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

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Congress Watch
February 2003

Acknowledgments

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About Public Citizen

Public Citizen is a 125,000 member non-profit organization based in Washington, D.C., with nearly 4,000 members in Texas. We represent consumer interests through lobbying, litigation, research and public education. Founded by Ralph Nader in 1971, Public Citizen fights for consumer rights in the marketplace, safe and affordable health care, campaign finance reform, fair trade, clean and safe energy sources, and corporate and government accountability. Public Citizen has five divisions and is active in every public forum: Congress, the courts, governmental agencies and the media. Congress Watch is one of the five divisions.

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Executive Summary

The Texas Medical Association and its political allies have made a number of sensational allegations about what they call a malpractice "crisis." We agree that there is a *temporary* "crisis" and malpractice insurance premium costs have spiked over the last two years. But arguments that it has been caused by "frivolous malpractice claims," or "abusive" lawsuits by consumers have no basis in fact.

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

1) The most significant, long-term malpractice "crisis" faced by Texans 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 cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

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

Highlights of this report include:

- **The cost of medical negligence to Texas patients and consumers is considerable, especially when measured against the cost of malpractice insurance to Texas doctors.** Extrapolating from Institute of Medicine (IOM) findings, we estimate that there are 3,260 to 7,261 preventable deaths in Texas each year that are due to medical errors. The costs resulting from preventable medical errors to Texas residents, families and communities are estimated at $1.3 billion to $2.2 billion each year. But the cost of medical malpractice insurance to Texas doctors is only $421.2 million a year.

- **The total number of Texas malpractice claims has dropped for two consecutive years.** Over the past 10 years for which statistics are available from the State Board of Medical Examiners, Texas saw its greatest number of malpractice claims in 1993 – almost a decade ago. This number fluctuated in subsequent years, reaching its second highest point in 1999, but the number of claims decreased in both 2000 and 2001.

- **"Repeat offender" doctors are responsible for the bulk of malpractice payments.** According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 6.5 percent of Texas doctors have made two or more malpractice payments to patients. These repeat offender doctors are responsible for 51.3 percent of all payments. Overall, they have paid out more than $1 billion in damages. Even more disturbing, just 2.2 percent of Texas doctors (845), each of whom has paid three or more malpractice claims, are responsible for 24.9 percent of all payments.

- **Repeat offender doctors suffer few consequences in Texas.** The Texas state government and the state's health-care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions have been few and far between for Texas physicians. Only 15.5 percent of those doctors who made four or more malpractice payments have been disciplined by the Texas State Board of Medical Examiners. Only 25.4 percent of those doctors who made six or more malpractice payments were disciplined.

- **Where's the doctor watchdog?** Texas ranks 32nd among all 50 states and the District of Columbia when its diligence in taking disciplinary action against doctors is measured. The rate of serious actions by the Texas State Board of Medical Examiners in 2001 – 2.5 per 1,000 physicians – is barely one-quarter of the rate in Arizona, the top-ranked state with 10.5 serious actions per 1,000 physicians.

- **Texas provides incomplete reports about doctor mistakes and offenses.** The Texas State Board of Medical Examiners provides only limited information about doctors who have committed offenses or medical errors. This shortcoming is highlighted when the information it provides is compared with reports developed for Public Citizen's own website, www.questionabledoctors.org.

- **No exodus of physicians from Texas is evident.** Although the Texas Medical Association has circulated an unsubstantiated estimate that more than half of the state's doctors plan to quit practicing in response to rising malpractice premiums, official state statistics show that the number of doctors in Texas has been increasing steadily. Between 1997 and 2002, the number of physicians and osteopaths practicing in Texas increased from 31,459 to 37,188 – an increase of 18.2 percent.

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

- **Financial management problems at major insurers compounded Texas' malpractice worries.** Pressure on physicians' premiums intensified during 2001 and 2002 as the number of malpractice insurers in Texas dropped from 17 to four. In at least three noteworthy cases, the departing companies had severe cash-flow problems that went beyond their medical liability businesses.

- **Insurance companies and their lobbyists admit caps on damages won't lower malpractice premiums.** Caps on damages for pain and suffering will significantly lower awards paid to catastrophically injured patients. But because such truly severe cases comprise a small percentage of medical malpractice claims, and because the portion of the insurance premiums that pay 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, and have said so on numerous public occasions.

- **Rather than facing "runaway litigation," doctors benefit from a claims gap.** A landmark Harvard Medical Practice Study and other studies have found that only a small percentage of medical errors result in lawsuits. Twelve years ago, Harvard researchers found that only one in 7.6 preventable medical errors committed in hospitals resulted in a malpractice claim. Researchers replicating this study made similar findings in Utah and Colorado. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims. In other words, for every six medical errors only one claim is filed.

