without “Caps” –200081
Politicians Should Reject Proposals that Reduce Accountability for Negligence83
Medical Providers Can Reduce the Number of Medical Malpractice Claims Brought Through Conflict
Management Systems and Honesty Policies.....85

Executive Summary

Section I: Lawsuits Are not Responsible for Rising Medical Malpractice Insurance Premiums

- **The number of medical malpractice payouts per 100 doctors has declined 11 percent from 1994 to 2003.** According to the federal Government's National Practitioner Data Bank, in 1994, there were 15,166 malpractice payouts made by physicians in the U.S., which represented 2.46 payouts per 100 doctors. In 2003, there were 15,295 payouts, which represented 2.19 payouts per 100 doctors. Moreover, the total number of payouts has dropped more than 8 percent during the "crisis," from 16,690 in 2001 to 15,295 in 2003.
- **Average physician medical malpractice payouts have increased only 1 percent a year after adjusting for medical services inflation.** According to the National Practitioner Data Bank, in 1994, the average medical malpractice payout in the U.S. was \$184,787. That amount climbed to \$291,378 by 2003, but when adjusted for medical services inflation the increase was only \$18,405, or 1.1 percent a year. Since the bulk of a malpractice payout customarily goes to cover medical expenses, the amount of payouts can be expected to rise along with the costs of medical services. In addition, since a malpractice payout also is intended to provide compensation for lost income over a patient's lifetime, payouts also can be expected to increase along with wages, productivity and life expectancy.
- **Jury verdicts rose only 1.1 percent from 2000 to 2002.** Doctors regularly cite data from Jury Verdict Research, a private research firm, showing that jury awards rose 100 percent from 1997 to 2000, from \$503,000 to \$1 million. Only time will tell if they cite updated figures showing that the median malpractice verdict rose from \$1 million in 2000 and 2001 to \$1,010,858 in 2002—an increase of only 1.1 percent. This increase did not even come close to keeping pace with medical services inflation.
- **Malpractice insurance costs have risen at three-fifths the rate of medical inflation.** While medical costs increased 125 percent from 1987 to 2002, the total amount spent by all health care providers on medical malpractice insurance has increased by 76 percent over that time.
- **Medical malpractice expenditures comprise less than 1 percent of overall health costs.** In 2002 health care expenditures rose 9.3 percent to \$1.553 trillion. Yet expenditures on all malpractice premiums reported to the National Association of Insurance Commissioners (NAIC) that year were only \$9.6 billion – making malpractice costs about .62 percent of national health care expenditures.
- **Malpractice insurance costs comprise 3.9 percent of a physician's practice income.** Doctors allocate 13 times more of their practice income for their own salaries than they pay in malpractice premiums. According to the federal government's Medicare program, doctors nationally spend an average of 52.5 percent of their practice incomes on their own

pay, about 31 percent on such overhead expenses as office payroll and rent, and only 3.9 percent on malpractice insurance.

- **Reduced fees—not insurance rates—are the biggest financial burden on doctors.** Doctors across the country have seen their fees slashed in recent years as managed care companies tried to increase profits, and government programs, such as Medicare and Medicaid, tried to cut costs. Medicare reimbursement rates no longer come close to keeping pace with increases in doctors’ practice expenses. The American Medical Association (AMA) estimates that since 1991 physician practice costs have risen by 35 percent, but Medicare payments have risen only 10 percent. That means practice costs have risen two-and-a-half times the rate of Medicare payments.
- **Rather than facing “runaway litigation,” doctors benefit from a claims gap.** A 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 7.6 instances of medical negligence committed in hospitals results in a malpractice claim. Researchers replicating this study made similar findings in Colorado and Utah. 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.
- **Empirical evidence does not confirm the existence of “defensive medicine.”** 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. The Congressional Budget Office (CBO) and The Government Accountability Office have both rejected the defensive medicine theory. The CBO “could find no statistically significant difference in per capita healthcare spending between states with and without malpractice tort limits.” Medical provider groups admitted to GAO investigators that “factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures.”
- **Defensive medicine hasn’t prevented wrong-patient surgery, medication errors, mammography errors, or hospital infections.** New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001. 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. The *New York Times* reported in June 2002 that studies indicate that some doctors and clinics miss as many as one in three cancers. 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.”
- **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) The result is that defense attorney fees are higher and verdicts are higher, pushing malpractice premiums higher. The Doctors Company entices customers by boasting that 49 percent of its premiums are spent on defense costs. A study by the West Virginia Insurance Commissioner found that one company spent 88 cents of each premium dollar on defense lawyers. Malpractice insurance defense costs far exceed defense costs in other lines of insurance.

- **Evidence indicates that the negotiation process in medical malpractice cases fails, directly leading to the high verdicts that doctors complain about.** An Ohio State University 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.
- **Few malpractice lawsuits are frivolous.** 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. If the case goes to trial, the costs can easily be doubled. 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.

Section II: The Insurance Cycle Is the Real Cause of Medical Malpractice Premium Spikes

- **Medical liability premium spike was caused by the insurance cycle and mismanagement, not the legal system.** 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 2001, the current market began to decline or “harden,” following an unusually prolonged period of health, called a “soft market,” in the property-casualty insurance line in the 1990s.
- **Congressional Budget Office links rising premiums to insurance company investment losses.** In January 2004, CBO noted that the 15 biggest medical malpractice insurers saw their investment returns drop by 1.6 percent from 2000 through 2002. “That figure corresponds to almost half of the 15 percent increase in [medical malpractice premium] rates estimated by the Centers for Medicare and Medicaid Services,” the CBO reported.

- **For much of the 1990s, doctors benefited from artificially lower premiums.** According to the International Risk Management Institute (IRMI), “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.”
- **Financial analysts recognize the true cause of premium spikes.** Weiss Ratings reports that, “Tort reform has failed to address the problem of surging medical malpractice premiums, despite the fact that insurers have benefited from a slowdown in the growth of claims... The escalating medical malpractice crisis will not be resolved until the industry and regulators address the other, apparently more powerful, factors driving premiums higher.” According to Weiss, six factors driving increases in medical malpractice rates are medical cost inflation, the cyclical nature of the insurance market, the need to shore up reserves for policies in force, a decline in investment income, financial safety, and the supply and demand for coverage.
- **Insurer mismanagement compounded the problems.** As the *Wall Street Journal* found in 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.”
- **The American Medical Association acknowledges that spikes in malpractice premiums are caused by insurance cycles.** A report by the AMA’s Board of Trustees to its House of Delegates, stated, “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.”
- **The end of the “hard” insurance market is in sight.** Insurers returned to profitability in 2002, indicating that the hard market bottomed out in 2001. According to the National Association of Insurance Commissioners, property/casualty insurers posted a net loss in 2001 but began a rebound in 2002. U.S. property/casualty insurers’ profits surged to \$29.9 billion in 2003, according to the Insurance Services Office Inc. and the Property Casualty Insurers Association of America. According to the Insurance Information Institute, return on equity in 2004 is likely to soar above double digits for the first time since 1997 because underwriting performance is expected to continue to improve and the investment environment should allow for the realization of significant capital gains as well as higher investment yields on the industry’s bond portfolio.

Section III: The Real Medical Malpractice Crisis Is Inadequate Patient Safety

- **Patients need protection from an epidemic of medical errors and unsafe practices in medicine.** Between 44,000 and 98,000 Americans die in hospitals each year due to *preventable* medical errors, according to the Institute of Medicine. By comparison the annual death toll from automobile accidents is 43,000, 42,000 die from breast cancer and 15,000 die from AIDS.
- **Medical journals, state reporting systems and news accounts document continuing, widespread inattention to patient safety.** 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. And a 2003 study published in the *New England Journal of Medicine* reported that operating room teams around the country leave sponges, clamps and other tools inside about 1,500 patients every year. The study found that surgical teams failed to count equipment before and after the operation, as required by standard practice, in one-third of cases where something was left behind.
- **The resources devoted to preventing medical errors are disproportionate to their toll in lives.** Deaths attributable to preventable medical errors in hospitals each year exceed those caused by breast cancer and AIDS. Yet while the federal government spent \$655 million on breast cancer prevention in 2003 and \$3.5 billion on AIDS prevention in 2001, only about \$130 million was committed in 2002, for the first time, for improving patient safety.
- **Physicians' cavalier attitudes toward medical errors are out of step with public opinion.** In 2002, the *New England Journal of Medicine* released a survey of physicians and the public on the issue of medical errors. On each of these issues, doctors were in significant disagreement with the public and the experts. 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.
- **Patients and consumers suffer the real costs of medical malpractice.** The cost resulting from preventable medical errors in hospitals to patients, families and communities is estimated at \$17 billion to \$29 billion each year. But the cost of medical malpractice insurance to health care providers is only \$9.6 billion a year—about half the minimum costs to society of preventable medical errors.
- **5.4 percent of doctors are responsible for 56.2 percent of medical malpractice payouts.** This is according to National Practitioner Data Bank data from September 1990 through 2003. Each of these doctors has made at least two payouts. Just 2 percent of doctors, each of whom has made three or more malpractice payouts, were responsible for 31.1 percent of all payouts. Only 0.9 percent of doctors, each of whom has made four or more malpractice

payouts, were responsible for 18.8 percent of all payouts. Eighty-three percent of doctors have never made a medical malpractice payout since the NPDB was created in 1990.

- **Doctors with repeated malpractice payouts suffer few consequences.** Only 8 percent of doctors who made two or more malpractice payouts were disciplined by their state medical board. 11.1 percent of doctors who made three or more malpractice payouts were disciplined by their state board. Only 14.4 percent of doctors who made four or more malpractice payouts were disciplined by their state board. Even of those doctors who made 10 or more malpractice payouts only 32.2 percent were disciplined by their state board.
- **Anesthesiologists' experience shows patient safety efforts do more than caps to reduce lawsuits and insurance premiums.** In 1985 the American Society of Anesthesiologists (ASA) began gathering claims files from 35 different insurers. The outcome of this Manhattan Project-like commitment was the issuance of standards and procedures to avoid injuries that resulted in savings beyond the wildest dreams of any "tort reformer." The number and severity of claims dropped dramatically. In 1972, anesthesiologists were the target of 7.9 percent of all medical malpractice claims, double their proportion among physicians. But from 1985 to 2001, they were targets of only 3.8 percent of claims. In the 1970s, 64 percent of anesthesiology claims involved permanent disability or death; by the 1990s, only 41 percent did. The increased patient safety measures paid off in savings to doctors. Remarkably, the average anesthesiologist's liability premium remained unchanged from 1985 to 2002 at about \$18,000 (and, if adjusted for inflation, it would be a dramatic decline).

Section IV: Malpractice Insurance Crisis Is not Threatening Access to Patient Care

- **Congressional watchdog agency finds claims of malpractice insurance "crisis" unsubstantiated.** The U.S. Government Accountability Office, formerly the General Accountability Office, essentially found that the AMA and allied groups manufactured a "crisis." The GAO compared conditions in five AMA-designated "crisis states," and found that the AMA's claims that medical services were unavailable in particular areas because of malpractice costs were not reliable; and claims that the overall number of doctors in the "crisis" states had declined were based on questionable surveys.
- **A case study in deception: The phony "doctor exodus" in Pennsylvania.** According to an independent study by the *Allentown Morning Call* newspaper, "Pennsylvania doctors are not leaving in droves because of rising malpractice premiums." "New state government statistics, the first to shed definitive light on a factually murky crisis that has consumed state officials and panicked consumers, show little or no dip in the number of doctors...And a separate set of previously undisclosed figures—from the Pennsylvania Medical Society itself—indicate there probably are more physicians in Pennsylvania than ever."
- **A spot-check of anecdotes cited by the AMA as evidence that there is reduced access to care in Pennsylvania found many of the stories to be false.** In February 2004, Public Citizen performed a spot-check of anecdotes contained in the appendix to

American Medical Association president-elect John C. Nelson's statement to a U.S. House subcommittee. Public Citizen's findings indicate that anecdotes of a doctor exodus are often inaccurate. For instance, the AMA claimed that Dr. Carol Ludolph, "a neurosurgeon in Philadelphia, said that \$170,000 in liability insurance premiums forced her to stop performing brain surgeries" in 2002. However, calls to her office confirmed that Dr. Ludolph is still taking new patients and still performing brain surgeries.

- **Stories of reduced access to trauma care are exaggerated.** A study published in 2003 in the *Journal of the American Medical Association* identified 10 states with the highest concentration of trauma centers. But five of those were states where the AMA claimed patients were threatened with lack of access to health care due to rising malpractice insurance premiums – i.e., that there were not enough doctors. Meanwhile, four of the six states that the AMA said are "currently OK" were found to have fewer than the recommended number of trauma centers, despite harsh caps on damages to victims of medical malpractice.
- **Shortage of rural doctors is a chronic problem, unrelated to malpractice.** For 25 - 30 years many rural communities have been under-served medically according to experts. The Council on Graduate Medical Education (COGME) reports that geographic maldistribution of health care providers and services are one of the most persistent characteristics of the American health care system. Physicians tend to practice in affluent urban and suburban areas. Even as an oversupply of some physician specialties is apparent in many urban health care service areas across the country, many inner-city and rural communities still struggle to attract an adequate number of health professionals to provide high-quality care to local people.
- **Why doctors practice where they do: Quality of life, not caps on damages.** Liability laws do not correlate with where doctors' locate their practice. While four of the states with the fewest per capita number of doctors in 2004 had enacted caps on non-economic damages, only three of the states with the most number of doctors per capita had enacted them. Similarly, while three of the states with the fewest number of doctors had enacted caps on punitive damages, only one of the states with the most number of doctors had capped punitive damages. Doctors choose to reside in states with a higher quality of life, not because of state liability laws. Like anyone else, doctors want to live in places where they can earn high incomes, enjoy cultural and leisure activities, and send their children to good schools. It is not surprising that doctors migrate to states on lists of "Best Places to Live."

Section V: Caps on Damages Are Unjust and Offer No Solution to Rising Premiums Caused by the Insurance Cycle

- **Caps on damages are unjust.** "Non-economic" damages are not as easy to quantify as lost wages or medical bills, but they compensate real injuries. They are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, loss of sexual function, lost bowel and bladder control, loss of limb) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility.

- **Three academic studies demonstrate severely handicapped and female patients are hurt the most by caps.** These 2004 studies from physicians at the Harvard Medical School, social scientists at the RAND Institute for Civil Justice and a law professor at the University of Buffalo analyzed the impact of California's twenty-nine year old \$250,000 limit on non-economic damages. Each study reached the same conclusion – caps are a particularly harsh method of reducing malpractice awards.
- **Average reductions for grave injuries were seven times larger than for those with minor injuries, according to the study by the Harvard Medical School.** Verdicts for injuries such as deafness, numbness, disfigurement, chronic pain and the like, which do not always result in wage loss or high medical expenses, were virtually wiped out by the cap. The authors concluded that caps are a clumsy and inequitable solution to the perceived problem of unjust jury awards. .
- **Plaintiffs with the most severe injuries felt the impact of MICRA the most often, according to the study by the RAND Institute.** Patients with the most serious injuries, such as brain damage, a variety of catastrophic injuries, and paralysis, had their awards capped most frequently, and when they do, they suffered median reductions of more than a million dollars. Cases with the greatest percentage losses in total awards are those with small economic losses but great damage to the plaintiff's quality of life. An example is the case of a 42-year old woman who underwent an unnecessary mastectomy because of a mistaken diagnosis of cancer; the jury verdict was \$78,000 for economic losses and \$1.5 million for the non-economic losses to her quality of life. Under the MICRA cap, the judge reduce her total award to \$338,000, 78 percent less than the jury had decided was fair compensation.
- **California women sustain greater proportional losses from the cap than men, according to the University of Buffalo study.** Verdicts for women were reduced an average of 48 percent as compared to only 40 percent for men. California caps have a particularly harsh impact on women who are victims of gynecological malpractice. In the gynecological cases studied the average reduction was 64 percent. Elderly women and parents of children who died as the result of malpractice were also hard hit by the one size fits all California cap, according to the author.
- **California's lower malpractice insurance premiums are the result of insurance reform not the damage cap.** In 1975, California passed the Medical Injury Compensation Reform Act (MICRA), the centerpiece of which is a \$250,000 cap on non-economic damages (with no inflation adjustments). But California premiums continued to rise after enactment of the MICRA cap. In 1976, the first year of MICRA, the total premiums earned by California insurers was \$228.5 million but by 1988, after thirteen years of MICRA, premiums had skyrocketed to \$663.2 million, a jump of 190 percent. Malpractice premiums only began to decrease in 1988 after passage of Prop 103. Prop 103 was the nation's most stringent reform of the insurance industry's rates and practices. Within three years of California's passage of Prop 103, medical malpractice premiums dropped 20 percent, and since 1988 total premiums earned have decreased about 2 percent, dropping from \$663.2 million in 1988 to \$647.2 million in 2001.

- **Caps on Malpractice Awards Do Not Improve Access to Primary Care.** Government data shows that 53 percent of the 15 states with the worst access to primary care impose medical malpractice damage caps. Among the 15 states with the highest percentages of population lacking primary medical care, eight impose malpractice caps, according to the Health Professional Shortage Area database maintained by the U.S. Department of Health and Human Services. In fact, two of the four states with the greatest underserved populations have malpractice caps. Meanwhile, among the 15 states with the smallest percentages of population lacking primary care, nine do *not* have malpractice caps, according to the Health Professional Shortage Area database. The alleged “crisis” states of New Jersey, Pennsylvania, Connecticut, Illinois and Ohio are ranked 2nd, 8th, 9th, 13th and 14th best in the country for their population’s access to primary care.
- **Medical providers can reduce the number of medical malpractice claims brought through conflict management systems and honesty policies.** Most victims of medical malpractice want the same thing – and it isn’t money. Patients and families with medical concerns usually want a combination of three things: an acknowledgement of their suffering with an apology if appropriate, a straightforward explanation of what happened, and assurances that the incident will not be repeated. Steve Kraman, chief of staff at the Veterans Affairs Medical Center in Lexington, Kentucky puts it this way: “If you treat people the way that they want to be treated, they don’t want to take you to court.” Hospitals and insurers that have honesty policies or conflict management systems have seen a reduction both in the number of malpractice claims filed and in payouts, *without legislation and without taking away patients’ rights*. The Veterans Affairs Medical Center in Lexington has a policy of telling patients when mistakes are made and automatically compensating victims. Despite readily acknowledging fault, the center ranks in the lowest 25 percent of all VA medical centers in malpractice expenses.

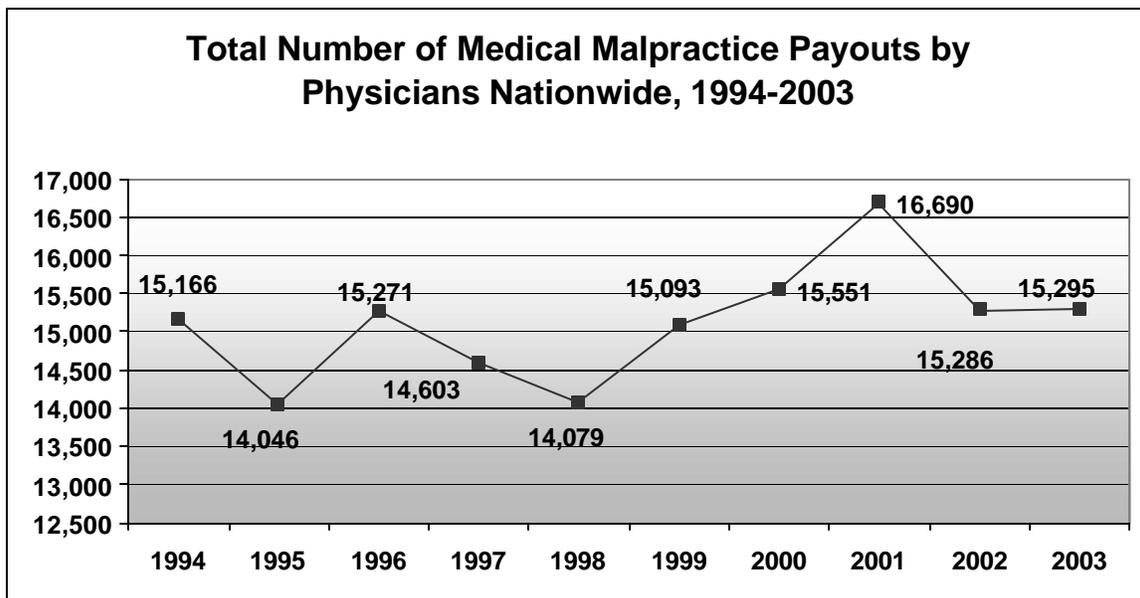
Section I

Lawsuits Are not Responsible for Rising Medical Malpractice Insurance Premiums

Malpractice Payouts per Doctor Have Declined

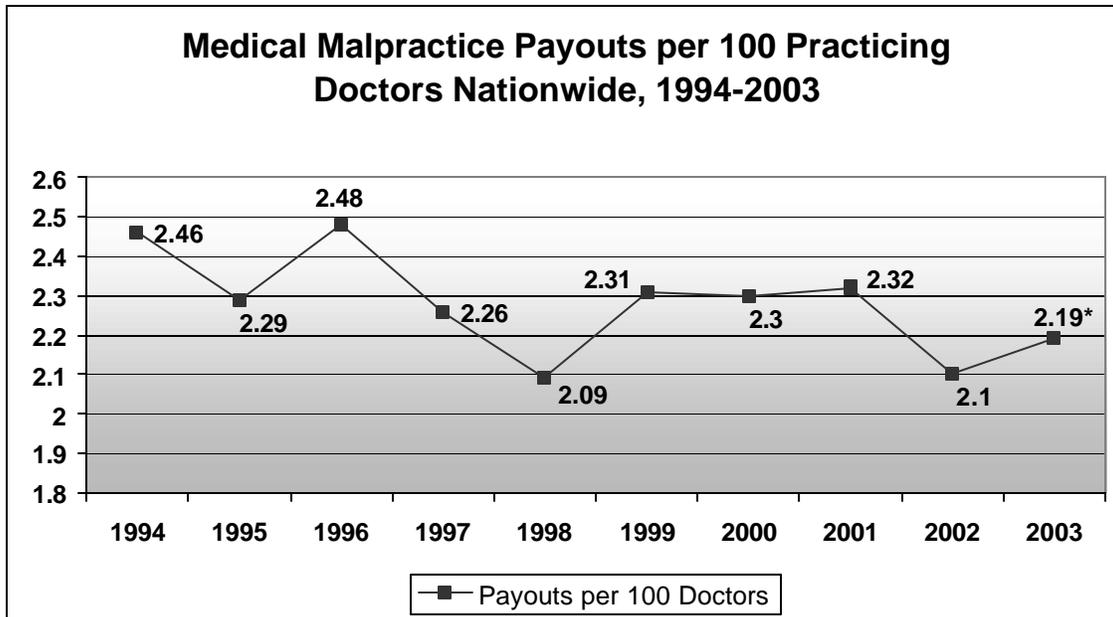
According to claims made by physicians and their lobbyists, medical malpractice payouts have become more common because patients are lining up to play the “lawsuit lottery.” In fact, the number of payouts made to victims of malpractice has declined since 1996 when measured against the growing number of practicing doctors.

