The Facts About Medical Malpractice in Rhode Island

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Acknowledgments

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Executive Summary

The Rhode Island Medical Society and its political allies have made dire predictions about an impending malpractice "crisis" in their state. These worries are based on the experiences of other states, where some doctors have faced significantly increased malpractice insurance premiums over the past two years. Rhode Island's medical establishment may be reacting to the potential for a *temporary* "crisis" – but its arguments that this is being triggered by "frivolous" malpractice claims or an explosion of "meritless" lawsuits have no basis in fact.

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

1) The most significant, long-term malpractice "crisis" faced by Rhode Island residents is the unreliable quality of medical care being delivered by a relatively small proportion of doctors – a problem that health-care providers have not adequately addressed. Restricting access to legal remedies for patients who seek compensation for injuries, as is proposed under legislation introduced in Rhode Island, would only decrease deterrence and reduce the quality of care.

2) The medical malpractice premium "crisis" that Rhode Island doctors have seen in other states is not a long-term problem nor is it being caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance premiums 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.

Highlights of this report include:

- **The cost of medical negligence to Rhode Island patients and consumers is considerable, especially when measured against the cost of malpractice insurance to Rhode Island doctors.** Extrapolating from Institute of Medicine (IOM) findings, we estimate there are 164 to 365 deaths in Rhode Island each year that are due to *preventable* medical errors. The costs resulting from preventable medical errors to Rhode Island residents, families and communities are estimated at $63 million to $108 million each year. But the cost of medical malpractice insurance to Rhode Island doctors is only $21.6 million a year.

- **There has been a decrease in the annual malpractice payouts by Rhode Island's doctors when inflation is considered.** According to the National Practitioner Data Bank (NPDB), the total value of malpractice payouts made to patients in Rhode Island in 2001 was $22.8 million, up from $21.1 million in 1992. This increase of $1.7 million represents a change of only 8 percent over nine years, or 0.9 percent a year. During this same period, costs of medical care increased 47 percent nationwide, an average of 5.2 percent a year.

- **There has been a significant decrease in the number of malpractice payouts made in Rhode Island.** NPDB statistics contradict suggestions by Rhode Island doctors and their political allies that malpractice payouts have grown much more frequent. NPDB data show that the number of payouts actually declined 21 percent from 73 in 1997 to 58 in 2001 (the most recent five years for which statistics are complete).

- **Million-dollar malpractice payouts have remained flat.** Proponents of legislation to impede the legal access of injured patients assert that "verdicts and settlements in medical malpractice actions exceeding $1 million have increased steadily over the past 20 years." In fact, payouts reported to the National Practitioner Data Bank show that Rhode Island has experienced no such recent pattern. From 1992 through 2001, the average number of malpractice payouts of a million dollars or more was less than two per year, and never exceeded three in any of those years. In 2001, the total number of payouts of $1 million or more was three, the same as in 1992. Additionally, the number of malpractice payouts between $500,001 and $1 million showed no steady, upward trend during these years, averaging just over eight per year. In 2001, the total number of payouts in this range was 11, less than the 13 in 1992.

- **As a group, Rhode Island doctors have seen a decrease in their liability insurance premiums, when inflation is considered.** According to data from the National Association of Insurance Commissioners (NAIC), the total amount that Rhode Island doctors paid in malpractice insurance premiums in 2001 was $21.6 million, compared with $19.5 million in 1996. This is an increase of only 11 percent during this period (the most recent five years for which data is complete). When adjusted for medical inflation, which was 19.8 percent during this same period, and the growing number of physicians in the state, this represents a significant decline in actual dollars.

- **Malpractice insurance premiums are lower in Rhode Island than in neighboring states.** A comparison of medical malpractice premiums charged by one insurance group that serves Rhode Island, Connecticut and Massachusetts shows that Rhode Island doctors generally pay less – in some cases, much less – than their counterparts in neighboring states. And one of these two adjacent states, Massachusetts, imposes a $500,000 cap on malpractice awards. According to data from *Medical Liability Monitor*, rates for general surgeons ranged from 14 percent to 40 percent less in Rhode Island than in Connecticut or Massachusetts; rates for Ob/Gyns ranged from 6 percent to 23 percent less in Rhode Island than in the other two states; and rates for internists ranged from 2 percent to 23 percent less in Rhode Island than in the other states.

- **Malpractice payouts are insignificant when compared with the state's overall healthcare expenditures.** Total spending on health care in Rhode Island was $4.5 billion in 1998. In that year, doctors' malpractice payouts made to patients in Rhode Island totaled $14.5 million – the equivalent of only 0.32 percent of healthcare expenditures in the state.

- **There is no sign that doctors are abandoning Rhode Island.** Rhode Island's medical environment has attracted a steady increase in physicians. In 2002, there were 2,915 practicing physicians and osteopaths with Rhode Island addresses, compared with 2,623 in

1999, an increase of 11 percent. According to the American Medical Association, Rhode Island had 277 doctors per 100,000 residents in 1990. By 2001, that ratio had increased to 365 doctors per 100,000 residents. This is the seventh highest ratio in the nation.

- **Repeat-offender doctors are responsible for half of medical malpractice payouts.** According to the NPDB, which covers malpractice judgments and settlements since September 1990, 4.8 percent of Rhode Island's doctors have made 52.7 percent of all payouts. These repeat-offender doctors are responsible for two or more malpractice payouts to patients and they have paid out $104.7 million in damages. Even more disturbing, just 1.6 percent of Rhode Island's doctors, each of whom has paid three or more malpractice claims, are responsible for nearly 26 percent of all payouts.

- **Less than a third of doctors with four or more malpractice payouts have been disciplined.** According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, 19 Rhode Island physicians have made four or more malpractice payouts, but only 31.6 percent of those doctors have been disciplined by the Rhode Island State Board of Medical Licensure and Discipline.

