Medical Misdiagnosis in New Jersey:

Challenging the Medical Malpractice Claims of the Doctors' Lobby

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About Public Citizen

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Executive Summary

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

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

1) The medical malpractice "crisis" in New Jersey, as in the rest of the country, is not a long-term problem nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country's economic slowdown.

2) A more significant, longer-term malpractice "crisis" faced by New Jersey residents is the unreliable quality of medical care being delivered – a problem that health care providers have not adequately addressed. Taking away people's legal rights, as is proposed under a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Highlights of this report include:

- **The cost of medical negligence to New Jersey's patients and consumers is considerable, especially when measured against the cost of malpractice insurance to New Jersey's doctors.** Extrapolating from Institute of Medicine (IOM) findings, we estimate that medical errors cause 1,316 to 2,930 preventable deaths in New Jersey each year. The cost resulting from preventable medical errors to New Jersey's residents, families and communities is estimated at $508 million to $867 million each year. But the cost of medical malpractice insurance to New Jersey's doctors is less than $290 million a year.

- **The annual amount of medical malpractice insurance premiums paid in New Jersey has barely increased since 1992.** The amount New Jersey health-care providers paid in premiums for malpractice insurance in 2001 was $290 million – compared with $256 million in 1992. This is an overall increase of only 13 percent, or 1.4 percent a year. During that same time period, health care costs increased by 46.7 percent nationwide or 5.2 percent a year. Adjusting for inflation and a growing number of doctors in the state, this increase in malpractice premiums represents a significant decline in dollar values.

- **Annual malpractice payments to patients by New Jersey insurers have barely increased since 1992.** The amount of malpractice payments made by insurers to New Jersey patients in 2001 was $235 million – compared with $231 million in 1992. This is an overall increase of only 2 percent, far below the medical inflation index over that period of time.

- **There has been no "explosion" in malpractice litigation in New Jersey.** Physicians and their lobbyists justify efforts to restrict patients' legal rights by describing "unbridled lawsuits," and a legal system that is "running amok" – but official state statistics show that the number of malpractice lawsuits filed over the past two years has dropped significantly from previous years. Malpractice cases filed in 1998 numbered 1,776 but declined to 1,656 in 2002 – a drop of 7 percent.

- **"Repeat offender" doctors are responsible for the bulk of malpractice payments.** According to the federal government's National Practitioner Data Bank (NPDB), which covers malpractice judgments and settlements since September 1990, 5.5 percent of New Jersey's doctors have made two or more malpractice payments to patients. These repeat offender doctors are responsible for 61.1 percent of all payments. Overall, they have paid out $939.4 million. Even more surprising, 2.1 percent of New Jersey's doctors (636), each of whom has paid three or more malpractice claims, are responsible for 36.9 percent of all payments.

- **Repeat offender doctors suffer few consequences in New Jersey.** The New Jersey state government and the state's health care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions have been few and far between for New Jersey physicians. Only 10.8 percent of those doctors who made four or more malpractice payments have been disciplined by the New Jersey Board of Medical Examiners. And only 20 percent of those doctors who made five or more malpractice payments have been disciplined.

- **Where's the doctor watchdog?** In 2001, only 105 doctors in New Jersey had serious sanctions levied against them by the state's Board of Medical Examiners for incompetence, misconduct, ethical lapses or other offenses. Most of these doctors were not required to stop practicing even temporarily. New Jersey ranks 23rd among the states when its diligence in taking disciplinary actions is measured. But it is important to emphasize that New Jersey has a great deal of room for improvement – it disciplines doctors at only one-third the rate of the top state (Arizona).

- **The spike in medical liability premiums was caused by the insurance cycle, not by "skyrocketing" malpractice awards.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.

- **Poor business strategies by a leading insurance company compounded New Jersey's problems.** Pressure on physician premiums intensified after May 2002, when one of New Jersey's biggest carriers, Medical Inter-Insurance Exchange (MIIX), announced it would stop renewing policies. The company had covered 37 percent of all the doctors in

New Jersey. The state's Department of Banking and Insurance attributed the company's problems to its ill-fated decisions to expand into other states and to increase its stock market investments.

- **Malpractice insurance has remained affordable for the vast majority of New Jersey physicians.** The Commissioner of Banking and Insurance has reported to the Legislature that "relatively few" – approximately 7.4 percent – of the state's doctors have experienced large premium increases, even in high-risk specialties.

- **No exodus of physicians from New Jersey is evident.** Despite gloomy rhetorical descriptions of "doctors leaving the profession in droves," there is no shortage of doctors in New Jersey. Statistics from American Medical Association show that New Jersey ranks 8th best among all 50 states and the District of Columbia for its ratio of doctors to residents – and this ratio has improved significantly in recent years. In 1990, New Jersey had 267 doctors per 100,000 residents. By 2001, that ratio had climbed to 328 doctors per 100,000 residents. This places the state well ahead of the national average, which in 2001 was 286 doctors per 100,000 residents.