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

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

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

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

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

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

Introduction: Misleading the Public to Escape Responsibility for Negligence

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

For the past year, physicians in Texas have received assistance from political allies in pushing for legal changes that would restrict the rights of patients to receive compensation when they have suffered from medical malpractice. The campaign has included orchestrated protest rallies at county courthouses,[1] irresponsible predictions about the state's impending "medical meltdown,"[2] self-serving rhetoric about "frivolous" or "abusive" malpractice lawsuits,[3] and undocumented claims that hundreds of doctors are planning to abandon their practices.[4]

Last year, after Gov. Rick Perry vetoed insurance-related legislation supported by physicians, the Texas Medical Association supported his opponent in the general election.[5] This year, Perry has declared a malpractice "emergency" – a move that bestows top priority to the doctors' proposals during the Legislature's session.

Linking their efforts with Texas business lobbyists, who are pursuing a broad set of anti-consumer legal restrictions, physicians are advocating a $250,000 "cap" on the amount an injured patient can receive for pain-and-suffering.[6] To give their campaign added muscle, the Texas Medical Association has hired a team of top-gun lobbyists – including the state's former Health and Human Services Commissioner, the former Insurance Commissioner, and the former Texas Secretary of State.[7]

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

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

The Costs of Medical Malpractice to Texas Patients & Consumers vs. Texas Doctors

In 1999, the Institute of Medicine (IOM) estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors.[8] 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 Texas should be measured by the cost to patients and consumers, not the premiums paid by doctors to their insurance companies. Extrapolating from the IOM findings, we estimate that there are 3,260 to 7,261 preventable deaths in Texas each year that are due to medical errors. The costs resulting from preventable medical errors to Texas residents, families and communities are estimated at $1.3 billion to $2.2 billion each year. But the cost of medical malpractice insurance to Texas doctors is $421.2 million a year.[9] [See Figure 1]

Figure 1

3,260 - 7,261

Preventable Deaths Due to Medical Errors Each Year

$1.3 billion - $2.2 billion

Costs Resulting from Preventable Medical Errors Each Year

$421.2 million

Cost of Texas Doctors' Annual Medical Malpractice Premiums

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

The Annual Number of Malpractice Claims Has Decreased in Texas

Medical and business leaders have quoted a claim by the American Medical Association that Texas is one of 12 states facing a so-called medical malpractice "crisis" characterized by an explosion of claims.[10] An examination of official state data, however, reveals a cycle in which the number of claims peaked three years ago and has decreased ever since.

- **The total number of Texas malpractice claims has dropped for two consecutive years**. Over the past 10 years for which statistics are available, Texas saw its greatest number of malpractice claims in 1993 – almost a decade ago. This number fluctuated in subsequent years, reaching its second highest point in 1999, but the number of claims decreased in both 2000 and 2001.[11] [See Figure 2]

- **State's largest insurer already has reported a turnaround.** The Texas Medical Liability Trust (TMLT), the state's largest medical malpractice insurer, reported to the Department of Insurance that despite losses in 2000 and the first half of 2001, it had made money in the third quarter of 2001, the last quarter for which it could provide statistics.[12]

Figure 2

Number of Medical Malpractice Claims per Year in Texas

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Claims	5,483	5,916	4,641	5,407	3,532	3,314	4,596	5,715	4,884	4,083

Source: Professional Liability Statistics, Texas State Board of Medical Examiners. This comparison cites the greatest number of claims listed for each given year, according to the Texas State Board of Medical Examiners' Professional Liability Statistics for 1993-2002. Annual totals fluctuate over the long-term as inactive claims are removed and claims for some years are filed after the fact.

Repeat Offender Doctors Are Responsible for Half of Medical Malpractice

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

- According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 6.5 percent of Texas' doctors have made two or more malpractice payments to patients.[13] These repeat offender doctors are responsible for 51.3 percent of all payments. Overall, they have paid out more than $1 billion in damages. Even more disturbing, just 2.2 percent of Texas' doctors (845), each of whom has paid three or more malpractice claims, are responsible for 24.9 percent of all payments. [See Figure 3]