- **The medical board is among the nation's less stringent when it comes to disciplining doctors.** Rhode Island ranks 35th among all states and the District of Columbia when its diligence in taking disciplinary actions against doctors is measured. In 2002, the state Board of Medical Licensure and Discipline levied serious sanctions against only 10 doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses, according to an ongoing Public Citizen project that tracks "Questionable Doctors" nationwide. Nationally in 2002, there were 3.6 serious actions taken for every 1,000 physicians. The rate of serious actions by the Rhode Island Board of Medical Licensure and Discipline – 2.6 per 1,000 physicians – was roughly one-fifth the rate in Wyoming, which is the top-ranked state with 11.9 serious actions per 1,000 physicians.

- **Five years after a disclosure law was adopted, consumers still can't get vital data.** Rhode Island has yet to fully implement a 1997 law that called for public disclosure of profiles containing information about individual physicians. Although some profiles are available online, they omit two crucial categories: malpractice information and criminal convictions. The system is scheduled for an update this summer, but the profiles still will not contain data on doctors' malpractice payouts.

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

- **Rhode Island doctors have endured insurance cycles for 28 years.** As recently as February, the Rhode Island Medical Society's board of directors acknowledged that the state had witnessed up-and-down cycles in the medical liability insurance industry since the mid-1970s. In an advisory to members, the board recounted major problems that occurred with medical liability insurers in 1975, when coverage became largely unavailable; for a number of years beginning in 1987, when nine different "risk retention groups" began going bankrupt; and again in 1993, when a large, unrated carrier, Premier Alliance, became insolvent. The primary cause for these problems, the board concluded, has been "under-reserving" of funds by the insurance companies.

- **Insurance companies and their lobbyists admit caps on damages won't lower malpractice premiums.** Caps on "non-economic damages" are not part of Rhode Island's current legislative proposal, but they are included in a federal bill that the state's U.S. senators and representatives are considering. These caps, which limit compensation for pain and suffering resulting from severe injuries such as brain damage, paralysis, loss of a limb, loss of reproductive capacity, disfigurement, blindness or deafness, significantly reduce awards paid to catastrophically injured patients. But, because such truly severe cases comprise a small percentage of medical malpractice claims and because the portion that pays for defense lawyer fees dwarfs the portion of the insurance premiums that pay for compensation, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this, and have said so on numerous public occasions.

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

- **Capping damages hurts women in particular.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on women. The largest part of economic damages in many tort claims is lost wages, and women earn on average less money than men do. Additionally, the most significant effect of many medical injuries inflicted on women is harm to reproductive capacity, which does not entitle them to receive economic damages, according to a study by the director of the Insurance Law Center at the University of Connecticut School of Law.

- **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 7.6 preventable medical errors committed in hospitals resulted 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.

- **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."

- **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.

- **Action could be taken on a national level to reduce medical errors.** The only way to reduce the cost of medical injuries is to reduce negligence and mistakes – and the best way to accomplish this is by reforming the regulatory oversight of the medical profession. Public Citizen recommends opening up the National Practitioner Data Bank to empower consumers

with information about their doctors. It also recommends implementing the "systems approach" advocated by the Institute of Medicine to establish mandatory nationwide error reporting systems, identify unsafe practices and raise performance standards. And Public Citizen recommends that Congress encourage better oversight of physicians through grants to state medical boards, tied to the boards' agreements to meet performance standards.

- **States should improve oversight of health-care providers.** When negligent doctors are disciplined, it is rarely for inferior care. Instead, state medical boards frequently respond to more easily documented things such as prescription drug violations, fraud convictions or disciplinary actions taken in other states. Governance of physicians would improve if medical and licensing boards were required to sever formal links with state medical societies. And legislatures could help ensure that medical boards have enough revenue to hire more investigators and legal staff to perform effective oversight. In addition, Rhode Island is demonstrating how medical errors can be addressed on the state level by considering two bills to reduce overwork among nurses. This is a constructive step, in light of studies that identify fatigue among nurses and medical residents as a significant contributing factor to patient injuries and deaths.

- **State regulators could make insurance rates more predictable.** J. Robert Hunter, Director of Insurance for the Consumer Federation of American, on behalf of Americans for Insurance Reform, has recommended a number of steps to state insurance regulators. These include thoroughly auditing insurance companies' pricing and profitability data; regulating excessive prices; freezing "stressed rates" until prices and jumps in loss reserves can be analyzed; and requiring medical malpractice insurers to use claims history as a rating factor. He also advocates creating a standby public insurer to write risks during "hard markets," and asking the National Association of Insurance Commissioners to stop the implementation of the deregulation of commercial rates and forms, which it is unwisely pushing.

Introduction: Overstating Problems and Undermining Patients' Legal Rights

There is no dispute that doctors are concerned about the prospect of rising medical malpractice premiums. And 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. It is important, however, that public policy regarding medical malpractice be guided by solid facts and a clear understanding of the situation – not by an artificial sense of "crisis" exaggerated to serve narrow interests.

Rhode Island's medical establishment has used dire language in its campaign to change state laws to inhibit injured patients from seeking compensation for negligence. "Access to quality health care services is already shrinking," warned the president of the Rhode Island Medical Society in a letter to members. "The word is out that Rhode Island is not a great place to be a doctor."[1]

In an advertisement distributed statewide, the Rhode Island Medical Society delivered the unsettling assessment that financial pressures on doctors are "intensifying" and that "no one can predict how doctors will respond to these pressures or what the impact on patients will be." The ad also suggested, "The next time you see your doctor for a routine appointment, you might turn the tables on him or her and ask, 'Hey, Doc, how's it going?'"[2]

In effect, Rhode Island's physicians have become the "victims" of malpractice, according to this advertisement. Meanwhile, the doctors and their political allies have firmly placed the blame on patients who, they allege have brought "many meritless claims" for steadily increasing amounts of money.[3]

In fact, as this report shows, conditions in Rhode Island do not constitute a "crisis," and litigation does not seriously threaten the cost of liability insurance or consumer access to health care in the state. Rhode Island doctors openly acknowledge that the insurance industry has experienced economic fluctuations[4] – and it is these pricing and profitability problems, not patient lawsuits that put sporadic pressure on malpractice insurance premiums.