- **The number of payouts increased by less than 1 percent since 1994.** In 1994, the number of medical malpractice payouts made by physicians in the U.S. was 15,166, according to the National Practitioner Data Bank,¹ which was created in September 1990 by the federal government to track malpractice judgments and settlements against physicians. In 2003, the number of payouts was 15,295 – an increase of only 129 payouts or .85 percent.
- **From 2001 to 2003, the number of malpractice payouts declined by 8.4 percent.** In 2001, the beginning of the medical malpractice “crisis,” the number of total medical malpractice payouts nationally was 16,690. By 2003, that number had *fallen* to 15,295, a drop of 1,395.



Source: National Practitioner Data Bank, Jan. 1, 1994 to Dec. 31, 2003.

- **The number of medical malpractice payouts per 100 doctors has declined 11 percent from 1994 to 2003.** In 1994, there were 15,166 malpractice payouts made by physicians in the U.S., according to the NPDB, which represented 2.46 payouts per 100 doctors. In 2003, there were 15,295 payouts, which represented 2.19 payouts per 100 doctors.



Sources: National Practitioner Data Bank, Jan. 1, 1994 to Dec. 31, 2003; totals of licensed practicing physicians are reported by all states and territories to the Federation of State Medical Boards of the United States. The total number of licensed physicians practicing in-state were 615,854 (1994), 614,290 (1995), 616,869 (1996), 646,891 (1997), 673,781 (1998), 653,241 (1999), 676,522 (2000), 718,135 (2001), 726,984 (2002), 697,949* (2003).

* Note: Rate for 2003 does not include reports on physician numbers from New Jersey, Utah, and Puerto Rico or reports on osteopath numbers from Nevada or Utah. Such additions would lower the rate.

- Population-adjusted medical malpractice case filings declined between 1992 to 2001.** In the 17 states reporting figures to the Court Statistics Project, medical malpractice filings per 100,000 population have decreased by 1 percent.² While there has been a gradual increase in the medical malpractice caseload it has not kept pace with the increase in population.

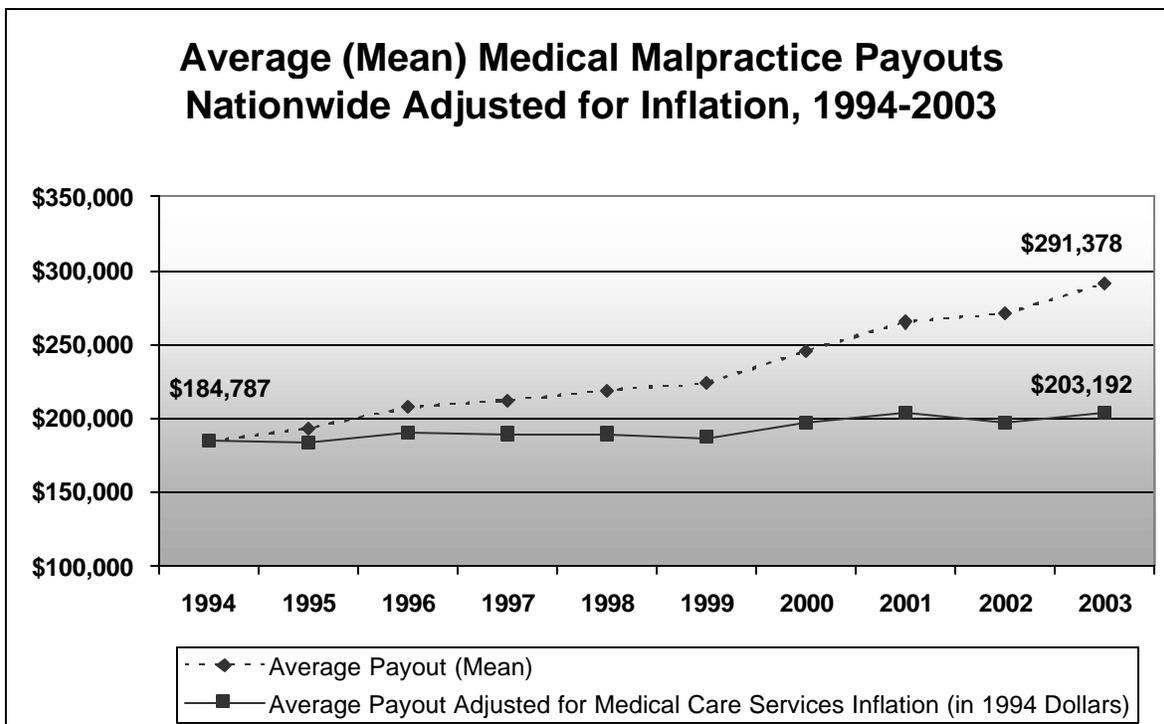
¹ The National Practitioner Data Bank, authorized by Congress and established by the Department of Health and Human Services, has collected nationwide information “relating to the professional competence and conduct of physicians, dentists and other health care practitioners” since September 1990. All insurers or health care providers paying medical malpractice judgments or settlements are required to report to the NPDB the amount of the payouts as well as information about the health care providers on whose behalf the payouts were made. General provisions of NPDB requirements are available on-line at: <http://www.npdb-hipdb.com/npdb.html>.

² *Examining the Work of State Courts, 2002*, National Center for State Courts, Court Statistics Project (2003).

Average Physician Medical Malpractice Payouts Have Increased Only 1 Percent a Year After Adjusting for Medical Services Inflation

Doctors and their lobbyists claim that payouts to survivors of medical malpractice are going through the roof. But that's not what has happened in the U.S. over the last decade.

- Malpractice payouts on behalf of doctors increased a modest 1.1 percent a year from 1994 to 2003 when adjusted for medical services inflation.** In 1994, the average medical malpractice payout in the U.S. was \$184,787, according to the NPDB. That amount climbed to \$291,378 by 2003, but when adjusted for medical services inflation the increase was only \$18,405, or 1.1 percent a year. Since the bulk of a malpractice payout customarily goes to cover medical expenses, the amount of payouts can be expected to rise along with the costs of medical services. In addition, since a malpractice payout also is intended to provide compensation for lost income over a patient's lifetime, payouts also can be expected to increase along with wages, productivity and life expectancy.
- The average malpractice payout on behalf of doctors remained flat during the so-called "crisis."** The average payout in 2001 was \$203,104 and the average payout in 2003 was \$203,192 after adjusting for medical services inflation.



Sources: National Practitioner Data Bank, Jan. 1, 1994 to Dec. 31, 2003; Bureau of Labor Statistics – Medical Care Services CPI-U.

Jury Verdicts Are not Rising

Doctors intent on taking away patients' legal rights regularly claim our system is based on "jackpot justice"—a bold attempt to mislead the public and promote harmful stereotypes. The fact is jury verdicts represent only about 7 percent of malpractice awards¹ and the award trend isn't even keeping pace with inflation.

- **Jury awards rose only 1.1 percent from 2000 to 2002.** Doctors regularly cite data from Jury Verdict Research (JVR), a private research firm, showing that jury awards rose 100 percent from 1997 to 2000, from \$503,000 to \$1 million.² Only time will tell if they cite updated figures showing that the median malpractice verdict rose from \$1 million in 2000 and 2001 to \$1,010,858 in 2002—an increase of only 1.1 percent.³ This increase did not even come close to keeping pace with medical services inflation. "From the jury-award median to the plaintiff recovery rate to the percentage of million-dollar awards, our med-mal statistics have remained relatively flat the last few years," said Jennifer Shannon, Jury Verdict Research managing editor. "It's safe to say the trend is no trend, according to our latest figures."⁴
- **There are significant limitations to Jury Verdict Research data that recommend not using this information.** Even though this report cites JVR data to counter misleading claims by doctors, Public Citizen does not recommend relying on JVR research. JVR's reported medians are not accurate indicators of the actual payouts received by victims of malpractice. JVR only collects jury *verdict* information that is reported to it by attorneys, court clerks and stringers. Other sources, such as the National Practitioner Data Bank or even the Physician Insurers Association of America Data Sharing Project, are more comprehensive because they include both verdicts *and* settlements. Ninety-three percent of all medical malpractice cases are settled,⁵ as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.

¹ Physician Insurer Association of America, PIAA Data Sharing Project, 2001 Ed.

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

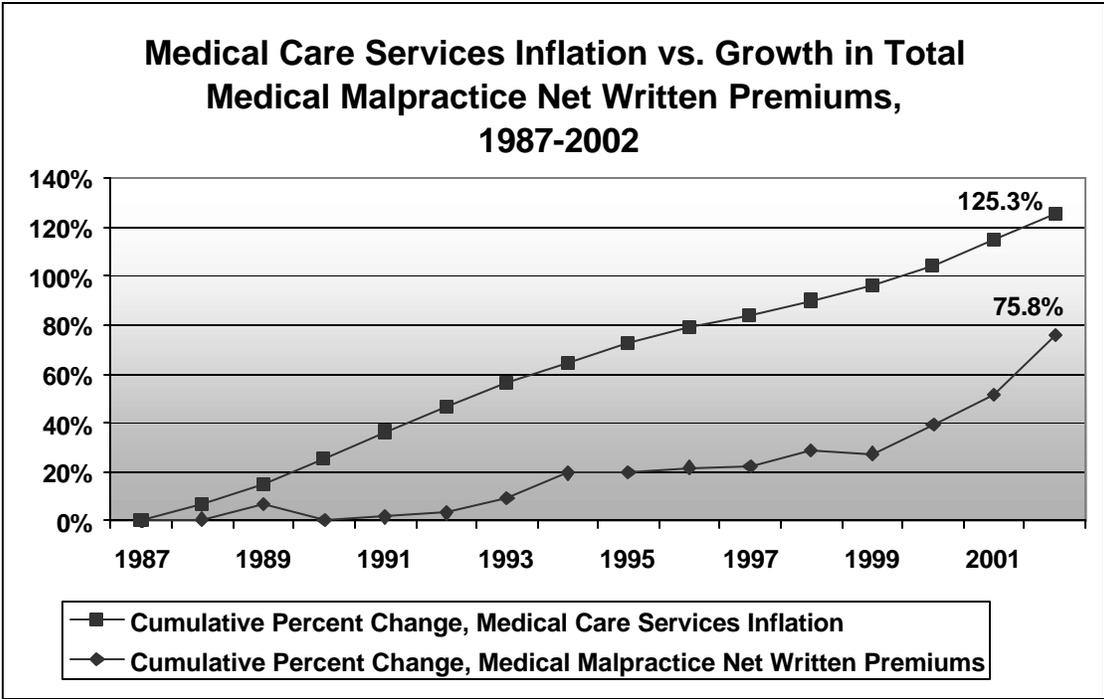
³ Jury Verdict Research News Release: "Medical Malpractice Jury Award Median Up Slightly; Overall Compensatory Award Down 30%" April 1, 2004.

⁴ *Id.*

⁵ Physician Insurer Association of America, PIAA Data Sharing Project, 2001 Ed.

Malpractice Insurance Costs Have Risen at Three-fifths the Rate of Medical Inflation

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.”¹ That comparison is misleading. The more appropriate comparison is to medical services inflation, which increases about 5 to 6 percent a year on average,² because the bulk of damage payouts go to pay medical bills. But while medical costs have increased 125 percent since 1987, the total amount spent by all health care providers on medical malpractice insurance has increased by 76 percent over that time.



Sources: Bureau of Labor Statistics – Medical Care Services CPI-U; Best’s Aggregates and Averages of Property Casualty, 2002.

The table on the following page provides year-by-year statistics on the rate of medical care services inflation and the growth in total malpractice net written premiums from 1987-2002.

Medical Care Services Inflation vs. Growth in Total Malpractice Net Written Premiums, 1987-2002

Year	CPI-U Index	Annual Percent Change	Cumulative Percent Change	Industry MedMal Net Written Premiums (000's)	Annual Percent Change	Cumulative Percent Change
1987	130.0	–	–	4,004,185	–	–
1988	138.3	6.4%	6.4%	4,027,825	0.6%	0.6%
1989	148.9	7.7%	14.5%	4,278,009	6.2%	6.8%
1990	162.7	9.3%	25.2%	4,014,622	-6.2%	0.3%
1991	177.1	8.8%	36.2%	4,067,803	1.3%	1.6%
1992	190.5	7.6%	46.5%	4,133,567	1.6%	3.2%
1993	202.9	6.5%	56.1%	4,370,812	5.7%	9.2%
1994	213.4	5.2%	64.2%	4,780,537	9.4%	19.4%
1995	224.2	5.1%	72.5%	4,800,552	0.4%	19.9%
1996	232.4	3.7%	78.8%	4,875,486	1.6%	21.8%
1997	239.1	2.9%	83.9%	4,892,496	0.3%	22.2%
1998	246.8	3.2%	89.9%	5,145,066	5.2%	28.5%
1999	255.1	3.4%	96.2%	5,104,093	-0.8%	27.5%
2000	266.0	4.3%	104.6%	5,586,584	9.5%	39.5%
2001	278.8	4.8%	114.5%	6,072,468	8.7%	51.7%
2002	292.9	5.0%	125.3%	7,043,043	15.9%	75.8%

Sources: Bureau of Labor Statistics – Medical Services CPI; Best's Aggregates and Averages of Property Casualty, 2002.

¹ Statement of Richard Anderson Before House Energy and Commerce Committee, July 17, 2002.

² Calculation based on Bureau of Labor Statistics – Medical Care Services CPI-U Index from 1987 – 2002.

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

- **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. Indeed, average Americans place a greater value on their own lives, as measured by the amount they spend on life insurance. From 1992 to 2002, the amount spent on individual life insurance premiums grew at an annual rate of 4.8 percent. It jumped by 11.2 percent from 2001 to 2002.¹
- **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 2000.² 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.³ 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.⁴ 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.⁵

¹ American Council of Life Insurance, *Life Insurers Fact Book 2003*

² Table H-7, Divisions—Households (All Races) by Median and Mean Income, 1976 to 2000, U.S. Census Bureau.

³ <http://www.ihrsa.org/industrystats/opbenchmarks.html>

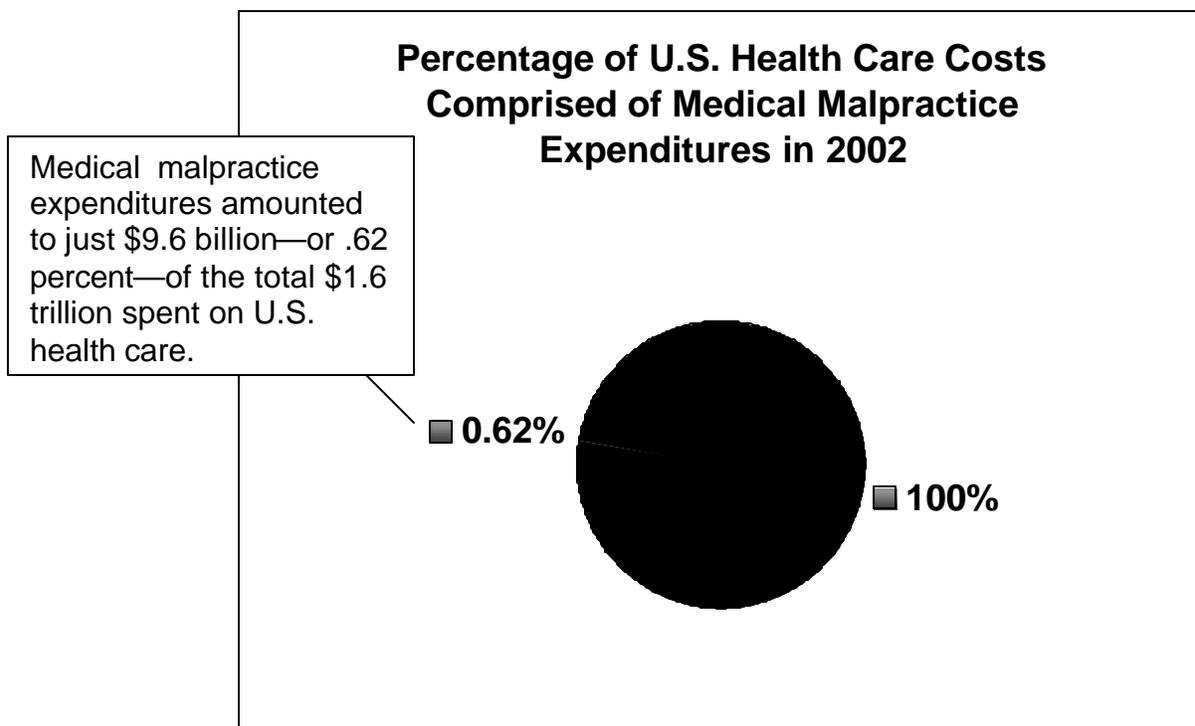
⁴ Table 12. Estimated life expectancy at birth in years, by race and sex, National Vital Statistics Report, Vol. 50, No. 6, March 21, 2002. www.cdc.gov

⁵ www.ssa.gov

Medical Malpractice Expenditures Comprise Less than 1 Percent of Overall Health Care Costs

Proponents of taking away patients' legal rights argue as if rising health care costs are being driven by medical malpractice costs. In fact, it's just the opposite—rising malpractice payouts are a result of large increases in health care costs.

- **Expenditures on medical liability comprise less than 1 percent of overall health care costs.** In January 2004, when the federal Centers for Medicare and Medicaid Services (CMS) actuaries released a 13-page report on the growth in health care expenditures, the subject of medical malpractice costs rated only an 11-word mention. That's probably because 2002 health care expenditures rose 9.3 percent to \$1.553 trillion.¹ Yet expenditures on malpractice premiums reported to the National Association of Insurance Commissioners (NAIC) that year were only \$9.6 billion – making malpractice costs about .62 percent of national health care expenditures.²



Source: Center for Medicare and Medicaid Services; National Association of Insurance Commissioners.

