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

Congress Watch
March 2003

Acknowledgments

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Executive Summary

The major findings in this report are the following:

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

- **Between 44,000 to 98,000 Americans die in hospitals each year due to *preventable* medical errors, according to the Institute of Medicine (IOM).** By comparison, the annual death toll is 43,000 from automobile accidents, 42,000 from breast cancer, and 15,000 from AIDS.

- **The costs of doctor negligence and the medical liability system is much greater for patients than doctors.** The IOM estimates the annual costs to society for medical errors in hospitals at $17 billion to $29 billion. These costs include disability and health care costs, lost income, lost household production and the personal costs of care. They do not include medical malpractice occurring outside the hospital setting. By contrast, the National Association of Insurance Commissioners reports that the total amount spent on medical malpractice insurance in 2000 was $6.4 billion – at least three to five times less than the costs of malpractice to society.

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

- **The landmark Harvard Medical Practice Study and other studies have found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers found that only one in eight preventable medical errors committed in hospitals results in a malpractice claim. Researchers replicating this study made similar findings in Utah and Colorado. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. In other words, for every 6 medical errors only 1 claim is filed.

- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the Medicare Payment Advisory Commission (MedPAC), liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the past year. The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

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

- **Malpractice insurance costs have risen at half the rate of medical inflation, debunking the myth of "out-of-control juries."** While medical costs have increased by 113 percent since 1987, the total amount spent on medical malpractice insurance has increased by just 52 percent over that time—less than half of medical services inflation.

- **Government data shows that medical malpractice awards have increased at a much slower pace than claimed by Jury Verdict Research.** According to the federal government's National Practitioner Data Bank (NPDB), the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2001, from $100,000 to $135,000. By contrast, data from Jury Verdict Research (JVR), a private research firm, shows that awards rose 100 percent from 1997 to 2000, from $503,000 to $1 million. The reasons for the huge difference: JVR only collects jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.

- **Government data shows that medical malpractice awards have increased at a slower pace than health insurance premiums.** According to the federal government's National Practitioner Data Bank, the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2000, from $100,000 to $135,000. But during the same time, the average premium for single health insurance coverage has increased by 39 percent. [See Figure, "Growth in Health Insurance Costs and Malpractice Awards Compared."] Payments for health care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice awards.

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

- **There is no growth in the number of new medical malpractice claims.** According to the National Association of Insurance Commissioners (NAIC), the number of new medical malpractice claims declined by about four percent between 1995 and 2000. There were 90,212 claims filed in 1995; 84,741 in 1996; 85,613 in 1997; 86,211 in 1998; 89,311 in 1999; and 86,480 in 2000.

- **For much of the 1990s, doctors benefited from artificially lower premiums.** According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, "What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income." IRMI also noted: "Clearly a business cannot continue operating in that fashion indefinitely."
- **One major insurer appears to have triggered a "crisis" in at least four states studied.** Case studies on Mississippi, Nevada, Pennsylvania, and West Virginia in this briefing book show that the "crisis" in at least these four states was triggered after a leading company, The St. Paul Companies, Inc., withdrew from the medical liability marketplace in December 2001. That decision had more to do with St. Paul's reckless cash flow policies than it did with malpractice claims or jury awards.

- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy is booming and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.

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

- **Five percent of doctors are responsible for 54 percent of malpractice payouts in the U.S.** Public Citizen's analysis of the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, found that 5.1 percent of doctors (35,009) have been responsible for two or more malpractice awards to patients. These doctors are responsible for 54 percent of all payouts reported to the Data Bank. Of these, only 7.6 percent have been disciplined by state medical boards. Only 17 percent of doctors (1 out of 6) who have made 5 or more malpractice payouts have been disciplined. (For consistency, doctors' records are experessed as payouts reported by the NPDB. In nine states with supplemental insurance funds, a small portion of duplicate payouts maybe included in this number).

Few, If Any, Malpractice Lawsuits Are "Frivolous"

- **Plaintiffs drop ten times more claims than they pursue**. Based on Physician Insurer Association of America (PIAA) figures, Public Citizen estimates that about 54 percent of claims are being abandoned by patients. Attorneys often may send a statutorily required notice of intent to claim or file a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim. We estimate that the number of cases withdrawn voluntarily by plaintiffs was 92,621, *ten times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent.*

- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files. The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, "These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care."

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

- **“Non-economic” damages aren’t as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called “non-economic” damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to PIAA, the average payment between 1985 and 2001 for a “grave injury,” which encompasses paralysis, was only $454,454.

- **No evidence supports the claim that jury verdicts are random “jackpots.”** Studies conducted in California, Florida, North Carolina, New York, and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered. In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.

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

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

Solutions to Reduce Medical Errors and Long-term Insurance Rates

- **Implement patient safety measures proposed by the Institute of Medicine.** The “systems approach” to patient safety advocated by the Institute of Medicine shows promise. Some three years after the release of its report little has been done to establish mandatory nationwide error reporting systems, identify unsafe practices, or raise performance standards. Although experts using the systems approach have identified a number of promising strategies to reduce malpractice, few have been implemented.

- **Open the National Practitioner Data Bank.** Information about doctor discipline, including state sanctions, hospital disciplinary actions and medical malpractice awards is now contained in the National Practitioner Data Bank. HMOs, hospitals and medical boards can look at the National Practitioner Data Bank but consumers cannot, because the names of

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

- **Improve oversight of physicians.** Less than one-half of one percent of the nation's doctors face any serious state sanctions each year. 2,708 total serious disciplinary actions a year, the number state medical boards took in 2001, are a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by medical errors annually. State medical boards should be strengthened and more doctors should be disciplined for incompetence.

- **Limit physicians' workweek to reduce hazards created by fatigue.** American medical residents work among the highest—if not the highest—number of hours in the professional world. They work up to 120 hours a week, including 36-hour shifts for several weeks at a time. After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10% blood alcohol level. In other words, doctors who would be considered too unsafe to drive may still treat patients for 12 more hours. Residents should be limited to an 80-hour workweek.

Introduction

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

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

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

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

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

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

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

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

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

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

- **Medical journals, state reporting systems and news accounts document continuing, widespread disregard for patient safety.**

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

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

  ***Wrong-patient surgery*.** According to a study published in the *Annals of Internal Medicine*, New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.[4] (There were nine such instances in Florida in 2001.[5]) In trying to determine how such shocking errors could occur, the New York researchers analyzed one case in detail. The case study determined that medical personnel had ignored "many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure."