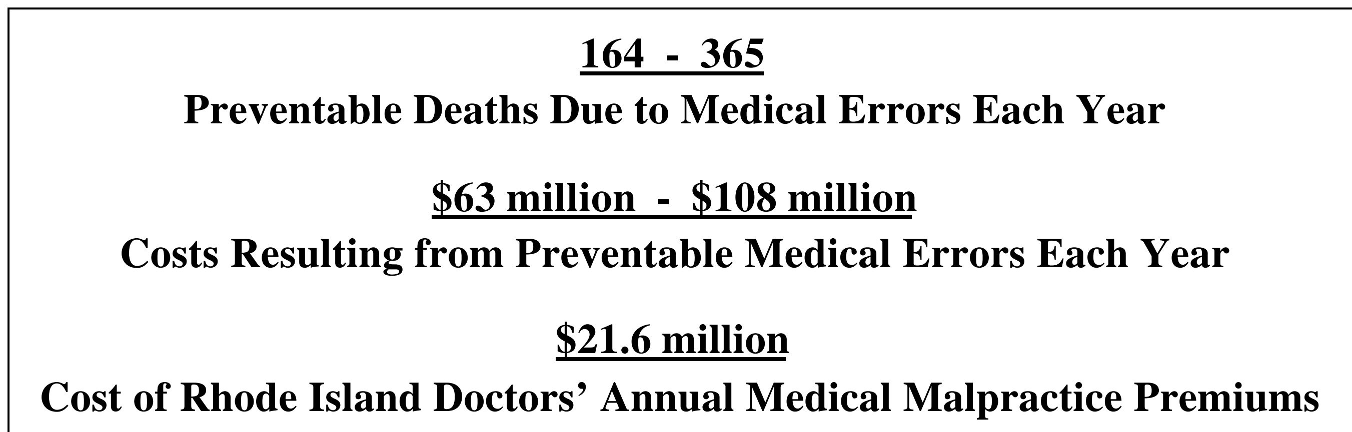
The real long-term threat to quality health care in Rhode Island is the frequency of medical mistakes, and the lack of oversight and discipline against the very small number of medical professionals who commit most of the state's malpractice. This report provides suggestions for averting these problems in the future.

Costs of Medical Malpractice to Rhode Island's Patients & Consumers

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.[5] 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 Rhode Island 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 164 to 365 preventable deaths in Rhode Island each year that are due to preventable medical errors. The costs resulting from preventable medical errors to Rhode Island's residents, families and communities are estimated at $63 million to $108 million each year. But the cost of medical malpractice insurance to Rhode Island's doctors is only $21.6 million a year.[6] [See Figure 1]

Figure 1



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

Rhode Island Doctors' Medical Malpractice Payouts: Reliable Sources vs. Rhetoric

Medical leaders in Rhode Island have made gloomy pronouncements that the state is on the brink of a crisis that could "erode" health care and cost almost every doctor in the state "many thousands of dollars" in malpractice insurance premiums.[7] Mirroring this rhetoric, legislation introduced in the General Assembly describes the prospect of "soaring" premiums resulting from "meritless claims" and steadily increasing malpractice awards.[8] These assertions, by doctors and politicians alike, are not supported by government statistics or other reliable sources.

- **There has been a decrease in the amounts of Rhode Island's annual malpractice payouts.** According to the federal government's National Practitioner Data Bank (NPDB), the total value of malpractice payouts made to patients in Rhode Island in 2001 was $22.8 million, up from $21.1 million in 1992.[9] [See Figure 2] This increase of $1.7 million represents a change of only 8 percent over nine years, or 0.9 percent a year. During this same period, costs of medical care increased 46.7 percent nationwide, an average of 5.2 percent a year.[10] (Health-care costs, which directly affect health insurance premiums, make up the lion's share of most medical malpractice awards.)

Figure 2

Total Malpractice Payouts, R.I. Physicians, 1992-2002

Year	Malpractice Payouts, R.I. Physicians
1992	$21,148,750
1993	18,457,750
1994	12,205,800
1995	13,969,800
1996	10,685,750
1997	17,338,000
1998	14,522,750
1999	19,930,750
2000	15,428,800
2001	22,805,250

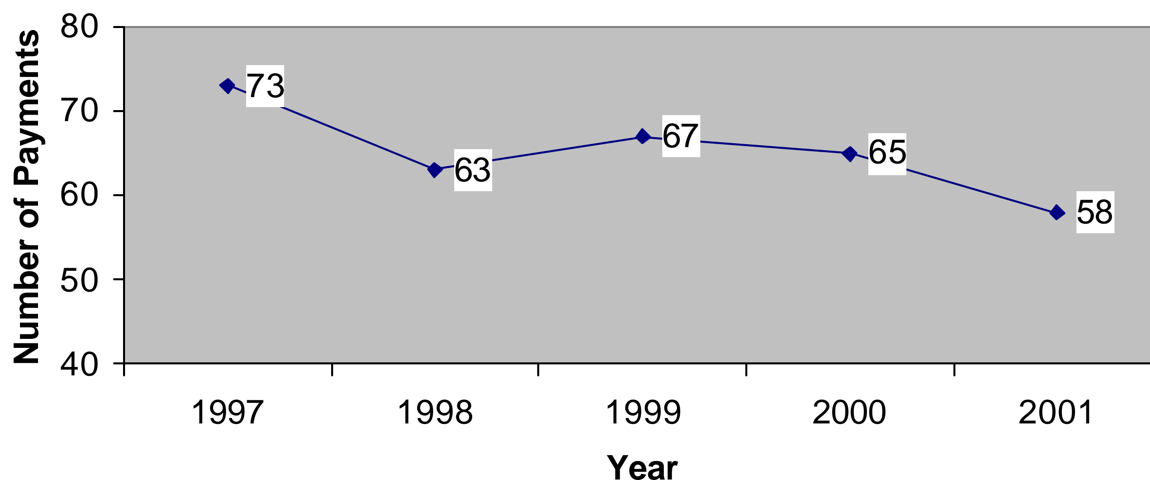
Source: National Practitioner Data Bank, Sept. 1, 1990 – Sept. 30, 2002.