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

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

- **Plaintiffs drop 10 times more claims than they pursue**. Based on Physician Insurer Association of America (PIAA) figures, Public Citizen estimates that about 54 percent of claims are being abandoned by patients. Attorneys often may send a statutorily required notice of intent to claim or file a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim. We estimate that the number of cases withdrawn voluntarily by plaintiffs was 92,621, *10 times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent.*

- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files. The doctors were asked to

judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, "These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care."

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

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

- **Empirical evidence does not confirm the existence of "defensive medicine" – and patient injuries refute it.** The Congressional Budget Office was asked to quantify the savings from reduced "defensive medicine" if Congress passed H.R. 4600. This bill, which passed the House in 2002, contained very stringent restrictions on a patient's ability to recover damages. CBO declined, saying that any such "estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health-care spending. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending." In addition, numerous studies continue to document preventable medical errors ranging from invasive procedures performed on the wrong patients, medication errors, misreading of test results and unsanitary conditions – all mistakes that any widespread practice of "defensive" medicine could have been expected to reduce.

Introduction: Misleading the Public to Escape Responsibility for Negligence

There is no dispute that medical malpractice rates are rising in New Jersey and across the country, in some cases to a considerable degree. No one wants to see doctors forced to pay more to insure themselves against liability, even if they are surgeons earning $500,000 a year.

For the past year, physicians and their allies have resorted to high-pressure tactics in New Jersey, as they have attempted to restrict the rights of patients to receive compensation when they have suffered from medical malpractice. The campaign has included bus caravans organized by physicians and their lobbying groups,[1] rallies orchestrated at the capital[2] and – most recently – threats of an impending statewide strike by thousands of New Jersey doctors.[3]

Despite this strong-arm campaign by physicians, ample evidence – including an analysis by the state Department of Banking and Insurance – has shown that the so-called malpractice "crisis" was fueled significantly by the failed business strategies of New Jersey's largest malpractice insurer.[4] In fact, the former deputy executive director of the Medical Society of New Jersey has claimed that the Medical Society's push to revise the state's malpractice laws represents a conflict of interest, motivated by a desire to protect its stake in the troubled Medical Inter-Insurance Exchange (MIIX). Neil Weisfeld, who left the Medical Society of New Jersey in April 2002, has since filed a "whistleblower" lawsuit against his former employers.[5]

On a fact sheet that the Medical Society of New Jersey compiled to support its lobbying efforts, the doctors' group acknowledged that current problems with rising malpractice insurance rates stemmed from the cyclical nature of the insurance business and a downturn in the national economy. But in their proposed remedies, the physicians have overlooked insurance reforms – instead fixating on their desire to limit on how much injured patients can receive for doctor negligence.[6] The New Jersey Legislature is now considering the physicians' package of proposals – including a $250,000 cap on "non-economic" damages for pain and suffering.

This report shows that the spike in some medical malpractice premiums is an insurance industry pricing and profitability problem – not a litigation problem. This report also exposes the real long-term threats to quality health care in New Jersey: the frequency of medical mistakes, and the lack of practitioner oversight and discipline. And it provides suggestions for averting these problems in the future.

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

The Costs of Medical Malpractice to New Jersey's Patients & Consumers vs. New Jersey's Doctors

In 1999, the Institute of Medicine (IOM) estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors.[7] The IOM also estimated the costs to individuals, their families and society at large for these medical errors at $17 billion to $29 billion a year. These costs include disability and health-care costs, lost income, lost household production and the personal costs of care.

The true impact of medical malpractice in New Jersey should be measured by the cost to patients and consumers, not the premiums paid by doctors to their insurance companies. Extrapolating from the IOM findings, we estimate that 1,316 to 2,930 preventable deaths in New Jersey each year are due to medical errors. The costs resulting from preventable medical errors to New Jersey's residents, families and communities are estimated at $508 million to $867 million each year. But the cost of medical malpractice insurance to New Jersey's doctors is only $289.5 million a year.[8] [See Figure 1]

Figure 1

1,316 - 2,930
Preventable Deaths Due to Medical Errors Each Year

$508 million - $867 million
Costs Resulting from Preventable Medical Errors Each Year

$289.5 million
Cost of New Jersey Doctors' Annual Medical Malpractice Premiums

Sources: Preventable deaths and costs are prorated based on population and based on estimates in To Err is Human, Institute of Medicine, November 1999. Malpractice premiums are based on "Medical Malpractice Net Premium and Incurred Loss Summary," National Association of Insurance Commissioners, July 18, 2001.

Trends in New Jersey Medical Malpractice Premiums, Award Payments and Lawsuits: Reliable Sources Contradict Doctors

The medical lobby frequently claims that malpractice award payments are "skyrocketing" because of "frivolous lawsuits" and "jackpot justice." These arguments rely on anecdotes and selective information. Data from reliable sources portray much less of a "crisis."