Figure 3

Number of Medical Malpractice Payments by Texas Doctors 1990 – 2002

Number of Payment Reports	Number of Doctors that Made Payments	Percent/Total Doctors (38,352)	Total Number of Payments	Total Amount of Payments	Percent of Total Number of Payments
All	8,641	22.5%	12,628	$2,228,312,200	100.0%
1	6,131	16.0%	6,131	$1,129,559,700	48.6%
2 or More	2,510	6.5%	6,497	1,098,752,500	51.3%
3 or More	845	2.2%	3,167	499,569,550	24.9%
4 or More	322	0.8%	1,598	243,297,300	12.7%
5 or More	132	0.3%	838	119,406,300	6.6%

Source: National Practitioner Data Bank Annual Reports, Sept. 1, 1990-Sept. 30, 2002. (For these calculations, Public Citizen employs American Medical Association statistics from 1995, midway through the time period, for the total of non-federal, licensed doctors in Texas.)[14]

Repeat Offenders Suffer Few Consequences

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

- Only 15.5 percent of those doctors who made four or more malpractice payments were disciplined by the Texas State Board of Medical Examiners. Only 25.4 percent of those doctors who made six or more malpractice payments were disciplined.[15]

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

- **Physician Number 35809** settled seven malpractice lawsuits between 1992 and 2001 involving improper performance of treatment, three incidents of failure to diagnose, two incidents of failure to treat, two incidents of improper performance of surgery, and unnecessary surgery. The damages add up to $1,527,500.

- **Physician Number 35846** settled nine malpractice lawsuits between 1992 and 2002 involving failure to diagnose, seven incidents of improper management of course of treatment, improper treatment, and failure to supervise treatment. The damages add up to $1,995,000.

- **Physician Number 36243** settled six malpractice lawsuits between 1990 and 1999 involving improper performance of surgery, improper treatment, an improper anesthesia related incident, improper surgery, improper performance of surgery, failure to diagnose, and improper management of medication regimen. The damages add up to $1,640,000.

- **Physician Number 36270** settled eight malpractice lawsuits between 1992 and 2002 involving two incidents of wrong diagnosis, surgery on the wrong body part, two incidents of improper surgery, improper treatment, improper performance of treatment, and unnecessary surgery. The damages add up to $2,925,000.

- **Physician Number 36361** settled eight malpractice lawsuits between 1991 and 2001 involving failure to treat, four incidents of improper performance of surgery, unnecessary surgery, improper surgery, and a miscellaneous incident. The damages add up to $2,571,250.

- **Physician Number 36876** settled seven malpractice lawsuits between 1991 and 2000 involving improper treatment, two incidents of surgery, delay in diagnosis, delay in surgery, three incidents of improper management of surgical patient, and improper positioning of surgical patient. The damages add up to $2,466,250.

- **Physician Number 37234** settled six malpractice lawsuits between 1993 and 1999 involving wrong medication ordered, three incidents of improper performance of surgery, improper surgery, delay in treatment, and failure to maintain infection control. The damages add up to $1,697,500.

- **Physician Number 37941** settled 26 malpractice lawsuits between 1994 and 2001 involving four incidents of retained foreign body in surgical patient, 14 incidents of improper performance of surgery, four incidents of wrong treatment performed, two incidents of failure to diagnose, two incidents of improper treatment, and two incidents of improper monitoring. The damages add up to $4,040,000.

- **Physician Number 68177** settled six malpractice lawsuits between 1995 and 1997 involving three incidents of improper surgery, surgery on the wrong body part, improper performance of surgery, and two incidents of improper treatment. The damages add up to $2,782,500.

- **Physician Number 162558** settled six malpractice lawsuits between 2000 and 2002 involving five incidents of failure to diagnose and one incident of wrong diagnosis. The damages add up to $1,450,000.

Where's the Doctor Watchdog?

In 2001, only 105 doctors in Texas had serious sanctions levied against them by the Texas State Board of Medical Examiners for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses and other offenses, according to an ongoing Public Citizen project that tracks "Questionable Doctors" in Texas and other states.[16] [See Appendix]

- **Texas ranks in the bottom half of states for its discipline of physicians.** The Texas State Board of Medical Examiners is dangerously lenient with doctors, repeatedly letting serious and sometimes repeat offenders off the hook. For more than 10 years, Public Citizen's Health Research Group has ranked state medical boards based on the rate of serious disciplinary actions (revocation, suspension, surrender and probation) per 1,000 doctors in the state. Texas ranks 32nd of all states when its diligence in taking disciplinary actions is measured. The rate of serious actions by the Texas State Board of Medical Examiners in 2001 – 2.54 per 1,000 physicians – is barely one-quarter of the rate in Arizona, the top-ranked state with 10.52 serious actions per 1,000 physicians.[17]

- **Texas provides incomplete reports about doctor mistakes and offenses.** The Texas State Board of Medical Examiners provides only limited information about doctors who have committed offenses or medical errors. As examples, below are five reports on doctors currently licensed to practice medicine in Texas despite having committed serious offenses. In each case, information developed for Public Citizen's questionabledoctors.org is followed by the information that is available from the Texas State Board of Medical Examiners' website. [18]

Doctor A

From www.questionabledoctors.org: Engaged in a sexual relationship with four patients and also admits he has a history of alcoholism; he represents that he has never treated patients while under the influence of alcohol. Was given 60 months probation after suspension was stayed and restrictions were placed on his practice; category of offense: sex abuse.