- **There has been a significant decrease in the number of malpractice payouts made in Rhode Island.** Statistics from the National Practitioner Data Bank contradict suggestions by Rhode Island doctors and their political allies that malpractice payouts have become much more frequent. NPDB data show that the number of annual malpractice payouts to patients declined by 21 percent, from 73 in 1997 to 58 in 2001, during the most recent five years for which complete statistics are available.[11] [See Figure 3]

- **Million-dollar malpractice payouts have remained flat.** Proponents of Rhode Island's legislation to limit the legal rights of injured patients assert that "verdicts and settlements in medical malpractice actions exceeding $1 million have increased steadily over the past 20 years, resulting in losses to many malpractice insurers."[12] In fact, data reported to the National Practitioner Data Bank show that the state has experienced no such recent pattern. From 1992 through 2001, the average number of malpractice payouts of a million dollars or more was less than two per year, and never exceeded three in any of those years. In 2001, the total number of payouts of $1 million or more was three – the same as in 1992. Additionally, the number of malpractice payouts between $500,001 and $1 million showed no steady, upward trend during these years, averaging 9.4 per year. In 2001, the number of payouts in this range was 11, less than the 13 in 1992.[13] [See Figure 4]

Figure 3

Number of Malpractice Payouts in Rhode Island, 1997-2001



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

Figure 4

Malpractice Payouts Exceeding $500,000 in Rhode Island, 1992-2001

Year	Number of Payouts Between $500,001 – $1,000,000	Number of Payouts More Than $1,000,000
1992	13	3
1993	9	2
1994	8	0
1995	8	1
1996	3	0
1997	11	0
1998	5	1
1999	13	3
2000	13	1
2001	11	3
Average	**9.4**	**1.4**

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

- **Malpractice payouts are insignificant when compared with the state's overall healthcare expenditures.** Total spending on health care in Rhode Island was $4.5 billion in 1998, the last complete year for which data is available from government sources.[14] In that year, doctors' malpractice payouts made to patients in Rhode Island totaled $14.5 million.[15] Thus, doctors' malpractice payouts were equivalent to only 0.32 percent of healthcare expenditures in the state.

Rhode Island Doctor's Medical Malpractice Premiums: Rising Less than Inflation Rate

As a group, Rhode Island doctors have seen a decline in the premiums they pay, when inflation is considered. According to the National Association of Insurance Commissioners (NAIC), the total amount that Rhode Island doctors paid in malpractice insurance premiums in 2001 was $21.6 million, compared with $19.5 million in 1996. This is an increase of only 11 percent during this period (the most recent five years for which statistics are complete). When adjusting for medical inflation, which was 19.8 percent for this same period) and the growing number of physicians in the state, this represents a significant decline in actual dollars.[16] [See Figure 5]

Figure 5

Total Medical Malpractice Premiums Paid in Rhode Island, 1996-2001

Year	Direct Premiums Earned
1996	$19,478,952
1997	22,358,738
1998	22,196,884
1999	25,102,502
2000	21,777,121
2001	21,581,983

Source: National Association of Insurance Commissioners, "Medical Malpractice Insurance Net Premium and Incurred Loss Summary," July 2001.

- **Malpractice insurance premiums are lower in Rhode Island than in neighboring states.** A comparison of medical malpractice premiums charged by one insurance group that serves Rhode Island, Connecticut and Massachusetts shows that Rhode Island doctors generally pay less – in some cases, much less – than their counterparts in neighboring states. And one of these two adjacent states, Massachusetts, imposes a $500,000 cap on malpractice awards. According to data published by the insurance industry magazine, *Medical Liability Monitor*, rates for general surgeons ranged from 14 percent to 40 percent less in Rhode Island than in Connecticut or Massachusetts; rates for Ob/Gyns ranged from 6 percent to 23 percent less in Rhode Island than in the other two states; and rates for internists ranged from 2 percent to 23 percent less in Rhode Island than in the other states.[17] [See Figure 6]

Figure 6

Annual Malpractice Premiums, Rhode Island Compared with Neighboring States

State	Company	General Surgery	Ob/Gyn	Internal Medicine
Connecticut	ProSelect (ProMutual Group)	$43,438	$69,499	$7,405
Massachusetts	ProMutual	30,246	84,566	9,356
Rhode Island	ProSelect (ProMutual Group)	26,040	65,307	7,243

Source: "Trends in 2002 Rates for Physicians' Medical Professional Liability Insurance," *Medical Liability Monitor*, October 2002.

No Evidence of Doctors Abandoning Rhode Island

In published comments, the president of the Rhode Island Medical Society described his state as "an increasingly hostile environment" and proclaimed: "The word is out that Rhode Island is not a great place to be a doctor."[18] Statistics indicate, however, that Rhode Island's medical environment has attracted a steady increase in physicians. And a lawyer for the Board of Medical Licensure and Discipline has observed, "Rhode Island has more doctors today than at any time in the state's history. The residency training program is larger than it has ever been."[19]

- **The number of doctors residing and practicing in state has grown steadily.** In 2002, there were 2,915 practicing physicians and osteopaths with Rhode Island addresses, compared with 2,623 in 1999, an increase of 11 percent.[20] [See Figure 7]

- **The number of licensed doctors also has risen.** Many doctors from Connecticut and Massachusetts also are licensed to practice in Rhode Island. In the past two years alone, the number of licensed doctors active in Rhode Island increased by nearly 6 percent, from 3,624 in 2000 to 3,838 in 2002.[21]

- **Rhode Island's ratio of doctors-to-residents has increased.** According to the American Medical Association, Rhode Island had 277 doctors per 100,000 residents in 1990. By 2001, that ratio had increased to 365 doctors per 100,000 residents. This is the seventh highest ratio in the nation.[22]

Figure 7

Licensed Physicians and Osteopaths with Rhode Island Addresses

Year	Number of Licensed Doctors
1999	2,623
2000	2,723
2001	2,867
2002	**2,915**

Source: Rhode Island Board of Medical Licensure and Discipline

Repeat-Offender Doctors Are Responsible for Half of Medical Malpractice Payouts

The insurance and medical communities have argued that medical liability litigation constitutes a giant "lottery," in which lawsuits are random events bearing no relationship to the care given by a physician.[23] 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 paid multiple claims, and it is these doctors who are responsible for much of the malpractice in Rhode Island. During the 12 years the National Practitioner Data Bank has been operating, 84 percent of Rhode Island doctors have made no medical malpractice payouts.