- **The annual amount of medical malpractice insurance premiums paid in New Jersey has barely increased since 1992.** The amount New Jersey health-care providers paid in premiums for malpractice insurance in 2001 was $290 million – compared with $256 million in 1992. This is an overall increase of only 13 percent, or 1.4 percent a year.[9] [See Figure 2, "Premiums Collected by Insurers"] During that same time period, health care costs increased by 46.7 percent nationwide – or an average of 5.2 percent a year.[10] Adjusting for inflation and a growing number of doctors in the state, this increase in malpractice premiums represents a significant decline in dollar values.

- **The annual malpractice payments to patients by New Jersey insurers have barely increased since 1992.** The amount of malpractice payments made by insurers to New Jersey patients in 2001 was $235 million – compared with $231 million in 1992. [See Figure 2, "Payments Made by Insurers"] This is an overall increase of only 2 percent; again, far below the medical inflation index over that period of time.

Figure 2

Medical Malpractice Premiums, Payments and Profits in New Jersey, 1992-2001

Year	Premiums Collected By Insurers	Payments Made By Insurers	Profit or (Loss)	N.J. Loss Ratio	National Loss Ratio*	N.J. Profit Ranking*
92	$255,851,980	$230,869,088	$24,982,892	90.2%	77.2	48th
93	265,016,491	216,784,665	48,231,826	81.8%	67.1	45th
94	274,344,487	206,190,443	68,154,044	75.2%	53.1	40th
95	289,091,353	229,562,204	59,529,149	79.4%	54.3	45th
96	283,199,059	302,507,621	(19,308,562)	106.8%	60.3	52nd
97	290,195,653	174,208,844	115,986,809	60.0%	54.2	25th
98	282,824,490	157,515,817	125,308,673	55.7%	71.7	19th
99	268,303,239	100,344,429	167,958,810	37.4%	75.5	8th
00	307,227,631	143,798,992	163,428,639	46.8%	80.0	14th
01	289,521,949	235,010,132	54,511,817	81.2%	97.7	17th
Total profits:			**$808,784,097**			

Source: National Association of Insurance Commissioners, "Medical Malpractice Insurance Net Premium and Incurred Loss Summary", July 18, 2002. National ratio and rankings are based on 54 states and territories (including District of Columbia, Guam, Puerto Rico, and the Virgin Islands.)

- **Premiums have covered malpractice payments by insurance companies in New Jersey.** Although the insurance industry has claimed it has been paying out about $1.50 in malpractice payments for every one dollar it has collected in premiums nationwide over the past two years,[11] this was not the case for insurance companies doing business in New Jersey during nine of the 10 years between 1992 and 2001. [See Figure 2, "Profit or (Loss)"]

- **There has been no "explosion" in malpractice litigation in New Jersey.** Physicians and their lobbyists justify their effort to restrict patients' legal rights by describing "unbridled lawsuits," and a legal system that is "running amok." But state statistics show that patients have been bringing fewer legal claims, especially over the past two years in which the insurance and medical communities have been declaring a malpractice "crisis." Malpractice cases filed in 1998 numbered 1,776 but declined to 1,656 in 2002 – a drop of 7 percent.[12] [See Figure 3]

Figure 3

Malpractice Cases Filed in New Jersey

Year	Malpractice Cases Filed
1998	1,776
1999	1,787
2000	1,772
2001	1,613
2002	1,656

Source: Civil Practice Division, Administrative Office of the Courts, New Jersey. Numbers reflect totals for the 12 months preceding June of each year listed.

- **Malpractice insurance has remained affordable for the vast majority of New Jersey physicians.** In her report to the Legislature, the Commissioner of Banking and Insurance reported that:[13]

  "Relatively few providers (approximately 7.4 percent) experienced large [30 percent of more] premium increases… Even in high-risk specialties, such increases usually occurred for less than 10 percent of policyholders."

  The two largest malpractice insurers in New Jersey are the MIIX company (with 37 percent of the market) and Princeton Insurance (with 36 percent of the market). Doctors who received "large" premium increases from MIIX represented only 4.3 percent of its policyholders. Doctors who received "large" premium increases from Princeton represented only 7.7 percent.

Repeat Offender Doctors Are Responsible for the Bulk of Medical Malpractice

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

- According to the federal government's National Practitioner Data Bank (NPDB), which covers malpractice judgments and settlements since September 1990, 5.5 percent of New Jersey's doctors have made two or more malpractice payments to patients.[14] These repeat offender doctors are responsible for 61.1 percent of all payments. Overall, they have paid out $939.4 million in damages. Even more surprising, 2.1 percent of New Jersey's doctors (636), each of whom has paid three or more malpractice claims, are responsible for 36.9 percent of all payments. [See Figure 4]

Figure 4

Number of Medical Malpractice Payments and Amounts Paid by New Jersey Doctors 1990 – 2002

Number of Payment Reports	Number of Doctors that Made Payments	Percent/Total Doctors (29,757)	Total Number of Payments	Total Amount of Payments	Percent of Total Number of Payments
All	4,854	16.3%	8,267	$1,805,822,050	100.0%
1	3,217	10.8%	3,217	$866,430,750	38.9%
2 or More	1,637	5.5%	5,050	$939,391,300	61.1%
3 or More	636	2.1%	3,048	$488,054,050	36.9%
4 or More	316	1.1%	2,088	$274,271,900	25.3%
5 or More	153	0.5%	1,436	$143,877,950	17.4%

Source: National Practitioner Data Bank

Repeat Offenders Suffer Few Consequences

The New Jersey state government and the state's health care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions have been few and far between for New Jersey physicians.

