

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



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About Public Citizen

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Executive Summary

It is understandable that health care providers are concerned by sharp rises in medical malpractice insurance costs reported for some doctors in certain parts of the country. Nobody wants to see physicians forced to pay more to insure themselves, even if they are specialists who earn hundreds of thousands of dollars a year.

The Washington State Medical Association claims that its state will face “unlimited health care costs” and a “crisis” in health care access if laws are not changed to limit the legal rights of injured patients to seek compensation. It is essential, however, that discussions of public policy and attempts to address the issue of medical liability insurance be based on solid facts, not a false sense of “crisis” generated to serve special interests.

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

- 1) The Washington medical establishment is talking about a “crisis” where none exists. For much of the 1990s, its health care providers saw very little in the way of malpractice insurance rates increases. Even with the cost of some premiums rising in recent months, the malpractice situation in Washington remains more moderate than it is in other states – including many that limit non-economic damages in malpractice cases. Furthermore, increases in malpractice insurance premiums for some health care providers is not a long-term problem, nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country’s economic slowdown.
- 2) The most significant, long-term malpractice “crisis” faced by Washington state 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. Taking away people’s legal rights, as is proposed under a \$350,000 cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Other highlights of this report include:

- **The cost of medical negligence and errors to Washington patients and consumers is considerable, especially when measured against the cost of malpractice insurance to Washington’s health care providers.** Based on findings by the Institute of Medicine, there are an estimated 920 to 2,048 deaths in Washington each year that are due to *preventable* medical errors. The annual costs resulting from preventable medical errors to Washington residents, families and communities are estimated at \$355 million to \$606 million each year. But the cost of medical malpractice insurance to Washington’s health care providers is only \$110 million.

- **Malpractice payouts to injured patients by Washington doctors have remained flat.** Adjusting for inflation, the total value of malpractice payouts by Washington doctors to injured patients has remained flat over the last nine years, according to the National Practitioner Data Bank (NPDB). Measured in 2001 dollars, the value of malpractice payouts was \$54.5 million in 1993 compared with \$56.1 million in 2001. This is a total increase of \$1.6 million over eight years, or only 0.4 percent per year.
- **Adjusting for inflation, the dollar value of malpractice payouts in 2001 was 25.7 percent lower than it was in 1997.** In 1997, the value of malpractice payouts in Washington was \$75.5 million, compared with \$56.1 million in 2001. This represents a decrease of \$19.4 million, or 25.7 percent in four years.
- **The number of medical malpractice payouts per year has declined in Washington.** NPDB statistics show that there were 241 medical malpractice payouts in 1993 compared with only 225 in 2001, a decrease of 6.6 percent.
- **The average dollar value of malpractice payouts per doctor in Washington has decreased.** The average value of a malpractice payout to an injured patient per doctor in 2001 was less than it was eight years earlier. In 1993, the average amount of a malpractice payout was \$3,509 per doctor, adjusted for inflation; in 2001, the value was \$3,065 per doctor, a 12.6 percent decrease over eight years. In 1997, the average amount of a malpractice payout in Washington was \$4,525 per doctor; in 2001, it was \$3,065 per doctor, a 32.3 percent decrease.
- **The number of malpractice lawsuits filed in Washington courts each year has remained steady since 1994.** In 1994 there were 452 medical malpractice lawsuits filed in Washington courts, compared with 465 in 2002 – just 13 more lawsuits per year, or an increase of 2.9 percent over eight years.
- **As a group, Washington health care providers have experienced a drop in malpractice insurance costs.** Adjusting for inflation, Washington health care providers paid less in total malpractice insurance premiums in 2001 than in 1991, according to insurance industry data. Health care providers paid \$133.8 million in malpractice premiums in 2001, compared with \$135.6 million in 1991. This represents a 1.4 percent *decrease*. During this time period the costs of medical care *increased* 58 percent nationally.
- **Medicare's local adjustment for the cost of medical malpractice insurance in Washington is much less than the national average.** The federal government's Medicare actuary calculates that Washington doctors spend an average of only 2.52 percent of their practice incomes on malpractice insurance. This means Washington doctors pay 21.2 percent less than the national average.
- **Overall medical business expenses in Washington dwarf malpractice insurance costs.** The index established by the Department of Health and Human Services (HHS) for the costs of running a physician's practice show that doctors with practices in Seattle/King County pay 46.5 percent of their income to cover overhead costs, such as rent,

utilities and labor. This same index shows that Seattle/King County doctors pay only 2.52 percent of their incomes to cover malpractice insurance costs.

- **Health care providers' malpractice premiums are insignificant compared with total health spending.** Total spending on health care in Washington State was \$19.3 billion in 1998, the last year for which data is available from government sources. That same year, Washington health care providers paid \$104.3 million in malpractice insurance premiums – equivalent to only 0.54 percent of all the money spent on health care in the state.
- **The average malpractice premium per doctor in Washington is the median for the nation.** When the “cost burden” of physician’s medical malpractice premiums is calculated (by dividing total premiums paid by the number of licensed doctors), Washington ranks 26th, exactly in the middle of the 50 states and the District of Columbia – according to an insurance industry report card.
- **There is no evidence of doctors abandoning Washington.** The number of in-state practicing doctors in Washington has jumped 3,720 over the last decade, from 15,533 in 1993 to 19,253 in 2003. This is an overall increase of 23.9 percent, or 2.4 percent a year. In comparison, Washington’s overall population experienced an annual average increase of 1.7 percent from 1993 to 2002.
- **Repeat-offender doctors are responsible for much of medical malpractice payouts.** According to the federal government’s National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, just 3.5 percent of Washington’s doctors have been responsible for 42.6 percent of all malpractice payouts to patients. Overall, these 488 doctors, all of whom have made two or more payouts, have paid \$240 million in damages.
- **Washington has not done enough to rein in those doctors who repeatedly commit medical errors.** According to the National Practitioner Data Bank and Public Citizen’s analysis of NPDB data, the number of disciplinary actions (license suspension or revocation, or a limit on clinical privileges) against Washington physicians could be improved. Only 13.3 percent (65 of 488) of Washington doctors who made two or more malpractice payouts were disciplined by the Medical Quality Assurance Commission. And only 45.2 percent (14 of 31) of Washington doctors who made five or more malpractice payouts were disciplined by the commission.
- **The Washington Medical Quality Assurance Commission is among the nation’s least diligent when it comes to disciplining doctors.** In 2002, Washington ranked 41st among all states and the District of Columbia for the frequency at which it takes serious disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. In 2002, commission levied serious sanctions against only 36 of its 16,154 doctors.

- **New system offers the public only limited information on physicians.** In April 2003, the state started making information about doctors' records public on the Internet. However, the only disciplinary records available are from the state Medical Quality Assurance Commission, and those records contain details only since 1998. The number of times a doctor has been sued, the outcomes, or the number of a doctor's malpractice payouts still is not available.
- **Washington's malpractice insurance market attracts viable competitors.** The medical malpractice insurance market in the state of Washington remains competitive compared with markets elsewhere. According to an insurance industry report card, the number of "A" rated competitors offering medical malpractice policies in Washington is five – exactly the national average per state.
- **Washington and California physicians pay comparable malpractice insurance rates, despite that California's "cap" on non-economic damages.** Washington internists pay less for malpractice premiums than their counterparts in California (\$9,779 vs. \$14,602), and Washington general surgeons pay virtually the same malpractice premiums as surgeons in California (\$35,253 vs. \$34,119). Ob/Gyns in Washington pay somewhat more in malpractice premiums than their counterparts in California, the equivalent of \$562 per month.
- **A cap on damages has no apparent bearing on how many premiums increased between 2001 and 2002 in California compared with Washington.** California's largest malpractice insurance carrier raised premiums an average of 8.6 percent last year, and Washington's largest carrier raised premiums exactly the same amount – 8.6 percent. This suggests that premium increases are more related to the insurance cycle than the liability system.
- **Medicare's local adjustment for the cost of malpractice insurance is lower for doctors in Seattle than for doctors in Los Angeles.** The Medicare actuary calculates that Seattle doctors spend an average of 2.52 percent of their practice incomes on malpractice insurance, compared with Los Angeles doctors, who spend 3.05 percent of their practice incomes on malpractice insurance.
- **A malpractice insurer serving both states generally charges less in Washington than California.** A comparison of median rates charged by the Doctors' Company, which writes malpractice insurance in both Washington and California, shows that rates for Washington internists are 9.3 percent less than rates for California internists; rates for Washington general surgeons are 23.4 percent less than for California general surgeons; and rates for Washington Ob/Gyns are 9.2 percent less than for California Ob/Gyns.
- **Washington's malpractice victims fare better than California's.** It's clear that caps have affected patients in California: it's not clear that doctors have benefited from those same caps. Injured patients in Washington receive 54 percent more compensation than injured patients in California. But despite California's \$250,000 cap on non-damages, California doctors don't play substantially less for medical malpractice insurance than Washington doctors.

- **Caps on malpractice awards do not improve access to primary care.** There is no apparent relationship between caps on medical malpractice awards and access to primary medical care. Among the 15 states with the highest percentages of population lacking primary medical care, nine impose malpractice caps. Conversely, among the 15 states with the smallest percentages of population lacking primary care, eight do *not* have caps.
- **“Non-economic” damages are real.** “Non-economic” damages are harder to quantify than 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 or eyesight) and inability to engage in daily activities or to pursue hobbies. This category also encompasses damages for disfigurement and loss of fertility.
- **Capping awards hurts children, women and minorities in particular.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on children, women and minorities, since they have no income or make less on average than either men or non-minorities, respectively. Also, the most significant effect of many medical injuries inflicted on women is harm to reproductive capacity, which entitles them to little in the way of economic damages.
- **Insurance companies and their lobbyists admit caps on damages will not lower malpractice premiums.** Caps on “non-economic damages” effect the most 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.
- **No evidence supports the claim that jury verdicts are random.** 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. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.
- **Rather than facing “runaway litigation,” health care providers benefit from a claims gap.** Various 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. Similar findings were found in Utah, Colorado and Florida.
- **The small number of claims pursued to a defense verdict are not frivolous.** Researchers at the American Society of Anesthesiologists had doctors review 103 randomly selected medical negligence claims. The doctors judged whether the physician in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases. The researchers concluded, “These observations indicate that neutral experts commonly disagree in their assessments when using the accepted standard of reasonable and prudent care.”