- According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 4.8 percent of Rhode Island's doctors are responsible for 52.7 percent of all payouts. These 155 repeat-offender doctors have made two or more malpractice payouts to patients and have paid out $104.7 million in damages.[24] Even more disturbing, just 1.6 percent of Rhode Island's doctors (52), each of whom has paid three or more malpractice claims, are responsible for nearly 26 percent of all payouts. [See Figure 8]

Figure 8

Number of Medical Malpractice Payouts and Amounts Paid by Rhode Island Doctors 1990 – 2002

Number of Payout Reports	Number of Doctors that Made Payouts	Percent/Total Doctors (3,231)	Total Number of Payouts	Total Amount of Payouts	Percent of Total Number of Payouts
All	518	16.0%	768	$191,271,650	100.0%
1	363	11.2%	363	$86,605,350	47.3%
2 or More	155	4.8%	405	$104,666,300	52.7%
3 or More	52	1.6%	199	$49,636,800	25.9%
4 or More	19	0.6%	100	$26,853,250	13.0%
5 or More	9	0.3%	60	$14,646,000	7.8%

Source: National Practitioner Data Bank Annual Reports, Sept. 1, 1990-Sept. 30, 2002. (For these calculations Public Citizen employs American Medical Association statistics from 1995, midway through the time period, for the total of non-federal, licensed doctors in Rhode Island.)[25]

Two-Thirds of Doctors with Four or More Malpractice Payouts Have not Been Disciplined

The Rhode Island state government and the state's health-care providers have taken action to discipline only a fraction of the state's repeat-offender doctors. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data:

- Of the 155 physicians in Rhode Island who have made two or more malpractice payouts to patients since 1990, only 22, or 14.2 percent, have been disciplined by the Rhode Island State Board of Medical Licensure and Discipline.

- Of the 19 physicians in Rhode Island who have who made four or more malpractice payouts, only 6, or 31.6 percent, have been disciplined by the board.[26]

The extent to which doctors can pay malpractice claims in Rhode Island and not be disciplined is illustrated by the following NPDB descriptions of the 10 worst offenders who practice in Rhode Island, *none* of whom has been disciplined by the state:

- **Physician Number 34812** made 14 malpractice payouts between 1992 and 1998 involving eight obstetrics related incidents, two incidents of failure to manage pregnancy, two treatment related problems, and two surgery related problems. The damages add up to $8,995,000.

- **Physician Number 62116** made four malpractice payouts between 1994 and 2000 involving a treatment related problem, failure to treat fetal distress, and two obstetrics related incidents. The damages add up to $2,510,000.

- **Physician Number 55230** made four malpractice payouts between 1994 and 2002 involving two surgery related problems, failure to obtain consent to perform surgery, two treatment related incidents, and improper performance of treatment. The damages add up to $2,405,000.

- **Physician Number 34620** made five malpractice payouts between 1991 and 2001 involving delay in delivery, two obstetrics related problems, failure to diagnose, and a surgical problem. The damages add up to $1,905,000.

- **Physician Number 34699** made four malpractice payouts between 1992 and 2002 involving improper choice of delivery method, two obstetrics related problems, and a treatment problem. The damages add up to $1,632,500.

- **Physician Number 34676** made four malpractice payouts between 1991 and 1996 involving improper performance of surgery, a surgical problem, failure to treat, and a treatment related problem. The damages add up to $960,000.

- **Physician Number 92505** made five malpractice payouts between 1996 and 1999 involving two incidents of improper performance of treatment, and three treatment related incidents. The damages add up to $531,000.

- **Physician Number 34610** made five malpractice payouts between 1992 and 2000 involving a surgical problem, three incidents of treatment problems, two incidents of failure to perform surgery, and two incidents of wrong treatment performed. The damages add up to $422,500.

- **Physician Number 34811** made five malpractice payouts between 1991 and 2001 involving two incidents of improper performance of surgery, failure to obtain consent for surgery, and two incidents of surgery related problems. The damages add up to $585,000.

- **Physician Number 34706** made four malpractice payouts between 1991 and 2000 involving improper performance of surgery, a surgery related problem, failure to obtain consent for surgery, and a miscellaneous incident. The damages add up to $182,250.

Where's the Doctor Watchdog?

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

- **The medical board is among the nation's less stringent when it comes to disciplining doctors.** In 2002, Rhode Island ranked 35th among all states and the District of Columbia for the frequency at which it takes disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. In 2002, the state Board of Medical Licensure and Discipline levied serious sanctions against only 10 doctors, according to an ongoing Public Citizen project that tracks "Questionable Doctors" nationwide. [27]

  Nationally in 2002, there were 3.6 serious actions taken for every 1,000 physicians. The rate of serious actions by the Rhode Island Board of Medical Licensure and Discipline – 2.6 per 1,000 physicians – was roughly one-fifth of the rate in Wyoming, which is the top-ranked state with 11.9 serious actions per 1,000 physicians.[28] [See Appendix]

- **Five years after a disclosure law was adopted, consumers still can't get vital data.** Rhode Island has yet to fully implement a 1997 law that called for public disclosure of profiles containing information about individual physicians. Although some profiles are available online,[29] they omit two crucial categories: malpractice information and criminal convictions. According to a lawyer for the Board of Medical Licensure and Discipline, the disclosure project has been undermined by clerical and computer programming problems and by the board's inability to effectively gather information from doctors. Even when the system is updated this summer, the lawyer said, the profiles will not contain data on doctors' malpractice payouts.[30]

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."[31]

- **The American Medical Association (AMA) acknowledges that spikes in malpractice premiums are caused by insurance cycles.** In a report by the AMA's Board of Trustees to its House of Delegates, the following statements acknowledged that increasing malpractice insurance premiums were linked to the insurance underwriting cycle:

  - "While the number of final settlements have decreased 16%, the expense of settling a medical liability case has also increased significantly. The insurance underwriting cycle is now at a point where insurers have both pricing power and a need to increase revenues through premiums as returns on investments are no longer able to subsidize underwriting loses [sic] and as insurers have suffered large claims losses in other areas."[32]