- Only 10.8 percent of those doctors who made four or more malpractice payments have been disciplined by the New Jersey Board of Medical Examiners. And only 20 percent of those doctors who made five or more malpractice payments have been disciplined.[15]

The extent to which doctors can commit negligence in New Jersey and not be disciplined is illustrated by the following NPDB descriptions of the worst 10 offenders who practice in New Jersey, *none* of whom have been disciplined by the state:

- **Physician Number 22283** settled 10 malpractice lawsuits, and lost two malpractice judgments between 1991 and 2002 involving four incidents of improper performance of surgery, two incidents of delay in diagnosis, two incidents of failure to diagnose, four incidents of obstetrics, two incidents of obstetrics – failure to manage pregnancy, and two incidents of obstetrics – improperly performed vaginal delivery. Damages add up to $9,345,000.

- **Physician Number 22651** settled nine malpractice lawsuits between 1991 and 2001 involving three incidents of obstetrics, improper performance of treatment/procedure, improper performance of surgery, two incidents of surgery, obstetrics – wrongful life/birth, and obstetrics – improperly performed vaginal delivery. Damages add up to $3,007,500.

- **Physician Number 22690** settled seven malpractice lawsuits between 1991 and 2002 involving five incidents of obstetrics, surgery, and delay in diagnosis. Damages add up to $2,135,000.

- **Physician Number 22742** settled 11 malpractice lawsuits between 1992 and 2002 involving seven incidents of improper performance of surgery, two incidents of surgery, surgery – retained foreign body, and failure to diagnose. Damages add up to $8,737,500.

- **Physician Number 264539** settled six malpractice lawsuits and lost two malpractice judgments between 1993 and 2001 involving four incidents of failure to diagnose, and four incidents of diagnosis. Damages add up to $2,893,750.

- **Physician Number 23109** settled eight malpractice lawsuits between 1992 and 2001 involving two incidents of delay in diagnosis, obstetrics – improperly performed vaginal delivery, two incidents of obstetrics, failure to diagnose, obstetrics – failure to manage pregnancy, and obstetrics – improperly performed C-section. Damages add up to $2,312,500.

- **Physician Number 59546** settled seven malpractice lawsuits between 1994 and 2001 involving two incidents of diagnosis, two incidents of surgery, surgery – retained foreign body, obstetrics, and treatment. Damages add up to $2,225,000.

- **Physician Number 60389** settled five malpractice lawsuits and lost one malpractice judgment between 1994 and 2001 involving obstetrics – improperly performed vaginal delivery, two incidents of obstetrics, delay in delivery – induction or delivery, and two incidents of improper performance of surgery. Damages add up to $2,737,500.

- **Physician Number 60649** settled 20 malpractice lawsuits between 1994 and 2001 involving 12 incidents of failure to diagnose, and eight incidents of improper performance of surgery. Damages add up to $2,760,750.

- **Physician Number 78636** settled eight malpractice lawsuits and lost one malpractice judgment between 1994 and 2001 involving four incidents of improper performance of surgery, two incidents of failure to diagnose, surgery – improper management of patient, and surgery. Damages add up to $2,750,000.

Where's the Doctor Watchdog?

In 2001, only 105 doctors in New Jersey had serious sanctions levied against them by the states Board of Medical Examiners for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses and other offenses, according to an ongoing Public Citizen project that tracks "Questionable Doctors" in New Jersey and other states.[16] Most of these doctors were not required to stop practicing, even temporarily.

For more than 10 years, Public Citizen's Health Research Group has ranked state medical boards based on the rate of serious disciplinary actions (revocation, suspension, surrender and probation) per 1,000 doctors in the state. For five of the last 10 years (and four of the last five years) New Jersey has ranked in the bottom half of all states. In 2001, the last year for which data are available, it ranked 23rd. The rate of serious actions in 2001, 3.53 per 1,000 physicians is barely more than one-third of the rate in Arizona, first in the country with 10.52 serious actions per 1,000 physicians.[17]

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

For much of the 1990s, doctors benefited from artificially lower insurance premiums. According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, "What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income." IRMI also noted: "Clearly a business cannot continue operating in that fashion indefinitely."[18]

