

# *Empty Promises:*

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The Failure of the New York State  
Health Department to Monitor  
Medical Errors

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New York State's Failure to Adequately  
Protect Patients

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***Empty Promise:***  
**The Failure of the New York State Health Department to  
Monitor Medical Errors**

**New York State's Failure to Adequately Protect Patients**  
***Executive Summary***

It has been a little over five years since the release of the National Academy of Sciences' Institute of Medicine's (IoM) landmark report, *To Err is Human*. Authored by a prestigious group of national experts in patient safety and quality improvement, the report documented for the first time the staggering number of medical errors occurring in the nation's hospitals. The IoM estimated that between 44,000 and 98,000 patients die each year in U.S. hospitals as a result of medical errors, many of which are preventable. The report also stated that the nation spends as much as \$29 billion in treating those injured by medical mistakes.

The IoM recommended that the nation work to cut in half the number of medical errors in hospitals within five years. On January 24, 2000, Health Commissioner Novello pledged to meet that goal in New York State.

Five years later, there is no evidence that such progress has been made, and in fact, the Department has no program in place that measures the frequency and severity of medical errors occurring in the licensed healthcare facilities it oversees. It is that failure to monitor the safety and quality of the New York State health care system that is at the heart of our criticism of the Department.

During the past five years the medical and hospital lobbies have ratcheted up their rhetoric over what they claim is a "malpractice crisis" that purportedly is putting health providers out of business. While there is little or no evidence to back up these claims, policymakers continue to be deluged by dire warnings of the impact of this "crisis" on New Yorker's access to health care. As recently as last week, at hearings on reauthorization of the Health Care Reform Act (HCRA), legislators were besieged with "doom and gloom" predictions of hospital closures and loss of health care services.

In their efforts to advance legislation that would limit the legal rights of the most seriously injured patients, it is noteworthy that there is no mention of the health care system's failure to make patient safety a priority. A safer health care system would substantially reduce the amount of malpractice

that occurs – reducing harm and the cost of insurance – a “win-win” for both patients and providers.

Billions of public dollars are spent on the delivery of health care services through HCRA funding mechanisms; yet as the state begins to debate how to allocate HCRA funds for the next few years, it does not have oversight programs that would ensure that the public’s money purchases safe, high-quality care. It is simply inexcusable that five years after the IoM report and Commissioner Novello’s empty promise, New York is poised to once again spend billions of dollars on health care, while ignoring an epidemic of medical errors.

**This report examines the state of hospital patient safety in New York and the action (or more accurately, inaction) of the New York State Health Department to safeguard consumers. This report finds that the Health Department has failed to deliver on the Commissioner’s promise in 2000 to reduce medical errors and, in fact, cannot even tell New Yorkers whether they are any safer today than five years ago.**

Specifically, this report finds:

- **The New York State Health Department has apparently failed to meet its goal of a 50% reduction in hospital medical errors. Sadly, it still has no program to adequately track such errors.** In January 2000, Health Commissioner Novello pledged to cut medical errors in half in five years. The Department has no proof of success in this area and has not yet developed a program that comprehensively tracks such errors. Indeed, there is no reference to medical error harm reduction on the Department’s website. Obviously, it is impossible to cut the number of errors in half if the state does not even know how many are occurring in the first place!
- **Between 3,000 and 7,000 hospital patients in New York are killed annually due to medical mistakes—an estimated total of between 15,000 and 35,000 since 2000.** The 1999 Institute of Medicine (IoM) study estimated that between 44,000 and 98,000 American hospital patients were killed each year due to medical mistakes. Assuming that such errors are spread evenly across the nation, this translates to between 3,000 and 7,000 patients killed by medical mistakes in New York hospitals each year. During the five years since Health Commissioner Novello pledged to cut medical errors in half, it is likely that between 15,000 and 35,000 New York hospital patients have been killed by medical errors.

- **Between \$1 billion to \$2 billion are spent each year as a direct result of patients' injuries caused by medical mistakes in New York hospitals.** The IoM estimated that the nation spent between \$17 billion and \$29 billion annually to cover the additional health costs resulting from treating injured patients. In New York, this translates into an additional \$1 billion to \$2 billion spent annually to treat these injuries. Since 2000 this means that an additional \$5 to \$10 billion was spent to treat preventable injuries in New York hospitals.
- **New York State hospitals fail to adequately report "incidents" to the Health Department.** According to a 2004 audit by the New York State Comptroller's office, four years after the Department's pledge to cut medical errors in half, hospitals were not fully complying with requirements to report "incidents" that occur in hospitals – such as injuries that occur due to medical mistakes.
- **One-third of New York hospitals may have violated federal law by failing to report to the federal government limitations imposed on any physicians' clinical privileges between 1990 and 2003.** Hospitals' failure to adequately report incidents to state authorities is matched by an apparent failure to report as required by federal law. According to the federal government, one-third of New York State hospitals have not reported taking any disciplinary action against any physician in the years from 1991 through 2003! Either these hospitals have had no problems with their physicians (which given the huge number of errors seems unlikely), they are not reporting the ones that do occur, or they are not punishing medical misconduct. In any case, this data shows an apparently careless approach to patient safety.
- **Despite the large number of medical mistakes, very few New York State physicians were reported to have had their clinical privileges restricted to the federal government.** There are very few reports sent to the federal government by New York State hospitals and other health entities that have taken serious disciplinary actions against physicians. According to this report's analysis, since 1991 health care entities have not punished more than 105 physicians in any one year. Typically, only between 40 and 79 physicians were sanctioned in New York.
- **The Health Department has failed to comply with a 1996 law and release hospital "report cards" to document the quality of**

