

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



**Congress Watch
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Acknowledgments

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Executive Summary

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

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

Highlights of the report include:

- **The costs of medical negligence to Pennsylvania’s patients and consumers is considerable, especially compared to the cost of malpractice insurance to Pennsylvania’s doctors.** Extrapolating from Institute of Medicine findings, we estimate that there are 1,920 to 4,277 preventable deaths in Pennsylvania each year that are due to *preventable* medical errors. The costs resulting from preventable medical errors to Pennsylvania’s residents, families and communities is estimated at \$742 million to \$1.3 billion each year. But the cost of medical malpractice insurance to Pennsylvania’s doctors is less than \$731 million a year.
- **Government data show that the size of medical malpractice payouts has increased at a much slower pace in Pennsylvania than claimed by the Pennsylvania Medical Society.** According to the federal government’s National Practitioner Data Bank (NPDB), the median medical malpractice payout by a Pennsylvania physician to a patient rose 33 percent from 1997 to 2001, from \$150,000 to \$200,000, or 8 percent a year. By contrast, medical organizations in Pennsylvania quote data from Jury Verdict Research (JVR), a private research firm, indicating that verdicts rose almost 43 percent from 1997 to 2000, from \$700,000 to \$1 million, or 14 percent a year. The reason for the difference: JVR collects only jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower payouts than jury verdicts.

- **Government data show that the average amount of medical malpractice payouts in Pennsylvania has increased at a slower pace than national health insurance premiums.** While NPDB data show that the median medical malpractice payout in Pennsylvania rose 33 percent from 1997 to 2001 (an average of 8.3 percent a year). The national average premium for single health insurance coverage increased 39 percent over that time period (9.5 percent a year). Payments for health care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice payouts.
- **Government data reveals little growth in the number of medical malpractice payouts in Pennsylvania.** According to the NPDB, there was only a modest increase in the total number of malpractice payouts in Pennsylvania from 1995 through 2001. The difference between the 957 payouts in 1995 and the 1,049 payouts reported in 2001 is less than 10 percent over six years, or 1.6 percent a year.
- **Large verdicts in Pennsylvania have dramatically declined.** The number of large jury verdicts in Pennsylvania and the amounts paid for medical malpractice in these large verdicts decreased dramatically in recent years. From 2000 to 2002, the number of jury awards of \$1 million or more dropped by 50 percent (from 44 to 22) while the overall amount of these awards decreased by over 75 percent (from \$415 million to \$93 million).
- **At the height of the so-called medical malpractice "crisis," the number of licensed physicians in Pennsylvania actually *increased* by 7.5 percent.** According to data provided by the Pennsylvania State Medical Board, the government agency charged with issuing medical licenses to qualified doctors, 34,330 physicians were licensed and practicing medicine in Pennsylvania during 2001. In 2002, the Board issued 36,921 licenses – a 7.5 percent increase over 2001. This increase in physician population is not isolated. Over the past seven years, the number of doctors licensed and residing in Pennsylvania increased by 14 percent. The theory that skyrocketing medical malpractice insurance premiums are forcing doctors to flee the state is not borne out by the facts.
- **Nationally, Pennsylvania ranks 5th in doctor population.** According to the American Medical Association (AMA), Pennsylvania is home to five percent of the nation's doctors, a distinction that ranked the state's physician population as 5th highest in the nation. Further, the AMA reports that Pennsylvania has one of the largest physician populations under the age of 35, with 5.5 percent of the nation's younger doctors practicing in Pennsylvania.
- **Only 10.6 percent of the state's physicians are responsible for the bulk of medical malpractice payouts.** According to the federal government's NPDB, which covers malpractice judgments and settlements since September 1990, just 10.6 percent of the state's doctors are responsible for 84 percent of all the money paid out in malpractice cases. Even more troubling, only 4.7 percent of Pennsylvania's doctors (1,838) are responsible for 51.4 percent of all the money paid out.