- **The resources devoted to preventing medical errors are disproportionate to their toll in lives.** Deaths attributable to medical errors each year exceed those caused by breast cancer and AIDS. Yet while the federal government spends $655 million on breast cancer prevention[6] and $3.5 billion on AIDS prevention,[7] only about $130 million has been committed this year, for the first time, for improving patient safety.[8]

- **Physicians' cavalier attitudes toward medical errors are out of step with public opinion.** The *New England Journal of Medicine* recently released a survey of physicians and the public on the issue of medical errors.[9] The public understands this problem far better than do physicians. The public is more likely than physicians to agree with patient safety experts' assessments of how to reduce medical errors. The public understands the need for

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

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

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[1] Institute of Medicine, To Err Is Human: Building a Safer Health System, November, 1999.
[2] Berens, "Infection Epidemic Carves Deadly Path," *Chicago Tribune*, July 21, 2002. This number is attributed to the "Tribune's analysis, which adopted methods commonly used by epidemiologists."
[3] Barker et al, "Medication Errors Observed in 36 Heath Care Facilities," 162 Arch Intern Med. 1897 (2002).
[4] Chassin & Becher, "The Wrong Patient," 136 Ann Intern Med. 826 (2002).
[5] Agency for Health Care Administration, *Risk Management Reporting Summary*, March 2002.
[6] "Fiscal Year 2003 Defense Appropriations Conference Summary Of Agreements," Committee on Appropriations, October 9, 2002. See also: http://216.239.53.100/search?q=cache:azyKTgpXKNEC:www.house.gov/appropriations/news/107_2/03defconf.htm+%22breast+cancer%22+FY+2002+budget+&hl=en&ie=UTF-8
[7] Kaiser Family Foundation, *Federal HIV/AIDS Spending: A Budget Chartbook*, 2001.
[8] *HHS Announces $50 Million Investment to Improve Patient Safety*. Press Release, October 11, 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/news/press/pr2001/patsafpr.htm; Phone conversation with Veterans Health Administration FOIA Officer, Clay Johnson, December 19, 2002; Phone conversation with Agency for Healthcare Research and Quality Public Inquiries Officer, Paula Hunt, December 19, 2002.
[9] *Views of Practicing Physicians and the Public on Medical Errors*, The New England Journal of Medicine, 347:1933-1944 (Dec. 12, 2002).

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

- **The landmark Harvard Medical Practice Study found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in eight medical errors committed in hospitals results in a malpractice claim.[1] Researchers replicating this study made similar findings in Colorado and Utah.[2] [See figure "Malpractice Claims Gap: Ratio of Medical Errors to Claims Filed."]

- **Actual numbers collected by government agencies show a similar claims gap.** A Florida statute requires hospitals to report "adverse incidents," defined as "an event over which health care personnel could exercise control" that results in death or injury. Tables prepared by Florida's Agency for Health Care Administration have compared reports of adverse incidents to filing of new malpractice claims. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims.[3] In other words, for every 6 medical errors only 1 claim is filed. [See figure "Florida Malpractice Claims Gap: 1996-1999 Ratio of Medical Errors to Claims Filed.".]

- **By any measure, it is clear that the number of medical errors far outstrips the number of lawsuits.** On hospital discharge forms, health information management specialists are asked to record an "external cause of injury," or "E-code" for a patient. A number of codes correspond to "medical misadventures" during surgical and medical care.[4] Public Citizen obtained E-Code information from those states that collect such data and will supply it either for free or for less than $100. In each of the states for which we were able to obtain accurate data, medical injuries outnumbered compensation payments to injured patients by ratios similar to those found by academic researchers. [See figure "Malpractice Compensation Gap: Hospital E-Code Injuries vs. Malpractice Payments."]

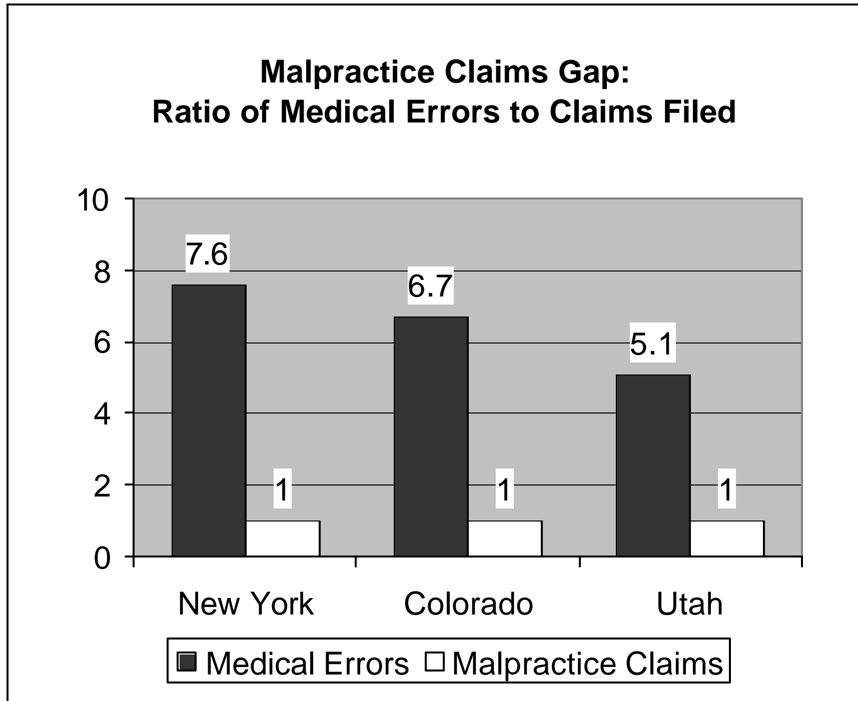
- **Overall tort expenditures are less than the cost of medical injuries.** Because so few medical injuries result in compensation to patients, the overall expenditures made for medical liability are far below the projected injury costs. The Institute of Medicine estimated the costs of preventable medical injuries in hospitals alone at between $17 billion and $29 billion.[5] The Utah Colorado Medical Practice study estimated it at $20 billion.[6] By contrast, the National Association of Insurance Commissioners reports that the total amount spent on medical malpractice insurance in 2000 was $6.4 billion.[7] This is at least three to five times less than the cost of malpractice to society. [See figure "Malpractice Compensation Gap: Annual Costs of Medical Negligence vs. Medical Liability Expenditures."]