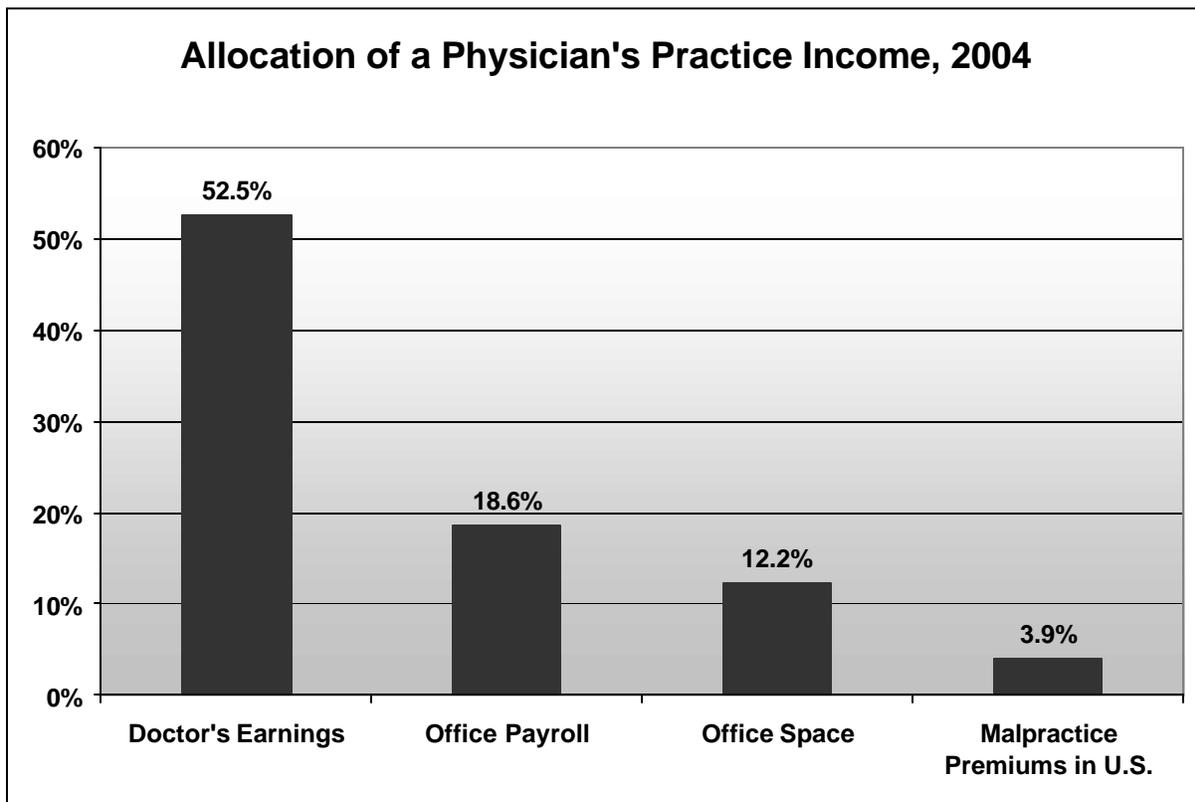
¹ Katharine Levit, Cynthia Smith, Cathy Cowan, Art Sensenig, Aaron Catlin and the Health Accounts Team, National Health Statistics Group, Office of the Actuary, Centers for Medicare and Medicaid Services, "Health Spending Rebound Continues in 2002," *Health Affairs*, Vol. 23, No. 1, January-February 2004.

² National Association of Insurance Commissioners, "Medical Malpractice Insurance Net Premium and Incurred Loss Summary," 2003 edition.

Malpractice Insurance Costs Comprise 3.9 Percent of a Physician's Practice Income

The federal government's Medicare program calculates that doctors retain the majority of their practice income as their own salaries and spend relatively little for malpractice insurance. The large difference between these two numbers undercuts claims that the cost of malpractice insurance is a major reason doctors feel financial pressures.

- **Doctors allocate 13 times more of their practice income for their own salaries than they pay in malpractice premiums.** According to the federal government's Medicare program, doctors nationally spend an average of 52.5 percent of their practice incomes on their own pay, about 31 percent on such overhead expenses as office payroll and rent, and only 3.9 percent on malpractice insurance.



Source: "Annual Percent Change in the Revised and Rebased Medicare Economic Index, 2004 – Cost Categories and Price Measures," Centers for Medicare and Medicaid Services (CMS), Nov. 7, 2003.

Doctors' Bottom Line not Affected by Malpractice Awards, According to New Earnings Data

Malpractice awards have no impact on doctors' net income, based on a comparison of the latest survey of physicians' earnings with medical malpractice payouts reported in 2002 to the National Practitioner Data Bank.

Public Citizen compared the average physician compensation in nine census regions to the amount of malpractice damages paid out per doctor in those regions. According to *Medical Economics* magazine's 2002 survey, physicians in the South earn the most—even though that region is home to eight of the American Medical Association's 19 malpractice "crisis states."¹

The disparity is most easily explained by the findings of an the Medicare Economic Index Update, that only 3.9 percent of doctors' gross income is spent on malpractice insurance premiums. Public Citizen found:

- Malpractice damages per physician are lowest (\$2,704) in the Pacific states, three of which, California, Alaska and Hawaii, place caps on non-economic damages. But while damage caps have drastically reduced recoveries for injured patients, doctors have not received a corresponding benefit. Median physician income in this region is just \$158,900, lower than in five other, more "litigious" regions. *Medical Economics* reported in 2003 that office expenses were highest in this region,² which suggests that Santa Monica's rent control ordinance, and not MICRA, might be a better California model for assisting financially-stressed doctors.
- Malpractice damages per physician are highest in the Middle Atlantic states of New York, Pennsylvania, and New Jersey (\$8,343). Yet doctors in these three "crisis" states earn an average of \$150,000—\$10,000 more than their neighbors in New England, where the malpractice payout per physician is *less than half* (\$4,164). Perhaps the difference can be attributed to doctors' payroll costs, which are \$10,000 lower, on average, in Mid-Atlantic states than in New England.
- Doctors' income is highest in the West South Central states (\$200,000), despite the fact that almost three-quarters of those doctors practice in the "crisis" states of Texas and Arkansas and despite a malpractice payout per physician of \$4,771, higher than in six other regions.
- Doctors' income is second highest in the East South Central states (\$190,900), despite "crises" in Kentucky and Mississippi and a malpractice payout per physician of \$3,781.
- Four of the West North Central states were featured in another *Medical Economics* article, titled "Malpractice Crisis? Not Here!"³ According to that article, jurors in states like South Dakota and Minnesota are among the most parsimonious. Perhaps they are equally parsimonious when paying bills, for in this region doctors' median income is only \$160,000, third lowest, despite also having the second lowest payout per physician (\$3,043).

- The region with the second highest payout per physician is the South Atlantic states (\$4,942). But while nearly two thirds of these doctors practice in “crisis” states, their median income of \$170,000 is surpassed by that of doctors in only three other regions.

Doctor Income vs. Per-Doctor Malpractice Payout*		
Region	Average Income (2002)	Malpractice Payout Per Doctor (2002)
NORTHEAST	\$150,000	
New England (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut)	\$140,000	\$4,164
Middle Atlantic (New York, New Jersey, Pennsylvania)	\$150,000	\$8,343
MIDWEST	\$161,000	
East North Central (Ohio, Indiana, Illinois, Michigan, Wisconsin)	\$175,000	\$4,513
West North Central (Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas)	\$160,000	\$3,043
SOUTH	\$180,000	
South Atlantic (Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida)	\$170,000	\$4,942
East South Central (Kentucky, Tennessee, Alabama, Mississippi)	\$190,900	\$3,781
West South Central (Arkansas, Louisiana, Oklahoma, Texas)	\$200,000	\$4,771
WEST	\$160,000	
Mountain (Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada)	\$170,000	\$3,059
Pacific (Washington, Oregon, California, Alaska, Hawaii)	\$158,900	\$2,704

* By region, as classified by the US Census Bureau.

Sources: Income figures are from the *Medical Economics* study “Physicians’ Earnings,” Sept. 19, 2003. Malpractice payout data is from an inquiry to the public use file of the National Practitioner Data Bank, divided by the number of doctors as reported by the American Medical Association.

¹ Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia and Wyoming. See “AMA Announces Wyoming as 19th Medical Liability Crisis State,” statement from the American Medical Association, July 9, 2003. Available at <http://www.ama-assn.org/ama/pub/article/9255-7865.html>.

² “Practice Expenses,” Nov. 7, 2003.

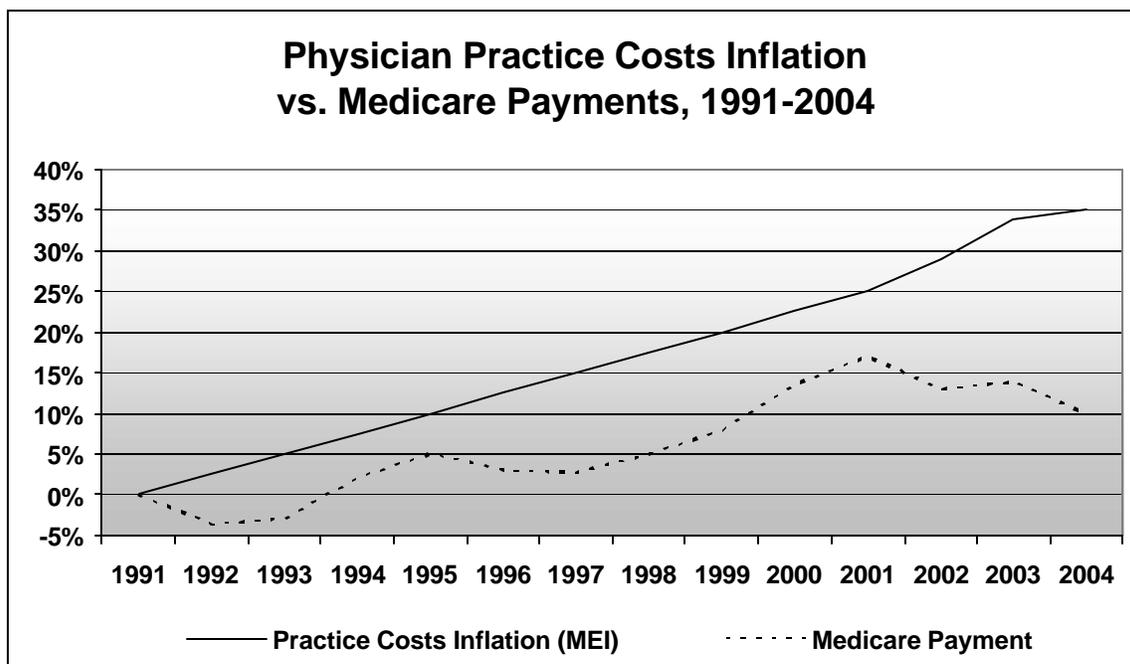
³ July 12, 2002 issue.

Reduced Fees – Not Insurance Rates – Are the Biggest Financial Burden on Doctors

Doctors across the country have seen their fees slashed in recent years as managed care companies tried to increase profits, and government programs, such as Medicare and Medicaid, tried to cut costs.

Medicare reimbursement rates no longer come close to keeping pace with increases in doctors' practice expenses. The AMA estimates that since 1991 physician practice costs have risen by 35 percent, but Medicare payments have risen only 10 percent. That means practice costs have risen two-and-a-half times the rate of Medicare payments.

This pressure on fees has contributed greatly to doctor stress and sensitivity to any increases in their practice costs. In fact, the long-term reduction in fees paid to doctors represents a much more significant burden than the recent, temporary spike in malpractice insurance rates. The tort system is a convenient whipping boy for doctors who will continue to chafe from cost containment measures, but survivors of medical negligence should not be made to compensate for declining reimbursement rates

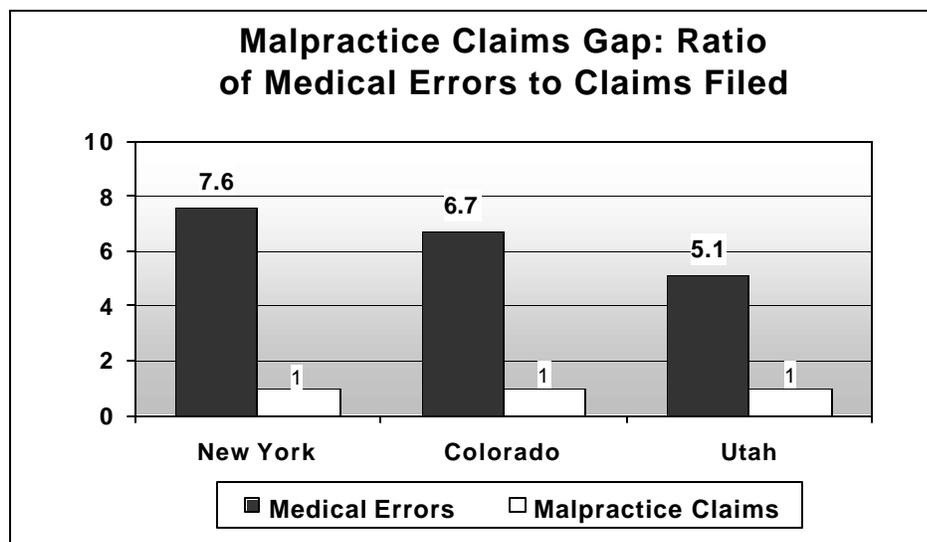


Sources: American Medical Association Website, based on physician practice cost inflation (Medicare Economic Index – MEI) all years, Centers for Medicare and Medicaid Services (CMS); 1992-97 payments, Physician Payment Review Commission; 1998-2003 payments, American Medical Association; 2004 projections, CMS.

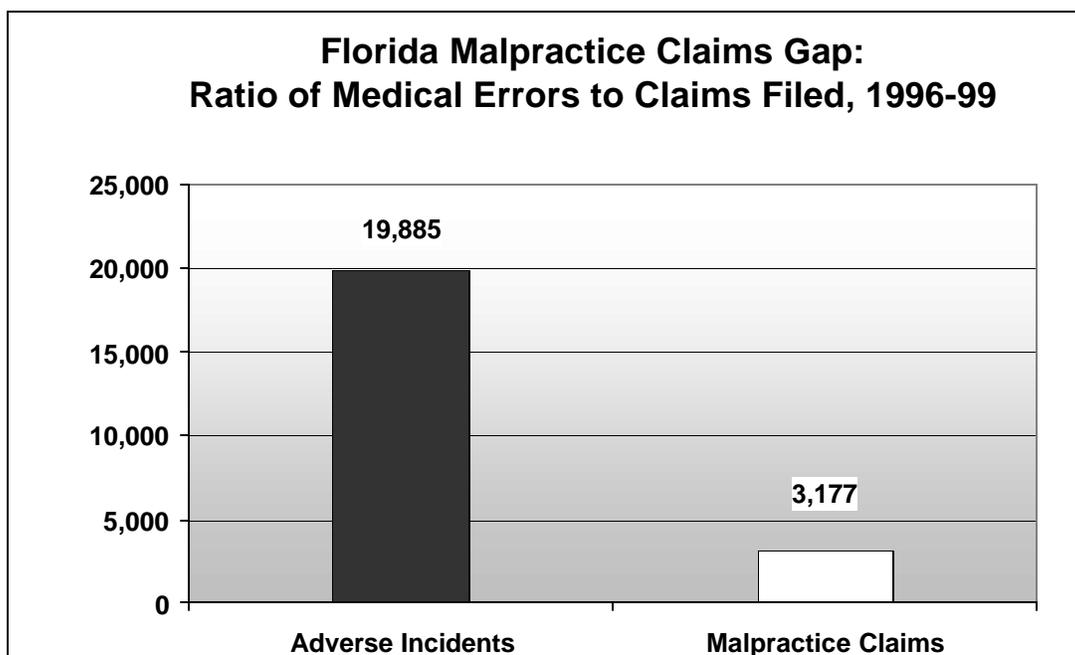
Rather than Facing “Runaway Litigation,” Doctors Benefit from a Claims Gap

There is convincing evidence from around the nation that the majority of patients who suffer injuries from medical malpractice never file lawsuits.

- **A 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 7.6 instances of medical negligence committed in hospitals results in a malpractice claim.¹ Researchers replicating this study made similar findings in Colorado and Utah.²
- **Florida’s health agency shows 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 the filing of new malpractice claims. From 1996 through 1999 (the most recent year for which complete data is available³), Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims.⁴ In other words, for every six preventable medical errors only one claim is filed.



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.

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 Although the number of reported adverse incidents is available through 2001, the number of reported new malpractice claims is available only through 1999.

http://www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/Risk/statistics.shtml

⁴ 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."

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

In many states, when questions about malpractice “reform” arise, doctors and their lobbyist’s claim that a fear of litigation has prompted physicians to perform additional medical tests – resulting, they say, in higher costs and risks to patients. A search of studies and scholarly literature, however, finds no empirical evidence that doctors are actually practicing this sort of “defensive” medicine:

- **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. 5. This bill, which contained very stringent restrictions on patients’ ability to recover damages, passed the U.S. House in 2003. 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. ...[U]sing a different data set, CBO could find no statistically significant difference in per capita health care spending between states with and without malpractice tort limits.¹

- **The General Accounting Office has rejected the defensive medicine theory.** Medical provider groups admitted to GAO investigators that “factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures.” For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can mitigate

defensive practices. According to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit.”²

A 1996 study by two economists has been cited by the Bush Administration to argue that tort “reform” will yield a 5 to 9 percent savings in health care costs from decreased defensive medicine. “However,” said the GAO, “this study did not control for other factors that can affect hospital costs, such as the extent of managed care penetration in different areas. When controlling for managed care penetration in a 2000 follow-up study, the same researchers found that the reductions in hospital expenditures attributable to direct tort reforms dropped to about 4 percent. Moreover, preliminary findings from a 2003 study [by CBO] that replicated and expanded the scope of these studies to include Medicare patients treated for a broader set of conditions failed to find any impact of state tort laws on medical spending.”³

- **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 2001.⁴ There were nine such instances in Florida in 2001.⁵ 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.⁶ 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.”⁷
- **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.⁸ Studies indicate 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.”⁹ 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”?¹⁰ Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.¹¹

- **Defensive medicine hasn’t caused hospitals to keep nursing staffs up-to-strength.** Two reports published in the past 6 months concluded that patients in hospitals where nurses had heavier workloads had a higher risk of dying.¹² One report found specifically that each additional patient per nurse corresponded to a 7 percent increase in both patient mortality and deaths following complications.¹³ Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts.

¹ Congressional Budget Office, Cost Estimate for H.R. 5, HEALTH Act of 2003, ordered by the House Committee on the Judiciary, submitted March 10, 2003.

² United States General Accounting Office, Report GAO-03-836, “Medical Malpractice: Implications of Rising Premiums on Access to Health Care,” p. 27, August 2003. Available on-line at: <http://www.gao.gov/new.items/d03836.pdf>.

³ *Id.*, p. 29.

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 Barker et al, “Medication Errors Observed in 36 Health Care Facilities,” 162 *Arch Intern Med.* 1897, 2002.

⁷ Bates et al, “The Costs of Adverse Drug Events in Hospitalized Patients,” 277 *JAMA* 307, 1997.

⁸ Moss, “Spotting Breast Cancer: Doctors Are Weak Link,” *New York Times*, June 27, 2002.

⁹ 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.”

¹⁰ *Id.*

¹¹ U.S. Department of Health and Human Services, “Confronting the New Health Care Crisis,” July 24, 2002.

¹² J. Needleman, P. Buerhaus, S. Mattke, M. Stewart, K. Zelevinsky, “Nurse-Staffing Levels and the Quality of Care in Hospitals,” *New England Journal of Medicine*, 2002; 346:1715-1722, May 30, 2002. Also: L.H. Aiken LH, S.P. Clarke, D.M. Sloane et al., “Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction,” *JAMA*, 2002;288:1987-1993, Oct. 23/30, 2002.

¹³ *Id.*

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 spent 88 cents of each premium dollar on defense lawyers.³
- **Malpractice insurance defense costs far exceed defense costs in other lines of insurance.** According to National Association of Insurance Commissioners (NAIC) figures for 2000, defense costs incurred as a portion of direct premiums written amounted to 4.8 percent for passenger auto liability, 7.1 percent for commercial auto liability, 16.5 percent for commercial general liability, and 28.9 percent for product liability.⁴ 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.⁵
- **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.⁶ 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.”⁷ 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.⁸

- **According to Physician Insurer Association of America figures, even after accounting for inflation, the average payment to defense lawyers per malpractice claim ballooned from \$11,000 in 1985 to more than \$26,000 in 2001.**⁹ Whether the reason is higher hourly fees charged by the lawyers or more hours being devoted to each claim, the trend clearly represents greater resources being thrown in to defending claims. Meanwhile, a 2004 *Legal Times* article documents how in-house counsel have abandoned efforts to rein in the legal fees they pay to defense lawyers.¹⁰ At the end of the 1990s, insurers began auditing defense lawyers' bills and using billing codes to compare different law firms' efficiency. But, according to the article, these methods have been abandoned. Insurers found fee auditing to be "too disruptive to their relationship with outside counsel." Comparisons of billing codes were deemed too much effort and data remained in drawers never to be studied. Rather than trying new techniques to reduce their legal expenses, insurers have focused solely on reducing compensation to victims.
- **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 University 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."¹¹

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

² Id.

³ Office of the West Virginia Insurance Commission, *Medical Malpractice: Report on Insurers with over 5% Market Share*, November 2002.

⁴ National Association of Insurance Commissioners, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001).

⁵ 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>

⁶ See <http://www.thedoctors.com/resources/I-27/DocBrochure/Protectdoc4-5.html>, <http://www.medicalassurance.com>

⁷ <http://www.kammco-msc.com>

⁸ 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.