From Texas State Board of Medical Examiners website: An agreed order was entered suspending the physician's license; however the suspension was stayed and he was placed on probation for five years under various terms and conditions. Action due to unprofessional or dishonorable conduct and inability to practice medicine with reasonable skill and safety to patients as a result of any mental or physical condition.

Doctor B

From www.questionabledoctors.org: Six patients filed lawsuits against him alleging substandard care: on 5/29/95 during surgery, a patient suffered severe burns from the inside out of her lower right leg with subsequent infection; the case was non-suited with no payment made to the patient. In 7/92 patient filed a lawsuit alleging that Doctor B was negligent in improperly placing the needle for a nerve block by placing it through the

patient's lung pleura and failing to diagnose properly and treat the pneumothorax following the nerve block; the case was settled for $10,000. On 7/9/93 after performing a hip replacement, the patient noticed a drop foot and filed a lawsuit alleging that he negligently damaged her nerves. On 9/23/94, a patient filed a lawsuit alleging that Doctor B negligently operated and fused the wrong level of patient's neck; the case was settled for $40,000. On 3/4/94 the doctor was unassisted by a general/vascular surgeon during a procedure in which he tore a vein; he reportedly attempted to stop the bleeding with the use of ligature clips, which caused further injury and bleeding. The patient lost four units of blood during the aborted procedure and within a few days developed deep vein thrombosis; the patient filed a lawsuit which was settled for $100,000. On 2/11/89 a patient sued alleging Doctor B was negligent in failing to obtain adequate closed reduction of a fracture; the case was settled for $35,000. The doctor denies that his care was below standard.

Public reprimand and suspension stayed for 36 months probation with terms and conditions.

From Texas State Board of Medical Examiners website: An agreed order was entered suspending the physician's license, staying the suspension, and placing the physician on probation for three years under certain terms and conditions. It is further ordered that the physician be publicly reprimanded. Action due to the practice of medicine inconsistent with public health and welfare.

Doctor C

From www.questionabledoctors.org: Doctor administered an overdose of Ketalar and Valium to an outpatient surgical patient, placing her under general anesthesia and not conscious sedation as he intended. He and his staff failed to properly monitor and manage her once she was placed under general anesthesia. The overdose he administered caused her to go into respiratory arrest and she suffered severe anoxic brain injury and died three days later. No one in his operating room was advanced cardiac life support (ACLS) certified. Doctor C did not have sufficient knowledge of and skill with anesthesiology to anticipate the life-threatening complications which developed during this surgery.

Suspension [24 months] and probation [96 months]. Cause of action was substandard care.

From Texas State Board of Medical Examiners website: Medical license temporarily suspended. The disciplinary panel concluded that Dr. C's continuation in the practice of medicine would constitute a continuing threat to the public welfare…. Dr. C's license was suspended for 10 years and probated for the last eight years under various terms and conditions, due to professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

Doctor D

From www.questionabledoctors.org: He pled guilty to one count of deadly conduct, a third-degree felony. Doctor D's conviction was the result of him driving by his former business partner's home and discharging several rounds from his pistol. He served 120 days in jail and is currently on maximum supervised probation for eight years; additionally, he

must perform 600 hours of community service, pay a $5,000 fine, pay restitution to the family of the home, and participate in psychiatric counseling for three years. Doctor admitted to a total of four drive-by shooting incidents of his former business partner's garage and automobiles.

Put on five years probation by the medical board because of this criminal conviction.

From Texas State Board of Medical Examiners website: An agreed order was entered, suspending the physician's license. However, the suspension was stayed and the physician's license is placed on probation for five years under certain terms and conditions. Action due to unprofessional conduct that is likely to deceive or defraud the public or injure the public.

Doctor E

From www.questionabledoctors.org: Arrested for writing prescriptions in exchange for sexual favors. Doctor E pled guilty to fraudulent delivery of a prescription for a non-medical purpose and was given deferred adjudication, a $2,000 fine and placed on community supervision for four years. Suspension stayed. Probation and $1,000 fine from medical board.