**medical care in New York.** Not only have too many of New York's hospitals failed to follow state and federal laws, but also the Health Department itself has ignored a requirement in patient safety legislation passed in 1996. That law required the Department to develop hospital "report cards" that would have provided policymakers and the public with information on the quality of medical care at each institution. Eight years later – and despite repeated assurances by the Department that such "report cards" would soon be released – no such program exists.

There can be no better indicator of the Department's indifference to aggressively monitor hospitals' health quality than its failure to follow the Legislature's statutory directive in this area.

- **The hospital and medical lobbies argue that increasing malpractice premiums reduce patient access to care. However, New York State has one of the highest *per capita* number of doctors in the nation, with the pool of doctors growing at a significantly higher rate than the state's overall population.** From 1980 through 2003 the *per capita* number of active physicians practicing in New York increased 51%. During the period 1980 through 2003, the state's population grew a mere 9%.
- **National data shows that New York's number of physicians *per capita* is increasing at the national rate and at a rate faster than California.** According to data obtained from the American Medical Association, New York's increase in its *per capita* number of physicians matched the national average and far exceeded that of California – the state held up as a model of "reform" by the medical and hospital lobbies.
- **New York State significantly outpaces California, where malpractice insurance rates are lower (because of the enactment of Proposition 103 rate-making reforms), in the number of practicing physicians *per capita*.** The AMA and other liability cap advocates consider California a model for medical malpractice "reform," but lower insurance rates aren't enough to keep doctors in practice there. New York ranks 3<sup>rd</sup> in the number of overall doctors per 100,000 people, but California only ranks 18<sup>th</sup>.

**The New York State Health Department Has Apparently Failed to Meet Its Goal of a 50% Reduction in Medical Errors. In Fact, It Still Has No Program to Adequately Track Such Errors.**

On January 24, 2000, New York State Health Commissioner Antonia Novello pledged to meet the Institute of Medicine's goal of a 50 percent reduction in hospitals' medical errors within five years.<sup>1</sup>

Five years ago the National Academy of Sciences' Institute of Medicine's (IoM) landmark report, *To Err is Human*, was released. Authored by a prestigious group of national experts in patient safety and quality improvement, the report documented for the first time the staggering number of medical errors occurring in the nation's hospitals. The IoM estimated that between 44,000 and 98,000 patients die each year in U.S. hospitals as a result of medical errors, many of which are preventable. The report also stated that the nation spends as much as \$29 billion (1999 dollars) in treating those injured by medical mistakes.<sup>2</sup>

Based on the IoM estimates, as many as 7,000 New Yorkers are killed as the result of hospitals' medical errors, and the additional health care costs to treat those injuries could be as high as \$2 billion annually.

The Institute of Medicine called on the nation to cut medical errors in half over the next five years.<sup>3</sup> As mentioned above, New York State pledged to meet the IoM's ambitious goal.

Yet five years later there is no evidence that such progress has been made, and in fact, there is no evidence that the Department has any program in place to even begin to measure the incidence of medical errors in the licensed healthcare facilities it oversees. It is that failure to monitor the safety and quality of the New York State health care system that is at the heart of our criticism of the Department. Given that billions of taxpayer dollars are spent on the delivery of health care services through the Health Care Reform Act's funding mechanisms, it is inexcusable that the state continues to spend this money without having in place the oversight programs that would ensure that the money is well-spent.

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<sup>1</sup> New York State Health Department, "NYPORTS News & Alert," Issue #14, January 2004.

<sup>2</sup> National Academy of Sciences' Institute of Medicine, *To Err is Human: Building A Better Health Care System*, November 1999, p. 1.

<sup>3</sup> *Ibid*, page 3.

**Between 3,000 and 7,000 New York Hospital Patients Are Annually Killed Due To Medical Mistakes.**

In late 1999, the National Academy of Sciences Institute of Medicine (IoM) released its landmark report *To Err is Human*. The report examined the problem of medical errors in America’s health care system and called for dramatic reforms to bolster patient safety. In its report, the IoM, after reviewing all available studies, estimated that hospital patient deaths resulting from medical errors were a leading cause of death in America.