- **Empirical evidence does not confirm the existence of “defensive medicine” – and patient injuries refute it.** The Congressional Budget Office (CBO) declined to quantify the savings from reduced “defensive medicine” if Congress passed H.R. 5, a strict tort reform bill. CBO stated that such “estimates are speculative in nature...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.” In addition, numerous studies document preventable errors ranging from invasive procedures performed on the wrong patients, medication errors, and misreading of test results – all mistakes that 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.** 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, since studies show that fatigue among nurses and medical residents contributes significantly to patient injuries and deaths, states should pass legislation reducing overwork among nurses and residents.
- **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. Some of these recommendations 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.

Introduction: Overstating Problems and Undermining Patients' Legal Rights

A bill pending in Washington's Legislature, which resembles proposals in numerous states and in the U.S. Congress, would place a \$350,000 cap on medical malpractice payouts for pain and suffering, known as "non-economic" damages. In pursuing such legislation, health care providers and their political allies essentially are blaming patients and their lawyers for a temporary spike in medical malpractice insurance premiums.

Proponents of a cap on non-economic damages in Washington also are pursuing a legal change that has been found unconstitutional by the Washington State Supreme Court, which ruled more than 10 years ago that "the measure of damages is a question of fact within the jury's province."¹

The Washington State Medical Association makes the dire claim that physicians are being pushed to "the breaking point" by malpractice lawsuits and may consider closing down or moving their practices.² The association is coordinating its campaign with the state's business lobby, which is eager to limit consumer rights in the areas of product liability and general liability.³ And the association has run statewide advertisements featuring physicians who, it claims, have been "victimized" by high malpractice insurance rates. (Ironically, the WSMA admits it was chagrined to discover that its ads featured an obstetrician-gynecologist who has made at least five malpractice payouts and lost his hospital privileges for placing his patients at risk.⁴)

While proponents of a \$350,000 cap on non-economic damages argue that increased litigation and rising payouts have caused an increase in malpractice insurance premiums, this report demonstrates that such claims are not supported by reliable data. The insurance industry has experienced economic fluctuations – and it is these pricing and profitability problems, not patients' lawsuits, that have triggered spikes in malpractice insurance premiums for some specialists.

The real long-term threat to the quality of health care in Washington is the excessive number of preventable medical errors, the absence of regulations requiring their disclosure and the Washington Medical Quality Assurance Commission's lax discipline of doctors who repeatedly harm patients. This report provides suggestions for fixing those underlying flaws.

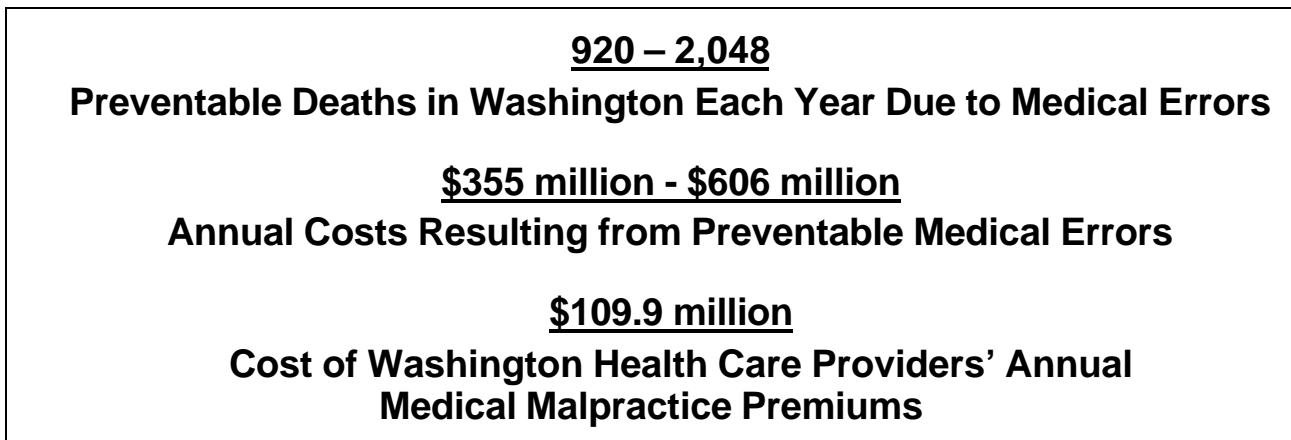
Costs of Medical Malpractice to Washington Patients & Consumers vs. Its Health Care Providers

In 1999, the Institute of Medicine (IOM) estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors.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 Washington should be measured by the cost to patients and consumers, not the premiums paid by doctors and hospitals to their insurance companies. Extrapolating from the IOM findings, we estimate that 920 to 2,048 preventable deaths in Washington each year are due to medical errors. The cost resulting from preventable medical errors to Washington residents, families and communities is estimated at \$355 million to \$606 million each year. But the cost of medical malpractice insurance to Washington health care providers is only \$109.9 million a year.⁶ [See Figure 1]

Figure 1

The Real Cost of Medical Malpractice in Washington



Sources: Preventable deaths and costs are pro-rated based according to population, 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.

Malpractice Payouts by Washington Doctors Have Remained Flat

The Washington State Medical Association has complained that a “lottery mentality” is creating a “rapidly rising trend in loss severity” from medical malpractice lawsuits.⁷ These assertions are not supported by statistics from the federal National Practitioner Data Bank (NPDB), especially for the so-called malpractice “crisis” years of 2000 and 2001.

- **Adjusting for inflation, the total value of malpractice payouts by Washington doctors to injured patients has remained flat over the last nine years.** Measured in 2001 dollars, the value of malpractice payouts was \$54.5 million in 1993 compared with \$56.1 million in 2001.⁸ This is a total increase of \$1.6 million over nine years, or only 0.3 percent per year. [See Figure 2] If adjustments were made for the increased number of doctors and the growing population over the last decade, the 2001 value of payouts would actually represent a decline.
- **Adjusting for inflation, the dollar amount of malpractice payouts in 2001 was 25 percent lower than it was in 1997.** In 1997, malpractice payouts in Washington totaled \$75.5 million, compared with \$56.1 million in 2001. This represents a decrease of \$19.4 million, or 25.7 percent in four years.
- **Washington’s total malpractice payouts in 2001 were \$56.1 million, which is slightly less than the nine-year average of \$56.6 million.**

Figure 2

Total Malpractice Payouts, Washington Physicians, 1993-2001

Year	Total Payouts Value	Total Payouts (Adj. \$2001)
1993	\$44.5 million	\$54.5 million
1994	37.6 million	44.9 million
1995	53.1 million	61.7 million
1996	37.7 million	42.6 million
1997	68.4 million	75.5 million
1998	57.4 million	62.4 million
1999	60.7 million	64.5 million
2000	45.7 million	47.0 million
2001	56.1 million	56.1 million
Average	\$48.6 million	\$56.6 million

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

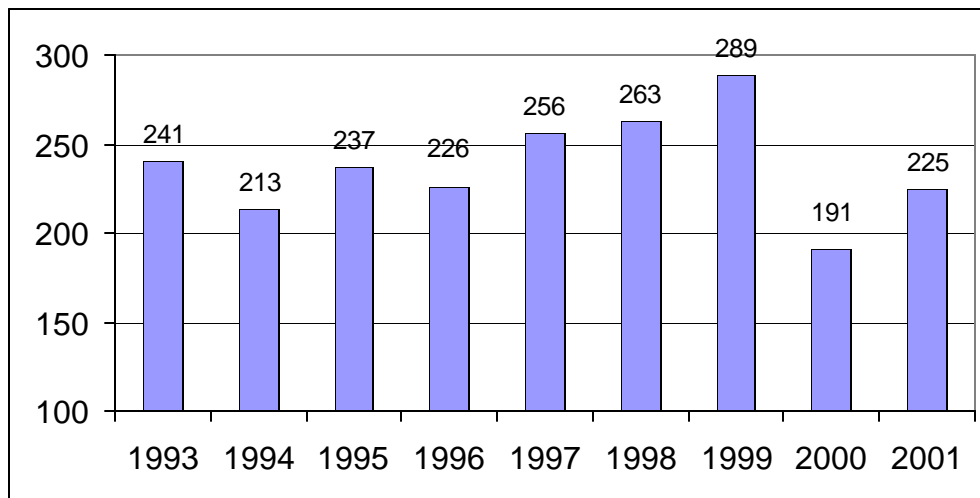
The Number of Payouts in Washington Has Declined

A report commissioned by the Washington State Medical Association claims that “unexpected increases in paid claim frequency” have made it difficult for medical liability insurers to operate profitably in Washington.⁹ This premise, however, is not borne out by reputable data that shows the frequency of claims actually has decreased.