- **Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues.** According to experts at the federal government's Medicare Payment Advisory Commission (MedPAC), who have no axe to grind about medical liability, liability insurance premiums make up just a tiny part of a physician's expenses and

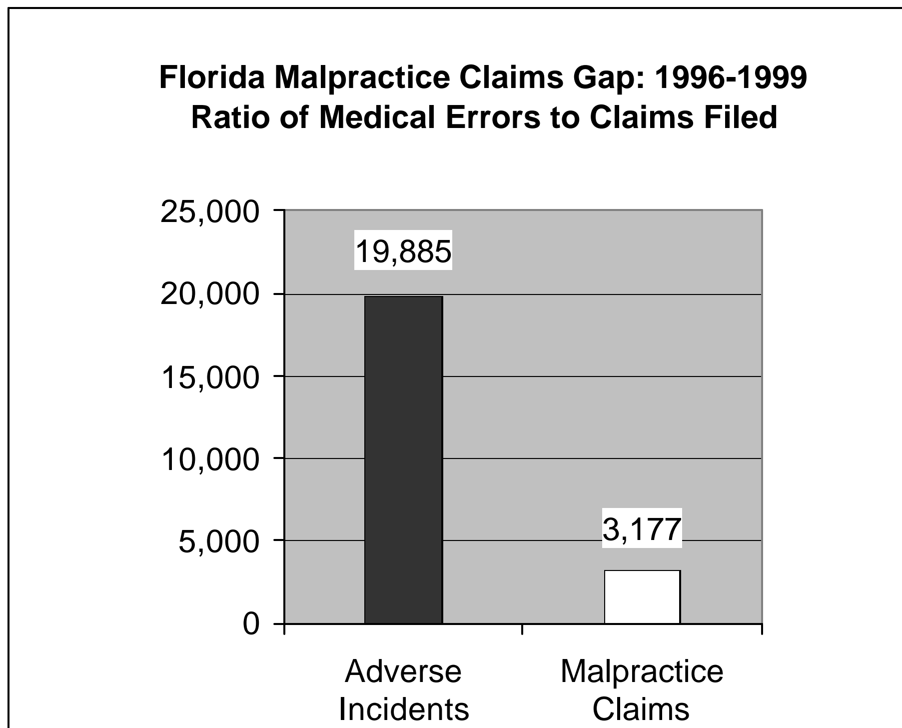
have increased by only 4.4 percent over the last year.[8] The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

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

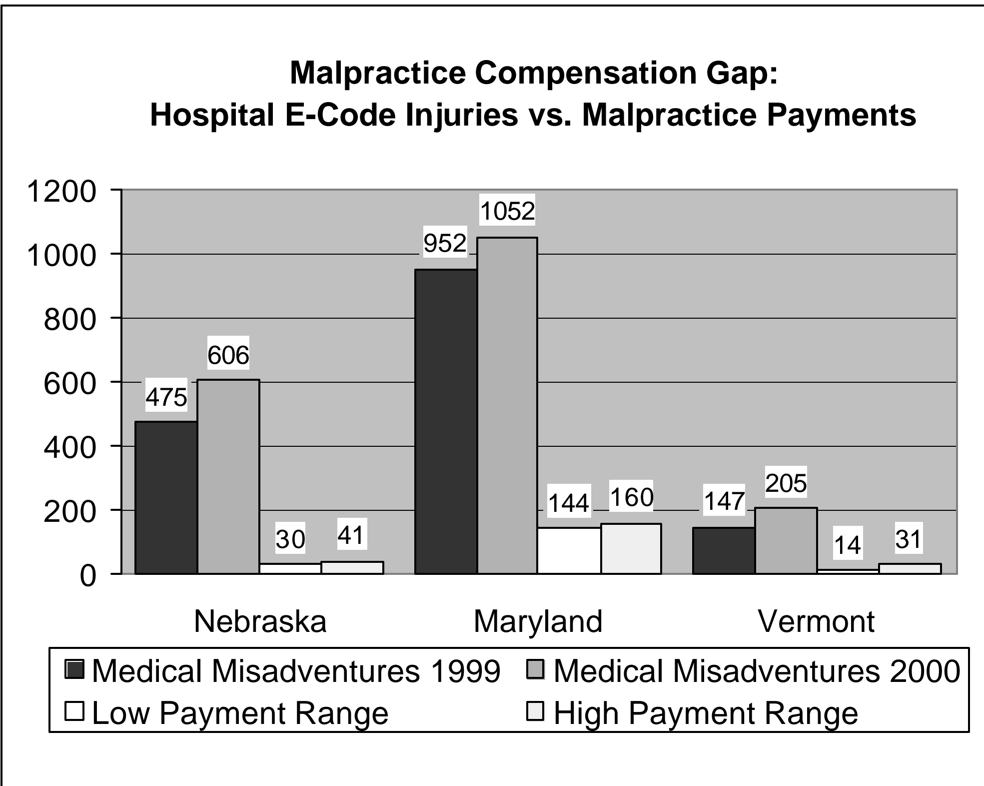
[1] Harvard Medical Practice Study Group, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990).
[2] Studdert et al, "Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," 33 Ind. L. Rev. 1643 (2000).
[3] The Agency for Health Care Administration; Division of Health Quality Assurance. Reported malpractice claims by district compared to reported adverse incidents 1996, 1997, 1998, 1999.
[4] Adverse events characterized as "misadventures" include accidental cuts during surgery, foreign objects left in a patient during surgery, infections caused by failure of sterile precautions, and performance of inappropriate operations. They do not include abnormal reactions and other complications that occur during medical care. A misadventure does not necessarily constitute "medical negligence," which is a legal term of art. However, a "misadventure" would constitute malpractice if it was a deviation from the standard of care and resulted in more than momentary harm to a patient.
[5] Institute of Medicine, To Err is Human (2000).
[6] Studdert et al supra note 2.
[7] NAIC, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001).
[8] Official Transcript, Medicare Payment Advisory Commission, Public Meeting, December 12, 2002.
9 Congressional Budget Office Cost Estimate, H.R. 4600, September 24, 2002.



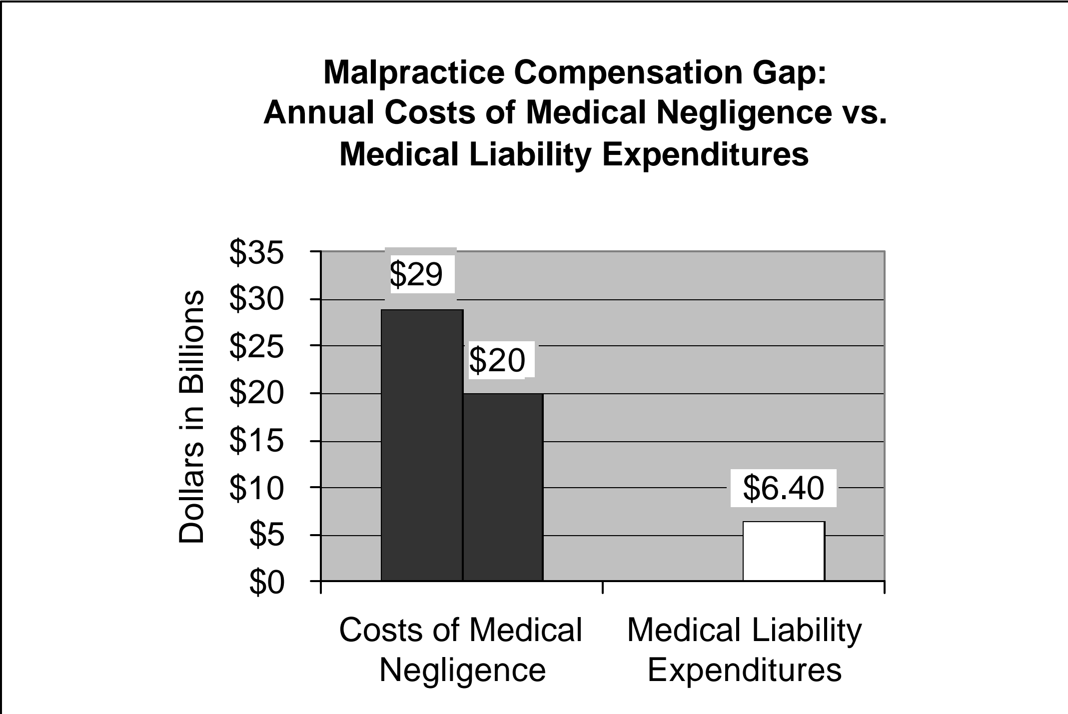
Source: Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990); Studdert et al, "Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from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