**Figure 1  
Leading Causes Of Death In America<sup>4</sup>**

<b>Cause of death</b>	<b>Number of deaths</b>
Heart disease	725,192
Cancer	549,838
Cerebrovascular diseases	167,366
Chronic lower respiratory diseases	124,181
<i>Deaths due to medical errors (high estimate)</i>	<i>98,000</i>
Accidents (unintentional injuries)	97,860
Diabetes mellitus	68,399
Influenza and pneumonia	63,730
Alzheimer’s disease	44,536
<i>Deaths due to medical errors (low estimate)</i>	<i>44,000</i>
Kidney disease	35,525
Septicemia	30,680

As the above chart shows, patient deaths resulting from medical mistakes in hospitals are as high as the fifth leading cause of death in America.

Assuming that hospitals’ medical mistakes consistently occur across the nation, this report estimates that between 3,000 and 7,000 New York hospital patients are killed annually due to medical errors. During the five years that the Department failed to monitor medical errors, between 15,000 and 35,000 New York patients have been killed.

<sup>4</sup> U.S. Centers for Disease Control and Prevention and the Institute of Medicine. From New York State Conference of Blue Cross and Blue Shield Plans, “The Facts About Medical Errors,” [www.nysblues.org](http://www.nysblues.org).

## **Between \$1 Billion to \$2 Billion Are Spent Annually to Treat New York Hospital Patients' Injuries Caused By Medical Mistakes.**

Furthermore, the IoM estimated that \$17 to \$29 billion is added to the nation's health bill for taking care of the medical needs of patients injured by medical mistakes.<sup>5</sup> The \$17-29 billion cost estimate dwarfs the aggregate of the medical malpractice premiums currently paid by physicians nationwide.<sup>6</sup>

Moreover, *the IoM estimates of injury and cost are considered by many experts to be low because the report did not look at medical errors occurring outside of hospitals.* For example, medical error reporting is not required in New York for errors occurring in outpatient clinics, physicians' offices and retail pharmacies. Nonetheless, the numbers are staggering. The IoM called for sweeping changes in order to substantially reduce the number of medical errors. Policy makers must focus on patient safety and reducing medical errors.

Assuming that the additional health care costs for treating injured hospital patients is spread evenly throughout the nation, this report estimates that between \$1 billion and \$2 billion is spent each year in New York to treat injuries resulting from medical errors. This staggering sum is a needless cost that could have been considerably reduced had the Department met its goal of reducing hospital errors.

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<sup>5</sup> National Academy of Sciences' Institute of Medicine, To Err is Human: Building A Better Health Care System, November 1999, p. 1.

<sup>6</sup> U.S. Department of Health and Human Services, Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System, July 2002, p. 7. Report estimates that nationally physicians annually spend \$6.3 billion on medical malpractice insurance premiums.

## New York State Hospitals Fail To Adequately Report “Incidents” to the Health Department.

### **New York Patient Occurrence Tracking System (NYPORTS)**

In 1985, the New York Legislature enacted a law establishing a hospital incident reporting system. Incident reporting was envisioned as a proactive way to identify and correct problems in hospitals *before they resulted in further injuries or deaths*. After several attempts to come up with a workable reporting system, the Health Department created the New York Patient Occurrence Tracking System (NYPORTS). NYPORTS was implemented statewide in 1998.<sup>7</sup>

### **NYPORTS information is out-of-date and underutilized.**

The release of the first NYPORTS report, in February 2001, found a high rate of hospital noncompliance with the Department’s reporting mandate. Commissioner Novello reacted by calling for higher sanctions for hospitals that ignored their reporting duties and pledged to publicly punish those hospitals that continue to violate the law. The Commissioner’s quote in the DOH news release read:

*“For those hospitals that have ignored these critical reporting requirements, which are in place to help reduce medical errors and, in essence, help save lives, we will identify you, single you out and sanction you in a public forum. Hospital noncompliance with these reporting requirements is unacceptable to this Department.”<sup>8</sup>*

**Comptroller’s Audit of the NYPORTS program shows continued serious under-reporting.** On September 28 2004, State Comptroller Hevesi released an audit of the NYPORTS program. The report found that while the Department had taken some action on improving NYPORTS reporting compliance, as promised by Commissioner Novello, the information on NYPORTS was not complete and often was not reported in a timely manner. These deficiencies result in a database that fails to live up to its potential as a valuable tool to improve the quality of patient care. The audit found that even though the Department has the ability to require noncompliant facilities to develop written plans of corrective action or may even publicly sanction the offending facilities, the Department has rarely done so. During the twenty-nine month period that the audit reviewed, only two medical facilities were sanctioned for their failure to report occurrences on NYPORTS.<sup>9</sup>

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<sup>7</sup> New York State Office of the State Comptroller, Department of Health: Maintaining Information on Adverse Patient Incidents at Hospitals and Clinics, 2003-S-27, September 28, 2004, p. 9.

<sup>8</sup> New York State Department of Health News Release, “State Health Department Study Shows That Majority of New York hospitals Are Not Reporting Adverse Incidents,” February 21, 2001.