  - "For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market surged, investments by these historically conservative insurers rose to 10.6% in 1999, up from a more typical 3% in 1992. With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates. The industry reported realized capital gains of $381 million last year, down 30% from the high point in 1998, according to the A. M. Best Company, one of the most comprehensive sources of insurance industry data." [33]

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

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

rates due to competition, but a subdued economy, lower interest rates and investment yields, the withdrawal of a major medical malpractice writer and a strong hardening of the reinsurance market. Rates will, at some point, reach an acceptable level to insurers and capital will once again flow into the Medical Malpractice market."[34]

- **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.[35]

- **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.[36]

- **Rhode Island doctors have endured insurance "crises" for 28 years.** As recently as February, the Rhode Island Medical Society's board of directors acknowledged that the state had witnessed up-and-down cycles in the medical liability insurance industry since the mid-1970s. In an advisory to members, the board recounted major problems that occurred with medical liability insurers in 1975, when coverage became largely unavailable; for a number of years beginning in 1987, when nine different "risk retention groups" began going bankrupt; and again in 1993, when a large, unrated carrier, Premier Alliance, became insolvent. The primary cause for these problems, the board concluded, has been "under-reserving" of funds by the insurance companies.[37]

Caps on Damages Are a False "Solution"

Caps on "non-economic damages" are not part of the proposal currently in the state Legislature, but they are included in a federal bill that Rhode Island's U.S. senators are considering and has already passed the U.S. House of Representatives. There is convincing evidence that limits on awards for pain and suffering penalize severely injured patients the most, without cutting the frequency of medical errors or reducing the rates doctors pay for liability insurance.

- **"Non-economic" damages are not as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called "non-economic" damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control, loss of limb) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to Physician Insurers Association of America (PIAA), the average total payment 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.[38] 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.** The PIAA Data Sharing Report also demonstrates the relationship between the severity of an injury and the size of the settlement or verdict.[39] PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications.[40] 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.[41]

- **Capping awards hurts women in particular.** 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."[42]

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

Caps on damages for pain and suffering will significantly lower the awards paid to catastrophically injured patients. But because such truly severe cases comprise a small percentage of medical malpractice claims, and because the portion of the medical liability premium dollar that pays for compensation is dwarfed by the portion that pays for defense lawyer fees, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this – so don't take our word for it, take theirs.

- **Premium on the Truth:**

  "Insurers never promised that tort reform would achieve specific savings." – American Insurance Association[43]

  "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." – Sherman Joyce, president of the American Tort Reform Association[44]

  "Many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years." – Victor Schwartz, general counsel to the American Tort Reform Association[45]

- **Florida:**

  "No responsible insurer can cut its rates after a bill (that caps damages at $250,000) passes." – Bob White, president of First Professionals Insurance Co.[46]

- **Mississippi:**

  "Regardless of what may result from the ongoing tort reform debate, please remember that such proposed public policy changes are critical for the long-term, but do not provide a magical 'silver-bullet' that will immediately affect medical malpractice insurance rates … The 2003 rate change [a 45 percent increase] would happen regardless of the special session outcome." – Medical Assurance Company of Mississippi[47]

- **Nevada:**

  "The primary insurer for Las Vegas obstetricians, American Physicians Assurance, has no plans to lower premiums for several years, if ever, said broker Dennis Coffin." – The Las Vegas Review-Journal[48]

  "[John Cotton of the Nevada Physicians' Task Force] noted that even if the bill reflected a cap of $5, there would not be an immediate impact on premiums." – Minutes of the Nevada Assembly Committee on Medical Malpractice Issues[49]

- **New Jersey:**

  During a hearing on medical malpractice issues, New Jersey Assemblyman Paul D'Amato asked Patricia Costante, Chairwoman and CEO of MIIX Group of Companies, "[A]re you telling the insured physicians in New Jersey that if this State Legislature passes caps that you'll guarantee that you won't raise your premiums, in fact, you'll reduce them?" Costante replied: "No, I'm not telling you [or them] that."[50]

  The New Jersey Medical Society commissioned Tillinghast-Towers Perrin, a leading actuarial firm, to analyze the effects of a $250,000 cap on pain and suffering damages. The findings: "We would expect that a $250,000 cap on non-economic damages will produce some savings, perhaps in the 5 percent to 7 percent range for physicians." – Letter from Tillinghast-Towers analysts James Hurley and Gail Tverberg[51]

- **Ohio:**

  "In the short run, we may even see prices go up another 20 percent, and people will say, 'Gee, what happened, I thought we addressed this?'" – Ray Mazzotta, president of Columbus-based Ohio Hospital Insurance Co.[52]

  "The stroke of the governor's pen [enacting caps on damages] will not result in immediate lowering of rates by responsible companies." – Frank O'Neil, spokesman for Birmingham, Ala.-based Medical Assurance[53]

- **Wyoming:**

  During a hearing on medical malpractice insurance issues, Bruce Crile of the Doctors' Company and Melissa Dennison of OHIC Insurance Company testified that insurance rates would not drop if caps on damages were imposed. "Both the Doctors' Company and OHIC's actuaries say a cap of $500,000 is meaningless for purposes of ratemaking. Even with caps enacted premiums will still increase, but with predictability of the risk there will be a moderating of rate increases." – Minutes of the Wyoming Legislature's Joint Labor, Health and Social Services Interim Committee[54]