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



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



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

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

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

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

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

Sources:

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

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

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

- **Government data shows that medical malpractice awards have increased at a much slower pace than claimed by Jury Verdict Research.** According to the federal government's National Practitioner Data Bank (NPDB), the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2001, from $100,000 to $135,000.[1] By contrast, data from Jury Verdict Research (JVR), a private research firm, shows that awards rose 100 percent from 1997 to 2000, from $503,000 to $1 million.[2] The reasons for the huge difference: JVR only collects jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.

- **Malpractice insurance costs have risen at half the rate of medical inflation, debunking the myth of "out-of-control juries."** At a July 2002 congressional hearing, Dr. Richard Anderson of The Doctors Company complained that "since 1990, [malpractice] claims costs have risen annually by 6.9 percent, nearly three times the rate of inflation."[3] The appropriate comparison is to health care inflation, because the bulk of damage awards go to pay medical bills.[4] But while medical costs have increased by 113 percent since 1987, the total amount spent on medical malpractice insurance has increased by just 52 percent over that time—less than half of medical services inflation.[5] [See figure "Medical Care Services Inflation vs. Growth in Malpractice Written Premiums."]

- **Government data shows that medical malpractice awards have increased at a slower pace than health insurance premiums.** According to the federal government's National Practitioner Data Bank, the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2000, from $100,000 to $135,000.[6] But during the same time, the average premium for single health insurance coverage has increased by 39 percent.[7] [See Figure, "Growth in Health Insurance Costs and Malpractice Awards Compared."] Payments for health care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice awards.

- **Medical malpractice awards are increasing in line with other general social trends.** In addition to medical costs, malpractice awards include two other main elements, lost wages and pain and suffering. These, like medical costs, are in turn multiplied by life expectancy. All of these factors are affected by upward social trends. Juries have not changed their behavior, but the numbers jurors take into account in making awards have changed.

- **Increases in our standard of living lead to higher awards.** Median household income has risen by an average of about $1,000 each year, more than doubling over the past 20 years from $17,710 in 1980 to $42,151 in 2000.[8] This increase reflects not only inflation but also real increases in our affluence. Higher expectations about quality of life affect the valuation placed on a victim's pain and suffering. In years past, sickness and injury were viewed as an inevitable part of life. Today, health and safety are taken for granted, and most Americans expect to live a long, healthy life. Americans place a greater value on physical activity; the International Health, Racquet, and Sportsclub Association reports that health club memberships are increasing at a 9 percent annual rate.[9] It is more likely today that a plaintiff will have regularly engaged in recreational or other physical activities, making a disabling injury all the more severe.

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

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[1] National Practitioner Data Bank Annual Reports, 1997 through 2001.
[2] Jury Verdict Research, "Medical Malpractice: Verdicts, Settlements and Statistical Analysis," 2002.
[3] Statement of Richard Anderson Before House Energy and Commerce Committee, July 17, 2002.
[4] Institute of Medicine, *To Err is Human* (2000).
[5] Office of the West Virginia Insurance Commission, *Medical Malpractice: Report on Insurers with over 5% Market Share* (November 2002)
[6] National Practitioner Data Bank Annual Reports, 1997 through 2001.
[7] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits Surveys, 1998-2002; National Practitioner Data Bank Annual Reports, 1997 through 2001.
[8] Table H-7. Divisions—Households (All Races) by Median and Mean Income, 1976 to 2000. U.S. Census Bureau.
[9] http://www.ihrsa.org/industrystats/opbenchmarks.html
[10] Table 12. Estimated life expectancy at birth in years, by race and sex, National Vital Statistics Report, Vol. 50, No.6, March 21, 2002. www.cdc.gov
[11] www.ssa.gov

Medical Care Services Inflation vs. Growth in Malpractice Written Premiums

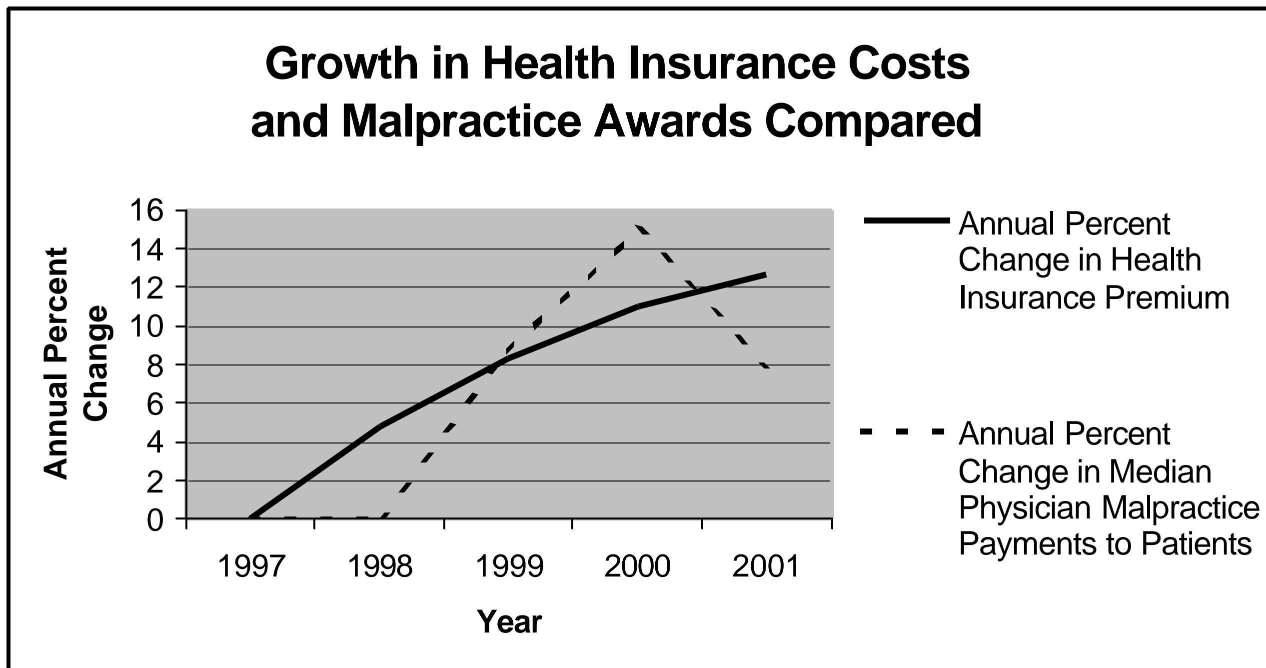
Year	CPI-U Index	Annual Percent Change	Cumulative Percent Change		Industry MedMal Net Written Premiums (000's)	Annual Percent Change	Cumulative Percent Change
1987	130.4	–	–		4,004,185	–	–
1988	139.0	6.6%	6.6%		4,027,825	0.6%	0.6%
1989	147.9	6.4%	13.4%		4,278,009	6.2%	6.8%
1990	161.5	9.2%	23.8%		4,014,622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