<sup>9</sup> New York State Office of the State Comptroller, Department of Health: Maintaining Information on Adverse Patient Incidents at Hospitals and Clinics, 2003-S-27, September 28, 2004.

**One-third of New York Hospitals Failed to Report to the Federal Government Limitations on *Any* Physicians' Clinical Privileges Between 1990 and 2003, As Required by Law.**

**The National Practitioner Data Bank**

The National Practitioner Data Bank (NPDB) was put in place over a decade ago because of concern in the U.S. Congress that medical malpractice and the need to improve the quality of medical care had become nationwide problems that warranted greater efforts than any individual State could undertake. The intent was to improve the quality of health care by encouraging state licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from state to state without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve restrictions or revocation of licensure, limitations or revocation of clinical privileges, professional society membership, and exclusions from participation in Medicare and Medicaid. The NPDB requires that hospitals report serious sanctions that they take against physicians.<sup>10</sup>

As part of the NPDB's public mission, the agency publishes statistical information about the program. The NPDB is prohibited from making physician-specific information available to the public. The NPBD reports state-specific data showing the number of hospital actions against the clinical privileges of physicians on staff. The NPDB keeps track of "serious" sanctions against physicians' clinical privileges at hospitals. According to the NPDB, such "serious" actions consist of either restrictions on clinical practice that exceeds 30 days or revocation of such privilege.<sup>11</sup>

**According to the NPDB, one third of New York's hospitals (93 of 266) have *never* reported a *single* restriction against their physicians.**<sup>12</sup> Perhaps those hospitals privilege and credential only exemplary doctors, but we believe the explanation is that they either routinely fail to report the sanctions that have occurred, or they fail to impose serious sanctions against doctors so as to be immune from NPDB reporting requirements.

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<sup>10</sup> U.S. Department of Health and Human Services, National Practitioner Data Bank, Annual Report 2003.

<sup>11</sup> *Ibid.*

<sup>12</sup> *Ibid.*, p. 69.

**Despite The Large Number of Medical Mistakes, Very Few New York State Physicians Had Their Clinical Privileges Restricted or Revoked In Reports Sent To The Federal Government.**

The National Practitioner Data Bank (NPDB) keeps track of the number of physicians annually sanctioned by hospitals and other health entities. According to the NPDB database, few physicians were reported to have been punished by New York hospitals:

**Figure 2**  
**The Number of Sanctioned New York State Physicians Reported to the National Practitioner Data Bank<sup>13</sup>**

Year	Number of physicians
1991	69
1992	66
1993	45
1994	48
1995	59
1996	40
1997	46
1998	61
1999	79
2000	105
2001	66
2002	65
2003	71

Thousands of physicians have clinical privileges to hospitals and other health care entities in New York. Each year thousands of New York hospital patients are killed and tens of thousands are injured by medical errors. Other than a brief spike in 2000 (perhaps a result of the IoM reports), health care institutions consistently reported fewer than 80 actions against the clinical privileges of doctors. Health care institutions are clearly not doing enough to either report sanctions, assure the continued competency of doctors they privilege or take actions against problem doctors.

<sup>13</sup> National Practitioner Data Bank, "National Practitioner Data Bank Public Use Data File," for New York State, combined codes 1610, 1630, 1632, 1635, 1636, 1640, 1645, 1650, November 2004. These categories combine actions taken against practitioners by hospitals, HMO's or membership organizations with peer review. Calculations by authors.

## Health Department Fails To Comply With 1996 Law And Release Hospital “Report Cards.”

In 1996, as part of the Health Care Reform Act, the DOH was required to expand its system for reporting hospital data beyond what had previously been disclosed in the Cardiac Bypass Surgery Mortality Rates. The new requirements directed the DOH to produce Hospital Report Cards that would include expanded hospital performance measurements and reporting to include other types of surgical and treatment procedures. As part of the law, a task force was established to study how best to create the “Hospital Report Cards.” In 2000, Governor Pataki signed the Patient Health Information and Quality Improvement Act that once again required the DOH to produce report cards.<sup>14</sup> To date the DOH has failed to act.

In January of 2000, a DOH spokesperson, when asked whether the DOH would be producing report cards, was quoted saying, “The Department will move forward with hospital report cards.”<sup>15</sup> A few months later, in April of 2000, Commissioner Novello was reported as promising to release report cards on individual hospitals by the end of that year.<sup>16</sup> In February of 2001, when asked why hospital report cards had not yet been issued, Commissioner Novello once again promised their availability by the end of the year.<sup>17</sup>

It has been over *eight years* since the Legislature passed the statute requiring Hospital Report Cards and almost four years since the last time Commissioner Novello promised their imminent availability.

Despite increasing evidence linking doctor and hospital experience to better outcomes, the state has chosen to ignore the value of its own data in improving the safety and quality of hospital care and has yet to publish annual volume statistics for all procedures and conditions. For the past five years the Center for Medical Consumers has published reports detailing hospital and doctor volumes for more than 40 procedures. These reports are based on the state’s own SPARCS and AmSurg databases.