- **Repeated malpractice payouts are rarely accompanied by disciplinary action for Pennsylvania’s physicians.** Public Citizen’s analysis of the federal government’s NPDB found that of 543 doctors who were responsible for 23.8 percent of all the money paid out in malpractice cases, only 5.1 percent had been disciplined by the Pennsylvania State Board of Medicine.
- **Where’s the doctor watchdog?** Pennsylvania’s State Board of Medicine is dangerously lenient with doctors, regularly letting serious and sometimes repeat offenders off the hook. In Public Citizen’s ranking of state medical boards, Pennsylvania ranked 36th out of 50 states and the District of Columbia. The ranking is based on the number of serious disciplinary actions per 1,000 doctors in each state. In 2001, nationally there were 3.36 serious actions taken for every 1,000 physicians. Pennsylvania is among the bottom third of U.S. states when its diligence in taking disciplinary actions is measured – 2.18 serious actions per 1,000 doctors.
- **The spike in medical liability premiums was caused by the insurance cycle, not by “skyrocketing” malpractice awards.** J. Robert Hunter, one of the country’s most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.
- **Insurer mismanagement compounded the problems.** Artificially low premiums in the 1990s, market competition, and accounting irregularities forced the Phico and St. Paul insurance companies to stop offering medical malpractice insurance in Pennsylvania. Phico Insurance Co. was the third-largest malpractice insurer in the state, and the St. Paul Companies, Inc. was the seventh largest. Together they carried about 18 percent of the state’s physicians. In each case, the departure of the insurance company from the market had little to do with malpractice award payments than with the mismanagement of the company itself. Phico had been placed under the supervision of insurance regulators and was later sued by the state’s Insurance Department. The lawsuit alleged that Phico directors ignored signs of financial trouble at the company and pressured the board to pay dividends at a time when the insurer’s surplus “was declining drastically and significant strengthening of loss reserves was required.” As the *Wall Street Journal* found in a front page investigative story on June 24, 2002, when malpractice claims increased in the 1980s, St. Paul and its competitors sharply raised rates. But, as the frequency and size of claims leveled off, St. Paul realized it had set too much money aside for malpractice payments. The company then released \$1.1 billion from its reserves between 1992 and 1997, which dramatically boosted its bottom line. St. Paul’s apparent profitability attracted numerous, smaller carriers into the malpractice insurance market, which led to widespread, competitive price-cutting. By the end of the 1990s, the revenue from premiums decreased to the point that insurers no longer could cover malpractice claims. Some collapsed and others, like St. Paul, withdrew from the market.

Introduction:

Misleading the Public to Escape Responsibility for Negligence

There is no dispute that medical malpractice rates are rising in Pennsylvania and across the country, in some cases to a considerable degree. No one wants to see a doctor forced to pay more to insure himself against liability, even if he is a surgeon making \$500,000 a year.

In response to the spike in rates that began in 2000, doctors loudly demanded that Pennsylvania enact malpractice tort “reform” in 2002, claiming that the cost of liability insurance threatened to drive them out of state or out of business. The Legislature responded by mid-March with a set of changes that limit the jurisdictions in which injured patients can file suits, allow malpractice payments to be paid over time, and prohibit patients from seeking compensation for damages already paid by a health insurer.

This exercise, however, did not curtail the rising premiums charged by malpractice insurers, and it did not contain the fix-all advocated for decades by physicians, insurance companies and business leaders – a \$250,000 cap on the amount that injured patients can be awarded for so-called pain and suffering. Fortunately for consumers, Pennsylvania’s constitution prohibits the General Assembly from limiting damages paid for personal injuries.

In the final days of 2002, Governor-elect Edward Rendell was able to avert a walkout by Pennsylvania physicians only by pledging to support an emergency bailout that will allow him to significantly cut doctors’ payments to a state insurance fund by imposing a new tax on health insurance.¹

To make certain their message about a malpractice “crisis” got through to the public and to political leaders in Pennsylvania during 2002, physicians lobbied openly, ran advertising campaigns – and frequently raised the specter of doctors closing their offices or leaving the state. Among other things, a strike by surgeons shut down the trauma center at Abington Memorial Hospital in the Philadelphia area was shutdown for nearly two. And physicians threatened to quit work at trauma facilities in Scranton, Pa., starting on Jan. 1, 2003.²

As one journalist commented regarding radio advertisements broadcast in favor of tort “reform,” “You’d think the day was fast approaching when no doctor would be left in Pennsylvania to care for your sick mother.”³

A survey done at midyear found that 57 percent of all Pennsylvania adults had been exposed to “some form of advertising about malpractice” – and that the advertising message that stuck with them the most was the claim by the doctors’ lobby that, “The cost of malpractice insurance is out of control.”⁴

Even after they had been subjected to this media bombardment, the same survey found that “Despite their criticisms of malpractice litigation, most Pennsylvanians can see themselves suing a health care provider to recover expenses or help others if hurt by a medical error.” In fact, 80 percent of respondents said they might sue to collect expenses resulting from a doctor’s malpractice – and 70 percent might sue to make sure similar mistakes didn’t injure others in the future.⁵

Amid the recent talk of insurance premiums and possible physician walkouts, little has been said about the need to reduce malpractice liability by reducing medical errors and decreasing the rate at which patients are harmed.