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

Growth in Health Insurance Costs and Malpractice Awards Compared

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

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



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

- **For much of the 1990s, doctors benefited from artificially lower premiums.** According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, "What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income." IRMI also noted: "Clearly a business cannot continue operating in that fashion indefinitely."[1]

- **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 loses [sic] and as insurers have suffered large claims losses in other areas."[2]
  >
  > "For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market surged, investments by these historically conservative insurers rose to 10.6% in 1999, up from a more typical 3% in 1992. With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates. The industry reported realized capital gains of $381 million last year, down 30% from the high point in 1998, according to the A. M. Best Company, one of the most comprehensive sources of insurance industry data." [3]

- **West Virginia Insurance Commissioner blames the market.** According to the Office of the West Virginia Insurance Commission (one of the states in the throes of a medical malpractice "crisis"), "[T]he insurance industry is cyclical and necessarily competitive. We have witnessed these cycles in the Medical Malpractice line in the mid-'70's, the mid-80's and the present situation. This particular cycle is, perhaps, worse than previous cycles as it was delayed by a booming economy in the '90's and is now experiencing not just a shortfall in rates due to competition, but a subdued economy, lower interest rates and investment yields, the withdrawal of a major medical malpractice writer and a strong hardening of the reinsurance market. Rates will, at some point, reach an acceptable level to insurers and capital will once again flow into the Medical Malpractice market."[4]

- **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.[5] He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy is booming and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.

- **The same trends are present in other lines of insurance.** Property/casualty refers to a large group of liability lines of insurance (30 in total) including medical malpractice, homeowners, commercial, and automobile. The property/casualty insurance industry has exhibited cyclical behavior for many years, as far back as the 1920s. These cycles are characterized by periods of rising rates leading to increased profitability. Following a period of solid but not spectacular rates of return, the industry enters a down phase where prices soften, supply of the insurance product becomes plentiful, and, eventually, profitability diminishes, or vanishes completely. In the down phase of the cycle, as results deteriorate, the basic ability of insurance companies to underwrite new business or, for some companies even to renew some existing policies, can be impaired. This is because the capital needed to support the underwriting of risk has been depleted through losses. The current market began to harden in 2001, following an unusually prolonged period of soft market conditions in the property-casualty section in the 1990s. The current hard market is unusual in that many lines of insurance are affected at the same time, including medical malpractice. As a result, premiums are rising for most types of insurance. The increases have taken policyholders by surprise given that they came after several years of relatively flat to decreasing prices.[6]

- **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."[7] 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."[8]

- **There is no growth in the number of new medical malpractice claims.** According to the National Association of Insurance Commissioners (NAIC), the number of new medical malpractice claims declined by about four percent between 1995 and 2000. There were 90,212 claims filed in 1995; 84,741 in 1996; 85,613 in 1997; 86,211 in 1998; 89,311 in 1999; and 86,480 in 2000.[9]

[1] Kolodkin, Charles, "Medical Malpractice Insurance Trends? Chaos!" International Risk Management Institute. http://www.irmi.com/expert/articles/kolodkin001.asp
[2] American Medical Association Report 35 of the Board of Trustees, p. 2, available at http://www.ama-assn.org/ama1/upload/mm/annual02/bot35a02.rtf..
[3] American Medical Association Report 35 of the Board of Trustees, p. 3, available at http://www.ama-assn.org/ama1/upload/mm/annual02/bot35a02.rtf.
[4] 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.
[5] Americans for Insurance Reform, "Medical Malpractice Insurance: Stable Losses/Unstable Rates," October 10, 2002. See also: http://www.insurance-reform.org/StableLosses.pdf.
[6] Hot Topics & Insurance Issues, Insurance Information Institute, www.iii.org
[7] Christopher Oster and Rachel Zimmerman,"Insurers' Missteps".
Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal* , June 24, 2002.
[8] Charles Kolodkin, Gallagher Healthcare Insurance Services, "Medical Malpractice Insurance Trends? Chaos!" ((September 2001), found at http://www.irmi.com/expert/articles/kolodkin001.asp.
[9] National Association of Insurance Commissioners, Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000 (2001).

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

- **Five percent of doctors are responsible for 54 percent of malpractice payouts in the U.S.** Public Citizen’s analysis of the federal government’s National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, found that 5.1 percent of doctors (35,009) have been responsible for two or more malpractice awards to patients. These doctors are responsible for 54 percent of all payouts reported to the Data Bank. Of these, only 7.6 percent have been disciplined by state medical boards. Only 17 percent of doctors (1 out of 6) who have made 5 or more malpractice payouts have been disciplined.[1] (For consistency, doctors’ records are experessed as payouts reported by the NPDB. In nine states with supplemental insurance funds, a small portion of duplicate payouts maybe included in this number).

- **A Vanderbilt University study found that doctors with past records of malpractice claims can be expected to have “appreciably worse claims experience” than other doctors in future years.**[2] Despite the fact that claims history predicts future claims, neither licensing boards nor the insurance market have been effective in reducing malpractice. There are over 6,000 doctors in the U.S. who have paid *four* or more malpractice claims, amounting to $6.5 billion. These numbers can be expected to grow.

- **Redacted records from the National Practitioner Data Bank demonstrate that lax discipline by medical boards allows questionable doctors to inflict repeated injuries on patients:**

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

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

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

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

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[1] National Practitioner Data Bank, Sept. 1, 1990 – Sept. 30, 2002.
[2] Sloan et al, “Medical Malpractice Experience of Physicians: Predictable or Haphazard?” 262 JAMA 3291 (1989)

Few *If Any* Malpractice Lawsuits Are "Frivolous"

- **The contingency fee system discourages attorneys from bringing frivolous claims.** Medical malpractice cases are brought on a contingency fee basis, meaning the attorney receives payment only in the event there is a settlement or verdict. If the claim is closed without payment, the attorney does not receive a fee. Since attorneys must earn money to stay in business, it follows that they would not intentionally take on a non-meritorious case.