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<sup>14</sup> Benjamin, El., Fatal Medical Errors Going Unpublicized, *Times Union*, February 13, 2001.

<sup>15</sup> Perez-Pena, R., New York State’s Ambitious Plan To Grade Hospitals Remains Stalled, *New York Times*, January 30, 2000.

<sup>16</sup> Lipowicz, A., Hospital Group is Lone Wolf in Error-Reporting Debate, *Crain’s New York Business*, April 4, 2000.

<sup>17</sup> Benjamin, El., Fatal Medical Errors Going Unpublicized, *Times Union*, February 13, 2001.

For the past two years the Alliance for Quality Health Care, using nationally recognized performance measurement tools and the SPARCS database has reported on risk-adjusted outcomes and surgical volumes for a number of surgeries and conditions. These reports on the comparative performance of hospitals in New York State are similar to what the Department had been repeatedly instructed to produce – but which have not been forthcoming.

The production of these reports by private organizations underscores that creating report cards is eminently “doable” and that any obstacles the Department of Health faces in implementing the hospital report cards law are surmountable. Indeed, the fact others are able to produce such report cards suggests the Department simply lacks the will to measure hospitals’ performance.

## Despite Claims to The Contrary, The Number of Doctors in New York State Has Increased Significantly.

The medical lobby claims that medical malpractice premiums that are higher than the national average have caused doctors in New York State to leave the state and retire early.

This claim is at odds with the facts. Despite malpractice insurance rates that are higher than the national average, according to data from the Federation of State Medical Boards, the number of New York doctors in practice, and the number of doctors being licensed, have both grown steadily, even exceeding overall population growth.

- The number of physicians practicing in New York rose 16.4% from 1995 to 2003 [See Figure 3], according to the Federation of State Medical Boards of the United States. However, the state's population grew a mere 5.7% from 1995 to 2003.<sup>18</sup>
- The increase of 8,250 physicians licensed in-state during that same period represented a 12.3% increase.

**Figure 3**  
**Doctors Licensed in New York State, 1995 – 2003<sup>19</sup>**

Year	Total licensed doctors	Doctors practicing in-state
1995	66,817	51,193
1996	67,218	53,409
1997	69,340	53,409
1998	70,180	54,926
1999	71,010	55,732
2000	72,290	55,531
2001	72,920	56,995
2002	74,063	56,995
2003	75,067	59,581
<b>Total Increase 1995-2003</b>	<b>8,250 12.3%</b>	<b>8,388 16.4%</b>

<sup>18</sup> American Medical Association, Physician Characteristics and Distribution in the US, 2005 Edition. New York's population in 1995 was 18,151,000 and in 2003 it was 19,190,000 – an increase of 5.7%.

<sup>19</sup> The Federation of State Medical Boards of the United States, Inc. "Summary of Board Actions," 1996 through 2004.

## Licensing of New Physicians in New York Has Been Steady.

New York State continues to issue physician licenses at a steady rate, according to the State Education Department. In fact, the number of physicians newly licensed in the state was higher in 2003 than any previous year, [See Figure 4].

**Figure 4**  
**New York State New Physician Licenses Issued, 1998 – 2003<sup>20</sup>**

Professional Title	1998	1999	2000	2001	2002	2003
Physician	3,593	3,671	3,491	3,496	3,656	3,674

- A 2002 report from the State University of New York at Albany’s Center for Health Workforce Studies found, “Overall, the job market for new physicians in New York State continues to be good.” And, according to the Center, new physician income jumped by 7.3% between 2001 and 2002.<sup>21</sup>
- The Center also reports that while the market is “soft” for some medical specialties, OB/GYNs is not one of them. In fact, median income for starting OB/GYNs has increased from \$145,000 in 2000 to \$161,000 in 2003.<sup>22</sup> (Note: First year physicians typically receive huge discounts in malpractice premiums.<sup>23</sup>)

<sup>20</sup> New York State Education Department, Office of the Professions, <http://www.op.nysed.gov/medcounts.htm>.

<sup>21</sup> University at Albany, State University of New York, Center for Health Workforce Studies, Residency Training Outcomes in New York State, 2002.

<sup>22</sup> University at Albany, State University of New York, Center for Health Workforce Studies, Physician Supply and Demand Indicators in New York and California, February 2003, p. 5. <http://chws.albany.edu>.

<sup>23</sup> Medical Liability Mutual Insurance Company, “2003 Annual Report,” p. 9. MLMIC grants a 50% reduction in premiums to physicians in their first year and a 25% reduction in their second and third year of private practice.