IRMI's findings were buttressed in a recent report by the West Virginia Insurance Commissioner. According to the Insurance Commission, "[T]he insurance industry is cyclical and necessarily competitive. We have witnessed these cycles in the Medical Malpractice line in the mid-'70s, the mid-80s and the present situation. This particular cycle is, perhaps, worse than previous cycles as it was delayed by a booming economy in the '90s and is now experiencing not just a shortfall in rates due to competition, but a subdued economy, lower interest rates and investment yields, the withdrawal of a major medical malpractice writer and a strong hardening of the reinsurance market. Rates will, at some point, reach an acceptable level to insurers and capital will once again flow into the Medical Malpractice market."[19]

Other authoritative insurance analysts and studies indicate that this is a temporary "crisis" unrelated to the legal system:

- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.[20]

- **The same trends are present in other lines of insurance.** Property/casualty refers to a large group of liability lines of insurance (a total of 30) including medical malpractice, homeowners, commercial, and automobile. The property/casualty insurance industry has exhibited cyclical behavior for many years, as far back as the 1920s. These cycles are characterized by periods of rising rates leading to increased profitability. Following a period of solid but not spectacular rates of return, the industry enters a down phase where prices soften, supply of the insurance product becomes plentiful, and, eventually, profitability diminishes or vanishes completely. In the down phase of the cycle, as results deteriorate, the

basic ability of insurance companies to underwrite new business or, for some companies, even to renew some existing policies can be impaired. This is because the capital needed to support the underwriting of risk has been depleted through losses. The current market began to harden in 2001, following an unusually prolonged period of soft market conditions in the property-casualty section in the 1990s. The current hard market is unusual in that many lines of insurance are affected at the same time, including medical malpractice. As a result, premiums are rising for most types of insurance. The increases have taken policyholders by surprise given that they came after several years of relatively flat to decreasing prices.[21]

- **Poor business decisions by a major insurance company fueled New Jersey's malpractice problems.** Pressure on physician premiums intensified after May 2002, when one of New Jersey's biggest carriers, Medical Inter-Insurance Exchange (MIIX) announced it would stop renewing policies. The company had covered 37 percent of all the doctors in New Jersey. The state's Department of Banking and Insurance attributed the company's problems to its ill-fated decisions to expand into other states and to increase its investments in the stock market. In her report to the Legislature, the Commissioner for Banking and Insurance stated:

  > "Several forces conspired to create the bad outcome. But in hindsight doctors and patients alike would have been better served by a MIIX that responded to the competitive pressures of the soft market by rededicating itself to its traditional focus on New Jersey physicians."[22]

Physician Exodus from New Jersey Is Not Evident

There is no shortage of doctors in New Jersey. One physician who serves in the Legislature has declared that the so-called malpractice crisis has "doctors leaving the profession in droves," but official numbers contradict this rhetoric.[23] According to statistics released by the American Medical Association, New Jersey ranks 8th best among all 50 states and the District of Columbia for its ratio of doctors to residents – and this ratio has improved significantly in recent years.[24] That data also shows:

- In 1990, New Jersey had 267 doctors per 100,000 residents. By 2001, that ratio had climbed to 328 doctors per 100,000 residents. This places the state well ahead of the national average, which in 2001 was 286 doctors per 100,000 residents.

- The improvement in New Jersey's ratio of doctors-to-residents represents a 22.8 percent advance over 11 years.

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

Although no comparable studies have been cited in New Jersey, there is convincing evidence from around the nation that the majority of patients who suffer injuries from medical malpractice never file lawsuits.

- **A landmark Harvard Medical Practice Study found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in eight medical errors committed in hospitals results in a malpractice claim.[25] Researchers replicating this study made similar findings in Colorado and Utah.[26] [See Figure 5]

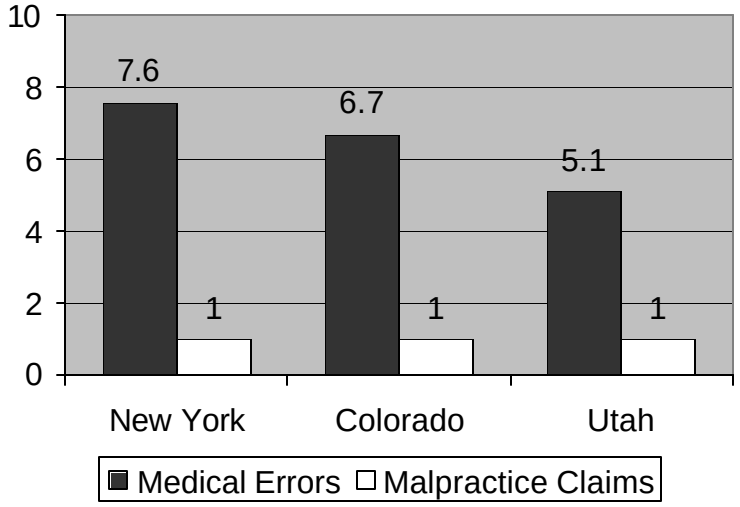
- **Actual numbers collected by government agencies show a similar claims gap.** A Florida statute requires hospitals to report "adverse incidents," defined as "an event over which health care personnel could exercise control" that results in death or injury. Tables prepared by Florida's Agency for Health 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.[27] In other words, for every 6 medical errors only 1 claim is filed. [See Figure 6]