⁹ Physician Insurers Association of America, *Cumulative Data Sharing Report*, January 1, 1985 – December 31, 2001.

¹⁰ Krysten Crawford, "When Good Ideas Go Bad," *Legal Times*, April 19, 2004.

¹¹ Merritt and Barry, "Is the Tort System in Crisis? New Empirical Evidence," 60 *Ohio St. L. J.* 315 (1999).

Few Malpractice Lawsuits Are “Frivolous”

Proponents of tort limits have claimed that medical liability insurance will become affordable only if action is taken against so-called “abusive” lawsuits filed by patients. They make comments about “frivolous lawsuits” and “junk lawsuits” in their efforts to promote a federal medical malpractice bill that would place caps on pain-and-suffering awards to injured patients.¹

In reality, 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 \$25,000.² If the case goes to trial, the costs can easily be doubled.³ 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.⁴ 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.
- **The small numbers 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.⁵ 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 "Remarks by the President on Medical Liability Reform," University of Scranton, Scranton, Pa., Jan. 16, 2003.

Transcript at: <http://www.whitehouse.gov/infocus/medicalliability/>

² Based on Public Citizen interviews with plaintiff attorneys.

³ N. Vidmar, *Medical Malpractice and the American Jury*, 1995.

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

⁵ Posner et al, "Variation in Expert Opinion in Medical Malpractice Review," 85 *Anesthesiology* 1049, 1996.

Section II

The Insurance Cycle Is the Real Cause of Medical Malpractice Premium Spikes

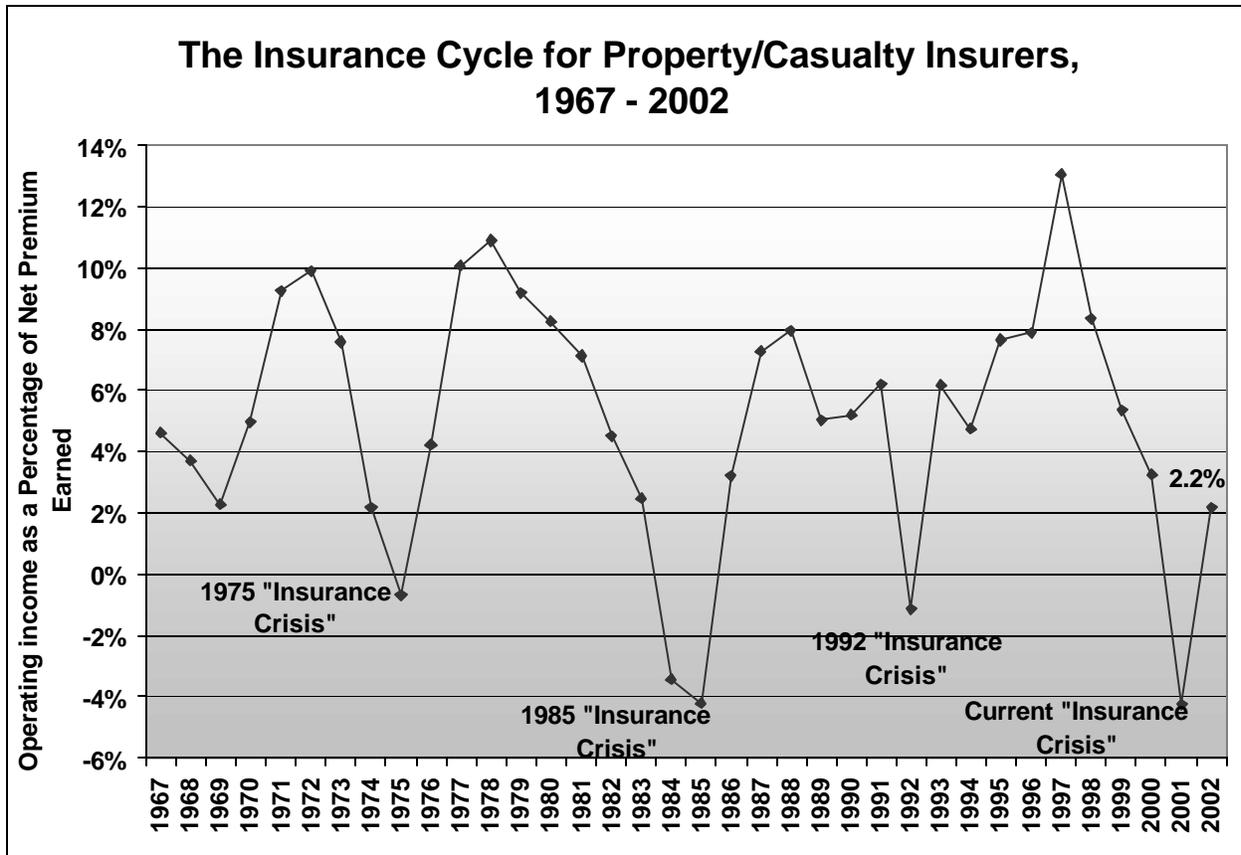
Medical Liability Premium Spike Was Caused by the Insurance Cycle and Mismanagement, Not the Legal System

Although the AMA and its ideological allies insist that patient litigation has triggered a medical malpractice insurance “crisis,” government agencies and experts in the insurance field largely attribute the temporary spike in the cost of malpractice insurance to a decade of under-pricing by carriers and a downturn in the U.S. economy since 2000. Recent industry profitability reports show the property/casualty insurance industry, of which medical liability is one line of business, to be on the rebound.

- **Downturns in the insurance cycle have occurred four times in the last three decades.** 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.

In 2001, the current market began to decline or “harden”, following an unusually prolonged period of health, called a “soft market,” in the property-casualty insurance line 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.¹

- **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.² 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.



Source: A.M. Best's Aggregates & Averages, Property/Casualty, page 349, 2003 Edition.

- Congressional Budget Office links rising premiums to insurance company investment losses.** In January 2004, the non-partisan Congressional Budget Office noted that the 15 biggest medical malpractice insurers saw their investment returns drop by 1.6 percent from 2000 through 2002. “That figure corresponds to almost half of the 15 percent increase in [medical malpractice premium] rates estimated by the Centers for Medicare and Medicaid Services,” the CBO reported.³
- 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.”⁴
- Financial analysts recognize the true cause of premium spikes.** Weiss Ratings, the “leading independent provider of ratings and analyses of financial services companies, mutual funds, and stocks,” reports that, “Tort reform has failed to address the problem of surging

medical malpractice premiums, despite the fact that insurers have benefited from a slowdown in the growth of claims... The escalating medical malpractice crisis will not be resolved until the industry and regulators address the other, apparently more powerful, factors driving premiums higher.”⁵ According to Weiss, six factors driving increases in medical malpractice rates are:

- **Medical cost inflation:** Medical costs have risen 75 percent since 1991.
 - **The cyclical nature of the insurance market:** In an attempt to catch up, insurers have tightened underwriting standards and raised premiums.
 - **The need to shore up reserves for policies in force:** The only way to shore up reserves is to increase premiums.
 - **A decline in investment income:** This is particularly critical for lines of business like medical malpractice, in which the duration of claims payouts typically spans several years.
 - **Financial safety:** To restore their financial health, many medical malpractice insurers will remain under pressure to increase rates.
 - **The supply and demand for coverage:** The number of medical malpractice carriers increased nationally through 1997 to 274, but has since fallen to 247 in 2002.
- **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.”⁶ 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.”⁷
 - **West Virginia Insurance Commissioner blames the market.** According to the Office of the West Virginia Insurance Commission (one of the states battered by a so-called medical malpractice “crisis” in 2002 and 2003), “[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.”⁸
 - **Missouri Insurance Director says “tort reform” won’t relieve financial pressure on doctors.** In a February 2003 report on medical malpractice insurance, the director of Missouri’s Department of Insurance concluded that “further ‘tort reforms’ will not provide relief to financially distressed physicians for several years, if at all.” His report also found that

“[p]hysicians are hard-pressed to absorb increased malpractice insurance costs when they have limited ability to pass on those expenses to managed care companies and government programs.”⁹

- **The American Medical Association 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.”¹⁰

“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 percent in 1999, up from a more typical 3 percent 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 percent from the high point in 1998, according to the A.M. Best Company, one of the most comprehensive sources of insurance industry data.”¹¹

¹ “Hot Topics & Insurance Issues,” Insurance Information Institute, www.iii.org

² Americans for Insurance Reform, “Medical Malpractice Insurance: Stable Losses/Unstable Rates,” Oct. 10, 2002.

See also: <http://www.insurance-reform.org/StableLosses.pdf>.

³ Congressional Budget Office, “Limiting Total Liability for Medical Malpractice,” Jan. 8, 2004.

⁴ Charles Kolodkin, “Medical Malpractice Insurance Trends? Chaos!” International Risk Management Institute. <http://www.irmi.com/expert/articles/kolodkin001.asp>

⁵ “Medical Malpractice Caps Fail to Prevent Premium Increases, According to Weiss Ratings Study,” at www.businesswire.com, June 2, 2003.

⁶ Christopher Oster and Rachel Zimmerman, “Insurers’ Missteps Helped Provoke Malpractice ‘Crisis,’” *Wall Street Journal*, June 24, 2002.

⁷ Charles Kolodkin, Gallagher Healthcare Insurance Services, “Medical Malpractice Insurance Trends? Chaos!” September 200, available at <http://www.irmi.com/expert/articles/kolodkin001.asp>.

⁸ “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.

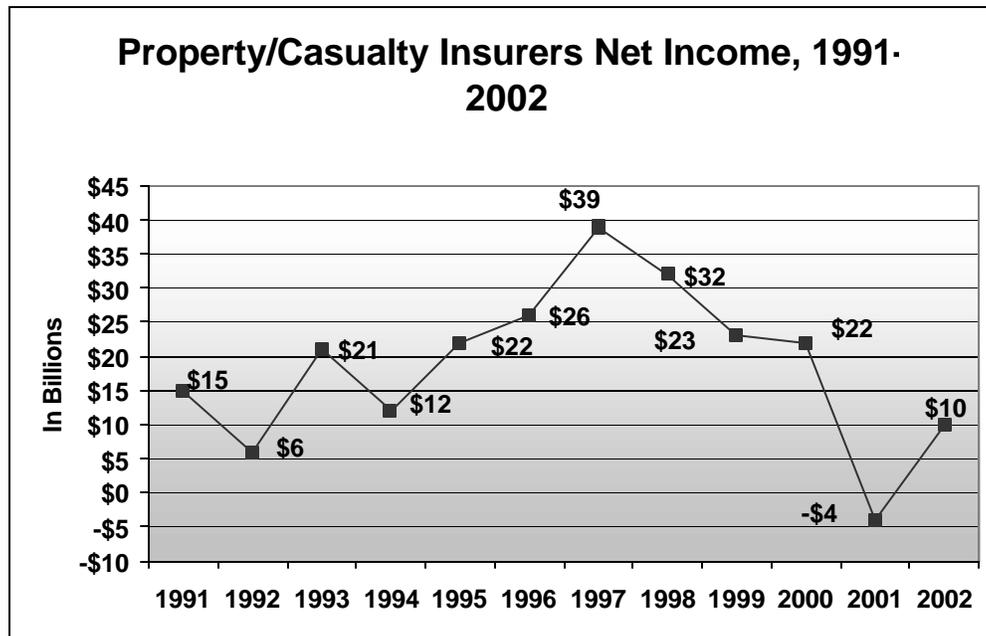
⁹ Scott B. Larkin, “Medical Malpractice Insurance in Missouri: The Current Difficulties in Perspective,” Missouri Department of Insurance, February 2003.

¹⁰ American Medical Association Report 35 of the Board of Trustees, at <http://www.ama-assn.org/ama1/upload/mm/annual02/bot35a02.rtf>.

¹¹ *Id.*

The End of the “Hard” Insurance Market Is in Sight

- **Insurers returned to profitability in 2002, indicating that the hard market bottomed out in 2001.** According to the National Association of Insurance Commissioners, property/casualty insurers, which includes the medical malpractice line of insurance, posted a net loss in 2001 but began a rebound in 2002.



Source: National Association of Insurance Commissioners, Statistical Compilations of 2000 and 2004.

- **U.S. property/casualty insurers’ profits increased dramatically in 2003.** U.S. property/casualty insurers’ profits surged to \$29.9 billion in 2003, according to the Insurance Services Office Inc. and the Property Casualty Insurers Association of America. Net written premiums in the industry increased 9.8 percent, to \$405.9 billion. In addition, the industry’s statutory surplus increased 21.6 percent to \$347 billion at year-end 2003. These remarkable gains were achieved in spite of catastrophe losses that more than doubled in 2003.¹
- **U.S. property/casualty insurers’ return on equity is likely to soar in 2004.** According to the Insurance Information Institute, return on equity in 2004 is likely to soar above double digits for the first time since 1997 because underwriting performance is expected to continue to improve and the investment environment should allow for the realization of significant capital gains as well as higher investment yields on the industry’s bond portfolio.²

¹ Judy Greenwald, “Insurer Profits Soar in 2003,” *Business Insurance*, April 14, 2004.

² Insurance Information Institute, “Special Report: Groundhog Forecast 2004,” February 2, 2004. <http://www.iii.org/media/industry/financials/groundhog>.

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 the awards paid to catastrophically injured patients. But because such 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.

National

“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

California

“I don't like to hear insurance-company executives say it's the tort [injury-law] system – it's self-inflicted,” – Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California⁴

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. (formerly Florida Physicians Insurance Company, Inc). The company is the largest medical malpractice insurer in Florida and has close ties to the Florida Medical Association⁵

Illinois

“There's a real question as to whether a cap on damages has a relationship to premiums... There doesn't seem to be a lot of evidence that supports a correlation between caps and premiums.” – Leo Jordan, retired vice president and counsel for Illinois-based State Farm Insurance Companies and past chair of the American Bar Association's Tort Trial and Insurance Practice Section⁶

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 Mississippi⁷

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.” – Coffin is the Account Representative for SCW Agency Group – Nevada, which represents the American Physicians Assurance Corp.⁸

“[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 Issues⁹

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.”¹⁰

Financial analysis shows malpractice award “caps” would have little impact on the premiums doctors pay. In an analysis requested by the Medical Society of New Jersey, actuaries estimate that a “cap” on non-economic damages in malpractice cases would have only a slight impact on the amount doctors pay in liability premiums. “We would expect a \$250,000 cap on non-economic damages would produce some savings, perhaps in the 5 percent to 7 percent range,” the firm of Tillinghast-Towers Perrin reports. “A cap of \$500,000 is likely to be of very little benefit to physicians.”¹¹

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 Company¹²

“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 Assurance¹³

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 Committee¹⁴

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- 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 Rachel Zimmerman and Christopher Oster, “Assigning Liability: Insurers’ Missteps Helped Provoke Malpractice ‘Crisis’; Lawsuits Alone Didn’t Cause Premiums to Skyrocket; Earlier Price War a Factor,” *The Wall Street Journal*, June 24, 2002.
- ⁵ Phil Galewitz, “Underwriter Gives Doctors Dose of Reality,” *The Palm Beach Post*, January 29, 2003 and Mike Salinero, “Insurers Tied To Florida Doctors,” *The Tampa Tribune*, March 22, 2003.
- ⁶ Leo Jordan, *Chicago Lawyer*, November 2003.
- ⁷ Julie Goodman, “Premiums Rise by 45 Percent; Insurance Group’s Hike Comes as Doctors Seek Relief,” *Clarion-Ledger* (Jackson, Miss.), September 22, 2002.
- ⁸ Joelle Babula, “Obstetricians Say Problems Remain,” *The Las Vegas Review-Journal*, October 1, 2002.
- ⁹ “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.
- ¹⁰ “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.
- ¹¹ “Review of Proposed Legislation,” by James D. Hurley and Gail E. Tverberg, Tillinghast-Towers Perrin, Atlanta, sent to Ray Cantor, director of governmental affairs, Medical Society of New Jersey, Jan. 7, 2003.
- ¹² “No Drop in Malpractice Rates Pending,” *The Associated Press*, January 10, 2003.
- ¹³ “No Drop in Malpractice Rates Pending,” *The Associated Press*, January 10, 2003.
- ¹⁴ Testimony at the Wyoming Legislature’s Joint Labor, Health and Social Services Interim Committee, December 4-6, 2002.

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:¹

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.**

¹ J. Robert Hunter, “Action Required by Insurance Commissioners to Regulate Insurance Industry,” Americans for Insurance Reform, July 30, 2002.

Section III

The Real Medical Malpractice Crisis Is Inadequate Patient Safety

Patients Need Protection from an Epidemic of Medical Errors and Unsafe Practices in Medicine

- **Tens of thousands of Americans—and perhaps as many as 195,000—die each year due to preventable medical errors.** In 1999, the Institute of Medicine (IOM) shocked Americans by estimating that between 44,000 and 98,000 patient deaths are caused each year by preventable medical errors.¹ The IOM extrapolated that figure from two reviews of randomly sampled hospital records conducted by the Harvard Medical Practice Study. The IOM then estimated the cost to our economy of those deaths at between \$17 billion and \$29 billion annually. Doctors immediately protested that the sample sizes were too small, and the reviewers' judgments too subjective, to make the estimates accurate. Yet subsequent to the Institute of Medicine's estimates, two more research teams—using much larger data samples and incorporating hospitals' own characterizations of factors leading to patients' deaths—also concluded that medical errors leave a death toll in the tens of thousands each year.
- **JAMA: 32,591 preventable deaths, 2.4 million extra days of hospitalization, and \$9.3 billion excess hospital charges in this country every year.**² An October 2003 study of common medical complications reported in the *Journal of the American Medical Association*, analyzed the discharge summaries of 7.4 million patient medical records at 994 hospitals in 28 states in 2000, which represents approximately 20 percent of U.S. hospitals. Researchers Zhan and Miller said, “Our estimates cover only selected types of medical injuries that were discovered during hospitalization and were recorded as ICD-9-CM codes. Nevertheless, our estimates clearly support the Institute of Medicine's contention that medical injuries are a serious epidemic confronting our health care system.” The authors concluded, “Our results clearly show that medical injuries in hospitals pose a significant threat to patients and incur substantial costs to society” and demonstrate the need “to develop strategies to prevent medical injuries.”
- **Health Grades: An average of 195,000 people in the U.S. died due to potentially preventable, in-hospital medical errors in each of the years 2000, 2001 and 2002.**³ The July 2004 HealthGrades Study finds nearly double the number of deaths from medical errors as found by the 1999 IOM report *To Err is Human*. Whereas the IOM and JAMA reports looked at samples of patient records, the HealthGrades study reviewed three years of Medicare data covering *all* its enrollees' hospital discharges in *all* 50 states. This Medicare population represents about 45 percent of all hospital admissions in the country. Extrapolating to the nation as a whole, the authors calculated that over those three years “an extra \$19 billion was spent in patient costs and over 575,000 preventable deaths occurred, as a direct result of the 2.5 million patient safety incidents that occurred in U.S. hospitals from 2000 through 2002.” According to the authors, “The economic consequence of patient safety incidents is staggering and makes the strongest business case for quality to date.”

¹ Institute of Medicine, *To Err is Human* (1999).

² Zhan, Chunliu, Miller, Marlene R., “Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization,” *Journal of the American Medical Association*, 2003;290:1868-1874.

³ *Patient Safety in American Hospitals*, study released by HealthGrades, July 2004.

- **Medical journals, state reporting systems and news accounts document continuing, widespread inattention to 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.”¹

Medication errors. A 2002 study 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.² 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 2001.³ (There were nine such instances in Florida in 2001.⁴) 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.”

Tools left in patients. According to a 2003 study published in the *New England Journal of Medicine*, operating room teams around the country leave sponges, clamps and other tools inside about 1,500 patients every year.⁵ The researchers checked insurance records from about 800,000 operations in Massachusetts for 16 years ending in 2001. They counted 61 forgotten pieces of surgical equipment in 54 patients. From that, they extrapolated a national figure of 1,500 cases yearly. The study found that surgical teams failed to count equipment before and after the operation, as required by standard practice, in one-third of cases where something was left behind.

- **The resources devoted to preventing medical errors are disproportionate to their toll in lives.** Deaths attributable to preventable medical errors in hospitals each year exceed those caused by breast cancer and AIDS. Yet while the federal government spent \$655 million on breast cancer prevention in 2003⁶ and \$3.5 billion on AIDS prevention in 2001,⁷ only about \$130 million was committed in 2002, for the first time, for improving patient safety.⁸
- **Physicians’ cavalier attitudes toward medical errors are out of step with public opinion.** In 2002, the *New England Journal of Medicine* released a survey of physicians and the public on the issue of medical errors.⁹ On each of these issues, doctors were in significant disagreement with the public and the experts. 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.

- **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 to that medication, 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.

¹ 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."

² Barker et al, "Medication Errors Observed in 36 Health Care Facilities," 162 *Arch Intern Med*. 1897 (2002).

³ Chassin & Becher, "The Wrong Patient," 136 *Ann Intern Med*. 826 (2002).