## New York State Ranks Near The Top in its *Per Capita* Number of Physicians.

The medical and hospital lobby has been arguing that New York's higher-than-the-national average malpractice premiums are eroding public access to medical care. Most recently, the Greater New York Hospital Association chose to enlist American Medical Association data to argue that the state has experienced a per capita decrease in its number of doctors. In a January 2005 report, they argued

“. . . the number of physicians engaged in patient care per 100,000 population in New York actually declined between 1998 and 2002.”<sup>24</sup>

Yet that same month, the American Medical Association released updated information that examined New York's *per capita* number of physicians. When comparing this new data with the Greater New York analysis, the data showed that New York State's *per capita* number of doctors was *unchanged* when comparing 1998 and 2003.<sup>25</sup>

It is odd to have chosen 1998 and 2002 as the years for comparison and as seen above, one year can make a dramatic change in findings. When examining the trend in the *per capita* number of physicians in New York State and the nation over the past 23 years, there is no difference in the rate of increase. Moreover, when compared with the state of California, the “model” state for reform for the medical and hospital lobbies, New York stacks up quite well.

**Figure 5**  
**Comparison of Physician/Population Ratios (Per 100,000)**  
**United States, New York State and California, 1980 – 2003**<sup>26</sup>

Year	United States	New York State	California
1980	195	280	248
1985	228	323	273
1990	242	342	270
1995	270	395	281
2003	295	423	294
<b>% Change</b>	<b>51%</b>	<b>51%</b>	<b>18%</b>

<sup>24</sup> Greater New York Hospital Association, Medical Malpractice Insurance Costs and Coverage, January 2005, p.25.

<sup>25</sup> American Medical Association, Physician Characteristics and Distribution in the US, 2005 Edition.

<sup>26</sup> Ibid, Table 5.17.

New York State's increase in physicians is even more impressive when considering the relatively modest increase in state population over the same period of time.

**Figure 7**  
**Comparison of Population Growth (Millions)**  
**United States, New York State, California**  
**1980 – 2003<sup>27</sup>**

<b>Year</b>	<b>United States</b>	<b>New York State</b>	<b>California</b>
1980	225,552	17,549	23,499
2003	290,810	19,190	35,484
<b>% Change</b>	<b>29%</b>	<b>9%</b>	<b>51%</b>

New Yorkers have certainly not lost access to medical care. Moreover, New Yorkers enjoy one the nation's highest *per capita* number of physicians in the nation.

**Figure 8**  
**Top 20 States**  
**Per Capita Number of Physicians, 2003<sup>28</sup>**

<b>Rank</b>	<b>State</b>	<b>Physician/Population Ratio</b>
1	Massachusetts	476
2	Maryland	450
3	New York	423
4	Vermont	416
5	Connecticut	397
6	Rhode Island	380
7	Hawaii	347
8	New Jersey	336
9	Pennsylvania	328
10	Minnesota	308
11	Maine	306
12	Washington	303
13	Virginia	303
14	Oregon	302
15	New Hampshire	299
16	Illinois	297
17	California	294
18	Florida	294
19	Colorado	287
20	Louisiana	286
<b>National Average</b>		<b>295</b>

<sup>27</sup> Ibid, Table 5.17.

<sup>28</sup> Ibid, Table 5.19.

## **Background: The Medical Lobby's Model For "Reform" – The California Medical Injury Compensation Reform Act Of 1975 (MICRA).**

National "tort reform" legislation has been advanced by supporters of limits on payments to injured patients. This legislation is based on a 1975 California law: the "Medical Injury Compensation Act (MICRA)." Among other limits on medical malpractice litigation in California, MICRA "capped" non-economic (pain and suffering) awards to injured patients at \$250,000. Note: The cap is in 1975 dollars and worth considerably less to injured parties today. The medical lobby in California has callously resisted attempts to adjust the cap for inflation. According to the Rand Institute, if California's cap had been adjusted for inflation, it would have been pegged at \$774,000 in 1999.<sup>29</sup> Moreover, proposed federal legislation also adopts the 1975 MICRA cap unadjusted for inflation! The AMA notes that malpractice premiums paid by California physicians in 2002 are considerably lower than those in New York State.<sup>30</sup>

There is a debate over whether MICRA is the reason that California physicians enjoy lower malpractice premiums. According to a California-based consumer group, a 1988 insurance reform initiative (Proposition 103), and not the state's 1975 malpractice law, is the reason California physicians' medical malpractice premiums dropped and have stabilized over the last 14 years. In a recent report, the group found that:<sup>31</sup>

- Twelve years after MICRA's enactment, doctors' premiums had nearly tripled and reached an all-time high in California.
- Insurance reform from Proposition 103 reduced California physicians' premiums by 20% within three years.
- Insurance reform required medical malpractice insurers to directly refund more than \$135 million to policyholders.

California's example provides an argument for reform of the insurance industry, rather than a basis for extending MICRA to other states.

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<sup>29</sup> Rand Institute for Civil Justice, Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA, 2004, p. xxvi.

<sup>30</sup> American Medical Association, From testimony before the U.S. House Judiciary Subcommittee on Commercial and Administrative Law, Re: Oversight Hearing on Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care? June 12, 2002.