This report shows that the spike in some medical malpractice premiums is an insurance industry pricing and profitability problem – not a legal system problem. With tactic that border on malpractice, Pennsylvania’s medical community is using this temporary insurance problem to give the public the false impression that malpractice damage awards are causing this temporary crisis. Despite the Pennsylvania Medical Society’s repeated claims and emphatic rhetoric that excessive damage awards have driven up costs and created a health care crisis, a consistent lack of factual support undermines these claims.

Moreover, this report exposes the real long-term threats to quality health care in Pennsylvania: 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 has proposed to shift the costs of injuries onto individuals, their families, voluntary organizations and taxpayers. This is unfortunate because doctors and patients and consumers should be allies on this issue – not be pitted against each other. Doctors should join with patients and consumers and work to reform the poor 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.

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.”⁶

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.”⁷

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.⁸
- **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.⁹

- **Insurer mismanagement compounded the problems.** Concerns about a malpractice insurance “crisis” surfaced in 2001 after two insurers left the Pennsylvania market. Phico Insurance Co. was the third-largest malpractice insurer in the state and the St. Paul Companies, Inc. was the seventh largest. Together they carried about 18 percent of the state’s physicians. In both cases, the departure of the insurance companies from the market had little to do with malpractice award payments and everything to do with artificially low premiums in the 1990s, market competition and risky accounting practices than with the mismanagement of the company itself. Phico had been placed under the supervision of insurance regulators and was later sued by the state’s Insurance Department. The lawsuit alleged that Phico directors ignored signs of financial trouble at the company and pressured the board to pay dividends at a time when the insurer’s surplus “was declining drastically and significant strengthening of loss reserves was required.”¹⁰

And a *Wall Street Journal* analysis of the decline in the medical liability insurance market made these points about The St. Paul Companies:¹¹

- “[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.”
- Some insurance carriers “rushed into malpractice coverage because an accounting practice widely used in the industry made the areas seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly \$3 billion last year.”
- When malpractice claims increased in the 1980s, St. Paul and its competitors sharply raised rates. But, as the frequency and size of claims leveled off, St. Paul realized it had set too much money aside for malpractice payments. The company then released \$1.1 billion from its reserves between 1992 and 1997, which dramatically boosted its bottom line.
- St. Paul’s apparent profitability attracted numerous, smaller carriers into the malpractice insurance market, which led to widespread, competitive price-cutting.
- By the end of the 1990s, the revenue from premiums decreased to the point that insurers no longer could cover malpractice claims. Some collapsed and others, like St. Paul, withdrew from the market.¹²

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

In 2000, the Institute of Medicine (IOM) estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors.¹³ 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 Pennsylvania should be measured by the cost to patients and consumers, not the premiums paid by doctors to their insurance companies. Extrapolating from the IOM findings, we estimate that there are 1,920 to 4,277 preventable deaths in Pennsylvania each year that are due to medical errors. The costs resulting from preventable medical errors to Pennsylvania's residents, families and communities is estimated at \$742 million to \$1.3 billion each year. But the cost of medical malpractice insurance to Pennsylvania's doctors is less than \$731 million a year.¹⁴ [See figure 1]

Figure 1

The Real Cost of Malpractice in Pennsylvania

<p><u>1,920 - 4,277</u> Preventable Deaths Due to Medical Errors Each Year</p> <p><u>\$742 million - \$1.3 billion</u> Costs Resulting from Preventable Medical Errors Each Year</p> <p><u>\$731 million</u> Cost of Pennsylvania Doctors' Annual Medical Malpractice Premiums</p>

Sources: Preventable deaths and costs are prorated based on population and based on estimates in To Err Is Human, Institute of Medicine, November 2000. Malpractice premiums are based on Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2001, National Association of Insurance Commissioners, and information on surcharges paid to the state's Medical Professional Liability Catastrophic Loss Fund reported by the Pennsylvania Insurance Department.

Pennsylvania Medical Malpractice Claims & Award Trends: Believe Government Sources, Not Doctors

The Pennsylvania Medical Society likes to claim that medical malpractice payouts are “skyrocketing” because of “frivolous lawsuits” and jackpot justice.” It is easy to be confused by the medical lobby’s claims because of the different types of data cited. Less rhetoric and a few facts are in order.