⁴ Agency for Health Care Administration, *Risk Management Reporting Summary*, March 2002.

⁵ Patient Safety Risk Factors for Retained Instruments and Sponges after Surgery, Gawande A.A., et al. *N Engl J Med* 2003, 348: 229-235, January 16, 2003.

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).

Patients and Consumers Suffer the Real Costs of Medical Malpractice

The true impact of medical malpractice should be measured by the cost to patients and consumers, not the premiums paid by doctors and other health care providers to their insurance companies. According to the Institute of Medicine (IOM), there are at least 44,000 to 98,000 deaths in hospitals each year that are due to preventable medical errors. The cost resulting from preventable medical errors to patients, families and communities is estimated at \$17 billion to \$29 billion each year. But the cost of medical malpractice insurance to health care providers is only \$9.6 billion a year—about half the minimum costs to society of preventable medical errors.

The Real Cost of Medical Malpractice to Patients and Consumers v. Health Care Providers

44,000 – 98,000

Annual Deaths Due to Preventable Medical Errors in Hospitals

\$17 billion – \$29 billion

Annual Costs Resulting from Preventable Medical Errors in Hospitals

\$9.6 billion

Cost of Health Care Providers' Annual Medical Malpractice Premiums (2003)

Sources: Preventable deaths and costs are prorated based on population and based on estimates in *To Err Is Human*, Institute of Medicine, November 2000. Doctors' Malpractice Premiums from the *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2002*, National Association of Insurance Commissioners, 2003.

State-by-State “Costs” of Medical Malpractice to Patients and Consumers vs. Health Care Providers

As the 1999 Institute of Medicine report To Err is Human found, preventable medical errors in hospitals result in 44,000 to 98,000 deaths each year and cost society \$17 billion to \$29 billion each year. The costs resulting from preventable medical errors in hospitals each year are so high that they far exceed the costs of annual medical malpractice premiums paid by doctors, hospitals and other medical providers. The table below compares all of these costs, prorated on a state-by-state basis.

State	Annual Preventable Deaths in Hospitals Due to Medical Errors	Annual Costs Resulting from Preventable Medical Errors in Hospitals (Millions)	Health Providers' Medical Malpractice Premiums Paid in 2002 (Millions)
Alabama	695 – 1,549	\$269 – \$458	\$130.7
Alaska	98 – 218	\$38 – \$65	\$16.1
Arizona	802 – 1,787	\$310 – \$529	\$204.4
Arkansas	418 – 931	\$161 – \$275	\$59.2
California	5,296 – 11,795	\$2,046 – \$3,490	\$797.5
Colorado	672 – 1,498	\$260 – \$443	\$117.2
Connecticut	532 – 1,186	\$206 – \$351	\$158.9
Delaware	123 – 273	\$47 – \$81	\$24.2
District of Columbia	89 – 199	\$35 – \$59	\$38.3
Florida	2,499 – 5,566	\$965 – \$1,647	\$825.1
Georgia	1,280 – 2,851	\$495 – \$844	\$315.9
Hawaii	189 – 422	\$73 – \$125	\$37.4
Idaho	202 – 451	\$78 – \$133	\$27.2
Illinois	1,942 – 4,325	\$750 – \$1,280	\$556.0
Indiana	951 – 2,117	\$367 – \$627	\$88.2
Iowa	458 – 1,019	\$177 – \$302	\$72.0
Kansas	420 – 936	\$162 – \$277	\$66.2
Kentucky	632 – 1,407	\$244 – \$416	\$124.1
Louisiana	699 – 1,556	\$270 – \$461	\$95.9
Maine	199 – 444	\$77 – \$131	\$40.1
Maryland	828 – 1,844	\$320 – \$546	\$209.6
Massachusetts	993 – 2,211	\$384 – \$654	\$239.1
Michigan	1,554 – 3,461	\$600 – \$1,024	\$227.5
Minnesota	769 – 1,713	\$297 – \$507	\$68.2
Mississippi	445 – 991	\$172 – \$293	\$63.4
Missouri	875 – 1,948	\$338 – \$577	\$205.0
Montana	141 – 314	\$54 – \$93	\$30.9
Nebraska	268 – 596	\$103 – \$176	\$26.5
Nevada	312 – 696	\$121 – \$206	\$81.0
New Hampshire	193 – 430	\$75 – \$127	\$36.4
New Jersey	1,316 – 2,930	\$508 – \$867	\$415.8
New Mexico	284 – 633	\$110 – \$187	\$39.7

State	Preventable Deaths Due to Medical Errors Each Year	Costs Resulting from Preventable Medical Errors Each Year (Millions)	Doctors' Medical Malpractice Premiums Paid in 2002 (Millions)
New York	2,967 – 6,608	\$1,146 – \$1,955	\$1079.0
North Carolina	1,259 – 2,803	\$486 – \$829	\$220.3
Ohio	1,775 – 3,954	\$686 – \$1,170	\$460.5
Oklahoma	540 – 1,202	\$208 – \$356	\$97.6
Oregon	535 – 1,191	\$207 – \$353	\$86.8
Pennsylvania	1,920 – 4,277	\$742 – \$1,266	\$499.0
Rhode Island	164 – 365	\$63 – \$108	\$33.0
South Carolina	627 – 1,397	\$242 – \$413	\$38.2
South Dakota	118 – 263	\$46 – \$78	\$15.3
Tennessee	890 – 1,981	\$344 – \$586	\$291.8
Texas	3,260 – 7,261	\$1,260 – \$2,149	\$633.6
Vermont	95 – 212	\$37 – \$63	\$18.7
Virginia	1,107 – 2,465	\$428 – \$729	\$181.4
Washington	922 – 2,053	\$356 – \$607	\$198.9
West Virginia	283 – 630	\$109 – \$186	\$91.9
Wisconsin	839 – 1,868	\$324 – \$553	\$82.3
Wyoming	77 – 172	\$30 – \$51	\$18.3
Total Premiums Paid			\$9.6 Billion

Sources: The range of deaths and costs resulting from preventable 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 for Medicine, 2000. Doctors' Malpractice Premiums from the *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2002*, National Association of Insurance Commissioners, 2003.

5.4 Percent of Doctors Are Responsible for 56.2 Percent of Medical Malpractice Payouts

The insurance and medical communities argue that medical malpractice 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 rigged, because some doctors’ numbers come up more often than others. According to the federal government’s National Practitioner Data Bank, a small percentage of doctors have paid multiple claims, and it is these doctors who are responsible for much of the malpractice committed in America.

- Just 5.4 percent of doctors have been responsible for 56.2 percent of all malpractice payouts to patients, according to NPDB data from September 1990 through 2003. Each of these doctors has made at least two payouts.
- Even more surprising, just 2 percent of doctors, each of whom has made three or more malpractice payouts, were responsible for 31.1 percent of all payouts.
- Only 0.9 percent of doctors, each of whom has made four or more malpractice payouts, were responsible for 18.8 percent of all payouts.
- 83 percent of doctors have never made a medical malpractice payout since the NPDB was created in 1990.

Number and Amounts of Medical Malpractice Payouts to Patients Paid by Doctors, 1990-2003

Number of Payout Reports	Number of Doctors Who Made Payouts	Total Number of Payouts	Percent/Total Doctors (736,264)*	Percent of Total Number of Payouts	Total Amount of Payouts
All	125,496	196,342	17.0	100.0	\$42,691,477,500
1	86,030	86,030	11.7	43.8	18,408,668,500
2 or more	39,466	110,312	5.4	56.2	24,282,809,000
3 or more	14,746	61,052	2.0	31.1	13,349,978,700
4 or more	6,668	36,933	0.9	18.8	8,083,473,400
5 or more	3,330	23,656	0.5	12.0	5,100,422,850

Source: National Practitioner Data Bank, Sept. 1, 1990 to Dec. 31, 2003.

* Based on number of physicians in 1997, the midpoint of the time period studied, as reported by the American Medical Association.

Doctors with Repeated Malpractice Payouts Suffer Few Consequences

State medical boards and health care providers have not done enough to rein in those doctors who repeatedly make medical errors and commit 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 physicians.

- Only 8 percent of doctors who made two or more malpractice payouts were disciplined by their state board.
- Only 11.1 percent of doctors who made three or more malpractice payouts were disciplined by their state board.
- Only 14.4 percent doctors who made four or more malpractice payouts were disciplined by their state board.
- Only 32.2 percent of doctors who made 10 or more malpractice payouts were disciplined by their state board.

U.S. Doctors with Two or More Medical Malpractice Payouts Who Have Been Disciplined (Reportable Licensure Actions), 1990 – 2003

Number of Payout Reports	Number of Doctors Who 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	39,466	3,174	8.0%
3 or more	14,746	1,654	11.1%
4 or more	6,668	960	14.4%
5 or more	3,330	576	17.3%
10 or more	388	125	32.2%

Source: National Practitioner Data Bank, Sept. 1, 1990 – Dec. 31, 2003.

Examples of Repeat Offender Doctors Who Have Gone Undisciplined

The extent to which doctors make multiple payouts to patients for medical malpractice claims and are not disciplined is illustrated by the following NPDB descriptions of 15 physicians licensed to practice medicine who have made between 4 and 27 malpractice payouts totaling over \$8 million per doctor yet have not been disciplined by their state medical board. The NPDB does not disclose to the public the identity of these physicians.

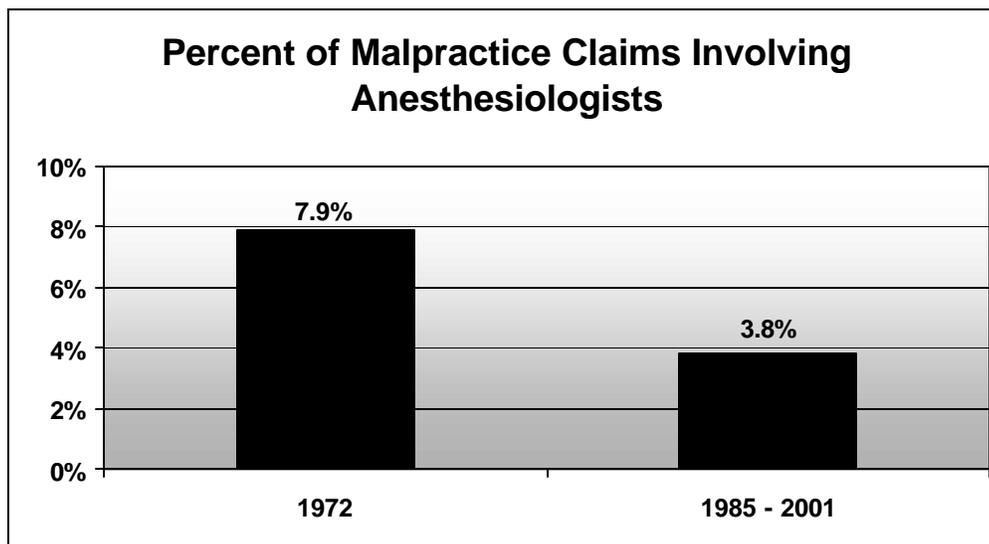
- **Physician Number 26714** made at least 6 malpractice payouts between 1994 and 2002, twice for failures to manage pregnancies, an improperly performed C-section, an improperly performed procedure, a retained foreign body during surgery and an unspecified obstetrics error. The damages add up to \$15,050,000.
- **Physician Number 122321** made at least 4 malpractice payouts between 1998 and 2002, twice for failures to diagnose, a wrong diagnosis and an improperly managed surgery. The damages add up to \$12,890,000.
- **Physician Number 24878** made at least 8 malpractice payouts between 1993 and 2002, four times for improperly performed surgeries, twice for unspecified monitoring errors and twice for unspecified surgical errors. The damages add up to \$12,712,000.
- **Physician Number 185782** made at least 4 malpractice payouts between 2002 and 2003, twice for improperly performed surgeries, a wrong diagnosis and an unspecified surgical error. The damages add up to \$12,625,000.
- **Physician Number 14059** made at least 14 malpractice payouts between 1991 and 2002, 12 times for unspecified obstetrics errors, a wrong surgery performed and a failure to manage a pregnancy. The damages add up to \$10,175,000.
- **Physician Number 493** made at least 6 malpractice payouts between 1992 and 2003, twice for improperly performed surgeries, twice for unspecified surgical errors, a failure to perform surgery and an unspecified treatment error. The damages add up to \$9,790,000.
- **Physician Number 33074** made at least 27 malpractice payouts between 1993 and 2002, eight times for failures to diagnose, three times for improperly performed surgeries, three times for failures to manage pregnancies, twice for retained foreign bodies during surgery, twice for unspecified treatment errors, twice for unspecified obstetrics errors, an unspecified diagnosis error, an improperly performed vaginal surgery, a delay in the treatment of identified fetal distress, a failure to treat, an improper performance of a procedure, performing surgery on a wrong body part and a failure to obtain consent before surgery. The damages add up to \$9,480,000.

- **Physician Number 23976** made at least 6 malpractice payouts between 1992 and 2003, twice for wrong diagnoses, twice for unspecified treatment errors, an improper management of surgery and an improper performance of surgery. The damages add up to \$9,390,000.
- **Physician Number 33119** made at least 11 malpractice payouts between 1991 and 2003, five times for unspecified obstetrics errors, twice for improperly managed labors, a failure to identify fetal distress, an improper performance of surgery, an improper choice of delivery method and an unspecified diagnosis error. The damages add up to \$9,240,000.
- **Physician Number 43965** made at least 21 malpractice payouts between 1992 and 2003, eight times for improperly performed surgeries, three times for unnecessary surgeries, twice for unspecified equipment errors, twice for surgeries on wrong body parts, a failure to obtain consent before surgery, a failure to obtain consent before drawing blood, a wrong treatment, an unspecified surgical error, a retained foreign body during surgery and an improper management of a medication regimen. The damages add up to \$8,722,500.
- **Physician Number 21437** made at least 4 malpractice payouts between 1991 and 2003, twice for delays in diagnosis, a failure to diagnose and an unspecified obstetrics error. The damages add up to \$8,577,500.
- **Physician Number 71586** made at least 4 malpractice payouts between 1995 and 2001, twice for failures to diagnose and twice for delays in diagnosis. The damages add up to \$8,435,000.
- **Physician Number 1995** made at least 6 malpractice payouts between 1993 and 2002, twice for unspecified obstetrics errors, an unspecified surgical error, a delay in treatment, a retained foreign body during surgery and an improper performance of surgery. The damages add up to \$8,363,750.
- **Physician Number 127753** made at least 4 malpractice payouts between 1998 and 2003 for an improper performance of vaginal surgery, a failure to identify fetal distress, an improperly managed labor and a delay in diagnosis. The damages add up to \$8,825,000.
- **Physician Number 118539** made at least 8 malpractice payouts between 1998 and 2003, three times for unspecified obstetrics errors, twice for unspecified diagnosis errors, twice for unspecified surgical errors and an improperly performed C-section. The damages add up to \$8,032,500.

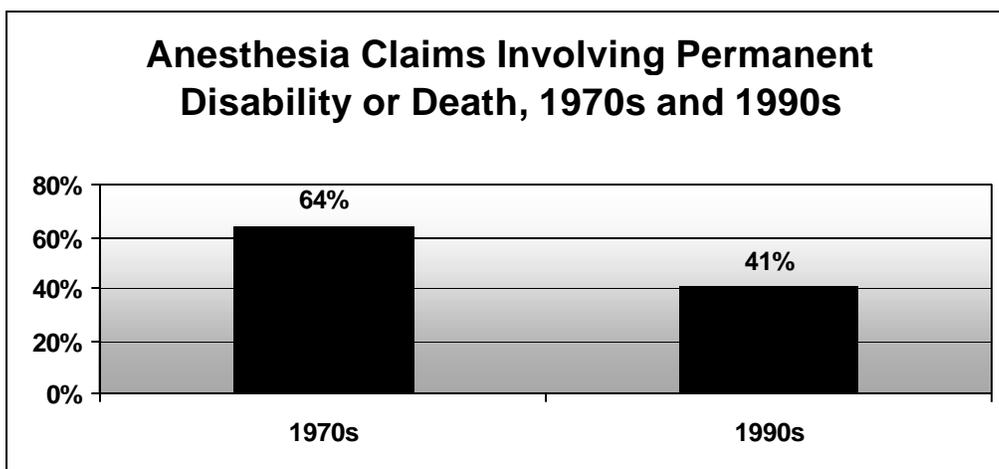
Anesthesiologists' Experience Shows Patient Safety Efforts Do More than Caps to Reduce Lawsuits and Insurance Premiums

Generally speaking, doctors have resisted courts' findings of negligent medical care, choosing to fight the system rather learn from mistakes. But an exception was the American Society of Anesthesiologists (ASA), which in 1985 initiated an effort to study malpractice claims. ASA established a Closed Claims Project at the University of Washington Medical School and gathered claims files from 35 different insurers. The outcome of this Manhattan Project-like commitment was the issuance of standards and procedures to avoid injuries that resulted in savings beyond the wildest dreams of any "tort reformer."

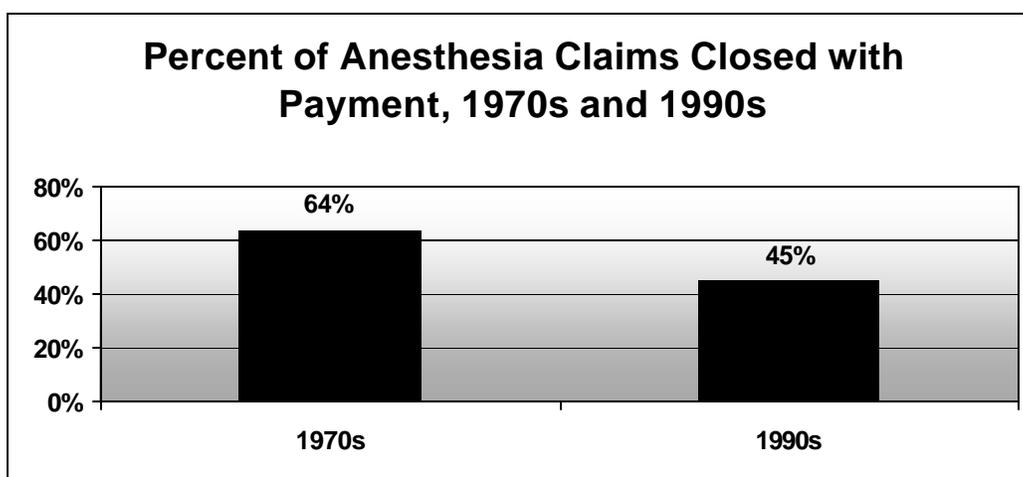
- The number and severity of claims dropped dramatically. In 1972, anesthesiologists were the target of 7.9 percent of all medical malpractice claims, double their proportion among physicians. But from 1985 to 2001, they were targets of only 3.8 percent of claims.
- In the 1970s, 64 percent of anesthesiology claims involved permanent disability or death; by the 1990s, only 41 percent did.
- The percent of anesthesia claims resulting in payments to plaintiffs dropped from 64 percent in the 1970s to 45 percent in the 1990s.



Sources: U.S. Department of Health, Education and Welfare, Secretary's Commission on Medical Malpractice, 1973; Physician Insurers Association of America, Cumulative Data Sharing Report, January 1, 1985 – December 31, 2001.

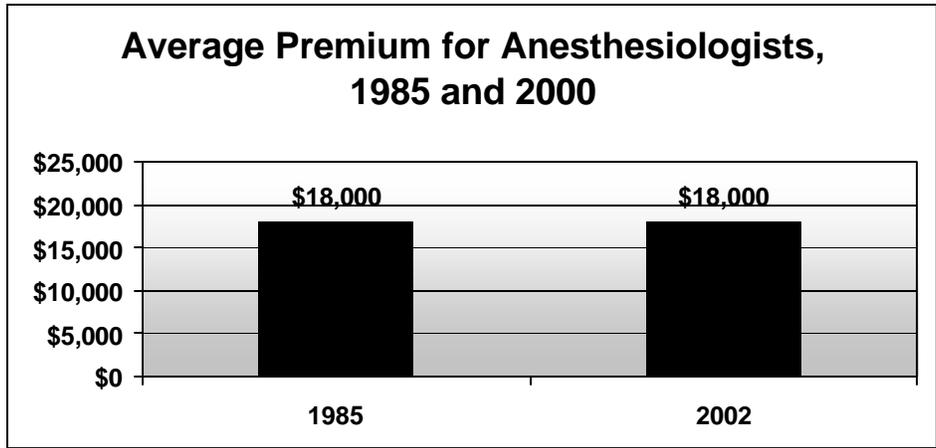


Source: American Society of Anesthesiologists, "Closed Claims Project Shows Safety Evolution," 2001.