<sup>31</sup> The Foundation for Taxpayer and Consumer Rights, *How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California*, February 2003.

As mentioned earlier, California has significantly fewer physicians *per capita* than does New York, a state that the AMA considers in “crisis.”

In addition, when compared to New York State – which does not have such a cap on malpractice payments – *California physicians charge, on average, as much in fees as their New York counterparts.* A 2002 study comparing *per capita* personal health spending in 50 states found that New Yorkers spent \$1,112 on physician services while Californians spent \$1,340 or *20 percent more.*<sup>32</sup> It is true that overall *per capita* health spending is higher in New York (\$4,708) than California (\$3,429), but the difference is not attributable to the costs of physician services. The savings California doctors have accrued from paying lower medical malpractice premiums than New York physicians have clearly not been “recycled” back into the health care system in the form of lower physician fees.

Clearly, if the goal is to further enrich insurance companies and, to some extent, bolster physician’s incomes, rather than making health care more affordable, MICRA is the model. But, why is a limit on the legal rights of injured patients in the public interest?

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<sup>32</sup> Martin, A. et al, Health Care Spending During 1991-1998: A Fifty State Review, *Health Affairs*, Vol. 21 No.4, July/August 2002, p. 114-5.

## Background: Current New York State Law.

Over the years New York State policymakers have debated the issues of medical malpractice and patient safety. The most sweeping changes to medical malpractice law were made during the 1985 legislative session, at a time of another purported malpractice “crisis,” and additional changes were made in 1986. In summary, the changes include the following:<sup>33</sup>

- **Periodic payment of judgments.** Under this change, unless the parties agree otherwise, malpractice payments in excess of \$250,000 are made periodically, rather than at one time. Pain and suffering payments are paid out over ten years.
- **Reduction in contingency fees.** Most malpractice lawyers (as do most plaintiff’s lawyers in any field) get paid on a contingency basis – meaning they only get paid if they win the case or if both parties agree to a settlement. The 1985 changes mandated a contingency compensation schedule limiting malpractice case contingency fees to no more than 30 percent of the first \$250,000 received; no more than 25 percent of the next \$250,000; 20 percent of the next \$500,000; 15 percent of the next \$250,000; and 10 percent of any and all amounts in excess of \$1.25 million.
- **New penalties for “frivolous” legal maneuvers by either the defense or the plaintiff.**
- **A state fund subsidizes the cost of malpractice premiums for doctors.** In 1985 the state created an “excess” medical malpractice coverage fund. This fund covers physician malpractice payments up to \$1 million in excess of a now \$1.3 million threshold.<sup>34</sup> This is, in essence, taxpayer financed “umbrella” insurance. It was intended when established in 1985 to help hold down premium increases due to what was then projected to be dramatic increases in the size of payouts.
- **A new standard for appellate review.** The changes of the mid-1980s changed the appellate standard for altering the award considered under an appeal. The old standard was that the court could only change an award if it “shocks the conscience of the

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<sup>33</sup> Chapter 294 of the laws of 1985.

<sup>34</sup> Further amended by Chapter 266 of the laws of 1986. Excess limit increased by Chapter 1 of the laws of 2002.

court.” The current standard is that the award “deviates from that which would be reasonable compensation.”<sup>35</sup>

- **Statute of limitations.** A change in 1975 created the current two and one-half year limit on the amount of time a legal action can be commenced after a medical injury occurred. The statute of limitations has three exceptions: (1) children are given a ten year limit; (2) if an injury occurs during a continuous course of treatment, an action can be brought at any time during treatment; and (3) if the injury is caused by a “foreign body,” in which case an action can be brought when the foreign body (for example, a surgical clamp) is discovered or should have been discovered by a reasonable person.<sup>36 37</sup>

These changes appear to be the reason why the malpractice experience in New York State has remained remarkably stable. Unfortunately, not nearly enough has been accomplished to reduce needless patients’ injuries and deaths resulting from medical negligence or mistakes.

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<sup>35</sup> Chapter 682, of the laws of 1986. Indeed, in New York as in other states, jury awards are often reduced by trial or appellate judges; and in any event likely do not represent what is actually paid out by defendants or received by plaintiffs or their families.

<sup>36</sup> Chapter 476, of the laws of 1975.

<sup>37</sup> Currently, injured patients must make a legal claim against the responsible physician or hospital within two and one-half years of the date the injury occurred. Other than the three specific exceptions detailed above, if a patient doesn’t find out about a medical mistake until years later, New York law could block any legal action against the physician. Patients harmed by medical mistakes should have the same legal rights as consumers harmed by exposure to toxic substances – the opportunity to commence a legal action within one year of the date that they find out about the medical mistake.

**Conclusion: Despite The Claim That New York Is A Leader In Making Patients Safe, The State Is Failing to Take Steps To In Protect The Public From Harm And To Improve Patient Outcomes.**

Other states and the federal government have begun implementing innovative programs in efforts to protect patients from preventable harm and improve the quality of care they receive. New York must do no less.