- **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.[28] 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 7]

- **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.[29] The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

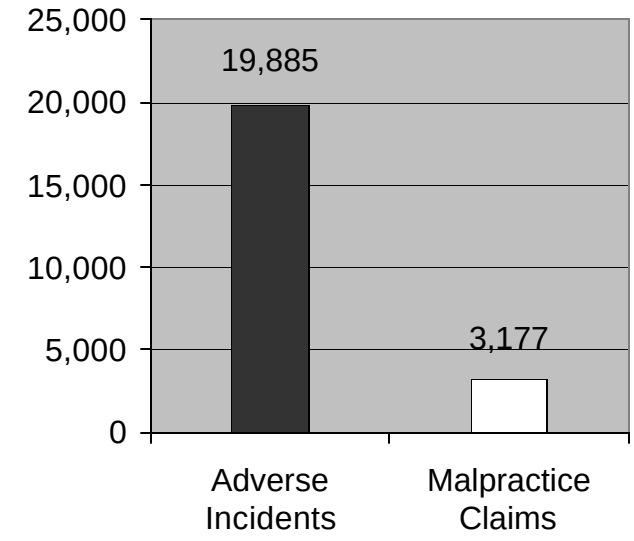
- **The compensation gap helps explain why, although medical injuries are costly, expenditures on medical liability comprise less than one percent of overall health care costs.** As the Congressional Budget Office reported, "Malpractice costs account for a very small fraction of total health care spending; 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."[30]

Figure 5
Malpractice Claims Gap:
Ratio of Medical Errors to Claims Filed



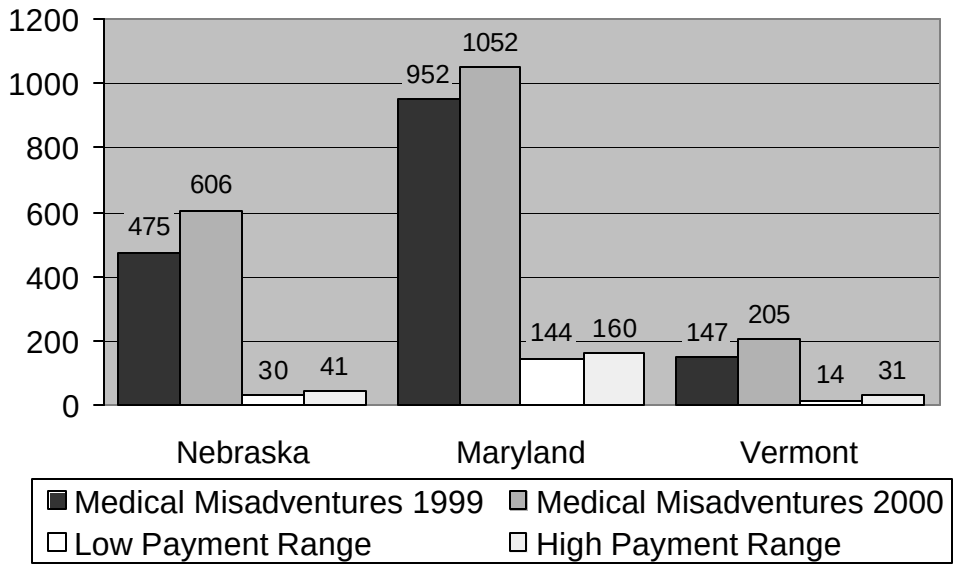
Source: Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990); Studdert et al, "Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from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

Figure 6
Florida Malpractice Claims Gap: 1996-1999
Ratio of Medical Errors to Claims Filed



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.

Figure 7
Malpractice Compensation Gap:
Hospital E-Code Injuries vs. Malpractice Payments



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

Few, if Any, Malpractice Lawsuits Are "Frivolous"

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.[31] If the case goes to trial, the costs can easily be doubled.[32] 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.[33] 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.[34] 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[35] Based on this figure, Public Citizen estimates that about 54 percent of claims are being abandoned by patients.[36] 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[37] 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*.[38]

- **The small numbers of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files.[39] 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.

Capping Damages Misses the Mark

Legislative proposals being probed by New Jersey's medical community do not emphasize improving medical care or reducing the instances of malpractice. They focus on creating financial protections for physicians and the providers. As in many states, the centerpiece of this legislation is the imposition of "caps" on the damages that can be awarded for patients' pain-and-suffering. There is convincing evidence that this is a misguided approach:

- **"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 Physicians Insurance Association of America (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.[40] In total, the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the criticism that jury verdicts are frequently unpredictable and irrational.