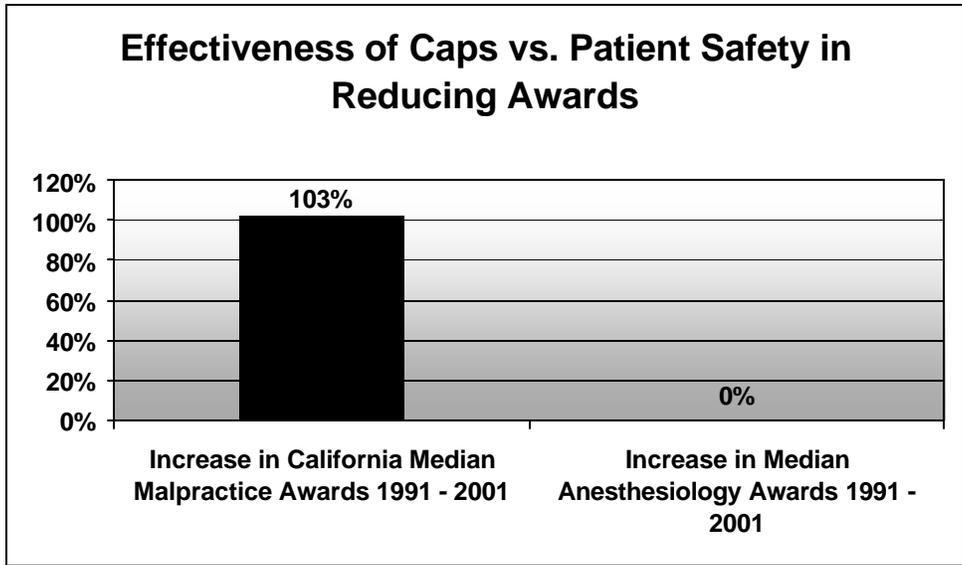


Source: American Society of Anesthesiologists, "Closed Claims Project Shows Safety Evolution," 2001.

- The increased patient safety measures paid off in savings to doctors. Remarkably, the average anesthesiologist's liability premium remained unchanged from 1985 to 2002 at about \$18,000 (and, if adjusted for inflation, it would be a dramatic decline).
- The safety effort proved far superior to damage caps in holding down awards. For example, during the 1990s, the median malpractice award in California, home to the most stringent cap on non-economic damages, increased by 103 percent; the median anesthesiology malpractice award remained constant.



Source: American Society of Anesthesiologists, "Another Malpractice Insurance Crisis Brewing for Anesthesiologists?," June 2002.



Sources: National Practitioner Data Bank, 2001 Annual Report; American Society of Anesthesiologists, "Closed Claims Project Shows Safety Evolution," 2001.

Health-Care Providers and Legislators Should Focus on Patient Safety Reforms

Physician groups, insurance companies and their political allies have essentially blamed patients and their lawyers for the temporary spike in some insurance premiums. The Kentucky Medical Association and its political supporters have continued to decry the costs of patient litigation, despite the fact that the state has a \$620,000 cap “non-economic” damages, which are awarded for the pain and suffering and loss of lifestyle due to paralysis, severe brain damage, disfigurement, blindness and deafness, of the loss of childbearing ability. Such damages exceed \$620,000 only in extreme cases of permanent significant injuries.

Efforts to convince politicians and policymakers that rising insurance rates are a result of “frivolous” lawsuits simply shifts attention away from much more serious problems. Instead, Kentucky’s regulators, officeholders and health-care providers should focus 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.** 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.

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* publications¹, 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 2003, state medical boards took 2,992 serious disciplinary actions out of a non-federal doctor population of

842,379.² This is a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by preventable medical errors annually.

In 2003, state discipline rates ranged from 11.58 serious actions per 1,000 doctors (Kentucky) to 1.46 actions per 1,000 physicians (Rhode Island), a 7.9 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, Oklahoma's rate of 7.88 serious disciplinary actions per 1,000 physicians, it would amount to a total of 6,638 serious actions a year. That would be 3,646 more serious actions than the 2,992 that actually occurred in 2003. 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.

Most of these disciplinary actions are unrelated to medical malpractice. 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.³ Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,⁴ 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.⁵

- **Adopt national computerized information systems that can collect and share health information on patients and their care.** While some hospitals and health care organizations have installed computer systems to manage patient information, there is not a national infrastructure for standardized data collection and exchange.⁶ Routine use of electronic records would give providers immediate access to information that can guide decision-making and prevent errors.⁷ The Institute of Medicine recommends that the information system includes records of patients' care, secure platforms for the exchange of information and data standards that would make the information understandable to all.⁸
- **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.⁹

- 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.¹⁰ 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.¹¹ 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.¹² 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.¹³ After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10 percent blood alcohol level.¹⁴ 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.¹⁵ 45 percent of residents who sleep less than four hours per night report committing medical errors.¹⁶ 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.¹⁷ If the maximum workweek for residents was limited to 80 hours it could considerably reduce mistakes due to fatigue and lack of supervision.
- Address the nursing shortage in America’s hospitals.** The country is currently in the midst of a severe nursing shortage. There are currently 126,000 vacant nursing positions at hospitals nationwide.¹⁸ The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) found that 24% of hospital errors were related to an “insufficient number of registered nurses on the job.”¹⁹ Conversely, several studies have shown that when nurse staff levels are optimized there are positive impacts on quality of care including fewer adverse events and lower mortality rates.²⁰ An emphasis must be placed on attracting and retaining a higher number of quality nurses. JCAHO recommends that organizational cultures of retention be created, the nursing educational infrastructure be bolstered, and financial incentives for investing in nursing be established.²¹

¹ More information available on the internet at: <http://www.questionabledoctors.org>

² “Ranking of the Rate of State Medical Boards’ Serious Disciplinary Action in 2003 (HRG Publication # 1696),” Public Citizen, April 14, 2004.

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- ³ J.D. Birkmeyer, C.M. Birkmeyer, D.E. Wennberg, M.P. Young, “Leapfrog Safety Standards: Potential Benefits of Universal Adoption.” The Leapfrog Group. Washington, DC, 2000. Available at: http://www.leapfroggroup.org/PressEvent/Birkmeyer_ExecSum.PDF.
- ⁴ D.W. Bates, L.L. Leape, D.J. Cullen, N. Laird, et al. “Effect of Computerized Physician Order Entry and a Team Intervention on Prevention of Serious Medical Errors,” *Journal of the American Medical Association*, 1998; 280:1311-6.
- ⁵ Sandra G. Boodman, “No End to Errors,” *Washington Post*, Dec. 3, 2002.
- ⁶ Institute of Medicine, *Patient Safety: Achieving a New Standard of Care* (2003).
- ⁷ *Id.*
- ⁸ *Id.*
- ⁹ J.D. Birkmeyer, “High-Risk Surgery – Follow the Crowd,” *Journal of the American Medical Association*, 2000; 283:1191-3; See also R.A. Dudley, K.L. Johansen, R. Brand, D.J. Rennie, A. Milstein, “Selective Referral to High Volume Hospitals: Estimating Potentially Avoidable Deaths,” *Journal of the American Medical Association*, 2000; 283: 1159-66.
- ¹⁰ “A Follow-Up Review of Wrong Site Surgery,” Joint Commission on Accreditation of Healthcare Organizations, *Sentinel Event Alert*, Issue 24, Dec. 5, 2001.
- ¹¹ “Joint Commission Issues Alert: Simple Steps By Patients, Health Care Practitioners Can Prevent Surgical Mistakes.” See Joint Commission on Accreditation of Healthcare Organizations website: <http://www.jcaho.org/news+room/press+kits/joint+commission+issues+alert+simple+steps+by+patients,+health+care+practitioners+can+prevent+surg.htm>
- ¹² Florida Agency for Health Care Administration, Risk Management Reporting Summary, 24 Hour Reports and Code 15 Reports, 2001, March 2002.
- ¹³ American Medical Student Association, “Fact Sheet, Support H.R. 3236 Limiting Resident-Physician Work Hours;” See also: <http://www.amsa.org/hp/rwhfact.cfm>
- ¹⁴ *Id.*
- ¹⁵ *Id.*
- ¹⁶ *Id.*
- ¹⁷ 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>.
- ¹⁸ Joint Commission on Accreditation of Healthcare Organizations, *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis* (August 2002).
- ¹⁹ *Id.*
- ²⁰ *Id.*
- ²¹ *Id.*

Section IV

Malpractice Insurance Crisis Is not Threatening Access to Patient Care

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

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

The GAO made the following findings:

- **Many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis.** The GAO study examined in-depth five states on the AMA’s crisis list: Florida, Mississippi, Nevada, Pennsylvania and West Virginia. The study failed to reveal convincing evidence that increased malpractice insurance premium costs had caused a significant number of physicians to move, retire or reduce high-risk services.¹
- The GAO report said: “In the five states with reported problems ... *we determined that many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to health care.* For example, some reports of physicians relocating to other states, retiring, or closing practices were not accurate or involved relatively few physicians.”² (emphasis supplied)
- Although the GAO confirmed instances in which “actions taken by physicians [in response to malpractice insurance rates] have reduced access to services...these were not concentrated in any one geographic area and often occurred in rural locations, where maintaining an adequate number of physicians may have been a long standing problem.”³ The GAO further reported that “the problems we confirmed were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services.”⁴
- **The GAO found no decreases in three of the services frequently cited by the AMA as being reduced.** After analyzing utilization rates among Medicare beneficiaries in the five states, the GAO found that spinal surgeries actually increased during the so-called “crisis” period. Moreover, the rate of spinal surgeries in the five “crisis” states was higher than the national average. Similarly, the GAO found that utilization rates of mammograms increased during the “crisis” period and were higher in the five states studied than the national average. Utilization of joint revision and repair services (hip, knee and shoulder repairs) in the five states studied was slightly below the national average but had not recently declined.⁵

- **AMA “surveys” of doctors were not reliable.** “Survey data used [by AMA] to identify service cutbacks in response to physician concerns about malpractice pressures are not likely representative of the actions taken by all physicians. ... AMA recently reported that about 24 percent of physicians in high-risk specialties responding to a national survey have stopped providing certain services; however, the response rate for this survey was low (10 percent overall), and AMA did not identify the number of responses associated with any particular service.”⁶
- **The GAO said its findings are relevant to other states.** In response to questions by the AMA regarding the application of its findings to states other than the five crisis states studied, the GAO said: “While we did not attempt to generalize our findings beyond these five states, we believe that – because they are among the most visible and often-cited examples of ‘crisis’ states – the experiences of these five states provide important insight into the overall problem.”⁷

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

- **Florida:** In Florida, where doctors’ successfully lobbied for the passage of a cap on damages, “[r]eports of physician departures ... were anecdotal, not extensive, and in some cases ... inaccurate. For example, state medical society officials told us that Collier and Lee counties lost all of their neurosurgeons due to malpractice concerns; however, we found at least five neurosurgeons currently practicing in each county as of April 2003. ... [O]ver the past two years the number of new medical licenses issued has increased and physicians per capita has remained unchanged.”⁸
- **Nevada:** “In Nevada, 34 OB/GYNs reported leaving, closing practices, or retiring due to malpractice concerns; however, confirmatory surveys conducted by the Nevada State Board of Medical Examiners found nearly one-third of these reports were inaccurate. ... Random calls [GAO] made to 30 OB/GYN practices in Clark County found that 28 were accepting new patients. ... Similarly, of the 11 surgeons reported to have moved or discontinued practicing, the board found four were still practicing.”⁹
- **Pennsylvania:** “In Pennsylvania, despite reports of physician departures, the number of physicians per capita in the state has increased slightly during the past six years. The Pennsylvania Medical Society reported that between 2002 and 2003, 24 OB/GYNs left the state due to malpractice concerns; however, the state’s population of women age 18 to 40 fell by 18,000 during the same time period.”¹⁰

¹ United States General Accounting Office, “Medical Malpractice: Implications of Rising Premiums on Access to Health Care,” GAO-03-836, August 2003. Available at <http://www.gao.gov/new.items/d03836.pdf>.

² GAO Study at p. 5.

³ GAO Study at p. 5.

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- ⁴ GAO Study at p. 13.
 - ⁵ GAO Study at p. 20.
 - ⁶ GAO Study at p. 20.
 - ⁷ GAO Study at p. 7.
 - ⁸ GAO Study at p. 17.
 - ⁹ GAO Study at p. 18.
 - ¹⁰ GAO Study at p. 18.

A Case Study in Deception: The Phony “Doctor Exodus” in Pennsylvania

Leaders of the medical community in Pennsylvania have insisted that the quality of the state’s health care is jeopardized by the relocation of doctors to other states that have enacted limits on patient rights and are perceived to be “doctor friendly.” They have maintained that Pennsylvania’s reserve of qualified physicians is dangerously low and that the state is having difficulty attracting new, young doctors. However, the chairman of the Pennsylvania Medical Society recently acknowledged to state lawmakers that the doctors group lacks statistical evidence to support its three-year claim that doctors are leaving the state in large numbers.¹ In fact, statistics from the state Insurance Department reveals that the opposite is true.

- **According to an independent study by the *Allentown Morning Call* newspaper done in 2004, “Pennsylvania doctors are not leaving in droves because of rising malpractice premiums, contrary to their relentless three-year campaign to convince state lawmakers and the public otherwise.”²**

As the article further found:

New state government statistics, the first to shed definitive light on a factually murky crisis that has consumed state officials and panicked consumers, show little or no dip in the number of doctors.

And a separate set of previously undisclosed figures – from the Pennsylvania Medical Society itself – indicate there probably are more physicians in Pennsylvania than ever.

The society’s statistics disprove the central point of its own aggressive lobbying campaign, one that demanded legal reforms to drive down insurance rates. It prompted lawmakers to give doctors \$230 million in tax dollars annually toward their insurance premiums. Applications for that cash were due in February [2004].

Those applications offer a new way to track the number of physicians.

Two years ago, as doctors first threatened to flee the state because of soaring premiums, there were 35,474 physicians, according to the state Insurance Department.

Now the figure is 34,997. That includes the number of applicants and a separate list of doctors who carried malpractice insurance at the end of last year but did not apply for the new state aid.

The total does not include an unknown number of doctors who moved to Pennsylvania over the last year, who are missed by Insurance Department record-keeping or who may not know the state has money set aside for them.

Whatever the final tabulation, it's clear doctors – even specialists – aren't staging a mass exodus. All parties agree the new statistics are the most accurate barometer of physician presence in Pennsylvania.

Confronted with the new state statistics, representatives of the medical society acknowledged that doctors are not abandoning the state in large numbers.

- **Mcare physician participation numbers are the best indicator of the number of physicians actively practicing in Pennsylvania.** Figures for physician population are the numbers of physicians paying to participate in the state's Mcare Fund, which is mandatory for all practicing physicians and is operated by the state insurance department. According to the insurance commissioner, Mcare collects mandatory assessments but does not independently collect additional physician population data.³ The department provided the state Senate with the aggregate number of physicians (excluding podiatrists and nurse midwives) used above.
- **The number of physicians grew at a considerably faster rate than Pennsylvania's overall population.** The state's overall population grew 3.3 percent in the nineties, from 11.8 million in 1990 to 12.3 million in 2000, compared to physician growth of 5.6 percent.⁴
- **A spot-check of anecdotes cited by the AMA as evidence that there is reduced access to care in Pennsylvania found many of the stories to be false.** In February 2004, Public Citizen performed a spot-check of anecdotes contained in the appendix to American Medical Association president-elect John C. Nelson's statement to a U.S. House subcommittee.⁵ Public Citizen's findings indicate that anecdotes of a doctor exodus are often inaccurate:
 - The AMA claimed that Dr. Seth Krum, an orthopedic surgeon who practices outside Philadelphia, was "considering leaving the state" in January 2003. Fifteen months later, however, Dr. Krum was still practicing and taking new patients.
 - The AMA claimed that Dr. Carol Ludolph, "a neurosurgeon in Philadelphia, said that \$170,000 in liability insurance premiums forced her to stop performing brain surgeries" in 2002. However, calls to her office confirmed that Dr. Ludolph is still taking new patients and still performing brain surgeries.
 - The AMA claimed that "neurosurgeons in Lancaster [Pennsylvania] blame high liability insurance costs for their inability to recruit an additional surgeon and two neurologists to their practice...this physician shortage could compromise their ability to treat patients." Their ability to treat patients seems uncompromised, however, because the neurosurgeon group in Lancaster was still taking new patients.
 - The AMA claimed that in February 2003 Dr. Terri Hellings, "a Levittown neurologist who makes house calls to elderly patients, is fed up with the state's skyrocketing liability

premiums” and “is thinking about leaving the state.” More than a year later, however, Dr. Hellings was still in Pennsylvania and still practicing.

- The AMA claimed that in April 2003 Geisinger Health System had “closed community-based obstetrics practices at Bloomsburg and Sunbury hospitals” in Pennsylvania forcing “pregnant patients [to] travel to Dunville for delivery.” A year later, however, Geisinger was still running its obstetrics operations at Bloomsburg and Sunbury.
- The AMA claimed that Dr. Margaret Hawn of Harrisburg, Pennsylvania “will stop delivering babies in June 2003 because of high medical liability insurance premiums and a legal climate that inspires fear in well-meaning doctors.” Ten months later, however, Dr. Hawn was still accepting new obstetrics patients.

¹ John M. R. Bull, “Doctors can’t prove thinning ranks; Medical society chief admits group lacks statistics to show physicians are leaving,” *Morning Call*, April 23, 2004.

² “Diagnosis of the numbers shows doctors not leaving state in droves,” *Allentown Morning Call*, April 18, 2004.

³ Insurance Commissioner M. Diane Koken, letter to Sens. Armstrong, Wagner, Greenleaf and Costa, Nov. 3, 2003.

⁴ U.S. Census Bureau, No. 18, Resident Population – States: 1980 to 2000. Statistical Abstract of the United States: 2001.

⁵ Subcommittee on Wellness and Human Rights, Committee on Government Reform, U.S. House of Representatives, October 1, 2003.

Stories of Reduced Access to Trauma Care Are Exaggerated

A recent survey found a plentitude of trauma care facilities in states the American Medical Association (AMA) says are experiencing a malpractice “crisis” – highlighting the misleading nature of the AMA’s scare tactics.

A study published in 2003 in the *Journal of the American Medical Association* identified 10 states with the highest concentration of trauma centers.¹ But five of those were states where the AMA claimed patients were threatened with lack of access to health care due to rising malpractice insurance premiums – i.e., that there were not enough doctors. Meanwhile, four of the six states that the AMA said are “currently OK” were found to have fewer than the recommended number of trauma centers, despite harsh caps on damages to victims of medical malpractice.

The *JAMA* study found that Illinois, Wyoming, Connecticut, Missouri and New York, each of which AMA lobbyists have claimed face a malpractice “crisis,” ranked among the top 10 in trauma centers per 1 million population.

The article also listed four states with strict damage caps – Indiana, Louisiana, New Mexico and Wisconsin – among states that do not have one trauma center per million residents, considered the minimum acceptable number for accessible trauma care. Those four states, along with California and Colorado, are described by AMA lobbyists as “currently OK” in terms of access to care. Of the six states the AMA holds up as examples of having accessible care, only one, Colorado, is in the top 10 in concentration of trauma centers.

¹ “National Inventory of Hospital Trauma Centers,” *Journal of the American Medical Association*, Vol. 289, No. 12, March 26, 2003.

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

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

- **Liability laws do not correlate with where doctors' locate their practice.** Figures 5 and 6 compare the ten states with the most per capita number of doctors in 2001 to the ten states with the fewest per capita number of doctors.¹
 - While four of the states with the fewest per capita number of doctors had enacted caps on non-economic damages, only three of the states with the most number of doctors per capita had enacted them. Similarly, while three of the states with the fewest number of doctors had enacted caps on punitive damages, only one of the states with the most number of doctors had capped punitive damages.
 - According to the U.S. Chamber of Commerce, Iowa, Utah, and South Dakota rank 5th, 8th and 9th for "reasonable litigation environment,"² yet those states rank 47th, 42nd, and 44th, respectively, in number of doctors. Only one state in the Chamber's legal climate top ten, Connecticut, also ranks in the top ten for doctors.
- **Doctors choose to reside in states with a higher quality of life, not because of state liability laws.** Like anyone else, doctors want to live in places where they can earn high incomes, enjoy cultural and leisure activities, and send their children to good schools. Doctors migrate to states on lists of "Best Places to Live":
 - 40 of the top 100 cities with "strong arts, cultural programs, and higher education" were in the ten states with the most per capita number of doctors, while there were none in the ten states with the fewest per capita number of doctors.³
 - 33 of the top 100 cities rated for plentiful leisure activities were in the ten states with the most per capita number of doctors, while there were none in the ten states with the fewest per capita number of doctors.⁴
 - 48 of the top 100 cities rated for having good schools were in the ten states with the most per capita number of doctors, while there were only seven in the ten states with the fewest per capita number of doctors.⁵

States With Most Doctors Per Capita

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

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

- The average median income for the ten states with the fewest per capita number of doctors for 2000 was \$54,552, versus \$70,360 for the ten states with the most per capita number of doctors.⁶ Not surprisingly, doctors want to live in more prosperous states—even though damage awards are higher in high-income states. The District of Columbia has the highest median damage award and the most doctors. Idaho, with the fewest doctors, has the third lowest median damage award.⁷
- Seven of the top ten states for doctors also rank in the top ten states in percentage of households earning \$200,000 or more in 2000.⁸ Doctors want to live in areas with lots of affluent people—such areas are more likely to have the leafy suburbs, premium housing, clubs, and other amenities that doctors want.
- Six of the top ten states for doctors also rank in the top ten states in percentage of professionals in the population.⁹ Six of the bottom ten states for doctors are in the ten states with the fewest professionals. Doctors want to live in areas where they may socialize with other educated people.
- Finally, the average population density of the states with the fewest per capita amount of doctors is 29 persons per square mile, versus 1,444 in the states with the most per capita number of doctors.¹⁰ Doctors' decisions on where to practice are largely in line with other Americans' decisions on where to live and work.