- **The high cost of preparing a medical malpractice case discourages frivolous claims—and meritorious claims as well.** Medical malpractice cases are very expensive for plaintiffs' attorneys to bring, with out-of-pocket costs for cases settled at or near the time of trial (when most cases are settled) ranging from $15,000 to $25,000.[1] If the case goes to trial, the costs can easily be doubled.[2] These costs do not include the plaintiff's attorney's time, and an attorney pursuing a frivolous case incurs opportunity costs in not pursuing other cases. An attorney incurs expenses beginning with the determination of whether a case has merit. First, the attorney is required to obtain copies of the patient's medical records from all the providers for analysis by a competent medically trained person. If that initial consultation reveals a likelihood of medical negligence, the records must then be submitted to medical specialists, qualified to testify in court, for final review. Typically, the records must be sent to experts outside of the plaintiff's state, as physicians within the state will refuse to testify against local colleagues. As a result, the experts who agree to review records and testify can and do charge substantial fees. Fees from $1,000 per hour to several thousand dollars are not uncommon.[3] Discovery involves taking the sworn testimony of witnesses and experts. Such depositions cost $300 and up, depending upon their length and complexity. If an expert witness is deposed, the plaintiff's attorney is charged for the witness' preparation time and time attending the deposition.

- **Plaintiffs drop 10 times more claims than they pursue**. The Physician Insurers Association of America (PIAA) reports that between 1985 and 2001 a total of 108,300 claims were "dropped, withdrawn or dismissed." This is 63 percent of the total number of claims (172,474) closed during the study period.[4] It is unclear what portion constitutes involuntarily dismissed cases (dismissed after a motion was filed by the defendant) rather than cases voluntarily dismissed by plaintiffs. According to researchers at the University of Washington School of Medicine, about nine percent of claims files are closed after the defendant wins a contested motion[5] Based on this figure, Public Citizen estimates that about 54 percent of claims are being abandoned by patients.[6] An attorney may send a statutorily-required notice of intent to claim or file a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim. We estimate that the number of cases withdrawn voluntarily by plaintiffs[7] was 92,621, *10 times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent*.[8]

- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files.[9] The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, "These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care." The percentage of all medical malpractice claims that go to trial is only 6.6 percent, according to PIAA, meaning that the parties and their attorneys ultimately reach agreement about liability five times more often than neutral doctors do. If truly frivolous lawsuits were being pursued, the proportion of claims going to trial would exceed the 38 percent of claims on which even doctors will disagree.

- **The costs of defending claims that are ultimately dropped are not unreasonable.** Medical liability insurers have complained about the costs of defending cases that are ultimately dropped. But the professional obligation of lawyers to exercise due diligence is essentially identical to the duty of physicians. The lawyer must rule out the possibility of proving medical negligence before terminating a claim, just as doctors must rule out the possibility of illnesses suggested by their patients' symptoms. The doctor performs his duty by administering tests; the lawyer performs hers by using discovery procedures. Both processes can lead to dead ends. But plaintiffs' lawyers have no financial incentive to abuse the litigation process: they are using their own time and money to pursue discovery activities, and are only paid for work on behalf of clients whose cases are successful.

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[1] Based on Public Citizen interviews with plaintiff attorneys.
[2] See Vidmar, Medical Malpractice and the American Jury (1995).
[3] According to the Physician Insurers Association of America, expert witnesses in a medical malpractice case are paid on average over $4,800.
[4] *Trend Analysis Report*, 2001 Edition, 6b-4
[5] Rosenblatt & Hurst, "An Analysis of Closed Obstetric Malpractice Claims," 74 *Obstetrics & Gynecology* 710 (1989).
[6] Another study, Sloan et al, *Suing for Medical Malpractice*, (1993) found the number was 5.9 percent, not nine percent. According to our queries to the database of Federal District Court Civil Cases, maintained by Professors Theodore Eisenberg and Kevin Clermont, about 4.7 percent of 10,075 medical malpractice cases between 1987 and 1992 were disposed of by pre-trial motion. To make a conservative estimate, however, we are going to use the nine percent figure.y
[7] .09 times 172,474 equals 15,679; subtracted from 108,300 equals 92,621 claims voluntarily withdrawn.
[8] 9,293/172,474=.054
[9] Posner et al, "Variation in expert opinion in medical malpractice review," 85 *Anesthesiology* 1049 (1996).

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

- **"Non-economic" damages are not as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called "non-economic" damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to PIAA, the average payment between 1985 and 2001 for a "grave injury," which encompasses paralysis, was only $454,454.

- **No evidence supports the claim that jury verdicts are random "jackpots."** Studies conducted in California, Florida, North Carolina, New York, and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered.[1] In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.

- **The insurance industry's own numbers demonstrate that awards are proportionate to injuries.** PIAA's Data Sharing Report also demonstrates the relationship between the severity of the injury and the size of the settlement or verdict.[2] PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications.[3] The average indemnity paid per file was $49,947 for the least severe category of injury and increased with severity, to $454,454 for grave injuries. All researchers found that the amount of jury verdicts fell off in cases of death, for which the average indemnity was $195,723. This is not surprising, as the costs of medical treatment for a grave injury are likely to be greater and pain and suffering would be experienced over a longer time period than in the case of death.[4]

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

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

[3] The NAIC scale grades injury severity as follows:
Emotional damage only (fright; no physical injury);
Temporary insignificant (lacerations, contusions, minor scars);
Temporary minor (infections, fall in hospital, recovery delayed);
Temporary major (burns, surgical material left, drug side-effects);
Permanent minor (loss of fingers, loss or damage to organs);
Permanent significant (deafness, loss of limb, loss of eye, kidney or lung);
Permanent major (paraplegia, blindness, loss of two limbs, brain damage);
Permanent grave (quadriplegia, severe brain damage, lifelong care or fatal prognosis);
Death

[4] Vidmar, Gross, Rose, supra at 284

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

Caps on damages for pain and sufferin7g 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.

Premium on the Truth:

"Insurers never promised that tort reform would achieve specific savings." – American Insurance Association[1]

"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 Association[2]

"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 Association[3]

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 California.[4]

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 Association.[5]

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 Mississippi[6]

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.[7]

"[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 Issues[8]

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."[9]

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."[10]

Ohio

"In the short run, we may even see prices go up another 20 percent, and people will say, 'Gee, what happened, I thought we addressed this?"' – Ray Mazzotta, president of Columbus-based Ohio Hospital Insurance Co.[11]

"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 Assurance[12]

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 Committee[13]

[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] Julie Goodman, "Premiums Rise by 45 Percent; Insurance Group's Hike Comes as Doctors Seek Relief," *Clarion-Ledger* (Jackson, Miss.), September 22, 2002.
[7] Joelle Babula, "Obstetricians Say Problems Remain," *The Las Vegas Review-Journal*, October 1, 2002.
[8] "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.
[9] "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.
[10] "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.
[11] "No Drop in Malpractice Rates Pending," *The Associated Press*, January 10, 2003.
[12] "No Drop in Malpractice Rates Pending," *The Associated Press*, January 10, 2003.
[13] Testimony at the Wyoming Legislature's Joint Labor, Health and Social Services Interim Committee, December 4-6, 2002.