- **The insurance industry's own statistics demonstrate that awards are proportionate to injuries.** PIAA's Data Sharing Report also demonstrates the relationship between the severity of an injury and the size of the settlement or verdict.[41] PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications.[42] 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.[43]

- **Capping awards hurts women the most.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on women – especially as it relates to a woman's ability to have children, according to a study by the director of the Insurance Law Center at the University of Connecticut School of Law. "This is so for two main reasons," reported Tom Baker, Connecticut Mutual Professor of Law. "First, the largest part of the economic damages in many tort claims is lost wages, and women earn on average less money than men. Second, the most significant effect of many medical and other injuries inflicted on women is harm to reproductive capacity. Although this may be hard to believe, harm to reproductive capacity does not entitle women to receive significant economic damages … [and] lowering the price of making a women infertile cannot be sound policy."[44]

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

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

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

- **The Congressional Budget Office has rejected the defensive medicine theory.** The Congressional Budget Office (CBO) was asked to quantify the savings from reduced "defensive medicine" if Congress passed H.R. 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.[45]

- **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.[46] There were nine such instances in Florida in 2001.[47] 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.[48] 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."[49]

- **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.[50] 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."[51] 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"?[52] Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.[53]

- **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.[54] One report found specifically that each additional patient per nurse corresponded to a seven percent increase in both patient mortality and deaths following complications.[55] Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts over-staffing.

Solutions to Reduce Medical Errors and Long-term Insurance Rates

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; 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:

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

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

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 ver 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.[56] Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,[57] 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.[58]

- **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.[59]

- **Surgery performed on the wrong part of the body, to the wrong patient, and performing the wrong procedure on a patient are all completely preventable, yet continue to occur.** Such mistakes should *never* happen, according to a special alert reissued December 5, 2001 by the Joint Commission on Accreditation of Healthcare Organizations.[60] 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.[61]

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.[62] After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10 percent blood alcohol level.[63] 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.[64] 45 percent of residents who sleep less than four hours per night report committing medical errors.[65] 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.[66] If the maximum workweek for residents was limited to 80 hours, it could considerably reduce mistakes due to fatigue and lack of supervision.

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.[67]

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,[68] too little discipline is being done. Too many state medical boards, despite their duty to protect the public, still believe their first responsibility is to rehabilitate "impaired physicians" and shield them from the public's prying eyes. Fewer than one-half of one percent of the nation's doctors face any serious state sanctions each year. 2,708 total serious disciplinary actions a year, the

number state medical boards took in 2001, are a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by medical errors annually.

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

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

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

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

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

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

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:[69]

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 roll back 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.

- **More strongly regulate auto and homeowners insurance to prevent shock price increases and insecurity for policyholders.** For example, insurance commissioners should prevent insurers, like State Farm, from overreacting by not writing new business in some states and by adopting draconian underwriting rules for renewal business. If the rate increases are shown to be high due to corporate policy (such as State Farm holding down prices as a marketing strategy), prices should not be allowed to go up suddenly. Instead, they should be spread over at least a three-year period to avoid "sticker shock" for policy holders.

- **Ask the National Association of Insurance Commissioners to stop implementation of the deregulation of commercial rates and forms, which it is unwisely pushing.**