States With Fewest Doctors Per Capita

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

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

- **Nearly all of *Modern Physician* magazine's top 75 places to run a medical practice are in the AMA's malpractice "crisis" states and "states showing problem signs"—only 8 are in states with the strictest caps.** *Modern Physician* included malpractice premiums in its criteria for picking the best places to practice medicine. Nevertheless, the strength of other criteria dictated that 17 of the top 30 cities picked were in AMA "crisis" states such as Georgia, North Carolina, and Washington.¹¹ While doctors insist that they will pack their bags and leave when malpractice premiums are too high, they in fact place many other criteria ahead of premiums, including low labor costs for support personnel, low state taxes, high Medicare reimbursement levels, and the educational attainment of their neighbors.

¹ *Health Care State Rankings 2001: Health Care in the 50 United States*, Morgan Quitno Press, 2001.

² Harris Interactive, *States Liability Systems Ranking Study*, January 2002.

³ CNN/Money, *Best Places to Live* (Nov. 24, 2002) <<http://money.cnn.com/best/bplive/>>.

⁴ CNN/Money

⁵ *Sperling's Best Places to Live*, (Mar. 30, 2001) <<http://www.bestplaces.net/>>.

⁶ Based on U.S. Census Bureau data.

⁷ National Practitioner Data Bank, 2001 Annual Report.

⁸ Based on U.S. Census Bureau data.

⁹ *Id.*

¹⁰ *Id.*

¹¹ "The List," *Modern Physician*, October 2003.

Most Complaints of Doctor Shortages Are Attributable to the Chronically Low Supply of Rural Physicians

To the extent that doctors practicing certain specialties are not available in some areas, it is not at all likely that it is caused by a spike in malpractice insurance rates or a result of unlimited non-economic damages. For 25-30 years many rural communities have not had the number of medical professionals that most experts consider adequate.¹

- **Access to medical care has long been a problem throughout rural America.** According to the Council on Graduate Medical Education (COGME), “Geographic maldistribution of health care providers and services [the tendency for physicians to practice in affluent urban and suburban areas] is one of the most persistent characteristics of the American health care system. Even as an oversupply of some physician specialties is apparent in many urban health care service areas across the country, many inner-city and rural communities still struggle to attract an adequate number of health professionals to provide high-quality care to local people. This is the central paradox of the American health care system: shortages amid surplus.”²

COGME also notes that, “The relative shortage of health professionals in rural areas of the United States is one of the few constants in any description of the United States medical care system.”³

- **Attracting and retaining rural doctors is currently a problem throughout the country—not just in states that do not limit malpractice awards.**
 - Rural doctors around the country find it difficult to recruit colleagues, and community groups in rural areas have similar troubles in recruiting doctors to work in their communities.⁴
 - Although nearly 25 percent of the U.S. population resides in rural areas, only about ten percent of the nation’s doctors work in these areas.⁵
- **A number of factors have been cited by doctors and researchers to explain the low supply of rural doctors.**
 - People who live in rural areas are more likely to be uninsured than are those who live in urban areas, meaning that they see a doctor less often or are often a financial liability for doctors who care for them.⁶
 - The percentage of public health recipients is also greater in rural areas.⁷ Low Medicare and Medicaid reimbursement rates can be crippling for these doctors.

- Rural doctors have a lower volume of patients, while costs for things such as equipment remain the same.⁸
- Rural doctors report that they are overworked.⁹ According to surveys conducted by the Oregon Medical Association, doctors in rural Oregon report that they work more hours per week than those in urban areas of the state.¹⁰
- Rural doctors are more likely to report that they receive inadequate assistance and coverage. One study of obstetricians and gynecologists in North Carolina investigated these doctors' perceptions of the adequacy of consultation and coverage and found that 13 percent of rural physicians but only 1.5 percent of urban physicians in North Carolina indicated that assistance (opportunities for colleagues to see patients and review charts) in high-risk delivery situations was "inadequate" or "very inadequate." In terms of coverage (opportunities for colleagues to assist in the primary doctor's absence), 16.7 percent of rural physicians and only 2.5 percent of urban physicians indicated that coverage was "inadequate" or "very inadequate."¹¹
- Studies indicate that women are much less likely to settle in rural areas than are men. As the percent of doctors who are women increases, it has been suggested that women's preferences for urban practice may be contributing to the problem of recruiting and retaining rural doctors.¹²
- **Numerous additional factors explain the limited numbers of rural doctors.** According to the Association of Maternal and Child Health Programs, the Oregon Health Department, as well as health departments in Alaska, Idaho, and Washington, cite the following barriers to attracting doctors to rural areas of their states:¹³
 - **"Burnout** is one reason it is so difficult to retain qualified primary care providers. Physicians note that as the only doctor in a small, isolated community they are on-duty 24-7 and can expect to be asked for medical opinions at the post office, grocery store or a 2:00 a.m. call at home from a worried family member. Taking time off for vacation or professional training means complicated arrangements for a substitute doctor."
 - **"Isolation** is a factor in rural practice, not just for the physician but also for their families. Physicians note that while they may find rural practice challenging and engaging, their families may be less enthusiastic. Rural areas offer limited employment opportunities for spouses and limited educational, recreational and social opportunities for children. Physicians are also isolated from colleagues. Rural physicians are not able to enjoy the day-to-day personal contact with peers for consultations, quality assurance and feedback."
 - **"Wages** are generally lower for non-urban practitioners. Higher rates of unemployment and poverty, uninsured residents and fewer patients mean rural communities are less able to match the financial incentives and job benefits offered in urban areas."

- **“Community and cultural connections** are important for both the physician and the patients they serve, but are not easily made. Physicians and health care providers are usually recruited from larger urban areas or from out-of-state and usually have limited knowledge of the health needs, culture or history of the people in their care. At the same time the physician is feeling disconnected, community members are reluctant to accept or support a new physician unless they have proven their commitment to the community over time.”
- **“The health care infrastructure** — such as a hospital, clinic and laboratory facilities — supports primary health care providers. Physicians are reluctant to locate in a community without a hospital or other supporting facilities.”

¹ Thomas Ricketts, “Special People for Special Places,” *The Journal of Rural Health*, Spring 1999, at 210.

² COGME at p. xiii.

³ COGME at p. 11.

⁴ Ricketts at p. 210.

⁵ Gamm, Larry D., Hutchison, Linnae L., Dabney, Betty J. and Dorsey, Alicia M., eds. (2003). *Rural Healthy People 2010: A Companion Document to Healthy People 2010. Volume 2*, at 17, available at <http://www.srph.tamushsc.edu/rhp2010/litreview/Volume2.pdf>.

⁶ Gamm, Larry D., Hutchison, Linnae L., Dabney, Betty J. and Dorsey, Alicia M., eds. (2003). *Rural Healthy People 2010: A Companion Document to Healthy People 2010. Volume 1*, at 19, available at <http://www.srph.tamushsc.edu/rhp2010/litreview/Volume1.pdf>.

⁷ Lisa K. Fondren and Thomas C. Ricketts, “The North Carolina Obstetrics Access and Professional Liability Study: A Rural-Urban Analysis,” *The Journal of Rural Health*, Spring 1993, at 135.

⁸ Andrew Kramer, “Rural Areas a Hard Sell for Doctors; Practicing Medicine in the Country is Becoming More of a Money-Losing Proposition. Fewer Hours and Lower Costs Lure Many to Cities,” *Los Angeles Times*, Oct. 12, 2003.

⁹ Ricketts at p. 210.

¹⁰ Conversation with Joy Conklin, Director of Socioeconomic Affairs, Oregon Medical Association, Aug. 2, 2004.

¹¹ Fondren and Ricketts.

¹² COGME at p. 17.

¹³ The Association of Maternal Child Health Programs, *From Rural to Remote: Family Health Care in Alaska, Idaho, Oregon, and Washington* (March, 2004) at 11, available at: <http://www.amchp.org/aboutamchp/Rural%20Health.pdf>

Section V

Caps on Damages Are Unjust and Offer No Solution to Rising Premiums Caused by the Insurance Cycle

Caps on Damages Are Unjust

Doctors and insurance companies across the country are pushing for a \$250,000 limit on non-economic damages, also known as “pain-and-suffering,” in medical malpractice cases. Such a cap has not been proven to effectively lower medical malpractice insurance costs. It does, however, penalize the most severely injured patients while reducing physician, hospital and HMO accountability, thereby lessening deterrence against errors and negligence.

- **“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, loss of sexual function, lost bowel and bladder control, loss of limb) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility.
- **Capping awards hurts children, women, seniors and minorities in particular.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on children, women and minorities. Children have no employment income, which is the basis for calculating most economic awards. One of the more significant medical injuries inflicted on women is harm to reproductive capacity, but that does not impact a woman’s earning capacity, and thus does not entitle her to economic damages despite the devastating emotional impact of such a loss. Retired seniors who suffer often deplorable neglect and abuse in nursing homes and other long-term care facilities have no employment income. Capping awards also has a disparate impact on minorities since they have lower incomes on average than whites. In some cases, low wage earners are denied the opportunity to earn more in the future due to injuries caused by medical negligence.
- **A cap on non-economic damages effects only the most seriously injured patients.** A cap on non-economic damages is cruel and unusual punishment, because it affects only those who are most catastrophically harmed. According to Physician Insurers Association of America (PIAA), the average total payment between 1985 and 2001 for a “grave injury,” which encompasses paralysis, was only \$454,454. This includes both economic damages (health care costs and lost wages) and non-economic damages. Since about one-third to one-half of a total award comprises non-economic damages, a \$250,000 cap affects only patients with “grave injuries.”¹
- **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.² 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 criticism 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.³ PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners’ classifications.⁴ 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.⁵
- **Kentucky jury verdicts data shows that large non-economic damage awards are reserved for serious injuries.** A survey of jury verdicts in Kentucky showed that juries seldom award large amounts for non-economic damages, and when they do, the case almost always involves a grave or very serious injury. Of the 92 jury verdicts in favor of victims of medical malpractice between 1998 and 2003, only 42 awarded non-economic damages in excess of \$250,000 (the maximum amount often suggested by proponents of tort limits). In 23 of these cases, plaintiffs were left either dead, dying of cancer, brain damaged or paralyzed. Other serious injuries that were compensated with a large non-economic damages award included: loss of a lung, loss of eyesight, loss of a penis and loss of a finger by an infant.⁶

¹ Frank A. Sloan, Penny Githens, Ellen Clayton, Gerald Hickson, Douglas Gentile and David Partlett, “Suing For Medical Malpractice,” *University of Chicago Press*, 1993.

² Kelso & Kelso, *Jury Verdicts in Medical Malpractice Cases and the MICRA Cap*, Institute for Legislative Practice (1999). N. Vidmar, F. Gross, M. Rose, “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).

³ *PIAA Data Sharing Report*, Report 7, Part 10.

⁴ 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

⁵ Vidmar, Gross, Rose, *supra* at 284.

⁶ *The 2003 Medical Negligence Report*, The Kentucky Trial Court Review, January 14, 2004.

The Inequitable Impact Of Non-Economic Damage Caps: Three Academic Studies Demonstrate Severely Handicapped and Female Patients Are Hurt the Most

Doctors and their insurers argue that California's 1975 law limiting "non-economic" damages in medical malpractice cases should be adopted by every state. But three 2004 studies analyzing the impact of California's Medical Injury Compensation Reform Act (MICRA) document its harsh treatment of the most vulnerable victims. MICRA limits at \$250,000 the amount of non-economic damages a plaintiff can recover at a medical malpractice trial.

The three studies were conducted by three different types of researchers: physicians from Harvard Medical School; social scientists at the RAND Institute for Civil Justice; and a law professor at the University of Buffalo. Yet each study reached the same conclusion—caps are a particularly harsh method of reducing malpractice awards against doctors. RAND Institute policies prohibit its researchers from making normative judgments, but the other researchers were blunt in condemning MICRA's unfairness.

Harvard Medical School: Reductions Imposed on Gravely Injured Patients' Awards Were Seven Times Larger than on Awards to Those with Minor Injuries.¹

To measure the impact of the \$250,000 non-economic damages cap the authors examined data from 152 plaintiff verdicts in California malpractice trials from 1985 to 2002. A surgeon and an internist, both with experience assessing injury types in malpractice litigation, independently scored the severity of each injury using the National Association of Insurance Commissioners (NAIC) nine-point scale. To ensure sufficient sample size for analyses, the nine levels of injury were collapsed into six categories: temporary injury and five levels of permanent injury—minor, significant, major, grave and death. Among their findings:

- **Average reductions for grave injury were seven times larger than those for minor injury.** The study found strong evidence that caps' fiscal impact on verdicts was distributed inequitably across different types of injuries. Mean reductions forced on grave injuries were seven times those imposed on minor injuries. Earlier studies had indicated, according to the authors, that plaintiffs with the most severe injuries appear to be at highest risk for inadequate compensation even without caps, so those worst-off may suffer a kind of "double-jeopardy" under caps.
- **Verdicts for injuries such as deafness, numbness, disfigurement, chronic pain and the like, which do not impair physical functioning or cause wage loss or high health care costs, were virtually wiped out by the cap because they attract relatively small economic damage awards.** The balance between economic and non-economic components of the award is critical. Non-economic damages constitute 10 percent or less of the overall award in verdicts with proportionally small reductions, but they account for the vast majority of awards with the largest

reductions. Hence, the drastic impact of caps on claims that center primarily on non-economic damages.

- **The authors concluded that caps are a clumsy and inequitable solution to the perceived problem of unjust jury awards.** Indeed, the authors noted that previous studies suggest that juries actually do a reasonable job of determining damages in negligence cases.
- **The authors suggest that if policymakers are determined to limit non-economic damages they should consider a sliding scale for non-economic damages based on severity of injury and age of the patient.** Under an alternative approach the award in each severity bracket would be capped, but at a level more commensurate with the severity of the injury than a flat cap permits. They conclude that “a decision to limit damages awards represents a social judgment that stabilizing the liability insurance market must be prioritized over allowing juries to determine levels of compensation for medical injuries... from an ethical perspective, care should be taken to choose that policy option that infringes least on the interest of patients and society in fair compensation. Use of a sliding scale of damages represents a more rational balancing of interests.”

Rand Institute: Severely Injured Patients’ Awards Reduced the Most²

Rand Institute researchers examined data from 257 plaintiff verdicts in California malpractice trials from 1995 to 1999; 195 were trials with non-fatal injury claims and 62 were death claims. The source for the data was the California Jury Verdicts Weekly (CJVW), a private publication that follows what juries are awarding for specific types of claims in the state. The authors cautioned that CJVW does not capture all trials and they have no way of determining the number of trials missed, so the results reported should be viewed just as a sample. Finally, the authors stated that they made no attempt to calculate the effects of MICRA on malpractice insurance premiums or on availability of malpractice insurance coverage in California. Among their findings:

- **Overall MICRA reduced defendants’ liabilities by 30 percent.** Jury awards in the sample of cases totaled \$421 million, but with the judge reducing non-economic damages to comply with the MICRA cap on non-economic damages and the MICRA limitation on attorney fees, the final judgments in those cases dropped to \$295 million or 30 percent. In death cases, defendants’ liabilities were reduced by 51 percent, compared with a 25 percent reduction in non-fatal injury claims.
- **The MICRA cap was imposed in 45 percent of the cases studied.** Verdicts in death cases were capped more often (58 percent) than those in non-fatal injury cases (41 percent). When their awards are capped, plaintiffs typically lost many hundreds of thousands of dollars. The median reduction in non-economic damages in all cases (fatal and non-fatal) was \$366,000.

- **Plaintiffs with the most severe injuries felt the impact of MICRA the most often.** The study showed that plaintiffs with the most serious injuries, such as brain damage, a variety of catastrophic injuries, and paralysis, had their awards capped most frequently, and when they do, they suffered median reductions of more than a million dollars (compared with a median reduction of \$286,000 for all non-fatal injury cases).
- **Cases with the greatest percentage losses in total awards are those with small economic losses but great damage to the plaintiff's quality of life.** These cases, with economic damages of less than \$100,000 frequently had non-economic damages awarded by the jury of more than a million dollars because the jury believed the plaintiff had suffered marked changes in the quality of life. An example is the case of a 42-year old woman who underwent an unnecessary mastectomy because of a mistaken diagnosis of cancer; the jury verdict was \$78,000 for economic losses and \$1.5 million for the non-economic losses to her quality of life. Under the MICRA cap, the judge reduced her total award to \$338,000, 78 percent less than what the jury had decided was fair compensation.

University of Buffalo: Women's Damage Awards Reduced the Most³

Professor Lucinda M. Finley at the University of Buffalo School of Law⁴ examined California jury verdict data to ascertain the effect of the cap on non-economic damages on various types of injuries and different types of injured plaintiffs. Using Westlaw and Lexis searches of California jury verdicts in medical malpractice cases from 1992 through 2002, she selected jury verdicts for plaintiffs that separated economic from non-economic damages, had an award of non-economic damages in excess of \$250,000 and identified the gender of the plaintiff for the study. Among the findings:

- **California women sustain greater proportional losses from the cap than men.** Comparison of 67 jury verdicts for women with 64 for men in California between 1992 and 2002 showed that MICRA reduced women's total verdicts by an average of 48 percent, as contrasted with a 40 percent reduction for men. The average compensatory award to male plaintiffs was significantly higher than women's to begin with. The MICRA cap served to increase the disparities. Before applying the cap, women's average jury awards were 52 percent of men's average awards. After the MICRA reduction, the women on average recovered only 45 percent of men's average recoveries.
- **California caps have a particularly harsh impact on women who are victims of gynecological malpractice.** In the 28 cases studied, MICRA produced an average 64 percent reduction in women's recovery. These are cases where only women are plaintiffs, exclude obstetrical cases involving injury to the baby and include misdiagnosed and delayed treatment for cervical or ovarian cancer, unnecessary hysterectomies, misdiagnosed ectopic pregnancies that ruptured, improperly performed episiotomies during delivery, vulvular burns with misapplication of caustic chemicals and death after cesarean section from undiagnosed internal bleeding.

The author explained that gynecological malpractice injuries impact women in unique ways—impaired fertility, impaired sexual functioning, incontinence, miscarriage, scarring in personally sensitive body areas—and, as a result, do not have significant economic losses in wage or medical expenses associated with them. Instead these injuries are primarily a matter of emotional suffering, lost sense of self, impaired self-esteem and the ability to engage in intimate relationships, physical pain and suffering and reduced quality and enjoyment of life. Since a high proportion of the award in gynecological malpractice cases depends on non-economic damages to obtain justice, no wonder then, that caps have a notably adverse impact on women.

- **Women and elderly victims suffer significant disparate impact from caps.** “They will lose greater percentages of their total compensatory awards than men who are of working age,” Professor Finley said.⁵ The negative effect will be especially pronounced for elderly women. Also adversely impacted are the recoveries in those cases where the victim died as a result of the negligent misconduct. In this group, the greatest effect is where the infant or child dies. The significance of these losses will be seen in loss of deterrence, greater dependence upon general societal funds to pick up the slack and the lost opportunity to bring these problems to public notice and regulatory attention. According to the author, “the most profound loss of all will be to the fairness and equality of our civil justice system, as the effects of cap laws send the message that women, the elderly, and the parents of dead children should not bother to apply.”⁶

¹ David M. Studdert, Y. Tony Yang, Michelle M. Mello, “Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California,” The Harvard School of Public Health, *Health Affairs*, July/Aug. 2004, Vol. 23, Issue 4, pg. 54.

² Nicholas M. Pace, Daniela Golinelli, and Laura Zakaras, “Capping Non-Economic Awards in Medical Malpractice Trials, California Jury Verdicts Under MICRA,” Prepared for the Rand Institute for Civil Justice, July 2004.

³ Lucinda M. Finley, “The Hidden Victims of Tort Reform: Women, Children and the Elderly,” paper delivered to Thrower Symposium, Emory Law School, February 19, 2004.

⁴ Lucinda M. Finley is the Frank G. Raichle Professor of Trial and Appellate Advocacy at the University of Buffalo School Of Law.

⁵ Finley, *supra* at 62.

⁶ Finley, *supra* at 63.

