

FIRST DO NO HARM:

A CONSUMER RESPONSE TO THE MEDICAL LOBBY'S CAMPAIGN TO LIMIT THE LEGAL RIGHTS OF INJURED PATIENTS

INTRODUCTION

Health care costs are once again at the forefront of public policy debates. Recently, the *New York Times* featured a report on the "Decade After Health Care Crisis, Soaring Costs Bring New Strains" as a Sunday edition front-page story.¹ Double-digit health insurance inflation is being reported from California to Illinois to Maryland. Congress finds itself unable to agree on a prescription drug benefit to seniors partially out of fear that its cost will bankrupt the Medicare Trust Fund. Some experts have predicted that American health care is about to implode in a dizzying spiral of out of control costs and increasing numbers of uninsured and underinsured.

These are serious, legitimate concerns that deserve immediate national attention because they can affect the health of the nation and everyone who lives within its borders.

Under the cover of this very real crisis in health care, organized medicine has launched a national effort to persuade state and federal lawmakers to embrace medical malpractice "reforms" that would in effect place significant limits on the size of legal awards to injured patients. The medical lobby claims among other things, that an avalanche of medical malpractice lawsuits has led to dramatic inflation of physicians' malpractice insurance premiums - which in turn are responsible for a significant part of the double-digit inflation in health care costs. Dr Richard Corlin, a former President of the American Medical Association (AMA), has been quoted claiming that "rapid increases in the costs of malpractice insurance" is one of the three principle reasons for health care cost inflation - along with an aging population and high tech medicine.²

¹ Toner, R. and Stolberg, S.J., Decade After Health Care Crisis, Soaring Costs Bring New Strains, *New York Times*, 8/11/02, p. A-1.

² *New York Times*, Ibid.

ARE MALPRACTICE INSURANCE COSTS RESPONSIBLE FOR HEALTH CARE INFLATION?

In a word, no: There is simply no evidence that tort “reforms” in other states (the AMA’s “model” tort reform state is California - a state that has restricted injured victim recovery for almost three decades³) have had a measurable impact on overall health spending. California, despite tort reforms and a highly competitive managed care health insurance environment, is experiencing double digit inflation in health insurance costs. And organized medicine needs to hone its math skills - physicians’ medical malpractice premiums account for only a miniscule percent of total health spending in America. The nation now spends approximately \$1.3 trillion on health care.⁴ Medical malpractice premiums for physicians are estimated to total \$6.3 billion annually,⁵ or one half of one percent. While billions more go to pay the liability insurance premiums of hospitals and other health care providers, in reality even a radical change in tort law is unlikely to put a dent in the double digit health care inflation Americans are experiencing.

Not content just to take advantage of the legitimate crisis in health care costs, and the public’s concern over its ability to afford health insurance, organized medicine paints other frightening scenarios for the public that they claim are the inevitable result of rapidly inflating physician medical malpractice premiums. According to the medical lobby, patients will find their access to physicians, particularly to obstetrical care, considerably reduced. Victims of trauma will languish without prompt medical attention because orthopedists and neurosurgeons cannot afford six figure liability insurance premiums. The quality of care will erode as doctors are forced to practice more “defensively.”

The medical lobby’s public relations machine is working in overdrive and campaign contributions are flowing. As a result, rank-and-file physicians are whipped up in a way that has seldom occurred in the past. And the public, Congress and even the President seem to be buying into AMA’s argument that rapidly inflating medical malpractice insurance premiums hurt everybody. According to the American Medical Association (AMA):

³ 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? Presented by Donald Palmisano, MD, JD, 6/12/02.

⁴ Heffler, S. et al (Office of the Actuary, CMS), Health Spending Projections for 2001/2011: The Latest Outlook, *Health Affairs*, March/April 2002, V. 22, N.2, Exhibit 1, p. 208.

⁵ 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.

- Seventy-one percent of Americans agree, “a main reason health care costs are rising is because of medical malpractice lawsuits.”⁶
- Seventy eight percent say that they “are concerned about access to care being affected because doctors are leaving their practices due to rising liability costs.”⁷

THE MEDICAL MALPRACTICE “CRISIS” IN NEW YORK: A CAMPAIGN OF DECEPTION

The AMA has identified a number of states where the medical malpractice situation is considered a “crisis.” One of those states is New York,⁸ whose physicians, led by the Medical Society of New York State, were so concerned that in April of this year they organized public protests against an “out-of-control medical liability system”⁹ which they warned would result in New Yorkers losing access to their physicians. According to a spokesperson, “Skyrocketing premiums have forced obstetricians to discontinue the obstetric side of their practices. This leaves women without access to the critical obstetrical care they need.”¹⁰

Are these charges leveled by the Medical Society of New York State and the AMA about New York being one of the states in “crisis” true? There is no doubt that New York physicians have been paying the nation’s highest medical malpractice insurance premiums for years. Has anything new happened to precipitate a “crisis?” We don’t believe so - and have written this report after examining the allegations made by the medical lobby about the state of medical malpractice insurance for physicians in New York in light of the available evidence. We hope it will separate objective, evidence-based fact from the medical lobby’s fiction.

It is our conclusion that the campaign launched in New York State this year is truly a campaign of deception. Much of what the medical lobby claims is occurring and its consequences are simply not true - and often is contradicted by the evidence.

⁶ 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? Presented by Donald Palmisano, MD, JD, 6/12/02.

⁷ American Medical Association, Ibid.

⁸ American Medical Association, Ibid.

⁹ Medical Society of the State of New York, American College of Obstetricians and Gynecologists NYS and NY Chapter of the American College of Surgeons, News Release, 4/22/02.