- **The number of medical malpractice payouts per year has declined in Washington.** Statistics from the NPDB show that there were 241 medical malpractice payouts in 1993 compared with only 225 in 2001, a decrease of 6.6 percent.¹⁰ [See Figure 3] If adjustments were made for the increased number of doctors and the growing population over the last decade, this actually would represent an even greater decline.
- **The number of malpractice payouts in 2001 was 5.5 percent below the average for 1993-2001.** From 1993 to 2001, an average of 238 malpractice payouts were made each year in Washington. In 2001, there were only 225 payouts, 5.5 percent below the average.
- **In 2001, the number of malpractice payouts in Washington was lower than it had been in all but two of the last nine years.**

Figure 3

Number of Malpractice Payouts in Washington, 1993-2001



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

The Average Malpractice Payout per Doctor in Washington Has Decreased

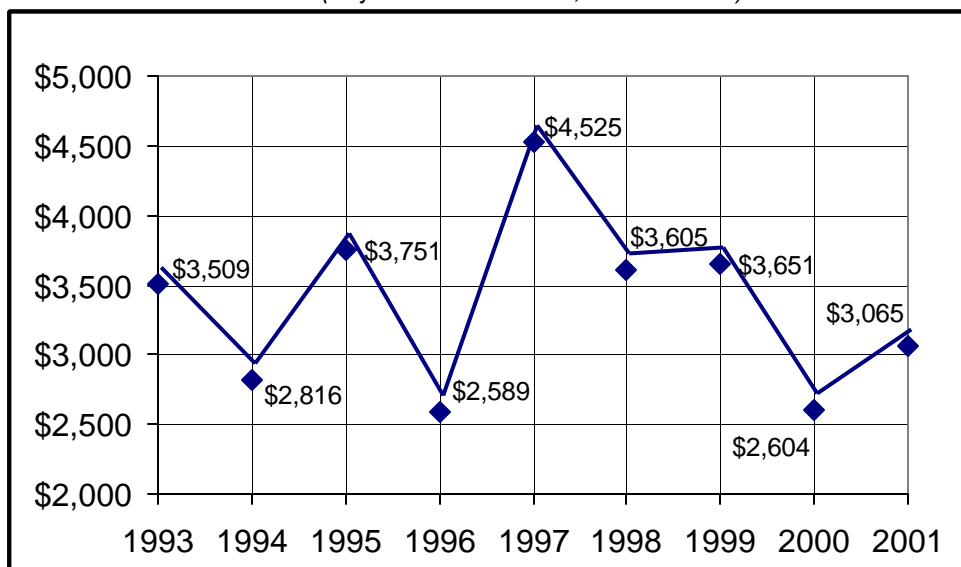
Proponents of caps on malpractice damages have claimed that the average amounts paid to injured patients are increasing, contributing significantly to recent spikes in some malpractice insurance premiums. When inflation is taken into account, however, the amount of money paid out per Washington doctor has barely increased over the past decade.

- **The average amount of a malpractice payout per doctor in 2001 was less than it was nine years ago.** In 1993, the average amount of a malpractice payout was \$3,509 per doctor; in 2001, the value was \$3,065 per doctor¹¹ – a 12.6 percent decrease over eight years. [See Figure 4]
- **The average payout per doctor has dropped dramatically since 1997.** In 1997, the average amount of a malpractice payout was \$4,525 per doctor; in 2001, it was \$3,065 per doctor, a 32.3 percent decrease.
- **The average payout per doctor in 2001 was less than the average payout per doctor for 1993-2001.** The average amount of a malpractice payout for 1993-2001 was \$3,346 per doctor. The average amount of payout in 2001 was \$3,065, or 8.4 percent less.

Figure 4

Average Amount of Malpractice Payouts per Doctor

(Adjusted for Inflation, 2001 dollars)



Sources: National Practitioner Data Bank, Sept. 1, 1990 – Sept. 30, 2002 and Washington Medical Quality Assurance Commission.

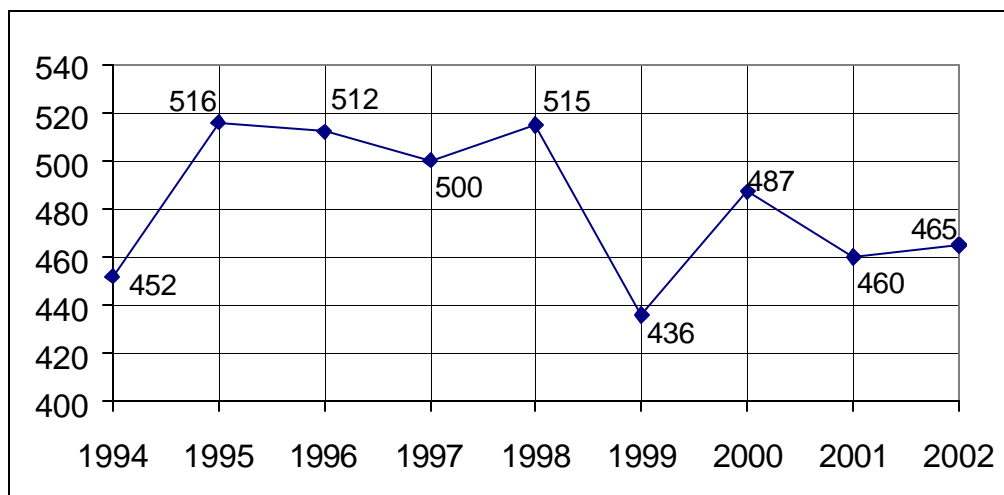
The Annual Number of Malpractice Lawsuits Filed Has Remained Steady

Those who propose limiting the legal rights of injured patients to seek compensation often claim that there has been an explosion of medical malpractice litigation. In fact, the number of medical liability lawsuits filed in Washington courts shows no such trend.

- **The number of malpractice lawsuits filed in Washington courts has remained steady since 1994.** In 1994 there were 452 medical malpractice lawsuits filed in Washington courts, compared with 465 in 2002, or just 13 more lawsuits over eight years. This is an eight-year increase of 2.9 percent, or only 0.4 percent a year.¹² [See Figure 5]
- **Washington's population has grown faster than the number of lawsuits filed.** Washington's population grew at a rate of 1.7 percent a year from 1994 to 2002 – nearly five times faster than the rate for medical malpractice lawsuits filed.¹³
- **The number of lawsuits filed in 2002 was below the average number of lawsuits filed over the last nine years.** An average of 483 medical malpractice lawsuits were filed each year from 1994 to 2002. In 2002, only 465 lawsuits were filed, which was 3.7 percent below the eight-year average.

Figure 5

Medical Malpractice Lawsuits Filed in Washington, 1994-2002



Source: Administrative Office of the Courts, Washington State.

As a Group, Washington Health Care Providers Have Experienced a Drop in Malpractice Insurance Costs

The bulk of a medical malpractice payout to an injured patient goes to cover medical bills. Therefore, the cost of liability insurance could be expected to rise in tandem with the cost of health care. In fact, medical costs have increased at a much steeper rate than medical liability insurance in Washington state as health care professionals benefited from widespread underpricing of malpractice premiums.

Like much of the country, Washington benefited from a “soft” market for liability insurance throughout most of the 1990s, as insurance companies made profitable investments and chose not to raise malpractice insurance premiums.¹⁴ As a result of these pricing and profit policies, the amount that insurance companies collected in malpractice premiums in Washington was less in 2001 than it had been 10 years earlier.

- **Adjusting for inflation, Washington health care providers paid less in total malpractice premiums in 2001 than in 1991.** As a group, health care providers paid \$133.8 million in malpractice premiums in 2001 (direct premiums earned), compared with \$135.6 million in 1991. [See Figure 6] This represents a 1.4 percent *decrease*. During this time period the costs of medical care *increased* 58 percent nationally.¹⁵
- **Medicare’s local adjustment for the cost of medical malpractice insurance in Washington is much less than the national average.** According to the government, Washington doctors spend an average of only 2.52 percent of their practice incomes on malpractice insurance, compared with a nationwide average of 3.2 percent.¹⁶ This means Washington doctors pay 21.2 percent less than the national average.
- **Overall medical business expenses in Washington dwarf malpractice insurance costs.** The federal government’s Medicare actuary calculates that nationwide, doctors running their own businesses spend an average of 42.3 percent of their practice incomes on overhead costs, things like rent, labor, utilities, and taxes. This index value, established by the Department of Health and Human Services (HHS), is 13 times higher than the HHS national index calculated for malpractice costs, which is 3.2 percent of the average practice income.¹⁷ In fact, doctors in Seattle/King County pay an average of 46.5 percent of their practice incomes to cover overhead costs, compared with 2.5 percent to cover malpractice insurance costs.¹⁸ These statistics weaken the argument that malpractice insurance costs would play a significant factor in driving doctors out of Washington.

Figure 6

**Medical Malpractice Premiums Earned,
Washington State – 1991-2001**

Year	Direct Premiums Earned	Direct Premiums Earned (Adj. \$2001)
1991	\$104,319,535	\$135,645,648
1992	103,487,197	130,631,889
1993	102,152,477	125,199,098
1994	103,351,774	123,506,403
1995	99,441,524	115,558,012
1996	96,736,692	109,190,574
1997	98,503,707	108,691,945
1998	104,276,876	113,296,826
1999	115,542,290	122,824,921
2000	109,888,191	113,015,609
2001	133,726,950	133,726,950

Source: National Association of Insurance Commissioners, "Medical Malpractice Insurance Net Premium and Incurred Loss Summary," July 18, 2001.

**Note:* Each state decides which insurance companies must report earnings/losses to the NAIC. Generally, state-administered funds, surplus lines insurers, self-insured organizations or in some cases, single-state insurers, do not report their premiums/losses. Companies reporting usually include most of the voluntary market (stock and mutual insurers) and most risk retention groups that are formed by doctors or hospitals.