- **Government data show that medical malpractice payouts have increased at a much slower pace in Pennsylvania than claimed by Pennsylvania Medical Society.** According to the federal government’s National Practitioner Data Bank, the median medical malpractice payout by a Pennsylvania physician to a patient rose 33 percent from 1997 to 2001, from \$150,000 to \$200,000, or less than 8 percent a year.¹⁵ By contrast, medical organizations in Pennsylvania quote data from Jury Verdict Research (JVR), a private research firm, indicating that median awards rose almost 43 percent from 1997 to 2000, from \$700,000 to \$1 million, or 14 percent a year.¹⁶ The reason for the difference, which is explained in the Appendix: JVR collects only jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts *and* settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.¹⁷
- **Government data show that medical malpractice payouts in Pennsylvania have increased at a slower pace than national health insurance premiums.** While NPDB data show that the median medical malpractice payout in Pennsylvania rose 33 percent from 1997 to 2001 (an average of 8.3 percent a year). The national average premium for single health insurance coverage increased 39 percent over that time period (9.5 percent a year).¹⁸ Payments for health care costs, which directly affect health insurance premiums, make up the lion’s share of most medical malpractice payouts.
- **Government data reveals little growth in medical malpractice claims paid in Pennsylvania.** According to the federal government’s NPDB, there has been only a modest increase in the total number of malpractice claims paid in Pennsylvania from 1995 through 2001. The difference between the 957 claims paid in 1995 and the 1,049 claims reported in 2001 is less than ten percent over six years, or 1.6 percent a year.¹⁹

Large Verdicts in Pennsylvania Have Dramatically Declined

Physicians have used anecdotal evidence to convince politicians and the media that they are being victimized by an explosion of large jury verdicts – knowing that occasional mega-awards grab headlines, even if they do not reflect broader trends.

These anecdotes are nothing short of misleading. The fact is that the number of large verdicts by Pennsylvania juries and the amount paid in medical malpractice cases decreased dramatically in recent years. From 2000 to 2002, the number of jury awards of \$1 million or more dropped by 50 percent (from 44 to 22) while the overall amount of these awards decreased by over 75 percent (from \$415 million to \$93 million). [See Figure 2]

Figure 2

Number of Verdicts of \$1 Million or More in Pennsylvania

Year	\$1 – \$4.9 Million	\$5 - \$9.9 Million	\$10 Million or more	Total Awards in Millions
2000 ^a	25	9	10	\$415
2001 ^b	29	3	5	\$185
2002 ^c	16	4	2	\$93

Sources: (a) Pennsylvania Department of Insurance, Table “Plaintiff Verdict Report for 2000.” (b) Pennsylvania Department of Insurance, Table “2001 PA Medical Malpractice Verdicts”. (c) Pennsylvania Department of Insurance, Table “2002 Jury Verdicts for Med Mal Cases”.

- In addition, a study by two senior Philadelphia judges found that in that city the number of big-money jury awards in malpractice cases dropped by one-third in 2001. While city juries awarded more than \$1 million in 30 cases in 2000, that number dropped to 20 cases in 2001.²⁰ In 2002, that number declined even further – to 14 – a drop of more than 50 percent from 2000.²¹

There Is No Evidence of a Physician Exodus from Pennsylvania

The medical community has insisted that the quality of Pennsylvania’s health care is in jeopardy as more and more doctors flee to other states that have limited the legal rights of patients and are perceived to be “doctor friendly.” They maintain that this unprecedented exodus of doctors has left Pennsylvania’s reserve of qualified physicians dangerously low and has hindered its ability to attract new, young doctors. A closer examination of these assertions reveals that the opposite is true.

- Between 1990 and 2000, a period during which the state’s population grew only 3.4 percent, the number of doctors in Pennsylvania increased by 13.5 percent.²²
- The Pennsylvania State Board of Medicine regulates the practice of medicine through the licensure, registration and certification of members of the medical profession. In 1995, the Board issued 32,367 medical licenses to physicians practicing in Pennsylvania. In 2002, the number of licensed physicians living in-state climbed to 36,921—a 14 percent increase. More importantly, during the alleged height of the medical malpractice “crisis” in 2001-2002, the number of physicians dramatically increased. The Board licensed 7.5 percent more physicians in 2002 than in 2001, calling into question the claims that doctors are leaving the state.²³

Figure 3

Licensed Medical and Osteopathic Physicians with a Pennsylvania Address

Year	Number of Licensed Doctors
1995	32,367
1996	33,786
1997	33,365
1998	34,841
1999	34,930
2000	35,763
2001	34,330
2002	36,921