From Texas State Board of Medical Examiners website: An agreed order was entered suspending the physician's license; However, the suspension was stayed and physician placed on probation for five years under certain terms and conditions. Actions due to conviction of felony or crime of a lesser degree that involves moral turpitude, unprofessional or dishonorable conduct, and failure to practice medicine in an acceptable manner consistent with public health and welfare.

Physician Exodus from Texas Is Not Evident

The Texas Medical Association has circulated the unlikely estimate that more than half of the state's doctors plan to quit practicing in response to rising malpractice premiums. In fact, a spokesman for the doctors admits that the association has no statistics to support this claim, only "anecdotal reports."[19] Official statistics show that the number of doctors in Texas has been steadily increasing, *not* decreasing, in recent years.

- In 1997, there were 31,459 physicians and osteopaths practicing in Texas. By 2002, the number of licensed doctors living in-state climbed to 37,188, an increase of 18.2 percent. [20] [See Figure 4]

- In 2001 and 2002, as talk of a malpractice "crisis" escalated, Texas gained 1,570 doctors, according to the State Board of Medical Examiners – the largest increase recorded during the past five years.

- According to the American Medical Association, Texas only had 188 physicians per 100,000 residents in 1990. By 2001, however, that ratio had increased to 219 physicians per 100,000 residents.[21]

Figure 4

Licensed Physicians and Osteopaths with Texas Addresses

Year	Number of Licensed Doctors
1997	**31,459**
1998	32,871
1999	33,622
2000	34,697
2001	35,618
2002	**37,188**

Source: Texas State Board of Medical Examiners

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

For much of the 1990s, doctors benefited from artificially lower insurance premiums. According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, "What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income." IRMI also noted: "Clearly a business cannot continue operating in that fashion indefinitely."[22]

IRMI's findings were buttressed in a recent report by the West Virginia Insurance Commissioner. According to the Insurance Commission, "[T]he insurance industry is cyclical and necessarily competitive. We have witnessed these cycles in the Medical Malpractice line in the mid-'70s, the mid-80s and the present situation. This particular cycle is, perhaps, worse than previous cycles as it was delayed by a booming economy in the '90s and is now experiencing not just a shortfall in rates due to competition, but a subdued economy, lower interest rates and investment yields, the withdrawal of a major medical malpractice writer and a strong hardening of the reinsurance market. Rates will, at some point, reach an acceptable level to insurers and capital will once again flow into the Medical Malpractice market."[23]

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

- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.[24]

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

basic ability of insurance companies to underwrite new business or, for some companies, even to renew some existing policies can be impaired. This is because the capital needed to support the underwriting of risk has been depleted through losses. The current market began to harden in 2001, following an unusually prolonged period of soft market conditions in the property-casualty section in the 1990s. The current hard market is unusual in that many lines of insurance are affected at the same time, including medical malpractice. As a result, premiums are rising for most types of insurance. The increases have taken policyholders by surprise given that they came after several years of relatively flat to decreasing prices.[25]

- **Management problems at major insurers compounded Texas' malpractice worries.** Pressure on physicians' premiums intensified during 2001 and 2002 as the number of malpractice insurers in Texas dropped from 17 to four.[26] In at least three of these cases – involving insurers that once combined to cover nearly 20 percent of the Texas market[27] – the departing companies had severe cash-flow problems that went beyond their medical liability businesses. The Frontier Insurance Group ceased insuring doctors after reporting to the Securities and Exchange Commission (SEC) in 2001 that it had tens of millions of dollars in losses across a range of divisions, most of which were unrelated to malpractice.[28] Phico Insurance Co. was placed into liquidation after the Pennsylvania Insurance Department alleged that Phico directors had ignored signs of financial trouble and pressured the board to pay dividends at a time when the company's surplus "was declining drastically."[29] And the St. Paul Companies, one of the nation's largest medical liability insurers at the time, withdrew from the market after reporting to the SEC that it had $84 million of exposure from the Enron collapse and held another $23 million in unsecured Enron debt. In August 2001, St. Paul's quarterly earnings report also warned that it faced liability for incalculable asbestos claims resulting from its ownership of two subsidiaries, Western MacArthur and USF&G.[30] Within the year, St. Paul had agreed to pay $988 million to settle those claims.[31]

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

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

- **Premium on the Truth:**

  "Insurers never promised that tort reform would achieve specific savings." – American Insurance Association[32]

  "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." – Sherman Joyce, president of the American Tort Reform Association[33]

  "Many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years." – Victor Schwartz, general counsel to the American Tort Reform Association[34]