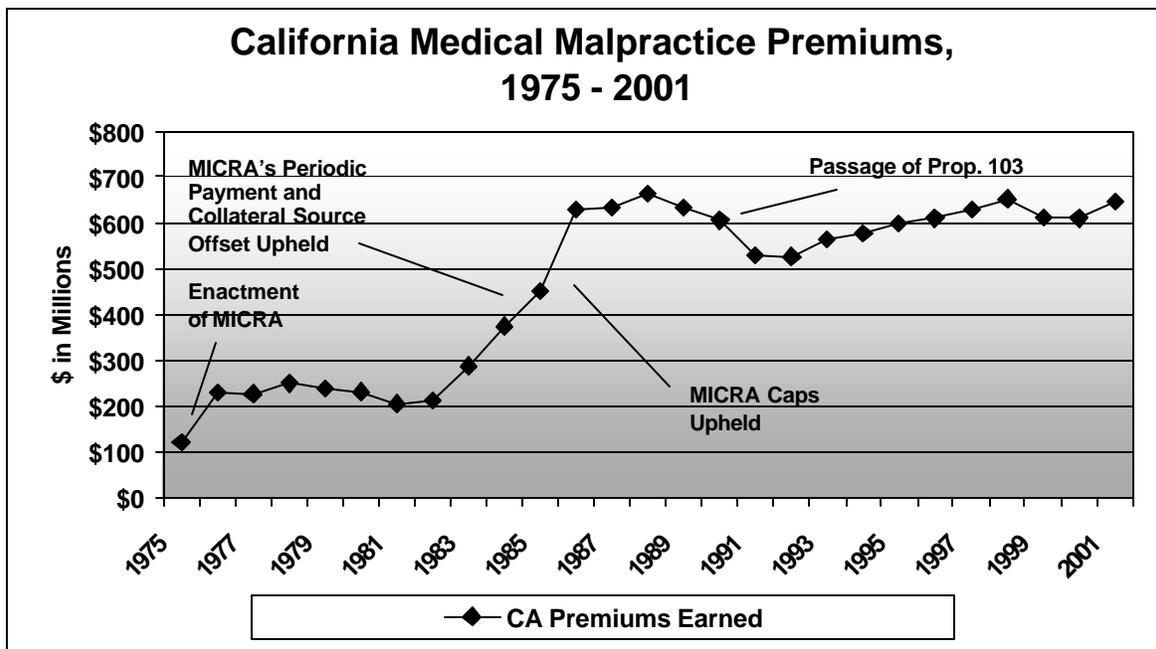
California's Lower Malpractice Insurance Premiums Are Due to Insurance Reforms, not Damage Caps

The experience with medical malpractice insurance rates in California is heavily promoted by doctors and insurance companies as justification for caps on non-economic damages. In 1975 California passed the Medical Injury Compensation Reform Act (MICRA), the centerpiece of which is a \$250,000 cap on non-economic damages (with no inflation adjustments). Ever since, this has been the model law for efforts to restrict patients' legal rights in other states.

Ironically, the California experience exemplifies the success of insurance reforms, not the imposition of damage caps, at keeping malpractice rates lower. In a revolt against skyrocketing auto and homeowners insurance rates, voters passed Proposition 103 in 1988. This strong pro-consumer measure, which also applied to lines of medical malpractice insurance, instituted a 20 percent rate rollback and made it much more difficult for companies to get future rate increases.

The effect on medical-malpractice insurance premiums was staggering. In the first 12 years of MICRA (1976-1988) malpractice insurance premiums earned (paid) *increased* 190 percent, but under Prop 103 premiums earned *declined* 2 percent from 1988-2001.¹

- **California premiums continued to rise after enactment of MICRA.** In 1976, the first year of MICRA, the total premiums earned by California insurers were \$228.5 million but by 1988 premiums had skyrocketed to \$663.2 million – a jump of 190 percent. Initially insurers argued that challenges to the constitutionality of MICRA prevented the lowering of premiums. However, MICRA's constitutionality was upheld in State Supreme Court decisions handed down in 1984 (periodic payments and collateral source provisions upheld) and 1985 (damage cap upheld). Nevertheless, premiums earned saw their largest jump in 1986 than in any year since MICRA's adoption despite the fact that insurance companies set premiums based on *what they expect that years' losses to be in the future*, not what happened in the past.
- **Medical malpractice premiums decreased after passage of Prop 103 in 1988.** In 1988, California voters, facing skyrocketing insurance premiums and angry at the failure of "tort reform" to deliver on its promise to reduce insurance rates, went to the ballot box and passed Prop 103 the nation's most stringent reform of the insurance industry's rates and practices. It was applicable to all lines of property-casualty insurance, including auto, homeowners, commercial and medical malpractice. Within three years of passage of Prop 103, medical malpractice premiums dropped 20 percent, and thereafter have generally followed the rate of inflation. Overall, since 1988 total premiums earned have decreased about 2 percent, dropping from \$663.2 million in 1988 to \$647.2 million in 2001.
- **California doctors are dissatisfied despite draconian caps.** A July 2001 report of the California Medical Association indicated that 43 percent of California doctors surveyed planned to leave medical practice in the next three years.² This percentage exceeds those of doctors in states without caps saying they will retire or leave the state because of high malpractice premiums: Ohio (34 percent),³ Nevada (20 percent),⁴ Mississippi (10 percent),⁵ and Arizona (2 percent).⁶



Source: The Foundation for Taxpayer and Consumer Rights, based on National Association of Insurance Commissioners' Reports on Profitability By Line By State, 1976-2001, Direct Premium Earned 1975. A.M. Best special data request.

Reasons Prop 103 Has Been So Successful at Reducing Rates

- **Prop 103 created a stringent disclosure and “prior approval” system of insurance regulation.** This requires insurance companies to submit applications for rate changes to the California Department of Insurance for review before they are approved. Prop 103 gives the California Insurance Commissioner the authority to place limits on an insurance company’s profits, expenses and projections of future losses (a critical area of abuse).
- **Prop 103 repealed anti-competitive laws in order to stimulate competition and establish a free market for insurance.** Prop 103 repealed the industry’s exemption from state antitrust laws, and prohibited anti-competitive insurance industry “ration organizations” from sharing price and marketing data among companies, and from projecting “advisory,” or future, rates, generic expenses and profits. It repealed the law that prohibited insurance agents/brokers from cutting their own commissions in order to give premium discounts to consumers. It permits banks and other financial institutions to offer insurance policies. And it authorizes individuals, clubs and other associations to unite to negotiate lower-cost group insurance policies.
- **Recent consumer challenge to medical malpractice insurance rate hike saves California doctors \$23 million.** California’s State Insurance Commissioner ruled in September 2003 that the second largest medical malpractice insurer’s rate request was excessive. The request was determined to be in violation of Prop 103 regulations. The Insurance Commissioner ordered medical malpractice insurer, SCPIE Indemnity, to slash its

proposed rate increase for doctors by 36 percent after an eight-month regulatory investigation of the firm's rate request. The Foundation for Taxpayer and Consumer Rights (FTCR), a California nonprofit, non-partisan organization that initiated the rate challenge called the ruling another tribute to the effectiveness of California's insurance reform initiative known as Prop103.

¹ All of the information in this section analyzing MICRA and Prop 103 is taken from the testimony of Harvey Rosenfield, President, The Foundation for Taxpayer and Consumer Rights, before the U.S. House Energy and Commerce Committee, Subcommittee on Health, Feb. 27, 2003.

² "Survey Reveals Widespread Physician Pessimism About Future of Medical Practice in California," *California Medical Association Press Release*, July 16, 2001.

³ "Survey: Malpractice Costs May Push Out Doctors," *Business First of Columbus*, April 16, 2004.

⁴ "Poll of Doctors Gauges Depth of Medical Crisis," *Las Vegas Review-Journal*, March 23, 2002.

⁵ "Doctor Exodus A Crisis in Mississippi," *The Cincinnati Post*, July 12, 2002.

⁶ "Malpractice Premiums Force Some Doctors to Leave Arizona," *Arizona Daily Star*, April 16, 2004.

Non-Economic Damage Awards Paid by Doctors in Texas Have Declined Dramatically

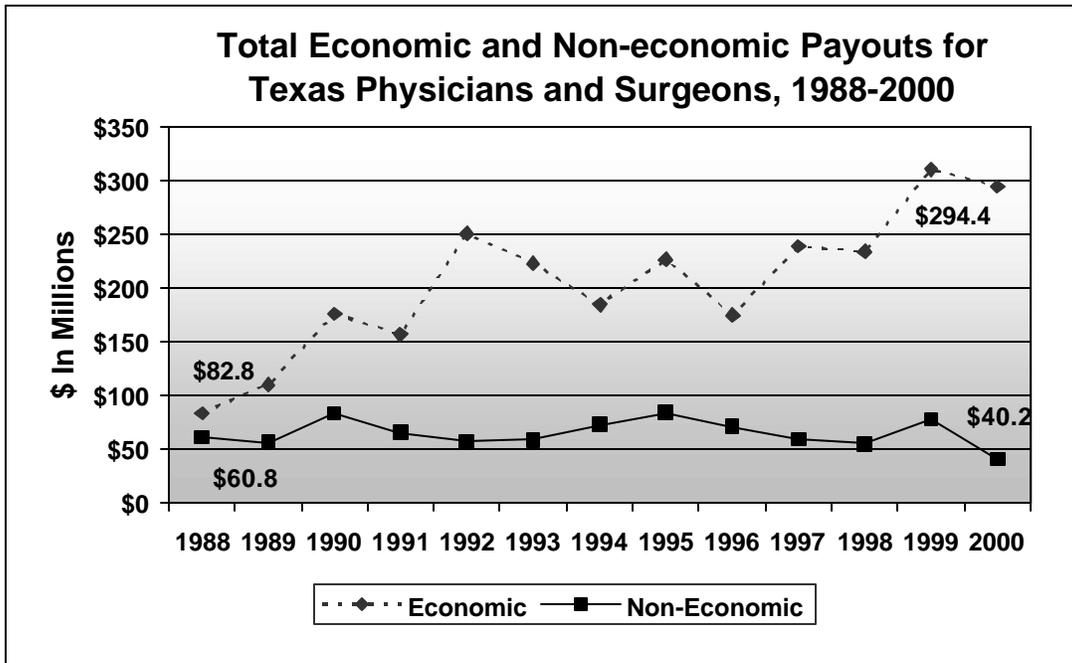
Caps on non-economic damages have been a priority of the medical lobby because it's politically easier to deny damages that aren't accompanied by an invoice or pay stub. However, it is clear from examinations of claims files that these damages are not "skyrocketing." In fact, they are barely growing at all.

Little data exists about the amounts and percentages of total medical malpractice awards paid by doctors that go towards economic and non-economic damages. Florida and Texas may be the only two states that collect such information. A soon-to-be published study of Florida claims files, presented by Duke University researchers at a DePaul University Law School conference in April 2004, found that nearly all of the growth in awards over the past decade can be attributed to wage losses.¹ In other words, as patients' incomes have grown, so have their losses when an injury disables them from work.

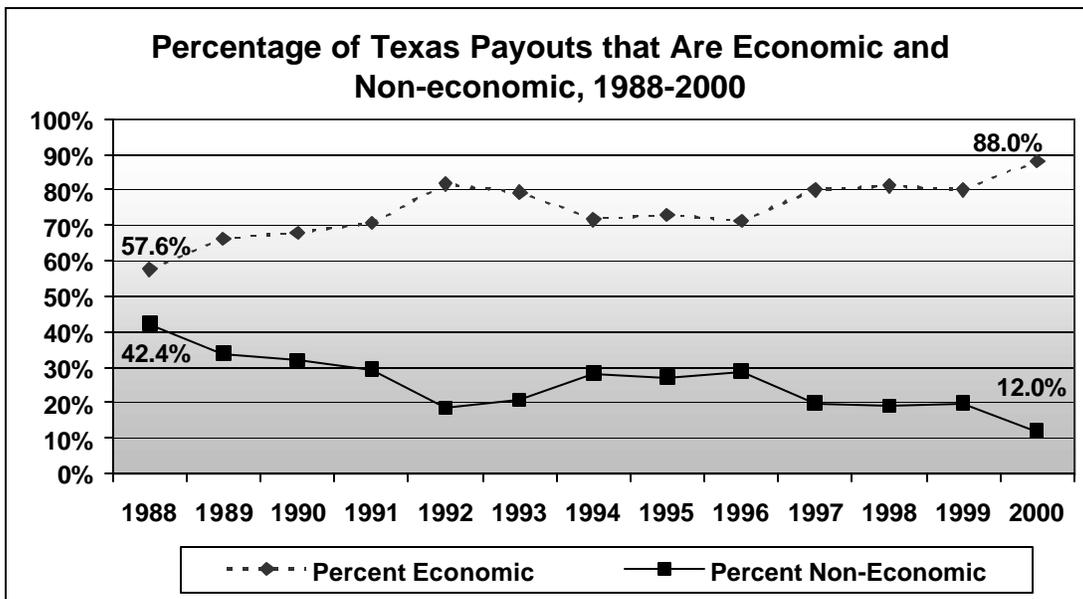
Texas law requires the Texas Department of Insurance to gather liability claims information from insurers, including the amounts of economic and non-economic damages payouts, and issue an annual report.

Texas Public Citizen analyzed 13 years of insurance company closed claims reports filed with the Texas Department of Insurance to determine payout trends in economic (lost income and medical care) vs. non-economic (pain and suffering due to injuries) damages.² The study found that increased payouts are due to a rapid acceleration in economic damages, not in non-economic damages. Thus, capping non-economic damages awarded to survivors of medical malpractice would do little, if anything, to stop the rise in the amount of overall malpractice payouts.

- **In Texas, economic damage awards in medical malpractice cases rose 212 percent between 1988 and 2000 while non-economic damages declined 34 percent.** In 1988, economic damage awards totaled \$82.8 million but had risen to \$294.4 million by 2000 – a 212 percent increase. Non-economic damage awards, however, totaled \$60.8 million in 1988 and declined to \$40.2 million in 2000 – a drop of 34 percent.
- **The non-economic percentage of total yearly medical malpractice payouts in Texas declined dramatically between 1988 and 2000 to just 12 percent of all payouts.** In 1988, non-economic damages comprised 42.4 percent of the total amount of medical malpractice payouts made by doctors. However, the non-economic share dropped dramatically to 12 percent by 2000. In contrast, economic damages comprised 57.6 percent of all doctor payouts in 1988 but climbed to 88 percent by 2000.



Source: Texas Department of Insurance Closed Claims Data, 1988-2000.



Source: Texas Department of Insurance Closed Claims Data, 1988-2000.

¹ Presentation made by Neal Vidmar, Professor, Duke University, at DePaul University Law School Chicago, Ill., April 15, 2004.

² Closed Claims Data for 1988 through 2000 were downloaded from the Texas Department of Insurance Web site. Available at <http://www.tdi.state.tx.us/index.html>. Field Q7C of this data indicates the business class associated with each claim. For this analysis, claims identified under the business class of “Physicians and Surgeons” (19) were used. If the payout is reached by settlements or verdict (either before or after a verdict) the insurance company is required to indicate in the closed claims survey whether or not the settlement was influenced by non-economic or exemplary damages. This information is indicated in either field Q11D2 or Q11E2. If either of these questions is answered in the affirmative, a breakdown of the settlement by damage category is provided. Where a claim was reportedly influenced by non-economic damages and no amount was attributed to non-economic or exemplary damages, an average non-economic and exemplary percentage was applied to the settlement amount (typically 30 percent and 10 percent, though they varied by year), so as not to underestimate the total amount under these categories. This occurred in only 36 out of 10,166 cases, and had a negligible effect on the outcome of the data analysis.

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. Rather, the Health Professional Shortage Area database maintained by the U.S. Department of Health and Human Services¹ shows that urbanization and affluence are the most frequent predictors of access to medical care.

- **53 percent of the 15 states with the worst access to primary care impose medical malpractice damage caps.** Among the 15 states with the highest percentages of population lacking primary medical care, eight impose malpractice caps. In fact, two of the four states with the greatest underserved populations have malpractice caps. [See Figure]
- **60 percent of the 15 states with the best access to primary care do not have medical malpractice damage caps.** Among the 15 states with the smallest percentages of population lacking primary care, nine do *not* have malpractice caps.² The alleged “crisis” states of New Jersey, Pennsylvania, Connecticut, Illinois and Ohio are ranked 2nd, 8th, 9th, 13th and 14th best in the country for their population’s access to primary care. [See Figure]
- **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.³ “Rural communities in Utah have long had a hard time attracting and retaining specialty physicians,” according to a Utah Medical Association spokesman.⁴
- **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.⁵
- **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.⁶ The American Medical Association has suggested that doctors leaving Nevada because of high insurance rates were flocking to California.⁷ Yet in 2003, *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.”⁸ 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.”⁹
- **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.¹⁰

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	No	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%
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 and Ohio did not have malpractice award caps during the year covered in this report.

¹ Health Professional Shortage Area database maintained by the Bureau of Primary Health Care, U.S. Department of Health and Human Services, available on-line at:

<http://bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm>

² *Health Care State Rankings 2001*, Kathleen O’Leary and Scott Morgan, Morgan Quitno Press, 2001.

³ National Practitioner Data Bank, 2001 Annual Report.

⁴ *Salt Lake City Tribune*, Aug. 7, 1997.

⁵ *Health Care State Rankings 2001*, Kathleen O’Leary and Scott Morgan, Morgan Quitno Press, 2001.

⁶ *Id.*

⁷ American Medical Association, “Statement to the Health Committee on Energy, Commerce, Re: Assessing the Need to Enact Medical Liability Reform,” presented by Donald J. Palmisano, Feb. 27, 2003.

⁸ “MDs: Missing Doctors?” *Hospitals and Health Networks*, February 2003.

⁹ *Id.*

¹⁰ Thomas C. Ricketts, Sarah E. Tropman, Rebecca T. Slifkin, Thomas R. Konrad, “Migration of Obstetrician-Gynecologists Into and Out of Rural Areas, 1985 to 1990,” *Medical Care*, Vol. 34, 1996.

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 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.
- **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 tort system 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 and severe brain damage), 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 President Bush’s Council of Economic Advisors phrased it very well in their 2002 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 to families, communities and taxpayers, and ultimately increases them. While it is unfortunate that doctors have had to cope with large temporary spikes in liability premiums, the silver lining is the message that the tort system is sending about preventable 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.

Medical Providers Can Reduce the Number of Medical Malpractice Claims Brought Through Conflict Management Systems and Honesty Policies

- **Most victims of medical malpractice want the same thing – and it isn't money.** Patients and families with medical concerns usually want a combination of three things: an acknowledgement of their suffering with an apology if appropriate, a straightforward explanation of what happened, and assurances that the incident will not be repeated.¹ But they rarely get their wish, as most physicians are hesitant to disclose details of medical errors or admit fault for fear of being sued.² Few patients who suffer from medical errors actually sue, however, and studies show that apologies and mediation policies can reduce these numbers even further. Steve Kraman, chief of staff at the Veterans Affairs Medical Center in Lexington, Kentucky puts it this way: “If you treat people the way that they want to be treated, they don't want to take you to court.”³
- **Hospitals and insurers that have honesty policies or conflict management systems have seen a reduction both in the number of malpractice claims filed and in payouts, *without legislation and without taking away patients' rights.***

The Veterans Affairs Medical Center in Lexington, KY has a policy of telling patients when mistakes are made and automatically compensating victims. Despite readily acknowledging fault, the center ranks in the lowest 25 percent of all VA medical centers in malpractice expenses.⁴

The National Naval Medical Center employs an Organizational Ombudsman and Mediator to resolve disputes that could potentially result in malpractice claims. During a 20-month period between 2001 and 2003, the mediator handled 170 cases. Of these, 169 were resolved to the satisfaction of both parties and none have resulted in legal claims.⁵

The Copic Companies, a Denver malpractice insurer, encourages its doctors to report medical injuries or complications and will pay patients up to \$30,000 to compensate them for medical costs and lost wages. The average payout for cases in the program was \$4,300 between October 2000 and March of 2003; Copic's average payout after a claim or lawsuit was \$52,000 between 1998 and 2003.⁶

- **A culture that encourages health care professionals to disclose errors will help prevent future errors.** The Lexington VA center found that errors are now being avoided because staff willingly come forward to highlight potential problems.⁷ Lessons learned from the Organizational Ombudsman and Mediator program are translated into immediate recommendations to facilitate improvements in care and reduce medical errors.⁸ By reducing the numbers of errors that occur, hospitals will also be reducing the number of medical malpractice claims brought by patients.

¹ See Houk & Moidel, “Integrated Conflict Management Systems in Healthcare: A Practical Innovation Whose Time Has Come,” *ACResolution*, Spring 2003.

² *Id.*

³ Julie Appleby, “Insurer, Hospitals try Apologies for Errors; Institutions see Lawsuits, Claims Diminish under such Policies,” *USA Today*, March 5, 2003.

⁴ *Id.*

⁵ Houk, *supra* note 1.

⁶ Appleby, *supra* note 3.

⁷ *Id.*

⁸ Houk, *supra* note 1.