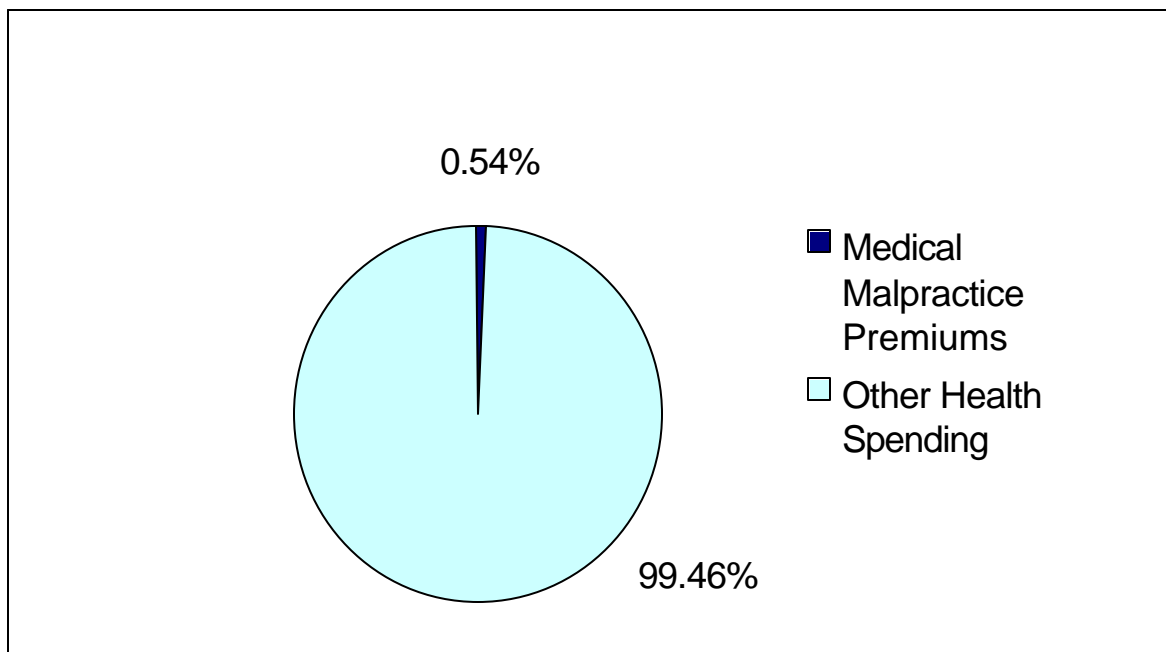
Health Care Providers' Malpractice Premiums Are Insignificant Compared with Total Health Spending

Malpractice insurance premiums paid by health care providers in Washington are insignificant when compared with the state's overall health care expenditures. If legislators really wanted to improve access to health, it would make more sense to focus on other issues. Total spending on health care in Washington state was \$19.3 billion in 1998, the last year for which this data is available from government sources.¹⁹

- That same year, Washington health care providers paid \$104.3 million in malpractice insurance premiums²⁰ – equivalent to only 0.54 percent of all the money spent on health care in Washington for that year. [See Figure 7]

Figure 7

Medical Malpractice Insurance Premiums as a Percentage of Total Washington Health Costs



Source: Center for Medicare and Medicaid Services, "Trends in State Health Care Expenditures and Funding: 1980-1998," Summer 2000.

The Average Malpractice Premium Per Doctor In Washington Is the Median for the Nation

When the “cost burden” of physician’s medical malpractice premiums is calculated (by dividing total premiums paid by the number of licensed doctors), Washington ranks 26th, exactly in the middle of the 50 states and the District of Columbia – according to an insurance industry report card. In fact, the cost burden of malpractice premiums per physician in Washington is only 44 percent of the cost burden in the most costly state, West Virginia – \$4,556 vs. \$10,307 respectively. [See Figure 8]

Figure 8

Physician Cost Burden – Average Liability Premium by State

Rank	State	Cost Burden/Physician	Rank	State	Cost Burden/Physician	Rank	State	Cost Burden/Physician
1	W.Va.	\$10,307	18	Mo.	\$5,524	35	Wyo.	\$3,703
2	N.J.	9,475	19	Ks.	5,144	36	Mass.	3,695
3	Az.	9,043	20	Ky.	4,982	37	Alas.	3,416
4	Ill.	8,166	21	Md.	4,875	38	Ore.	3,306
5	Ala.	7,946	22	La.	4,823	39	Miss.	3,242
6	Nev.	7,908	23	Col.	4,777	40	Idaho	3,164
7	Iowa	7,551	24	Ark.	4,761	41	N.M.	3,122
8	N.Y.	7,351	25	N.C.	4,661	42	Wis.	3,120
9	Ten.	7,329	26	Wash.	4,556	43	Ind.	2,916
10	Pa.*	7,257	27	R.I.	4,476	44	Min.	2,844
11	Fla.	7,227	28	Va.	4,452	45	Con.	2,796
12	Del.	6,953	29	Neb.	4,444	46	N.H.	2,760
13	Ga.	6,705	30	S.D.	4,444	47	D.C.	2,460
14	Ohio	6,103	31	Mich.	4,304	48	Vt.	2,013
15	Maine	5,752	32	Mon.	3,922	49	Ok.	1,501
16	Utah	5,729	33	Cal.	3,761	50	S.C.	426
17	N.D.	5,676	34	Tex.	3,724	51	Hawaii	252

Source: “Medical Liability Report Card 2000,” NORCAL Mutual Insurance Company, Nov. 14, 2002. Based on A.M. Best & Co. 2000 and American Medical Association Physician Survey.

Note: As a basis for this comparison, NORCAL Mutual used the numbers of all licensed physicians in each state, which is greater than the numbers of physicians practicing in each state.

* Figure for Pennsylvania includes premium surcharges paid to the state catastrophic fund.

No Evidence of Doctors Abandoning Washington

The Washington State Medical Association has advertised anecdotes regarding physicians who, it claims, may abandon their practices or leave the state if medical malpractice insurance premiums continue to increase.²¹ Statistics reveal that – far from an exodus of doctors – Washington continues to experience a steady and significant increase in the number of doctors.²²

- The number of in-state practicing doctors in Washington has jumped 3,720 over the last decade, from 15,533 in 1993 to 19,253 in 2003. This is an overall increase of 23.9 percent, or 2.4 percent a year. [See Figure 9]
- In comparison, Washington’s overall population experienced an annual average increase of 1.7 percent from 1993 to 2002.²³ This means the number of doctors increased at a rate 37.3 percent faster than the rate of population increase during this period.

Figure 9

Licensed Physicians and Osteopaths in Washington

Year	Number of Licensed Doctors
1993	15,533
1994	15,947
1995	16,448
1996	16,452
1997	16,685
1998	17,311
1999	17,667
2000	18,049
2001	18,301
2002	18,934
2003	19,253

Source: Washington Medical Quality Assurance Commission.

Repeat Offender Doctors Are Responsible for 43 Percent of Medical Malpractice Payouts

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

- According to the federal government’s National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, just 3.5 percent of Washington’s doctors have been responsible for 42.6 percent of all malpractice payouts to patients. [See Figure 10] Overall, these 488 doctors, all of whom have made two or more payouts, have paid \$240.4 million in damages.
- Just 1.1 percent of Washington doctors (160), each of whom has paid three or more malpractice claims, were responsible for 18.2 percent of all payouts. And the 31 doctors with five or more payouts, just 0.2 percent of all Washington doctors, accounted for 7.1 percent of all payouts.

Figure 10

Medical Malpractice Payouts to Patients and Amounts Paid by Washington Doctors, 1990 – 2002

Number of Payout Reports	Number of Doctors that Made Payouts	Percent/ Total Doctors (13,931)	Total Number of Payouts	Total Amount of Payouts	Percent of Total Number of Payouts
All	2,020	14.5%	3,012	\$564,888,500	100.0%
1	1,532	11.0%	1,532	\$324,443,300	57.4%
2 or More	488	3.5%	1,480	\$240,445,200	42.6%
3 or More	160	1.1%	824	\$103,048,250	18.2%
4 or More	63	0.5%	533	\$65,774,850	11.6%
5 or More	31	0.2%	405	\$39,969,750	7.1%

Source: National Practitioner Data Bank Annual Reports, Sept. 1, 1990 – Sept. 30, 2002
(For these calculations, Public Citizen used AMA 1995 figures for non-federal licensed doctors in Washington, the closest AMA year to the mid-point of the NPDB time period.)

Repeat Offenders Suffer Few Consequences

The Washington Quality Assurance Commission and the state's health care providers have not done enough 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,²⁴ the number of disciplinary actions (license suspension or revocation, or a limit on clinical privileges) against Washington physicians could be improved. [See Figure 11]

- Only 13.3 percent (65 of 488) of Washington doctors who made two or more malpractice payouts were disciplined by the Medical Quality Assurance Commission.
- Only 21.3 percent (34 of 160) of Washington doctors who made three or more malpractice payouts were disciplined by the Medical Quality Assurance Commission.
- Only 34.9 percent (22 of 63) of Washington doctors who made four or more malpractice payouts were disciplined by the Medical Quality Assurance Commission.
- Only 45.2 percent (14 of 31) of Washington doctors who made five or more malpractice payouts were disciplined by the Medical Quality Assurance Commission.