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

- **A search of the scholarly literature on medicine will turn up dozens of studies documenting the incidence of medical errors, but not one peer-reviewed study documenting purely defensive medicine.** One might laugh at the spectacle of a lobbying campaign constructed around a flimsy theory unsupported by any empirical evidence. Unfortunately, the evidence *disproving* the theory is so overwhelming and compelling as to be truly frightening. Several recent studies demonstrate that current disincentives to unsafe and sloppy practices are inadequate, and show how much more dangerous medical care would be if deterrents were further weakened.

- **The Congressional Budget Office has rejected the defensive medicine theory.** The Congressional Budget Office (CBO) was asked to quantify the savings from reduced “defensive medicine” if Congress passed H.R. 4600. This bill, which contained very stringent restrictions on patients’ ability to recover damages, passed the U.S. House in 2002. CBO declined, saying:

    > Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians’ responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.
    >
    > A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments that are disproportionately likely to experience malpractice claims. Using broader measures of spending, CBO’s initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending. Although the provisions of H.R. 4600 could result in the initiation of fewer lawsuits, the economic incentives for individual physicians or hospitals to practice defensive medicine would appear to be little changed.[1]

- **Defensive medicine hasn't prevented wrong-patient surgery.** New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.[2] There were nine such instances in Florida in 2001.[3] In trying to determine how such shocking errors could occur, researchers analyzed one case in detail. The case study determined that medical personnel had ignored "many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure." In this case, "defensive medicine" measures would have included follow-up questioning or record-checking when the patient told personnel she had not been admitted for cardiac treatment. Surely if the medical providers were frightened of lawsuits they would have made such minimal inquiries.

- **Defensive medicine hasn't prevented medication errors.** An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful.[4] The authors said this amounts to about 40 potential adverse drug events per day in a typical 300-patient facility. The errors were made in spite of the presence of observers from the research team—who could easily have been called as witnesses in a medical liability lawsuit. An earlier study by Boston researchers estimated that there are some 500 preventable adverse drug events in the average hospital each year, in spite of the fact that "drug injuries frequently result in malpractice claims, and in a large study of closed claims… accounted for the highest total expenditure of any type of procedure-related injury."[5]

- **Defensive medicine hasn't prevented mammography errors.** The *New York Times* reported in June 2002 some very disturbing facts about errors committed by radiologists in reading mammograms.[6] The theory of defensive medicine predicts that radiologists would err on the side of caution, and detect more false positives than false negatives. Unfortunately the opposite is true, with studies indicating that some doctors and clinics miss as many as one in three cancers. Despite the possibility of lawsuits, doctors with no aptitude for mammography continue to read mammograms. Clinics continue to employ doctors who read too few mammograms to keep their skills sharp. It appears that only reviews by regulators spur doctors and clinics to meet minimum standards.

- **Defensive medicine hasn't prevented hospital infections.** The *Chicago Tribune* reported on July 21, 2002 that some 75,000 Americans die each year because of infections acquired in hospitals that "were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses."[7] If medical providers fear being sued over the slightest lapse, why would doctors and nurses neglect to take the most elementary precautions of washing their hands and changing scrub uniforms? Why would American hospitals "have collectively pared cleaning staffs by 25 percent since 1995"?[8] Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.[9]

- **Defensive medicine hasn't caused hospitals to keep nursing staffs up-to-strength.** Two reports published in the past six months concluded that patients in hospitals where nurses had heavier workloads had a higher risk of dying.[10] One report found specifically that each additional patient per nurse corresponded to a seven percent increase in both patient mortality and deaths following complications.[11] Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts over-staffing.

[1] CBO supra note 22.
[2] Chassin & Becher, "The Wrong Patient," 136 *Ann Intern Med.* 826 (2002).
[3] Agency for Health Care Administration, *Risk Management Reporting Summary*, March 2002.
[4] Barker et al, "Medication Errors Observed in 36 Heath Care Facilities," 162 Arch Intern Med. 1897 (2002).
[5] Bates et al, "The Costs of Adverse Drug Events in Hospitalized Patients," 277 JAMA 307 (1997).
[6] Moss, "Spotting Breast Cancer: Doctors Are Weak Link," New York Times, June 27, 2002.
[7] Berens, "Infection epidemic carves deadly path," *Chicago Tribune*, July 21, 2002. This number is attributed to the "Tribune's analysis, which adopted methods commonly used by epidemiologists."
[8] Id.
[9] U.S. Department of Health and Human Services, *Confronting the New Health Care Crisis* (July 24, 2002)
[10] Needleman J., Buerhaus P., Mattke S., Stewart M., Zelevinsky K, *Nurse-Staffing Levels and the Quality of Care in Hospitals*, N Engl J Med (2002); 346:1715-1722, May 30, 2002. *See also:* Aiken LH, Clarke SP, Sloane DM, et al., *Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction,* JAMA, 2002;288:1987-1993, October 23/30, 2002.
[11] Aiken LH, Clarke SP, Sloane DM, et al., *Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction,* JAMA, 2002;288:1987-1993, October 23/30, 2002.

Doctors' Aversion to Settlements May Increase Malpractice Insurance Costs

- **Medical malpractice insurers market their product based on aggressive defenses, not on low costs.** The Doctors Company, a leading doctor-owned insurer, states on its website: "When litigation is necessary, we dedicate more resources than our competitors to defend your good name. Our claims representatives and defense attorneys combine their knowledge of regional laws and jury experience to develop *aggressive, successful, defense strategies... We will not consent to settle without your written permission."* (emphasis theirs)[1] In other lines of insurance coverage, claims managers dispassionately evaluate the insured's exposure and make an objective decision as to whether to settle the claim. This rational calculation takes a back seat to pride and other emotional considerations when medical malpractice insurance is involved.

- **The result is that defense attorney fees are higher and verdicts are higher, pushing malpractice premiums higher.** According to A.M. Best figures cited on The Doctors Company website, the average doctor-owned medical malpractice insurer spends 32 percent of premiums on defense costs. The Doctors Company entices customers by boasting that 49 percent of its premiums are spent on defense costs.[2] A study by the West Virginia Insurance Commissioner found that one company spends 88 cents of each premium dollar on defense lawyers.