[1] Dorothy Pennachio, *Medical Economics*, Aug. 9, 2002.
[2] Linda Denicola, "Physicians decry rising cost of insurance," *The Examiner*, Allentown, N.J., Nov. 21, 2002.
[3] Robert Hanley and Maria Newman, "Worried New Jerseyans Expect Doctors Not to Be In," *New York Times*, Jan. 30, 2003.
[4] Report to New Jersey Legislature, "Medical Malpractice Premium Data Summary," Holly Bakke, Commissioner, Department of Banking and Insurance, December 2002.
[5] Lindy Washburn, "Former New Jersey Medical Society Official Criticizes Malpractice Reform Push," *The Record*, Hackensack, N.J., Nov. 20, 2002.
[6] Linda Denicola, "Physicians decry rising cost of insurance," *The Examiner*, Allentown, N.J., Nov. 21, 2002.
[7] To Err is Human, Building a Safer Health System, Institute of Medicine, 1999, p. 26-27.
[8] "Medical Malpractice Net Premium and Incurred Loss Summary," National Association of Insurance Commissioners, July 18, 2001.
[9] National Association of Insurance Commissioners, "Medical Malpractice Insurance Net Premium and Incurred Loss Summary", July 18, 2002. Note: Each state decides which insurance companies must report earnings/losses to the NAIC. Generally, state-administered funds, surplus lines insurers, self-insured organizations or in some cases, single-state insurers, do not report their premiums/losses. Those companies reporting usually include most of the voluntary market (stock and mutual insurers) as well as most of the risk-retention groups that are formed by doctors or hospitals.
[10] Bureau of Labor Statistics, Medical Services CPI.
[11] Tanya Albert, "Liability Crisis Reaction: Doctor-Owned Insurance Fills Gap," *American Medical News*, Dec. 23, 2002.
[12] New Jersey Administrative Office of the Courts, Civil Practice Division, January 2003.
[13] Report to New Jersey Legislature, "Medical Malpractice Premium Data Summary," Holly Bakke, Commissioner, Department of Banking and Insurance, December 2002.
[14] National Practitioner Data Bank, Annual Reports, Sept. 1, 1990 – Sept. 30, 2002.
[15] Id.
[16] "Public Citizen's database is available at http://www.questionabledoctors.org/.
[17] "Questionable Doctors," Public Citizen's Health Research Group, 2002; see at: www.questionabledoctors.org.
[18] Charles Kolodkin, "Medical Malpractice Insurance Trends? Chaos!" International Risk Management Institute. http://www.irmi.com/expert/articles/kolodkin001.asp
[19] "State of West Virginia Medical Malpractice Report on Insurers with over 5 percent Market Share," Provided by the Office of the West Virginia Insurance Commission, November 2002.
[20] Americans for Insurance Reform, "Medical Malpractice Insurance: Stable Losses/Unstable Rates," Oct. 10, 2002. See also: http://www.insurance-reform.org/StableLosses.pdf.
[21] Hot Topics & Insurance Issues, Insurance Information Institute, www.iii.org
[22] Report to New Jersey Legislature, "Medical Malpractice Premium Data Summary," Holly Bakke, Commissioner, Department of Banking and Insurance, December 2002.
[23] Assemblyman Herbert Conaway, quoted by Linda Denicola, "Physicians Decry Rising Cost of Insurance," *The Examiner*, Allentown, N.J., Nov. 21, 2002.
[24] American Medical Association, "Physician Characteristics and Distribution in the U.S.," 2003 edition.
[25] Harvard Medical Practice Study Group, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990).
[26] 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).
[27] 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.
[28] 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.
[29] Official Transcript, Medicare Payment Advisory Commission, Public Meeting, Dec. 12, 2002.
30 Congressional Budget Office Cost Estimate, H.R. 4600, Sept. 24, 2002.
[31] Based on Public Citizen interviews with plaintiff attorneys.

[32] See Vidmar, Medical Malpractice and the American Jury (1995).
[33] According to the Physician Insurers Association of America, expert witnesses in a medical malpractice case are paid on average over $4,800.
[34] *Trend Analysis Report*, 2001 Edition, 6b-4
[35] Rosenblatt & Hurst, "An Analysis of Closed Obstetric Malpractice Claims," 74 *Obstetrics & Gynecology* 710 (1989).
[36] 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 use the nine percent figure.
[37] .09 times 172,474 equals 15,679; subtracted from 108,300 equals 92,621 claims voluntarily withdrawn.
[38] 9,293/172,474=.054
[39] Posner et al, "Variation in expert opinion in medical malpractice review," 85 *Anesthesiology* 1049 (1996).
[40] 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).
[41] *PIAA Data Sharing Report*, Report 7, Part 10.
[42] 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
[43] Vidmar, Gross, Rose, supra at 284
[44] Tom Baker, Report: "Research on Medical Malpractice: Implications for Tort Reform in Connecticut", January 2, 2003, citing Lucinda Finley, The Tort Reform Movement in the United States: Gender, Race and Class Disparities in Access to Justice, manuscript presented at 2001 Annual Meeting of Law & Society Association.
[45] CBO supra note 22.
[46] Chassin & Becher, "The Wrong Patient," 136 *Ann Intern Med*. 826 (2002).
[47] Agency for Health Care Administration, *Risk Management Reporting Summary*, March 2002.
[48] Barker et al, "Medication Errors Observed in 36 Heath Care Facilities," 162 Arch Intern Med. 1897 (2002).
[49] Bates et al, "The Costs of Adverse Drug Events in Hospitalized Patients," 277 JAMA 307 (1997).
[50] Moss, "Spotting Breast Cancer: Doctors Are Weak Link," New York Times, June 27, 2002.
[51] 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."
[52] Id.
[53] U.S. Department of Health and Human Services, *Confronting the New Health Care Crisis* (July 24, 2002)
[54] 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.
[55] 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.
[56] 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.
[57] 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.
[58] Sandra G. Boodman, "No End to Errors," *Washington Post*, Dec. 3, 2002.

[59] 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.
[60] "A follow-up review of wrong site surgery," JCAHO, Sentinel Event Alert, Issue 24, Dec. 5, 2001.
[61] "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
[62] American Medical Student Association, *Fact Sheet, Support H.R. 3236 limiting resident-physician work hours*; *See also:* http://www.amsa.org/hp/rwhfact.cfm.
[63] Id.
[64] Id.
[65] Id.
[66] 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.
[67] See http://www.citizen.org/publications/release.cfm?ID=7168
[68] www.questionabledoctors.org
[69] Americans for Insurance Reform, "Action Required by Insurance Commissioners to Regulate Insurance Industry," J. Robert Hunter, July 30, 2002.