Figure 11

Washington Doctors with Two or More Medical Malpractice Payouts Who Have Been Disciplined (Reportable Licensure Actions), 1990 – 2002

Number of Payout Reports	Number of Doctors that Made Payouts	Number of Doctors with One or More Reportable Licensure Actions	Percent of Doctors with One or More Reportable Licensure Actions
2 or More	488	65	13.3%
3 or More	160	34	21.3%
4 or More	63	22	34.9%
5 or More	31	14	45.2%
10 or More	3	3	100.0%

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

Examples of Doctors With Multiple Malpractice Payouts Who Have Not Been Disciplined

The extent to which doctors can make repeated medical malpractice payouts in Washington and not be disciplined is illustrated by the following NPDB descriptions of 10 doctors practicing in Washington, all of whom have made at least four malpractice payouts totaling \$890,000 or more, but *none* of whom has been disciplined by the state.²⁵

- **Physician Number 71620** made four malpractice payouts, including one lost malpractice judgment, between 1995 and 2001 involving two incidents of failing to diagnose a patient, and two incidents of delay in surgery. The damages add up to \$8,435,000.
- **Physician Number 40179** made five malpractice payouts between 1993 and 2002 involving leaving a foreign body in a surgical patient, two incidents of improper choice of delivery method, an improperly performed vaginal delivery, delay in delivery, and an obstetrics related incident. The damages add up to \$2,015,000.
- **Physician Number 39959** made four malpractice payouts between 1991 and 2000 involving leaving a retained foreign body in a surgical patient, surgery on the wrong body part, unnecessary surgery, and improper management of a surgical patient. The damages add up to \$1,770,000.
- **Physician Number 40291** made five malpractice payouts between 1992 and 1998 involving three surgery related incidents, surgery on the wrong body part, and improperly performing a surgery. The damages add up to \$1,592,000.
- **Physician Number 40508** made five malpractice payouts, including three lost malpractice judgments, between 1991 and 1994, involving five failures to diagnose a patient. The damages add up to \$1,437,500.
- **Physician Number 40148** made four malpractice payouts between 1993 and 2002 involving two incidents of improper performance of surgery, unnecessary surgery, and improper management of course of treatment. The damages add up to \$1,032,500.
- **Physician Number 40295** made six malpractice payouts between 1992 and 1997 involving six surgery related incidents. The damages add up to \$1,283,750.
- **Physician Number 40070** made nine malpractice payouts between 1991 and 2002 involving four incidents of improperly performed surgery, two surgeries on the wrong body parts, improper management of course of treatment, improper performance of treatment, and delay in treatment. The damages add up to \$1,203,500.

- **Physician Number 13859** made five malpractice payouts between 1991 and 1996 involving failure to diagnose, a diagnosis related incident, and three incidents of failure to treat (one incident took place in Kansas). The damages add up to \$891,250.
- **Physician Number 40479** made seven malpractice payouts between 1992 and 2002 involving two incidents of improper performance of surgery, surgery on the wrong body part, an anesthesia related incident, and three treatment related incidents. The damages add up to \$838,750.

Where's the Doctor Watchdog?

Chances that Washington could reduce its rate of malpractice claims by cutting the frequency of medical errors and negligence are weakened by the Washington State Medical Quality Assurance Commission's failure to diligently discipline doctors for incompetence and other offenses.

- **The Washington Medical Quality Assurance Commission is among the nation's least diligent when it comes to disciplining doctors.** In 2002, Washington ranked 41st among all states and the District of Columbia for the frequency at which it takes serious disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. In 2002, the Washington Medical Quality Assurance Commission levied serious sanctions against only 36 of its 16,154 doctors, according to Public Citizen's Health Research Group ranking of the rate of state medical boards' serious disciplinary actions in 2002.²⁶

Nationally in 2002, there were 3.6 serious actions taken for every 1,000 physicians. The rate of serious actions by the Washington Medical Quality Assurance Commission – 2.2 per 1,000 physicians – was less than one-fifth of the rate in Wyoming, which is the top-ranked state with 11.9 serious actions per 1,000 physicians.²⁷

Over the last decade, Washington has consistently ranked in the bottom half of states for the rate of doctor discipline. Its best rating was 24th out of 51, and its worst rating was 43rd. In six of the last seven years, Washington has been ranked 36th or worse.

- **New system offers the public only limited information on physicians.** In April 2003, the state started making information about doctors' records public on the Internet. However, the only disciplinary records available are from the state Medical Quality Assurance Commission, and those records contain details only since 1998. The number of times a doctor has been sued, the outcomes, or the number of a doctor's malpractice payouts still is not available. Any disciplinary actions taken by hospitals are not listed. If all this information were to be made available, consumers could make more intelligent decisions regarding their health care, and the marketplace might help to weed out doctors that pose ongoing problems.²⁸

Washington's Malpractice Insurance Market Attracts Viable Competitors

The medical malpractice insurance market in the state of Washington remains competitive compared with markets elsewhere. According to an insurance industry report card, the number of “A” rated competitors offering medical malpractice policies in Washington is five – exactly the national average per state. [See Figure 12]

Figure 12

“A” Rated Providers of Malpractice Insurance – Per State

Eight Providers	Six Providers	Five Providers		Four Providers	Three Providers
Florida	Alaska	Arizona	N.C.	Indiana	Alabama
Georgia	Idaho	Arkansas	Nevada	Maryland	Delaware
Missouri	Illinois	Colorado	N.H.	Michigan	Maine
Montana	Miss.	Conn.	N. Mexico	Oklahoma	N.J.
Virginia	Nebraska	D.C.	Texas	S. Carolina	Oregon
	Penn	Kansas	Vermont		Rhode Is.
	Tenn.	Kentucky	Wash.		S. Dakota
	Wisc.	Minn.			
					Two Providers
California					New York
Hawaii					Mass.
Iowa					Wyoming
N. Dakota					
Ohio					

Source: “Medical Liability Report Card 2000,” NORCAL Mutual Insurance Company, Nov. 14, 2002. Based on A.M. Best & Co.

Washington and California Physicians Pay Comparable Insurance Premiums

- Although the medical establishment has extolled California's liability law, which places a \$250,000 cap on the amount patients can receive for non-economic damages, many physicians in Washington pay much less to be insured than their counterparts in California, while others pay only slightly more. Several statistics illustrate this: [See Figure 13]
- **Washington internists pay much less for malpractice premiums than their counterparts in California.** The largest malpractice insurer in Washington, Physicians Insurance A Mutual Co. (which has 42.4 percent of the state's medical liability insurance market) charged internists \$9,779 in 2002. California's largest medical malpractice insurer, NORCAL Mutual (which has 27.6 percent of the market)²⁹ charged California internists a median amount of \$14,602 in 2002 – 49.3 percent more than Physicians Insurance.³⁰
- **General surgeons in Washington pay about the same malpractice premiums as their counterparts in California.** Washington surgeons covered by Physicians Insurance paid \$35,253 in 2002 premiums, while NORCAL Mutual charged California surgeons \$34,119. Moreover, California's NORCAL increased its 2002 general surgery rate substantially more than Physicians Insurance, 17 percent to 8.6 percent, respectively.³¹
- **Ob/Gyns in Washington pay somewhat more in malpractice premiums than their counterparts in California.** Washington Ob/Gyns covered by Physicians Insurance paid \$51,878 in malpractice premiums in 2002. California Ob/Gyns covered by NORCAL paid \$45,130. Thus, Washington Ob/Gyns paid 15 percent more in premiums than their California counterparts – \$562 more per month.³²
- **A cap on damages has no apparent bearing on how much premiums increased between 2001 and 2002 in California compared with Washington.** NORCAL Mutual Insurance Co. of California raised insurance premiums between 2 and 17 percent (for an average of 8.7 percent) last year during the peak of the so-called malpractice insurance "crisis." Physicians Insurance A Mutual Co. of Washington raised premiums the same amount – 8.6 percent. This suggests that premium increases are more related to the insurance cycle than the liability system.³³
- **Medicare's local adjustment for the cost of malpractice insurance is lower for doctors in Seattle than for doctors in Los Angeles.** The Medicare actuary calculates that Seattle doctors spend an average of 2.52 percent of their practice incomes on malpractice insurance, compared with Los Angeles doctors, who spend 3.05 percent of their practice incomes on malpractice insurance.³⁴

Figure 13

2002 Medical Liability Premiums – Washington and California

Specialty	Washington: Physicians Insurance A Mutual Co.	California: NORCAL Mutual Insurance Co.*
Internal Medicine	\$9,779 2002 increase: 8.6%	Median: \$14,602 2002 increase: 7%
General Surgery	\$35,253 2002 increase: 8.6%	Median: \$34,119 2002 increase: 17%
Ob/Gyn	\$51,878 2002 increase: 8.6%	Median: \$45,130 2002 increase: 2%

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

*NORCAL premiums differ according to location, ranging from \$35,718 to \$65,389 per year for Ob/Gyns, for instance. Public Citizen took the median premium from the various California rates to arrive at the figure used in the table. The percentage increase value was calculated the same way.

A Malpractice Insurer Serving Both States Generally Charges Less in Washington than California

The Doctors' Company, which writes malpractice insurance in both Washington and California, generally charges less in Washington, despite California's cap on non-economic damages in medical malpractice cases. And its most recent rate increases were much more moderate in Washington than in California. [See Figure 14]

- **The Doctors' Company charges Washington internists much less for malpractice premiums than it charges their counterparts in California.** The median value of premiums charged to Washington internists by the Doctors' Company is \$7,300, compared with the \$8,052 it charged to California internists.³⁵ This is 9.3 percent less.
- **The Doctors' Company charges Washington general surgeons much less for malpractice premiums than it charges their counterparts in California.** The median value of premiums charged to Washington general surgeons by the Doctors' Company is \$23,100, compared with the \$30,155 it charged to California general surgeons. This is 23.4 percent less.
- **The Doctors' Company charges Washington Ob/Gyns much less for malpractice premiums than their counterparts in California.** The median value of premiums charged to Washington Ob/Gyns by the Doctors' Company is \$34,209, compared with the \$37,661 it charged to California Ob/Gyns. This is 9.2 percent less.