- **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.[35]

- **Mississippi:**

  "Regardless of what may result from the ongoing tort reform debate, please remember that such proposed public policy changes are critical for the long-term, but do not provide a magical 'silver-bullet' that will immediately affect medical malpractice insurance rates … The 2003 rate change [a 45 percent increase] would happen regardless of the special session outcome." – Medical Assurance Company of Mississippi[36]

- **Nevada:**

  "The primary insurer for Las Vegas obstetricians, American Physicians Assurance, has no plans to lower premiums for several years, if ever, said broker Dennis Coffin." – The Las Vegas Review-Journal[37]

  "[John Cotton of the Nevada Physicians' Task Force] noted that even if the bill reflected a cap of $5, there would not be an immediate impact on premiums." – Minutes of the Nevada Assembly Committee on Medical Malpractice Issues[38]

- **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."[39]

  The New Jersey Medical Society commissioned Tillinghast-Towers Perrin, a leading actuarial firm, to analyze the effects of a $250,000 cap on pain and suffering damages. The findings: "We would expect that a $250,000 cap on non-economic damages will produce some savings, perhaps in the 5 percent to 7 percent range for physicians." – Letter from Tillinghast-Towers analysts James Hurley and Gail Tverberg[40]

- **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.[41]

  "The stroke of the governor's pen [enacting caps on damages] will not result in immediate lowering of rates by responsible companies." – Frank O'Neil, spokesman for Birmingham, Ala.-based Medical Assurance[42]

- **Wyoming:**

  During a hearing on medical malpractice insurance issues, Bruce Crile of the Doctors' Company and Melissa Dennison of OHIC Insurance Company testified that insurance rates would not drop if caps on damages were imposed. "Both the Doctors' Company and OHIC's actuaries say a cap of $500,000 is meaningless for purposes of ratemaking. Even with caps enacted premiums will still increase, but with predictability of the risk there will be a moderating of rate increases." – Minutes of the Wyoming Legislature's Joint Labor, Health and Social Services Interim Committee[43]

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

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

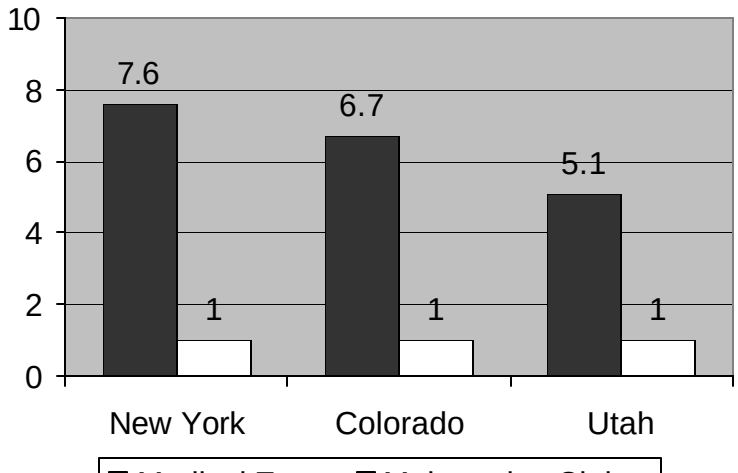
- **A landmark Harvard Medical Practice Study found that only a small percentage of medical errors result in lawsuits.** Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State compared medical records to claims files. They found that only one in 7.6 medical errors committed in hospitals results in a malpractice claim.[44] Researchers replicating this study made similar findings in Colorado and Utah.[45] [See Figure 5]

- **Actual numbers collected by government agencies show a similar claims gap.** A Florida statute requires hospitals to report "adverse incidents," defined as "an event over which health care personnel could exercise control" that results in death or injury. Tables prepared by Florida's Agency for Health Care Administration have compared reports of adverse incidents to filing of new malpractice claims. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims.[46] In other words, for every 6 medical errors only 1 claim is filed. [See Figure 6]