Source: The Pennsylvania State Medical Board

- According to the American Medical Association (AMA), Pennsylvania is home to 5 percent of the nation's doctors, a distinction that ranked the state's physician population the 5th highest in the nation. Further, the AMA reports that Pennsylvania has one of the largest physician populations under the age of 35, with 5.5 percent of the nation's younger doctors practicing in Pennsylvania.²⁴
- The head of the Pennsylvania Medical Professional Liability Catastrophe Loss Fund, John H. Reed, reported that there was no evidence of "any major departure of physicians from the state" and that Pennsylvania had "more doctors [in 2001] than we did five or 10 years ago."²⁵

In addition, reporter Ann Wlazelek of the *Morning Call* newspaper in Allentown, Pa., published an investigative report in March 2002 that claimed, "The advertising blitz used by doctors and hospitals to win \$400 million in state concessions on malpractice insurance by claiming large numbers of physicians are fleeing Pennsylvania is not supported by fact."²⁶ Wlazelek's other published findings included:

- In 2000, Pennsylvania ranked ninth in the nation for its high concentration of physicians, with 318 doctors for every 100,000 residents.
- The secretary of the Pennsylvania Medical Society circulated an unreliable claim that the state was about to lose 80 doctors who were preparing to leave or to modify their practices because of insurance rates. (The number did not reflect the fact that some doctors were quitting or leaving for reasons other than insurance. And it did not reflect the number of doctors who had moved into Pennsylvania.)
- Hospitals across the region confirmed that they had been "hit hard financially," but none of them have had to "eliminate services or close units."
- Although Pennsylvania doctors – in some specialties in particular – had encountered larger-than-normal insurance rate increases, some of their previous rates had been the result of "low-ball" pricing that insurers had used to increase volume.

Only 10.6 percent of the state's physicians are responsible for bulk of malpractice payouts

The insurance and medical community has 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 been responsible for the bulk of money paid out in Pennsylvania malpractice cases.

- According to the federal government’s National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 10.6 percent of the state’s doctors in 2000, had been responsible for two or more malpractice payouts to patients.²⁷ These doctors were responsible for 84 percent of all the money paid out in malpractice cases. Overall, they have paid out \$2.9 billion in damages. Even more troubling, only 4.7 percent of Pennsylvania’s doctors (1,838), were responsible for 51.4 percent of all the money paid out in malpractice cases.
- It is important to note that Pennsylvania operates a state catastrophic fund, which makes supplemental payments in addition to the primary payouts in some large malpractice cases. This means the number of payouts ascribed to a doctor often may be greater than the number of separate instances in which that doctor has lost or settled a malpractice case.

Figure 4

Number of Medical Malpractice Payouts and Amounts Paid by Pennsylvania Doctors

Number of Payouts Reported	Number of Doctors Who Made Payouts	Percent/ Total Doctors (39,052)	Total Number of Payouts	Dollar Amount of Payouts	Percent of Total Dollars Paid Out
All	8,247	21.12%	16,900	\$3,475,858,700	100.0%
1	4,096	10.49%	4,096	\$556,026,050	16.0%
2 or more	4,151	10.63%	12,804	\$2,919,832,650	84.0%
3 or more	1,838	4.71%	8,178	\$1,786,582,400	51.4%
4 or more	964	2.47%	5,556	\$1,198,807,650	34.5%
5 or more	543	1.39%	3,872	\$828,634,900	23.8%

Source: Public Citizen analysis of National Practitioner Data Bank.

Repeated Payouts Bring Few Consequences

Despite these alarming numbers, the Pennsylvania state government and the states health care providers have done little to rein in those doctors who are responsible for multiple malpractice payouts. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions have been few and far between for Pennsylvania physicians:

- Of the 543 doctors who were responsible for 23.8 percent of all the money paid out in malpractice cases(\$828,634,000), only 5.1 percent have been disciplined by the Pennsylvania State Board of Medicine.²⁸

The extent to which doctors can be responsible for repeated malpractice payouts to injured patients without being disciplined in Pennsylvania is illustrated by the following NPDB descriptions of 10 physicians, *none* of whom have been disciplined by the state:

- **Physician Number 32828** made payouts totaling \$9,115,00 between 1992 and 2001 involving improper diagnosis, failure to diagnose, surgery on a wrong body part, improper performance of surgery, unnecessary surgery and improper management of a surgical patient.
- **Physician Number 33094** made payouts totaling 8,102,500 between 1993 and 2001 involving obstetrics, a failure to diagnose, a retained foreign body, a failure to a manage pregnancy, a failure to treat, improper performance of a treatment, failure to obtain patient consent, improper performance of a vaginal delivery and surgery on a wrong body part.
- **Physician Number 33138** made payouts totaling \$5,402,500 between 1990 and 1996 involving a delay in performing surgery, improper performance of a surgery, failure to diagnose, failure to treat and a wrong diagnosis.
- **Physician Number 34328** made payouts totaling \$7,357,500 between 1991 and 2002 involving improper performance of a surgery, improper management of medications, failure to respond to a patient, failure to obtain consent, failure to monitor a patient, improper management of a surgical patient and a failure to order appropriate medication
- **Physician Number 43993** made payouts totaling \$6,977,500 between 1992 and 2001 involving improper management of medications, failure to obtain patient consent, improper performance of a surgery, a retained foreign body and improper treatment.
- **Physician Number 44218** made payouts totaling \$6,615,000 between 1992 and 2000 involving obstetrics, a failure to make a diagnosis, delay in delivery, improper choice of delivery method, failure to manage a pregnancy and delay in diagnosis.

- **Physician Number 56789** made payouts totaling \$10,358,080 between 1994 and 2001 involving a retained foreign body, failure to treat, an unnecessary surgery, improper performance of a surgery, failure to obtain consent, delay in a diagnosis and delay in performing a surgery.
- **Physician Number 67632** made payouts totaling settled \$6,026,250 between 1995 and 2002 involving a retained foreign body, a failure to obtain consent, improper management of a surgical patient and a failure to order appropriate medications.
- **Physician Number 86554** made payouts totaling \$6,250,000 between 1997 and 2002 involving the improper use of equipment, improper performance of a surgery, unnecessary surgery, a failure to diagnose and a failure to obtain patient consent.
- **Physician Number 87644** made payouts totaling \$5,560,000 between 1996 and 1999 involving a failure to refer to a specialist, an unnecessary surgery and improper management of a patient.

Where's the Doctor Watchdog?

There are 85 physicians out of 39,052 who have had serious sanctions levied against them by Pennsylvania's State Medical Board for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses and other offenses, according to an ongoing Public Citizen project that tracks "Questionable Doctors"²⁹ in Pennsylvania and other states. Most of these doctors were not required to stop practicing, even temporarily.

The Pennsylvania State Board of Medicine is dangerously lenient with doctors, repeatedly letting serious and sometimes repeat offenders off the hook. In Public Citizen's ranking of state medical boards, Pennsylvania ranked number 36 out of 50 states and the District of Columbia. The ranking is based on the number of serious disciplinary actions per 1,000 doctors in each state. In 2001, nationally there were 3.36 serious actions taken for every 1,000 physicians. Pennsylvania is among the bottom third of U.S. states when its diligence in taking disciplinary actions is measured – 2.18 serious actions per 1,000 doctors.³⁰

Capping Damages Misses the Mark

When Pennsylvania adopted its legislative package in March 2002, doctors and their representatives joined with legislators in heralding the changes. “Without question,” said Howard Richter, president of the Pennsylvania Medical Society, “the medical liability reforms contained in this legislation will place Pennsylvania in the forefront in addressing what is clearly becoming a national crisis for physicians and their patients.”³¹

The very fact that Pennsylvania finished 2002 facing threats of doctor walkouts, potential hospital closures, and an emergency bailout plan makes it obvious that the changes did not meet expectations of the doctor’s lobby. Their solution: pass a constitutional amendment to give the legislature the authority to impose caps on non-economic damages. No action could be more cruel and less warranted.

- **“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.³² 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.³³ PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners’ classifications.³⁴ The average indemnity paid per file was \$49,947 for the least severe category of injury and increased with severity, to \$454,454 for grave injuries. All researchers found that the amount of jury verdicts fell off in cases of death, for which the average indemnity was \$195,723. This is not surprising, as the costs of medical treatment for a grave injury are likely to be greater and pain and suffering would be experienced over a longer time period than in the case of death.³⁵

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:

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.³⁶ Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,³⁷ 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.³⁸
- **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.³⁹

- **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.⁴⁰ 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.⁴¹

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

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

Limit Physicians’ Workweek to Reduce Hazards Created by Fatigue

American medical residents work among the highest—if not the highest—number of hours in the professional world. They work up to 120 hours a week, including 36-hour shifts for several weeks at a time.⁴² After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10 percent blood alcohol level.⁴³ 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.⁴⁴ 45 percent of residents who sleep less than four hours per night report committing medical errors.⁴⁵ 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.⁴⁶ If the maximum workweek for residents was limited to 80 hours, it could considerably reduce mistakes due to fatigue and lack of supervision.