Figure 14

The Doctors' Company Rates – Washington v. California

Specialty	Washington: Doctors' Company 2002 Premiums*	California: Doctors' Company 2002 Premiums*
Internal Medicine	Median: \$7,300 2002 Increase: 4.4 percent	Median: \$8,052 2002 Increase: 7.6 percent
General Surgery	Median: \$23,100 2002 Increase: 4.4 percent	Median: \$30,155 2002 Increase: 7.6 percent
Obstetrics & Gynecology	Median: \$34,209 2002 Increase: 4.4 percent	Median: \$37,661 2002 Increase: 7.6 percent

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

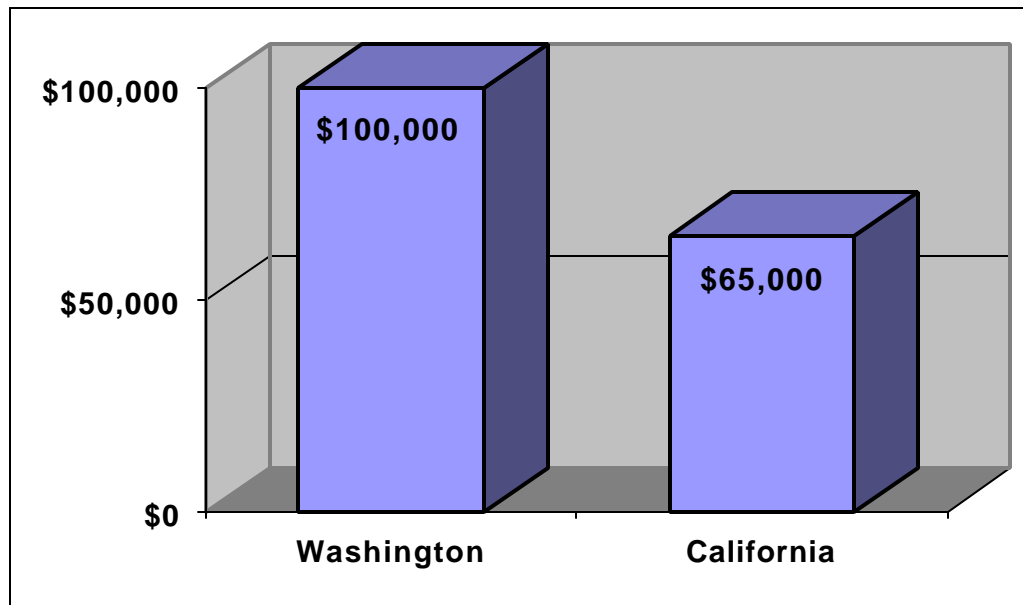
Washington's Malpractice Victims Fare Much Better than California's

Researchers agree that medical malpractice damage caps reduce compensation to injured patients by an average of 23 percent.³⁶ It is clear that caps on damages have harmed injured patients in California; it is not clear that California's doctors have benefited from those same caps by paying less for malpractice insurance.

Injured patients in Washington receive 54 percent more compensation than injured patients in California. Washington's injured patients receive an average of \$100,000 in malpractice compensation, compared with injured patients in California, who receive an average of only \$65,000.³⁷ [See Figure 15] This means Washington patients fare an average of 54 percent better. As shown in earlier comparisons, however, California doctors do not necessarily pay much less for medical malpractice insurance, despite their state's \$250,000 cap on non-economic damages.

Figure 15

Median Malpractice Patient Compensation, Washington vs. California – 2001



Source: "Mean and Median Malpractice Payment and Mean Delay Between Incident and Payment by State, 2001 and Cumulative," National Practitioner Data Bank, September 1990 - December 2001.

Caps on Malpractice Awards Do Not Improve Access to Primary Care

There is no apparent relationship between caps on medical malpractice awards and access to primary medical care. Among the 15 states with the highest percentages of population lacking primary medical care, nine impose medical malpractice caps. [See Figure 16] In fact, three of the four states with the greatest underserved populations have malpractice caps. Conversely, among the 15 states with the smallest percentages of population lacking primary care, eight do *not* have malpractice caps.³⁸

The Health Professional Shortage Area database maintained by the U.S. Department of Health and Human Services³⁹ shows that urbanization and affluence are the most frequent predictors of access to medical care.

- **Mississippi had the nation's worst access to medical care years before the current malpractice "crisis."** Mississippi, with just 149 physicians per 100,000 residents, ranks worst in the nation for the percentage of its population that lacks medical primary care. And Mississippi also ranked worst among states in terms of its medically underserved population in 1992 (33.3 percent),⁴⁰ long *before* a so-called "malpractice crisis" was proclaimed in that state.
- **Caps and low payouts to patients have not made primary care accessible in Utah.** The third worst state for the percentage of its population lacking primary medical care is Utah, which has a \$400,000 cap on damages and very low malpractice payouts to patients – ranking 49th nationally for the cumulative median size of payouts.⁴¹
- **Idaho also has malpractice caps – as well as a medically underserved population.** Idaho, another state that has a \$400,000 cap on non-economic damages, ranks fourth worst in the nation for the percentage of its population that lacks primary care.⁴²
- **The AMA claims California's caps attract doctors, but shortages continue to plague primary care.** The AMA has suggested that doctors leaving Nevada because of high insurance rates were flocking to California.⁴³ Yet, the San Diego Medical Society released a report claiming that 35 percent of physicians in San Diego "plan to retire, change professions or relocate within five years," and that "[s]ixty-four percent of the physicians say San Diego is 'experiencing a shortage of physicians.'" Moreover, the report states that "71 percent of local physicians report difficulty recruiting new physicians to their practices."⁴⁴

Figure 16

**Percent of Population Lacking Access to Primary Care,
States With “Caps” and Without “Caps” – 2000**

THE FIFTEEN WORST			
Rank	State	Malpractice Caps?	Population w/o Access
1	Mississippi	No *	26.9%
2	Alabama	Yes	22.7%
3	Utah	Yes	21.0%
4	Idaho	Yes	20.3%
5	District of Columbia	No	19.5%
6	South Dakota	Yes	19.2%
7	Louisiana	Yes	18.3%
8	Wyoming	No	17.9%
9	Missouri	Yes	17.8%
10	Georgia	No	16.3%
11	South Carolina	No	16.0%
12	New Mexico	Yes	15.9%
13	North Dakota	Yes	15.5%
14	Alaska	Yes	14.2%
14	Kentucky	No	14.2%
(27	Washington state	No	9.0%)
THE FIFTEEN BEST			
1	Hawaii	Yes	2.9%
2	New Jersey	No	3.5%
3	Vermont	No	3.7%
4	Massachusetts	Yes	4.0%
5	New Hampshire	No	4.3%
6	Delaware	No	4.5%
7	California	Yes	4.9%
8	Pennsylvania	No	5.5%
9	Connecticut	No	5.7%
10	Kansas	Yes	6.0%
11	Maryland	Yes	6.2%
12	Nebraska	No	6.6%
13	Illinois	No	6.7%
14	Ohio	No	7.0%
15	Virginia	Yes	7.2%

Source: *Health Care State Rankings 2001*, Morgan Quitno Press. * Note: Mississippi did not have malpractice award caps during the year covered in this report.

Non-economic Damages Are Real and Justified

Caps on “non-economic damages” are the centerpiece of malpractice “reform” proposals offered by physicians and their allies at the state and national levels. 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) 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.⁴⁵ 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.⁴⁶ PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners’ classifications.⁴⁷ 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.⁴⁸
- **Capping awards hurts children, women and minorities in particular.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on children, women and minorities. Children have no employment income, which is the basis for calculating most economic awards. One of the more significant medical injuries inflicted on women is harm to reproductive capacity, but that does not impact a woman’s earning capacity, and thus does not entitle her to economic damages despite the devastating emotional impact of such a loss. Capping awards also discriminates against minorities since they have lower incomes on average than whites. In some cases, low wage earners are denied the opportunity to earn more in the future due to injuries caused by medical negligence.

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 make up a small percentage of medical malpractice claims, and because the portion of the medical liability premium dollar that pays for compensation is dwarfed by the portion that pays for defense lawyer fees, caps do not lead to lower premiums. Insurance companies and their lobbyists understand this.

Premium on the Truth:

“Insurers never promised that tort reform would achieve specific savings.” – American Insurance Association⁴⁹

“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 Association⁵⁰

“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 Association⁵¹

“For too long we have placed blame and not fixed the problem. This mess is largely one of the insurance industry's own creation and we have to fix it.” – Matt Dolan, vice president, One Beacon Professional Liability Partners.⁵²

California

“I don't like to hear insurance-company executives say it's the tort [injury- law] system – it's self-inflicted,” – Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California.⁵³

Florida

“No responsible insurer can cut its rates after a bill (that caps damages at \$250,000) passes.” – Bob White, president of First Professionals Insurance Co. (formerly Florida Physicians Insurance Company, Inc). The company is the largest medical malpractice insurer in Florida and has close ties to the Florida Medical Association.⁵⁴

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 Mississippi⁵⁵

Nevada

“The primary insurer for Las Vegas obstetricians, American Physicians Assurance, has no plans to lower premiums for several years, if ever, said broker Dennis Coffin.” – Coffin is the Account Representative for SCW Agency Group – Nevada, which represents the American Physicians Assurance Corp.⁵⁶

“[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 Issues⁵⁷

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.”⁵⁸

Financial analysis shows malpractice award “caps” would have little impact on the premiums doctors pay. In an analysis requested by the Medical Society of New Jersey, actuaries estimate that a “cap” on non-economic damages in malpractice cases would have only a slight impact on the amount doctors pay in liability premiums. “We would expect a \$250,000 cap on non-economic damages would produce some savings, perhaps in the 5 percent to 7 percent range,” the firm of Tillinghast-Towers Perrin reports. “A cap of \$500,000 is likely to be of very little benefit to physicians.”⁵⁹