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

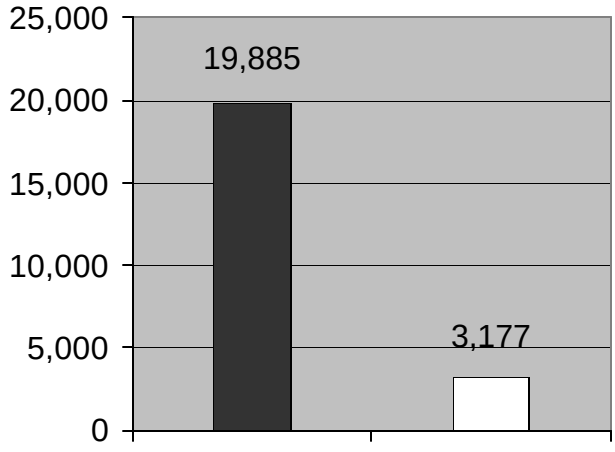
- **The compensation gap helps explain why, although medical injuries are costly, expenditures on medical liability comprise less than one percent of overall health care costs.** As the Congressional Budget Office reported, "Malpractice costs account for a very small fraction of total health care spending; even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums. In addition, some of the savings leading to lower medical malpractice premiums—those savings arising from changes in the treatment of collateral-source benefits—would represent a shift in costs from medical malpractice insurance to health insurance."[48]

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



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

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



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

Few Malpractice Lawsuits Are "Frivolous"

Physicians in Texas have been quick to classify patient lawsuits as "frivolous" or "abusive."[49] In reality, medical malpractice cases are brought on a contingency fee basis, meaning the attorney receives payment only in the event there is a settlement or verdict. If the claim is closed without payment, the attorney does not receive a fee. Since attorneys must earn money to stay in business, it follows that they would not intentionally take on a non-meritorious case.

- **The high cost of preparing a medical malpractice case discourages frivolous claims – and meritorious claims as well.** Medical malpractice cases are very expensive for plaintiffs' attorneys to bring, with out-of-pocket costs for cases settled at or near the time of trial (when most cases are settled) ranging from $15,000 to $25,000.[50] If the case goes to trial, the costs can easily be doubled.[51] 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.[52] 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.[53] The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, "These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care." The percentage of all medical malpractice claims that go to trial is only 6.6 percent, according to PIAA, meaning that the parties and their attorneys ultimately reach agreement about liability five times more often than neutral doctors do. If truly frivolous lawsuits were being pursued, the proportion of claims going to trial would exceed the 38 percent of claims on which even doctors will disagree.

- **The costs of defending claims that are ultimately dropped are not unreasonable.** Medical liability insurers have complained about the costs of defending cases that are ultimately dropped. But the professional obligation of lawyers to exercise due diligence is essentially identical to the duty of physicians. The lawyer must rule out the

possibility of proving medical negligence before terminating a claim, just as doctors must rule out the possibility of illnesses suggested by their patients' symptoms. The doctor performs his duty by administering tests; the lawyer performs hers by using discovery procedures. Both processes can lead to dead ends. But plaintiffs' lawyers have no financial incentive to abuse the litigation process: they are using their own time and money to pursue discovery activities, and are only paid for work on behalf of clients whose cases are successful.

Capping Damages Is a False "Solution"

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

- **"Non-economic" damages are not as easy to quantify as lost wages or medical bills, but they compensate real injuries.** So-called "non-economic" damages are awarded for the pain and suffering that accompany any loss of normal functions (e.g. blindness, paralysis, sexual dysfunction, lost bowel and bladder control) and inability to engage in daily activities or to pursue hobbies, such as hunting and fishing. This category also encompasses damages for disfigurement and loss of fertility. According to 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.[54] 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.[55] PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications.[56] 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.[57]

- **Capping awards hurts women the most.** Limiting medical malpractice awards for non-economic injury has a disproportionate impact on women – especially as it relates to a woman's ability to have children, according to a study by the director of the Insurance Law Center at the University of Connecticut School of Law. "This is so for two main reasons," reported Tom Baker, Connecticut Mutual Professor of Law. "First, the largest part of the economic damages in many tort claims is lost wages, and women earn on average less money than men. Second, the most significant effect of many medical and other injuries inflicted on women is harm to reproductive capacity. Although this may be hard to believe, harm to reproductive capacity does not entitle women to receive significant economic damages … [and] lowering the price of making a women infertile cannot be sound policy."[58]

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

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

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

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

  > Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.
  >
  > A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments that are disproportionately likely to experience malpractice claims. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending. Although the provisions of H.R. 4600 could result in the initiation of fewer lawsuits, the economic incentives for individual physicians or hospitals to practice defensive medicine would appear to be little changed.[59]

- **Defensive medicine hasn't prevented wrong-patient surgery.** New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.[60] There were nine such instances in Florida in 2001.[61] In trying to

determine how such shocking errors could occur, researchers analyzed one case in detail. The case study determined that medical personnel had ignored "many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure." In this case, "defensive medicine" measures would have included follow-up questioning or record-checking when the patient told personnel she had not been admitted for cardiac treatment. Surely if the medical providers were frightened of lawsuits they would have made such minimal inquiries.