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

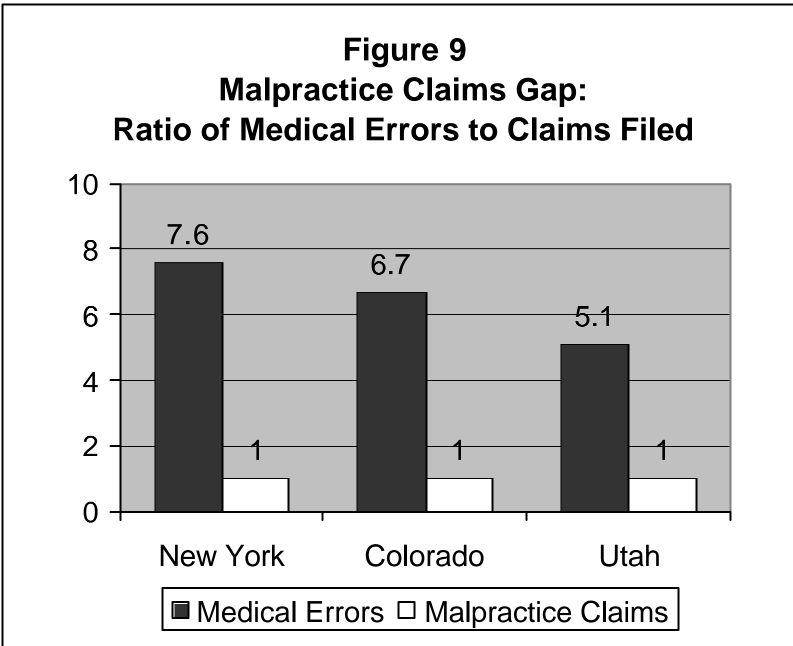
Although no comparable studies have been cited in Rhode Island, there is convincing evidence from around the nation that the majority of patients who suffer injuries from medical malpractice never file lawsuits.

- **A landmark Harvard Medical Practice Study found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in 7.6 instances of medical negligence committed in hospitals results in a malpractice claim.[55] Researchers replicating this study made similar findings in Colorado and Utah.[56] [See Figure 9]

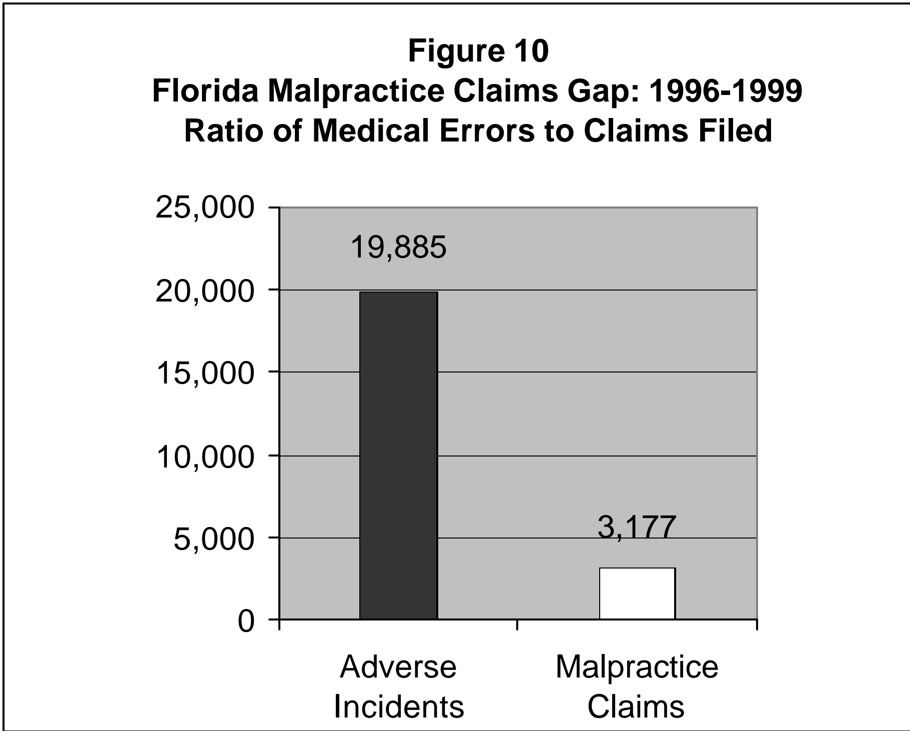
- **Actual numbers collected by government agencies show a similar claims gap.** A Florida statute requires hospitals to report "adverse incidents," defined as "an event over which health care personnel could exercise control" that results in death or injury. Tables prepared by Florida's Agency for Health 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.[57] In other words, for every six preventable medical errors only one claim is filed. [See Figure 10]

- **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.[58] 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 1 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."[59]



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



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

Few Malpractice Lawsuits Are "Frivolous"

Legislation introduced in the Rhode Island General Assembly contains provisions designed to make it harder for injured patients to seek compensation. Shortened statutes of limitations, tight deadlines for preparing cases and mandatory "certificates of merit" are needed, the bill's sponsors claim, to combat "the many meritless claims" that patients have filed.[60]

Additionally, the President and some members of the U.S. Senate and House have made similar comments about "frivolous lawsuits" in their efforts to promote a federal medical malpractice bill that would place caps on pain-and-suffering awards to injured patients. [61]

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

- **The high cost of preparing a medical malpractice case discourages frivolous claims – and meritorious claims as well.** Medical malpractice cases are very expensive for plaintiffs' attorneys to bring, with out-of-pocket costs for cases settled at or near the time of trial (when most cases are settled) ranging from $15,000 to $25,000.[62] If the case goes to trial, the costs can easily be doubled.[63] 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.[64] Discovery involves taking the sworn testimony of witnesses and experts. Such depositions cost $300 and up, depending upon their length and complexity. If an expert witness is deposed, the plaintiff's attorney is charged for the witness' preparation time and time attending the deposition.

- **The small numbers of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims files.[65] 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.

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

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

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

- **The Congressional Budget Office has rejected the defensive medicine theory.** The Congressional Budget Office (CBO) was asked to quantify the savings from reduced "defensive medicine" if Congress passed H.R. 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.[66]

- **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.[67] There were nine such instances in Florida in 2001.[68] 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.[69] 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."[70]

- **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.[71] Studies indicate that some doctors and clinics miss as many as one in three cancers. Despite the possibility of lawsuits, doctors with no aptitude for mammography continue to read mammograms. Clinics continue to employ doctors who read too few mammograms to keep their skills sharp. It appears that only reviews by regulators spur doctors and clinics to meet minimum standards.

- **Defensive medicine hasn't prevented hospital infections.** The *Chicago Tribune* reported on July 21, 2002 that some 75,000 Americans die each year because of infections acquired in hospitals that "were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses."[72] 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"?[73] Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.[74]

- **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.[75] One report found specifically that each additional patient per nurse corresponded to a 7 percent increase in both patient mortality and deaths following complications.[76] Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts over-staffing.