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.⁶⁰

“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 Assurance⁶¹

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 Committee⁶²

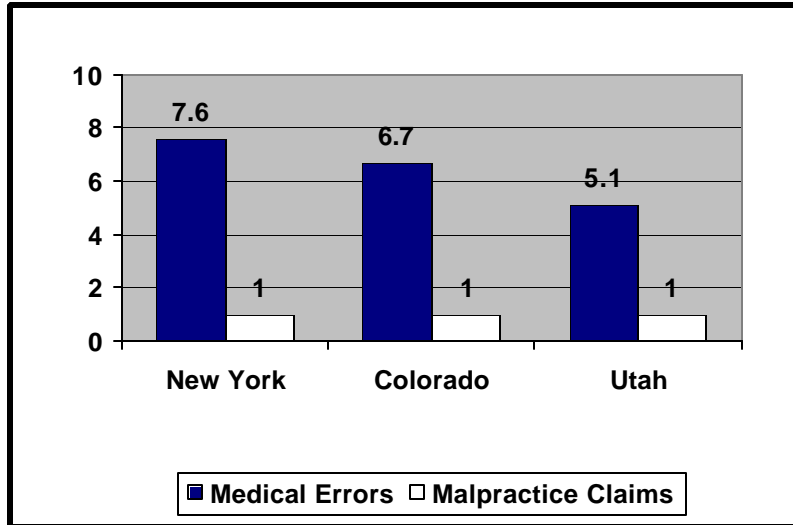
Rather than Facing “Runaway Litigation,” Health Care Providers Benefit from a Claims Gap

Although no comparable studies have been cited in Washington state, 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.⁶³ Researchers replicating this study made similar findings in Colorado and Utah.⁶⁴ [See Figure 17]
- **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.⁶⁵ In other words, for every six preventable medical errors only one claim is filed. [See Figure 18]
- **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.⁶⁶ 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.”⁶⁷

Figure 17

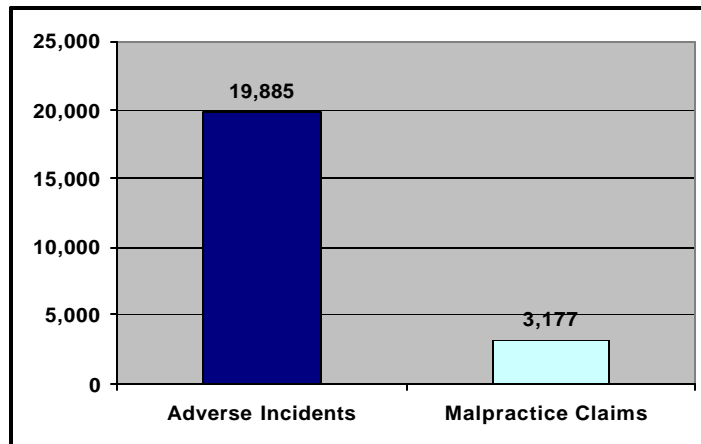
**Malpractice Claims Gap:
Ratio of Medical Errors to Claims Filed**



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

Figure 18

**Florida Malpractice Claims Gap: 1996 – 1999
Ratio of Medical Errors to Claims Filed**



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

Few Malpractice Lawsuits Are “Frivolous”

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

- **The high cost of preparing a medical malpractice case discourages frivolous claims – and meritorious claims as well.** Medical malpractice cases are very expensive for plaintiffs’ attorneys to bring, with out-of-pocket costs for cases settled at or near the time of trial (when most cases are settled) ranging from \$15,000 to \$25,000.⁶⁸ If the case goes to trial, the costs can easily be doubled.⁶⁹ 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.⁷⁰ 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.⁷¹ 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. 5. This bill, which contained very stringent restrictions on patients’ ability to recover damages, passed the U.S. House in 2003. CBO declined, saying:

Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians’ responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.

A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments. ...[u]sing a different data set, CBO could find no statistically significant difference in per capita health care spending between states with and without malpractice tort limits.⁷²

- **Defensive medicine has not prevented wrong-patient surgery.** New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.⁷³ There were nine such instances in Florida in 2001.⁷⁴ 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 has not 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.⁷⁵ 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.”⁷⁶
- **Defensive medicine has not prevented mammography errors.** The *New York Times* reported in June 2002 some very disturbing facts about errors committed by radiologists in reading mammograms.⁷⁷ 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 has not 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.”⁷⁸ 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”?⁷⁹ Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.⁸⁰
- **Defensive medicine has not 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.⁸¹ One report found specifically that each additional patient per nurse corresponded to a 7 percent increase in both patient mortality and deaths following complications.⁸² Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts over-staffing.

Solutions to Reduce Medical Errors

Physician groups and their political allies are essentially blaming patients and their lawyers for the temporary spike in some medical malpractice insurance premiums. And they continue to advocate for a solution – a cap on damages – that is unrelated to the source of the problem.

Proposals under consideration in the U.S. Congress and the Washington state Legislature would place caps on medical malpractice payouts for “non-economic damages” of \$250,000 and \$350,000 respectively. Non-economic damages refer to awards for pain and suffering, lost childbearing ability, or disfigurement. Such damages exceed \$250,000 or \$350,000 only in cases of permanent significant injuries. Thus, the cap will not affect patients with minor injuries nor reduce so-called “frivolous” lawsuits. Instead, it targets only victims of catastrophic injuries such as deafness, blindness, loss of limb or organ, paraplegia, or severe brain damage.

Such measures will only result in more medical malpractice and more lives ruined by the physical and emotional scars that result from medical negligence. Instead, the focus of the state’s elected officials should be on improving patient safety. Public Citizen recommends the following patient safety reforms:

Federal Patient Safety Reforms

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

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

State Patient Safety Reforms

- **Improve Oversight of Physicians**

Public Citizen has long sought greater consumer access to information about doctors, and there have been recent improvements in making that information available. Most state medical boards now provide some physician information on the Internet, but the information about disciplinary actions varies greatly, is often inadequate and can be difficult for people to access.⁸³

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,⁸⁴ too little discipline is being done. Too many state medical boards, despite their duty to protect the public, still believe their first responsibility is to rehabilitate "impaired physicians" and shield them from the public's prying eyes. Fewer than one-half of one percent of the nation's doctors face any serious state sanctions each year. In 2002, state medical boards took 2,864 serious disciplinary actions, a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by preventable medical errors annually.

State discipline rates ranged from 11.87 serious actions per 1,000 doctors (Wyoming) to 1.07 actions per 1,000 physicians (Hawaii), a tenfold difference between the best and worst states. In 2002, Washington state ranked 41st in the number of serious actions taken per 1,000 physicians, a decline from its ranking of 37th in 2001. This represents 2.23 serious actions per 1,000 doctors, well below the national average of 3.56. (Note: Most of these actions are unrelated to medical malpractice and instead involve sanctions for substance abuse, sexual and criminal offenses.)

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

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

The following state reforms would improve medical board performance:

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

- **Beef up medical board funding and staffing.** State legislatures should permit medical boards to spend all the revenue from medical licensing fees, rather than being forced to give part to the state treasury. The medical boards should raise their fees to \$500 a year. All boards could benefit from hiring new investigators and legal staff. Boards should employ adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements. They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care.
- **Require risk prevention.** States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk prevention program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.
- **Require periodic recertification of doctors based on a written exam and audit of their patients' medical care records.**

Federal and State Patient Safety Reforms

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

Medication errors are among the most common preventable mistakes, but safety systems have been put in place in very few hospitals. Although experts using the systems approach have identified a number of promising strategies to reduce malpractice, few have been implemented. Experts have estimated that more than 950,000 serious drug errors occur annually in hospitals alone.⁸⁵ Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,⁸⁶ 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.⁸⁷

- **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.⁸⁸

- **Prevent Wrong Procedure Surgery and Surgery Performed on the Wrong Body Part or to the Wrong Patient.**

Such mistakes should *never* happen, according to a special alert reissued December 5, 2001 by the Joint Commission on Accreditation of Healthcare Organizations.⁸⁹ 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.⁹⁰ Nevertheless, during 2001 in Florida hospitals alone there were 54 surgeries on the wrong part of the body, 16 wrong procedures performed and nine wrong patient surgeries.⁹¹ Had Florida mandated the JCAHO recommendations in 2000, these 79 incidents would not have occurred.

- **Limit Physicians’ Workweek to Reduce Hazards Created by Fatigue**

American medical residents work among the highest – if not the highest – number of hours in the professional world. They work up to 120 hours a week, including 36-hour shifts for several weeks at a time.⁹² After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10 percent blood alcohol level.⁹³ 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.⁹⁴ 45 percent of residents who sleep less than four hours per night report committing medical errors.⁹⁵ 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.⁹⁶ If the maximum workweek for residents was limited to 80 hours it could considerably reduce mistakes due to fatigue and lack of supervision.

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:⁹⁷

Investigations and Audits

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

- 1) The extent to which the extraordinarily high profitability of the insurance industry during much of the 1990s, and its lower profitability today, is related to the performance of interest rates and the stock market during those periods;
- 2) The extent to which today's rate increases are an attempt to recoup money that insurers lost in the stock market or in other poorly-performing assets;
- 3) The extent to which insurers are adversely affected by today's low interest rates;
- 4) Whether insurers' estimates of their future claims payments, which are the basis for rate increases, are unreasonably high today; and
- 5) Whether it is proper, or lawful, for insurers to seek substantial rate increases despite having hugely increased their surplus – the money they have “in the bank,” with policyholder-supplied funds, particularly if the insurer is overcapitalized.