**1. The state should immediately implement a hospital infection tracking system that requires reporting of every occurrence of a nosocomial infection.** At present only “outbreaks” must be reported to New York’s infectious disease reporting system. This information should be published annually by the state showing infection rates for each hospital, ambulatory surgery center and long term care facility licensed under Article 28.

The state should regularly advise licensed facilities of the state-of-the-art techniques in nosocomial infection control and require that these programs be in place at every licensed institution as a condition of their licensure.<sup>38</sup>

In addition, consumers should have easy access to hospital quality data already collected by the State Health Department. Such information should be contained in a “hospital profile” that includes reports of the experience level of a hospital and its physicians in performing particular surgeries and other treatments.

**2. The state should take a more aggressive role in assuring that where there is evidence linking volume to better outcomes, such practices are concentrated in centers of excellence.** For example, we issued a report detailing the fact that carotid endarterectomy, a surgical procedure whose benefit only outweighs its considerable risks when performed by experienced surgeons, is often being done by surgeons and in hospitals failing to meet minimum standards of experience. In 2003, our organizations sent a letter to Commissioner Novello asking that the state consider using its certificate of need program to protect patients undergoing carotid surgery from less experienced surgeons. To date we have not had a response.

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<sup>38</sup> Nosocomial infections are infections contracted by patients in hospital settings and considered a barometer of the quality of care provided in the hospital setting.

**3. The state should appoint an expert panel to review and monitor whether the Office of Professional Medical Conduct is effectively and efficiently identifying and disciplining physician misconduct.** The expert reviewers should be required to do a forensic analysis of the most recent year of OPMC activity, starting with complaints and following through the entire process until a final action. The review should be guided by the principle that the primary role of the physician discipline program is to protect the public from preventable harm.

**4. The state should immediately begin to act as a “prudent purchaser” in all of the programs it administers, including those that serve Medicaid beneficiaries and state employees, to drive quality of care in the state.** Abiding by this principle, the state would no longer purchase care that was unsafe and not of high quality. The state should immediately study the utility of adopting rapidly emerging federal “pay for performance” standards to drive improvements in safety and quality at the state level.

**5. The state should create a system of periodic recertification of physicians.** Both the Institute of Medicine<sup>39</sup> and the State Health Department<sup>40</sup> have recommended that physicians be recertified to assure that they continue to be able to practice as competent professionals. Over time, physicians may see some of their skills erode and it is difficult to keep current with the latest medical research and advances in technology. In an effort to identify these physicians *before* a patient gets harmed, a system of recertification based on testing competency is needed.

**6. The state should require health care providers who harm patients as a result of a medical mistake to tell the patient or patient’s family when such a mistake occurs.** Physicians are required by their own code of ethics to report medical mistakes even if such admission exposes them to liability.<sup>41</sup> The force of law should back up this common sense ethical requirement.

**7. Educate patients and their families what they can do to be active members in their healthcare and avoid medical errors.**

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<sup>39</sup> National Academy of Sciences’ Institute of Medicine, To Err is Human: Building A Better Health Care System, November 1999, p. 10.

<sup>40</sup> New York State Department of Health, Report of the New York State Advisory Committee on Physician Recredentialing: Phase One General Principles, Proposed Process, Recommendations, January 1988.

<sup>41</sup> American Medical Association, Current Opinions of the Council on Ethical and Judicial Affairs, E-8.12 “Patient Information.”

## Background: Geographic Distribution of New York State Registered Licensees.<sup>42</sup>

County	Number	County	Number	County	Number
Albany	1,394	Jefferson	200	Saratoga	327
Allegany	40	Kings	4,251	Schenectady	437
Bronx	1,781	Lewis	22	Schoharie	21
Broome	568	Livingston	60	Schuyler	25
Cattaraugus	109	Madison	103	Seneca	18
Cayuga	90	Monroe	2,634	Steuben	164
Chautauqua	206	Montgomery	81	St. Lawrence	166
Chemung	244	Nassau	7,988	Suffolk	4,050
Chenango	56	New York	14,300	Sullivan	97
Clinton	179	Niagara	256	Tioga	41
Columbia	114	Oneida	525	Tompkins	217
Cortland	60	Onondaga	1,659	Ulster	329
Delaware	50	Ontario	233	Warren	217
Dutchess	750	Orange	756	Washington	44
Erie	2,795	Orleans	32	Wayne	74
Essex	43	Oswego	105	Westchester	6,006
Franklin	95	Otsego	266	Wyoming	46
Fulton	68	Putnam	220	Yates	30
Genesee	69	Queens	4,442		
Greene	45	Rensselaer	260		
Hamilton	3	Richmond	1,334		
Herkimer	58	Rockland	1,183		

<sup>42</sup> New York State Education Department, see: [www.op.nysed.gov/medcounts.htm](http://www.op.nysed.gov/medcounts.htm), as of January 1, 2004.