Refine the Malpractice Insurance System

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

Improve Oversight of Physicians

Public Citizen has long sought greater consumer access to information about doctors, and there have been recent improvements in making that information available. Most state medical boards now provide some physician information on the Internet, but the information about disciplinary actions varies greatly, is often inadequate and can be difficult for people to access.⁴⁷

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,⁴⁸ 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.**

Appendix: Understanding Medical Malpractice Award Statistics

There are three principal sources of information on medical malpractice verdicts and awards: National Practitioner Data Bank, Physician Insurer Association of America (PIAA), and Jury Verdict Research. Each source has advantages and disadvantages.

National Practitioner Data Bank (NPDB): Federal law mandates reporting of *all* payments in settlement of malpractice claims to the NPDB, which is maintained by the Department of Health and Human Services.⁴⁹ NPDB, therefore, is the most comprehensive source of information. NPDB files contain information on the state in which cases arose, allowing comparison of award amount and frequency among different jurisdictions.

Physician Insurer Association of America (PIAA) Data Sharing Project. PIAA, a trade association, collects detailed claim information from some of its member companies. It is not comprehensive – only 12 percent of awards reported to NPDB get reported to PIAA. But it contains information on claims that are not ultimately paid, giving a broader picture of the claiming process than NPDB. PIAA also presents data correlating awards with injury severity, specialty of defendant, and type of malpractice.

Jury Verdict Research (JVR). JVR collects information on jury *verdicts* only, which are reported to it by plaintiffs attorneys, court clerks, and stringers. According to PIAA, jury verdicts represent only 6.75 percent of all claims. However, verdicts in favor of plaintiffs, the pool from which JVR collects award statistics, are only 4.1 percent of all payments made to plaintiffs. As a result, JVR reports are skewed significantly upwards for two reasons. First, attorneys who win large verdicts are more likely to report their victories to JVR. For example, 34 percent of the verdicts reported to JVR are plaintiff wins, 15 percent higher than the national average reported by PIAA. Second, jury verdicts are higher than the average settlement because cases involving severe injuries are more likely to go to trial, and the defendant has usually rejected a settlement offer for a much smaller amount.

Figure 5

Different Numbers from Different Sources: 2000 Median Malpractice Awards

Source	Jury Verdict Research	PIAA	NPDB
Median	\$1,000,000 (verdict)	\$150,000 (all)	\$125,000 (all) \$125,000 (settlement) \$235,000 (judgment)
Coverage	Less than 5%	12%	100%

Sources: “Medical Malpractice: Verdicts, Settlements and Statistical Analysis,” Jennifer E. Shannon and David Boxold, Jury Verdict Research, 2002; Physician Insurer Association of America, Claim Trend Analysis, 2001 Edition; National Practitioner Data Bank 2000 Annual Report.

For example, JVR reported that the median *verdict* in a malpractice trial in 2000 was \$1 million. It also reported that the median final demand from a plaintiff to settle a case was \$562,000 in 2000 – about half the final verdict. Even more noteworthy, the median final settlement offer from doctors was only \$80,000; way below what a jury thought the case was worth to the injured plaintiff. Doctors lose about 20 percent of cases.⁵⁰ Thus, many insurance companies make a conscious decision to risk a much higher jury verdict.

According to NPDB records, the median payment in a settlement in 2000 was only \$125,000, same as the median for all payments; but the median payment for a judgment was \$235,000. This amount is much lower than the JVR jury verdict figure (\$1 million) because the ultimate payment received by a plaintiff reflects judges' discretionary reductions in jury awards (so-called remittiturs) and discounts agreed to by plaintiffs in order to avert appeals.