Solutions to Reduce Medical Errors

Reducing compensation to victims of medical malpractice does not, as doctors contend, "reduce costs;" it merely shifts the costs of injuries away from dangerous doctors and unsafe hospitals and onto the injured patients, their families, and taxpayers. This, in turn, reduces the incentive to practice medicine with due regard to patient safety. The only way to reduce the cost of medical injuries is to reduce negligence; 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 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.[77] Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,[78] 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.[79]

- **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.[80]

- **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.[81] 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.[82]

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.[83] After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10 percent blood alcohol level.[84] 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.[85] 45 percent of residents who sleep less than four hours per night report committing medical errors.[86] 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.[87] If the maximum workweek for residents was limited to 80 hours, it could considerably reduce mistakes due to fatigue and lack of supervision.

Ensure Adequate Nurse Staffing

Two reports published in the past year concluded that patients in hospitals where nurses had heavier workloads had a higher risk of dying.[88] One report found specifically that each additional patient per nurse was associated with a 7 percent increase in both patient mortality and deaths following complications.[89] Both houses of the Rhode Island General Assembly now are considering two bills that address issues of nurse overwork and fatigue. One measure would prevent mandatory overtime for hourly paid nurses, except in cases of emergencies.[90] The other would require hospitals to ensure an adequate ratio of nurses-to-patients, depending on the types or care and injuries.[91]

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.[92]

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[93] and on the website www.questionabledoctors.org 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 1 percent of the nation's doctors face any serious state sanctions each year. The 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:[94]

Investigations and Audits

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

1) The extent to which the extraordinarily high profitability of the insurance industry during much of the 1990s, and its lower profitability today, is related to the performance of interest rates and the stock market during those periods;

2) The extent to which today's rate increases are an attempt to recoup money that insurers lost in the stock market or in other poorly-performing assets;

3) The extent to which insurers are adversely affected by today's low interest rates;

4) Whether insurers' estimates of their future claims payments, which are the basis for rate increases, are unreasonably high today; and

5) Whether it is proper, or lawful, for insurers to seek substantial rate increases despite having hugely increased their surplus – the money they have "in the bank," with policyholder-supplied funds, particularly if the insurer is overcapitalized.

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

Specific Reforms

- **Regulate excessive pricing.** One cause of the cycle is the lack of regulatory action to end excessive and inadequate rates during the different phases of the cycle. Insurance Commissioners should start now by regulating the excessive prices being charged by insurers. They should, at least, hold the necessary hearings to determine if the prices are not excessive.

- **Freeze particularly stressed rates until the examination of the prices and remarkable jumps in loss reserves can be fully analyzed.** For instance, medical malpractice and homeowner rates should be frozen. A rollback of unjustified rate increases that have already taken effect should then be in order. (The manner in which insurance rate rollbacks can be written and implemented to comply with all Constitutional requirements is explained in *Calfarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989), and *20th Century Ins. Co. v. Garamendi*, 8 Cal.4th 216 (1994). These cases substantially upheld Prop 103, the California insurance reform initiative that rolled back auto insurance rates by 20 percent.)

- **Require that risks with poorer experience pay more than good risks in lines of insurance where such methods are not in use today.** For example, require medical malpractice insurers to use claims history as a rating factor, and to give that factor significant weight. Auto insurers use an individual's driving record as a rating factor; workers compensation insurers use the employer's loss experience as a rating factor – so-called "experience mod." Malpractice insurers should do the same. In addition, insurance commissioners should require all medical malpractice insurers to offer all "good" doctors – *i.e.,* all doctors meeting an objective definition of eligibility based on their claims history, their amount of experience and perhaps other factors – the lowest rate.

- **Reduce the percentage of assets that insurers can invest in stocks or other risky assets.** Insurers should not be permitted to raise their rates in order to recoup losses on stocks or other risky assets. The less risky their investments, the more secure policyholders are, and the more stable are rates.

- **Create a standby public insurer to write risks when the periodic cycle bottoms and hard markets occur, such as a medical malpractice insurer funded by a start-up loan from the state to compete with the existing malpractice carriers.** Several states have created such carriers to write workers' compensation, and in many states such carriers have helped bring down workers' comp rates. Similarly structured medical malpractice insurers should have similar success.

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

Appendix: Public Citizen's "Questionable Doctors" Database

Public Citizen has published national and regional editions of its "Questionable Doctors" database in book form for more than a decade. The database now is available on-line at www.questionabledoctors.org. Here are answers to frequently asked questions regarding the database:

- **Who is named in the "Questionable Doctors Online" database?** "Questionable Doctors Online" currently contains information about disciplinary actions taken against allopathic doctors (MDs) and doctors of osteopathy (DOs) in 27 states. This information was gathered from state medical boards, the District of Columbia, the U.S. Department of Health and Human Services, the Drug Enforcement Administration, and the Food and Drug Administration. The extent of information each medical board provides regarding disciplinary actions varies by state; some boards enclose a detailed synopsis of the case history and findings, whereas others simply supply the physician's name and resulting action within a quarterly newsletter. We will add information from additional states as we receive updated information.

- **Why does Public Citizen have access to this information when it is so difficult to obtain?** In the fall of 1989, using a list published by the Federation of State Medical Boards, Public Citizen contacted all the medical boards from the 50 states and the District of Columbia and requested the name of every physician the boards had disciplined since the beginning of 1985. We also asked at that time to be placed on the boards' mailing lists to receive notification of future disciplinary orders. Since that initial request, Public Citizen has periodically contacted these boards to obtain additional information on disciplinary actions and has published the information in a series of books called *Questionable Doctors.* Most recently, we sent an email or letter to each state board in February 2002 requesting updated information to be used in "Questionable Doctors Online" – the first time we have posted this information on the web.

- **Can a consumer recommend a name to add?** No. The data come directly from the state or federal licensing agent.

- **Does the database include dentists or chiropractors?** No. Because we did not consistently receive information on such health care providers from all medical boards, we decided to eliminate the entries on such professionals from our database.

- **How do I know if doctors who have been disciplined are in my area?** The sanctioning authority (a state medical board or federal agency) provided the city and state listed for a disciplined physician. *However, please note that this is the address of record for the physician at the time of the disciplinary action and may reflect a personal residence, place of business or mailing address – not necessarily the doctor's current place of practice.*

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