- **Defensive medicine hasn't prevented medication errors.** An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful.[62] 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."[63]

- **Defensive medicine hasn't prevented mammography errors.** The *New York Times* reported in June 2002 some very disturbing facts about errors committed by radiologists in reading mammograms.[64] Studies indicate that some doctors and clinics miss as many as one in three cancers. Despite the possibility of lawsuits, doctors with no aptitude for mammography continue to read mammograms. Clinics continue to employ doctors who read too few mammograms to keep their skills sharp. It appears that only reviews by regulators spur doctors and clinics to meet minimum standards.

- **Defensive medicine hasn't prevented hospital infections.** The *Chicago Tribune* reported on July 21, 2002 that some 75,000 Americans die each year because of infections acquired in hospitals that "were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses."[65] 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"?[66] Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by five to nine percent.[67]

- **Defensive medicine hasn't caused hospitals to keep nursing staffs up-to-strength.** Two reports published in the past six months concluded that patients in hospitals where nurses had heavier workloads had a higher risk of dying.[68] One report found specifically that each additional patient per nurse corresponded to a 7 percent increase in both patient mortality and deaths following complications.[69] Nevertheless, nursing shortages persist, even though the defensive medicine theory predicts over-staffing.

Solutions to Reduce Medical Errors

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

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

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

Implement Patient Safety Measures Proposed by the Institute of Medicine

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

- **Medication errors are among the most common preventable mistakes, but safety systems have been put in place in very few hospitals.** Although experts using the systems approach have identified a number of promising strategies to reduce malpractice, few have been implemented. Experts have estimated that more than 950,000 serious drug errors occur annually in hospitals alone.[70] Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,[71] 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.[72]

- **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.[73]

- **Surgery performed on the wrong part of the body, to the wrong patient, and performing the wrong procedure on a patient are all completely preventable, yet continue to occur.** Such mistakes should *never* happen, according to a special alert reissued December 5, 2001 by the Joint Commission on Accreditation of Healthcare Organizations.[74] 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.[75]

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.[76] After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10 percent blood alcohol level.[77] 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.[78] 45 percent of residents who sleep less than four hours per night report committing medical errors.[79] 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.[80] If the maximum workweek for residents was limited to 80 hours, it could considerably reduce mistakes due to fatigue and lack of supervision.

Improve Oversight of Physicians

Public Citizen has long sought greater consumer access to information about doctors, and there have been recent improvements in making that information available. Most state medical boards now provide some physician information on the Internet, but the information about disciplinary actions varies greatly, is often inadequate and can be difficult for people to access.[81]

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[82] and on the website www.questionabledoctors.org too little discipline is being done. Too many state medical boards, despite their duty to protect the public, still believe their first responsibility is to rehabilitate "impaired physicians" and shield them from the public's prying eyes. Fewer than one-half of 1 percent of the nation's doctors face any serious state sanctions each year. The 2,708 total serious disciplinary actions a year, the number state medical boards took in 2001, are a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by medical errors annually.

State discipline rates ranged from 10.52 serious actions per 1,000 doctors (Arizona) to 0.73 actions per 1,000 physicians (District of Columbia), a 14.4-fold difference between the best and worst states. If all the boards did as good a job as the lowest of the top five boards, Kentucky's

rate of 6.32 serious disciplinary actions per 1,000 physicians, it would amount to a total of 5,089 serious actions a year. That would be 2,381 more serious actions than the 2,708 that actually occurred in 2001. It is likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top performances.

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

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

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

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

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

Solutions to Make Insurance Rates More Predictable

The following recommendations for state insurance regulators to implement have been made by J. Robert Hunter, Director of Insurance for the Consumer Federation of American, on behalf of Americans for Insurance Reform:[83]

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.

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

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

Appendix:
Public Citizen's "Questionable Doctors" Database

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

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

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

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

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

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

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[50] Based on Public Citizen interviews with plaintiff attorneys.
[51] See Vidmar, Medical Malpractice and the American Jury (1995).
[52] According to the Physician Insurers Association of America, expert witnesses in a medical malpractice case are paid on average over $4,800.
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Emotional damage only (fright; no physical injury);
Temporary insignificant (lacerations, contusions, minor scars);
Temporary minor (infections, fall in hospital, recovery delayed);
Temporary major (burns, surgical material left, drug side-effects);
Permanent minor (loss of fingers, loss or damage to organs);
Permanent significant (deafness, loss of limb, loss of eye, kidney or lung);
Permanent major (paraplegia, blindness, loss of two limbs, brain damage);
Permanent grave (quadriplegia, severe brain damage, lifelong care or fatal prognosis);
Death
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