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

Specific Reforms

- **Regulate excessive pricing.** One cause of the cycle is the lack of regulatory action to end excessive and inadequate rates during the different phases of the cycle. Insurance Commissioners should start now by regulating the excessive prices being charged by insurers. They should, at least, hold the necessary hearings to determine if the prices are not excessive.
- **Freeze particularly stressed rates until the examination of the prices and remarkable jumps in loss reserves can be fully analyzed.** For instance, medical malpractice and homeowner rates should be frozen. A rollback of unjustified rate increases

that have already taken effect should then be in order. (The manner in which insurance rate rollbacks can be written and implemented to comply with all Constitutional requirements is explained in *Calfarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989), and *20th Century Ins. Co. v. Garamendi*, 8 Cal.4th 216 (1994). These cases substantially upheld Prop 103, the California insurance reform initiative that rolled back auto insurance rates by 20 percent.)

- **Require that risks with poorer experience pay more than good risks in lines of insurance where such methods are not in use today.** For example, require medical malpractice insurers to use claims history as a rating factor, and to give that factor significant weight. Auto insurers use an individual’s driving record as a rating factor; workers compensation insurers use the employer’s loss experience as a rating factor – so-called “experience mod.” Malpractice insurers should do the same. In addition, insurance commissioners should require all medical malpractice insurers to offer all “good” doctors – *i.e.*, all doctors meeting an objective definition of eligibility based on their claims history, their amount of experience and perhaps other factors – the lowest rate.
- **Reduce the percentage of assets that insurers can invest in stocks or other risky assets.** Insurers should not be permitted to raise their rates in order to recoup losses on stocks or other risky assets. The less risky their investments, the more secure policyholders are, and the more stable are rates.
- **Create a standby public insurer to write risks when the periodic cycle bottoms and hard markets occur, such as a medical malpractice insurer funded by a start-up loan from the state to compete with the existing malpractice carriers.** Several states have created such carriers to write workers’ compensation, and in many states such carriers have helped bring down workers’ comp rates. Similarly structured medical malpractice insurers should have similar success.
- **Ask the National Association of Insurance Commissioners to stop implementation of the deregulation of commercial rates and forms, which it is unwisely pushing.**

¹ *Sofie vs. Fibreboard Corp.*, 112 Wn.2d 636 (1989).

² “The Impact of Medical Malpractice Insurance and Tort Law on Washington’s Health Care Delivery System,” Washington State Medical-Education and Research Foundation, September 2002.

³ *Id.*

⁴ Carol M. Ostrom, “*Malpractice Ad Enlists Doctor With Rocky Past*,” Seattle Times, March 14, 2003.

⁵ *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 2000, p. 26-27.

⁶ “Medical Malpractice Insurance, Net Premium and Incurred Loss Summary,” National Association of Insurance Commissioners, July 18, 2001, Table 2.

⁷ “The Impact of Medical Malpractice Insurance and Tort Law on Washington’s Health Care Delivery System,” Washington State Medical-Education and Research Foundation, September 2002.

⁸ National Practitioner Data Bank, Annual Reports, Sept. 1, 1990 – Sept. 30, 2002. Inflation calculations based on Bureau of Labor Statistics, Consumer Price Index.

⁹ “The Impact of Medical Malpractice Insurance and Tort Law on Washington’s Health Care Delivery System,” Washington State Medical-Education and Research Foundation, September 2002.

¹⁰ National Practitioner Data Bank, Annual Reports, Sept. 1, 1990 – Sept. 30, 2002.

¹¹ Number of payouts reported by the National Practitioner Data Bank, Annual Reports, Sept. 1, 1990 – Sept. 30, 2002. Number of in-state, practicing physicians reported by Washington Medical Quality Assurance Commission, April 2002.

¹² Information Technology Division, District of Columbia Courts, compiled March 4, 2003.

¹³ Population figures from U.S. Census Bureau, Quick Facts, <http://quickfacts.census.gov/>.

¹⁴ For a more detailed explanation of insurance economics and the rationale for recent premium increases, see the section in this report entitled “Medical Liability Premium Spike is Caused by the Insurance Cycle and Mismanagement, Not the Legal System.”

¹⁵ Bureau of Labor Statistics, Medical Services CPI.

¹⁶ “Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003 and Inclusion of Registered Nurses in the Personnel Provision of the Critical Access Hospital Emergency Services Requirement for Frontier Areas and Remote Locations,” 67 Federal Register 80171, Dec. 31, 2002. The federal government indexes the average malpractice insurance cost nationwide at 3.2 percent of a doctor’s practice income. For Washington, it assigns a local malpractice cost value of .788, indicating Washington doctors pay 77.8 percent of the national average in malpractice insurance costs. The 2.52 percent statistic for Washington is calculated by multiplying these two numbers.

¹⁷ *Id.*

¹⁸ *Id.* The federal government indexes the average overhead costs for a doctor’s practice at 42.3 percent nationwide. For Washington, it assigns a local overhead cost value of 1.1, indicating Washington doctors pay 110 percent of the national average in overhead costs. The 46.5 percent statistic is calculated by multiplying these two numbers.

¹⁹ Center for Medicare and Medicaid Services, “Trends in State Health Care Expenditures and Funding: 1980-1998,” *Health Care Financing Review*, Vol. 22, No. 4, Summer 2000.

²⁰ “Medical Malpractice Insurance, Net Premium and Incurred Loss Summary,” National Association of Insurance Commissioners, July 18, 2001, Table 2.

²¹ “The Impact of Medical Malpractice Insurance and Tort Law on Washington’s Health Care Delivery System,” Washington State Medical-Education and Research Foundation, Sep. 2002. And, Carol M. Ostrom, “*Malpractice Ad Enlists Doctor With Rocky Past*,” Seattle Times, March 14, 2003.

²² Medical Quality Assurance Commission, Department of Health, Washington State, data obtained via email Apr. 18, 2003.

²³ U.S. Census Bureau, “State Population Estimates: April 1, 2000 to July 1, 2002,” and “State Population Estimates: Annual Time Series, July 1, 1990 to July 1, 1999,” <http://eire.census.gov/popest/data/states.php>.

²⁴ National Practitioner Data Bank, public use files, Sept. 1, 1990 – Sept. 30, 2002.

²⁵ *Id.*

²⁶ Sidney Wolfe, M.D., “Public Citizen’s Health Research Group Ranking of the Rate of State Medical Boards’ Serious Disciplinary Actions in 2002,” March 27, 2003. Available on Public Citizen’s website at <http://www.questionabledoctors.org/>.

²⁷ *Id.*

²⁸ Richard Roesler, “Doctors’ Records Now on Internet,” *The Spokesman-Review*, April 16, 2003.

²⁹ “2001 California P & C Market Share Report,” California Department of Insurance, June 3, 2002. NORCAL was California’s leading medical malpractice insurer in 2001, with 27.6 percent of the market. Physicians Insurance A Mutual Co. held 42.38 percent of Washington’s malpractice premium market share in 2001, according to the Washington State Office of the Insurance Commissioner.

³⁰ “Trends in 2002 Rates for Physicians’ Medical Professional Liability Insurance,” *Medical Liability Monitor*, October 2002.

³¹ *Id.*

³² *Id.*

³³ *Id.*

³⁴ “Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003 and Inclusion of Registered Nurses in the Personnel Provision of the Critical Access Hospital Emergency Services Requirement for Frontier Areas and Remote Locations,” 67 Federal Register 80171, Dec. 31, 2002.

³⁵ The Doctors’ Company customers in seven counties representing 56 percent of California’s population are charged more for malpractice insurance than are its Washington state customers. The population percentage is calculated from county statistics from the U.S. Census Bureau, Quick Facts, <http://quickfacts.census.gov/>.

³⁶ “New Evidence on the Frequency and Severity of the Medical Malpractice Claims,” RAND R-3410-1CJ, 1986.

³⁷ National Practitioner Data Bank, 2001 Report.

³⁸ Kathleen O’Leary and Scott Morgan, *Health Care State Rankings 2001*, Morgan Quitno Press, 2001.

³⁹ Health Professional Shortage Area database maintained by the Bureau of Primary Health Care, U.S. Department of Health and Human Services, on-line at: <http://bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm>

⁴⁰ Daniel R. Hawkins Jr. and Sara Rosenbaum, “Lives in the Balance: A National, State and County Profile of America’s Medically Underserved,” report for the National Association of Community Health Centers, Washington, D.C., February 1992.

⁴¹ National Practitioner Data Bank, *2001 Annual Report*. Cumulative median is the median value of all the awards in a data range. In this case, it is all the malpractice payouts in a state from September 1990, the date when the NPDB started collecting payout data, to December 2001.

⁴² Kathleen O’Leary and Scott Morgan, *Health Care State Rankings 2001*, Morgan Quitno Press, 2001.

⁴³ “Statement to the Subcommittee on Health Committee on Energy and Commerce, U.S. House of Representatives, Re: Assessing the Need to Enact Medical Liability Reform,” American Medical Association, presented by Donald J. Palmisano, Feb. 27, 2003.

⁴⁴ San Diego County Medical Society, “Is There A Doctor In The House? San Diego’s Looming Physician Shortage,” Dec. 4, 2002.

⁴⁵ 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).

⁴⁶ *PIAA Data Sharing Report*, Report 7, Part 10.

⁴⁷ 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

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- ⁶⁷ Congressional Budget Office, Cost Estimate for H.R. 5, HEALTH Act of 2003, ordered by the House Committee on the Judiciary, submitted March 10, 2003
- ⁶⁸ Based on Public Citizen interviews with plaintiff attorneys.
- ⁶⁹ See Vidmar, *Medical Malpractice and the American Jury* (1995).
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- ⁷¹ Posner et al, "Variation in Expert Opinion in Medical Malpractice Review," 85 *Anesthesiology* 1049 (1996).
- ⁷² Congressional Budget Office, *supra*.
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