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- ¹ “Insurers: Pa. Med-Mal Fix Could Hurt Them as It Helps Doctors,” *Best’s Insurance News*, Jan. 6, 2003.
- ² “Trauma center reopened,” *Philadelphia Daily News*, Jan. 3, 2003.
- ³ Jon Delano, “Final outcome of malpractice reform uncertain,” *Pittsburgh Business Times*, March 1, 2002.
- ⁴ Princeton Survey Research Associates, “Pennsylvania Malpractice Study,” June 17-July 8, 2002, funded by the Pew Charitable Trusts.
- ⁵ Id.
- ⁶ Charles Kolodkin, “Medical Malpractice Insurance Trends? Chaos!” International Risk Management Institute. <http://www.irmi.com/expert/articles/kolodkin001.asp>
- ⁷ “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.
- ⁸ Americans for Insurance Reform, “Medical Malpractice Insurance: Stable Losses/Unstable Rates,” Oct. 10, 2002. See also: <http://www.insurance-reform.org/StableLosses.pdf>.
- ⁹ Hot Topics & Insurance Issues, Insurance Information Institute, www.iii.org
- ¹⁰ Associated Press, “Malpractice-panel member cited in suit,” *Philadelphia Inquirer*, Nov. 23, 2002.
- ¹¹ Rachel Zimmerman and Christopher Oster, “Insurers’ Missteps Helped Provoke Malpractice ‘Crisis,’” *Wall Street Journal*, June 24, 2002.
- ¹² Id.
- ¹³ To Err Is Human, Building a Safer Health System, Institute of Medicine, 2000, p. 26-27.
- ¹⁴ This is the total of liability premiums paid by Pennsylvania doctors in 2001 (\$372 million, according to the National Association of Insurance Commissioners, “1991 to 2001 Medical Malpractice Insurance Premiums and Losses By State”), and the total 2001 surcharges paid to the state’s Medical Professional Liability Catastrophe Loss Fund, (\$359 million, as reported by the Pennsylvania Insurance Department.)
- ¹⁵ National Practitioner Data Bank Annual Reports, 1997 through 2001.
- ¹⁶ Evelyn Brady, “Health-care crisis in Pa. puts patients on front line between warring sides,” *Times Leader*, Wilkes, Barre, Pa., Nov. 7, 2002.
- ¹⁷ Physician Insurer Association of America, Claim Trend Analysis, 2001 Edition.
- ¹⁸ 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 Pennsylvania Insurance Commission had no collective data on Pennsylvania rates but suggested that they mirrored national trends, phone call with Roseanne Placey, Press Secretary/Communications Officer for the Insurance Commissioner’s Office of Policy, Enforcement and Administration, January 14, 2003.
- ¹⁹ National Practitioner Data Bank, annual reports, 1997-2001.
- ²⁰ Josh Goldstein, “Malpractice issue may not be about money, study says,” *Philadelphia Inquirer*, Feb. 3, 2002.
- ²¹ Pennsylvania Department of Insurance, Table “2002 Jury Verdicts for Med Mal Cases”.
- ²² Medical Professional Liability Catastrophe Loss Fund (CAT Fund), “Internal Census,” Director John Reed.
- ²³ Pennsylvania State Medical Board Licensure Data obtained via email correspondence from Ms. Diane Miller, Clerical Supervisor, Bureau of Professional and Occupational Affairs, January 15, 2003.
- ²⁴ American Medical Association, “Physician Characteristics and Distribution in the U.S.,” (2001-2002 Edition)
- ²⁵ Josh Goldstein, “Recent Census of Doctors Show No Flight from Pennsylvania,” *Philadelphia Inquirer*, Oct. 2, 2001.
- ²⁶ Ann Wlazelek, “Doctors’ ad campaign baseless,” *Morning Call*, March 24, 2002.
- ²⁷ The NPDB is the most comprehensive source of information about a physician. It is the only database that collects information on both physician disciplinary proceedings and malpractice claim payments. The names of individual physicians are not made available to the public.
- ²⁸ National Practitioner Data Bank, “Relationship Between Frequency of Physician Medical Malpractice Payment Reports and Reportable Licensure Actions,” Sept. 1, 1990 - Sept. 30, 2002.
- ²⁹ “Public Citizen’s database is available at <http://www.questionabledoctors.org/>.
- ³⁰ “Questionable Doctors,” Public Citizen’s Health Research Group, 2002; See at: www.questionabledoctors.org.
- ³¹ Ovetta Wiggins and Josh Goldstein, “Legislators approve malpractice-law overhaul,” *Philadelphia Inquirer*, March 14, 2002.

³² 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).

³³ *PIAA Data Sharing Report*, Report 7, Part 10.

³⁴ 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

³⁵ Vidmar, Gross, Rose, *supra* at 284

³⁶ 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.

³⁷ 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.

³⁸ Sandra G. Boodman, “No End to Errors,” *Washington Post*, Dec. 3, 2002.

³⁹ 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.

⁴⁰ *A follow-up review of wrong site surgery*, JCAHO, Sentinel Event Alert, Issue 24, Dec. 5, 2001.

⁴¹ *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>

⁴² American Medical Student Association, *Fact Sheet, Support H.R. 3236 limiting resident-physician work hours*; See also: <http://www.amsa.org/hp/rwhfact.cfm>

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ 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>.

⁴⁷ See <http://www.citizen.org/publications/release.cfm?ID=7168>

⁴⁸ www.questionabledoctors.org

⁴⁹ Go to <http://www.npdb-hipdb.com/>.

⁵⁰ Physician Insurer Association of America, *Claim Trend Analysis*, 2001 Edition.