- **Malpractice insurance defense costs far exceed defense costs in other lines of insurance.** According to NAIC figures, defense costs incurred as a portion of direct premiums written amount to 4.8 percent for passenger auto liability, 7.1 percent for commercial auto liability, 16.5 for commercial general liability, and 28.9 percent for product liability.[3] Malpractice insurers seldom settle a case before the eve of trial, waiting until discovery is complete. They also take three times more cases to trial than other civil defendants. In 2000, the overall percentage of federal civil cases going to trial was 2.2, but 6.8 percent of medical malpractice cases went to trial.[4]

- **In reality, the liability insurance purchased by doctors is not just for risk management; it is also a public relations tool.** The Doctors Company and Medical Assurance both use the motto "Defending your reputation" in marketing themselves.[5] Kansas Medical Mutual Insurance Company (KaMMCO) cites "the existence of the National Practitioner Data Bank" as a reason that it is "more important than ever for health care professionals… to defend themselves against allegations of wrongdoing."[6] Doctors' complaints about high premiums must be viewed skeptically when much of the price quoted may pay for services entirely unrelated to managing risks of patient care. [7]

- **Evidence indicates that the negotiation process in medical malpractice cases fails, directly leading to the high verdicts that doctors complain about.** Pursuing a hardball defense strategy guided by emotion rather than reason will also affect the parties' ability to negotiate rational settlements. An Ohio State study compared medical and product liability negotiations. It found that product liability defense attorneys "correctly" predicted jury outcomes (i.e. rejected plaintiff demands that were higher than the jury's eventual verdict) in 12 of the 14 cases studied. By contrast, defense attorneys made the correct settlement decision in only eight of 17 medical malpractice cases in the study. In one case, the defendant rejected a demand of $2 million only to be hit with a judgment for more than $8 million. The authors concluded that, "In malpractice cases, plaintiffs gained more than defendants from rejecting settlement offers and proceeding to trial. In product liability cases, defendants gained more than plaintiffs from eschewing settlement and defending claims in court… It appears that malpractice defendants—rather than plaintiffs—may be somewhat too inclined to resist settlement and push cases to trial."[8]

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[1] http://www.thedoctors.com/resources/I-27/DocBrochure/Protectdoc4-5.html
[2] Id.
[3] National Association of Insurance Commissioners, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001).
[4] Query to database of Federal District Court Civil Cases, maintained by Professors Theodore Eisenberg and Kevin Clermont of Cornell University. http://teddy.law.cornell.edu:8090/questata.htm
[5] See http://www.thedoctors.com/resources/I-27/DocBrochure/Protectdoc4-5.html, http://www.medicalassurance.com
[6] http://www.kammco-msc.com
[7] Other "extras" that may be included in the price of malpractice insurance include Defendant Reimbursement Coverage, that pays a doctor $500 per day to attend a trial, offered by ISMIE; and "defense coverage associated with the investigation of Medicare and Medicaid billing errors, regulatory agency actions, and… an initial consultation with an attorney to discuss potential countersuits," offered by KaMMCO.
[8] Merritt and Barry, "Is the Tort System in Crisis? New Empirical Evidence," 60 Ohio St. L. J. 315 (1999).

Solutions to Reduce Medical Errors

Reducing compensation to victims of medical malpractice does not, as doctors contend, "reduce costs;" it merely shifts the costs of injuries away from dangerous doctors and unsafe hospitals and onto the injured patients, their families, and taxpayers. This, in turn, reduces the incentive to practice medicine with due regard to patient safety. The only way to reduce the cost of medical injuries is to reduce negligence and medical errors; the best way to accomplish this is by reforming the regulatory oversight of the medical profession. Public Citizen's recommendations for addressing the real medical malpractice problems are:

Federal Patient Safety Reforms

- **Open the National Practitioner Data Bank to Empower Consumers with Information About Their Doctors.**
  New York State is ahead of most states in that it provides consumers with on-line access to important information about their physicians – including a history of medical malpractice, a criminal history and a disciplinary record. Information about doctor discipline, including state sanctions, hospital disciplinary actions and medical malpractice awards is also contained in the National Practitioner Data Bank. HMOs, hospitals and medical boards can look at the National Practitioner Data Bank. Unfortunately, consumers cannot access the information because the names of physicians in the database are kept secret from the public. Congress should lift the veil of secrecy and allow the people who have the most to lose from questionable doctors to get the information they need to protect themselves and their families.

State Patient Safety Reforms

- **Improve Oversight of Physicians**
  Public Citizen has long sought greater consumer access to information about doctors, and there have been recent improvements in making that information available. Most state medical boards now provide some physician information on the Internet, but the information about disciplinary actions varies greatly, is often inadequate and can be difficult for people to access.[1]

  For more than a decade, Public Citizen's Health Research Group has been carefully scrutinizing the performance of state medical boards. As reported in our *Questionable Doctors* publication,[2] too little discipline is being done. Too many state medical boards, despite their duty to protect the public, still believe their first responsibility is to rehabilitate "impaired physicians" and shield them from the public's prying eyes. Fewer than one-half of one percent of the nation's doctors face any serious state sanctions each year. In 2002, state medical boards took 2,868 serious disciplinary actions, a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by preventable medical errors annually.

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

If all the boards did as good a job as the lowest of the top five boards, Oklahoma's rate of 7.56 serious disciplinary actions per 1,000 physicians, it would amount to a total of 6,089 serious actions a year. That would be 3,225 more serious actions than the 2,864 that actually occurred in 2002. It is likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top performances.

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

The following state reforms would improve medical board performance:

- **Reform medical board governance.** States should sever any remaining formal, debilitating links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees. At least 50 percent of the members of each state medical board and disciplinary board should be well-informed and well-trained public members who have no ties to health care providers and who, preferably, have a history of advocacy on behalf of patients. The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians who are trying to evade disciplinary actions.

- **Beef up medical board funding and staffing.** State legislatures should permit medical boards to spend all the revenue from medical licensing fees, rather than being forced to give part to the state treasury. The medical boards should raise their fees to $500 a year. All boards could benefit from hiring new investigators and legal staff. Boards should employ adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements. They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care.

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

- **Require periodic recertification of doctors based on a written exam and audit of their patients' medical care records.**

Federal and State Patient Safety Reforms

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

  Medication errors are among the most common preventable mistakes, but safety systems have been put in place in very few hospitals. Although experts using the systems approach have identified a number of promising strategies to reduce malpractice, few have been implemented. Experts have estimated that more than 950,000 serious drug errors occur annually in hospitals alone.[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]

- **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.[6]

- **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.[7] 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.[8] 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.[9] 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.[10] After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0. 10 percent blood alcohol level.[11] 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.[12] 45 percent of residents who sleep less than four hours per night report committing medical errors.[13] 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.[14] If the maximum workweek for residents was limited to 80 hours it could considerably reduce mistakes due to fatigue and lack of supervision.

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[1] See http://www.citizen.org/publications/release.cfm?ID=7168

[2] www.questionabledoctors.org

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

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

[5] Sandra G. Boodman, "No End to Errors," *Washington Post*, Dec. 3, 2002.

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

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

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

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

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

[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] 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.

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.**

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

Politicians Should Reject Proposals that Reduce Accountability for Negligence

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

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

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

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

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

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

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

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

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

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

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