¹⁰ American College of Obstetricians and Gynecologists NYS, News Release, 4/22/02

- **FACT:** New York’s physicians are not being forced to pay skyrocketing malpractice insurance premiums at this time. What is true is that medical malpractice premiums paid by doctors in New York have been among the highest in the country for many years.
- **FACT:** Despite the claims made by medical lobbyists, New Yorkers should not worry about losing access to health care services as a result of the pressure of malpractice liability on physicians. Pregnant women and their spouses should not be concerned about whether doctors will be available to deliver their babies. New York has more specialists, including obstetricians, per capita than California, a state that is the “gold standard” for limiting recovery by injured victims of malpractice in the name of tort reform.
- **FACT:** The best, most direct way to reduce medical malpractice lawsuits is by pursuing aggressive patient safety programs in hospitals, clinics, nursing homes and physicians’ offices. It is common sense that it is in everyone’s interest to reduce the incidence of malpractice. Yet, such efforts are routinely opposed - and often defeated - by the powerful lobbying efforts of organized medicine.

As we have said, this report is written to respond to the lobbyists for the medical industry in New York State who distort the truth and hope to scare the public, legislators, the executive and state government into submission. It is our hope that New Yorkers will look at the facts, distinguish evidence from rhetoric and ask their elected representatives and state government to base public policy on the wise advice Hippocrates gave to physicians: *“First Do No Harm.”*

FIRST DO NO HARM:
DEBUNKING THE CLAIMS OF THE MEDICAL LOBBY

The Medical Lobby’s Claims

New York physicians are fleeing the state or leaving practice due to skyrocketing malpractice premiums. New Yorkers will lose their access to health care services as a result.

The Evidence #1

Despite all the hype, there has been no significant increase in medical malpractice premiums this year. Why? Because there is no evidence that there has been an increase in the number of medical malpractice lawsuits in New York State or that the insurance carrier's loss experience requires such an increase.

Despite the medical lobby's shrill campaign, there has, in fact, been no significant increase in medical malpractice insurance premiums for New York physicians this year. According to the New York State Insurance Department's analysis, there is no compelling case for granting the state's largest malpractice insurance carrier, Medical Liability Mutual Insurance Company (MLMIC), a premium increase - its proposed increase was denied.¹¹ In addition, the state's second largest carrier, Physicians Reciprocal Insurance, did not seek a rate increase this year.¹²

Why did the state deny MLMIC's rate hike request and why did PRI keep premiums unchanged? *Because New York's medical malpractice loss experience does not warrant an increase in premiums.*

NEW YORK'S MALPRACTICE LITIGATION TRENDS OVER THE PAST TEN YEARS.

Federal law requires all insurers to report medical malpractice payments to the National Practitioner Data Bank (NPDB) - an entity that is part of the U.S. Department of Health and Human Services. In an effort to ensure that states, hospitals and other health facilities had access to physicians' disciplinary and malpractice histories, the U.S. Congress created the NPDB in the mid-1980s.¹³ The physician-specific information contained in the NPDB is not available to the public, but non-identifiable, aggregate data is available to researchers. We reviewed some aggregate data from the NPDB in order to evaluate organized medicine's portrayal of a medical malpractice system spinning out of control.

[A word about the NPDB; the General Accounting Office has criticized the NPDB for failing to receive all malpractice payments made by physicians across the nation. While we fully recognize the limitations in using the NPDB, there is no other publicly available information of physicians' medical malpractice

¹¹ Solnick, Claude, Denying hike, state freezes med mal rates, *Long Island Business News*, 7/19/02.

¹² *Long Island Business News*, Ibid.

¹³ General Accounting Office, National Practitioner Data Bank: Major Improvements are Needed to Enhance Data Bank's Reliability, GAO-01-130, November 2000.

experiences.¹⁴ Moreover, there is evidence that the NPDB information is reasonably accurate in New York. New York's largest medical malpractice insurer, the Medical Liability Mutual Insurance Company, has stated that in the year 2000 it paid claims on fewer than 900 physicians.¹⁵ Since the insurer covers nearly half of New York's privately insured physicians, it is likely that it paid nearly half of the claims (see below). We believe using the NPDB data to identify *trends* in malpractice insurance in New York State provides a useful and valid yardstick.]

According to the NPDB data we looked at, the annual number of physicians' malpractice payments has been *relatively steady* over the last ten years (see Appendix for full, county-by-county report). The average of the number of physician medical malpractice payments over the ten-year period was 1,931.

THE NUMBER OF ANNUAL PHYSICIANS' MEDICAL MALPRACTICE PAYMENTS IN NEW YORK STATE 1992-2001¹⁶

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Malpractice payments	1,943	1,977	2,019	1,675	1,751	1,823	1,950	2,023	2,111	2,090

The NPDB data is consistent with information derived from other sources. According to the New York State Office of Court Administration, the number of legal notices (Requests for Judicial Interventions or RJIs) filed with the courts prior to a medical malpractice claim, has remained steady as well. The average of the number of RJI's filed over the ten-year period was 4,115.

THE NUMBER OF ANNUAL MEDICAL MALPRACTICE REQUESTS FOR JUDICIAL INTERVENTIONS FILED IN NEW YORK STATE 1992-2001¹⁷

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
RJI's	3,753	3,976	4,021	4,330	4,408	4,441	4,273	3,624	4,022	4,301

The OCA data also has limitations. It does not distinguish between medical malpractice actions against individual physicians and actions brought against hospitals.

¹⁴ GAO, Ibid.

¹⁵ Medical Liability Mutual Insurance Company, 2000 Annual Report, "President's Report."

¹⁶ National Practitioner Data Bank, information obtained by the Patient Information Alliance. Used with permission.

¹⁷ State of New York, Unified Court System, Office of Court Administration, "Medical Malpractice RJI's Filed," undated. Received by authors in June 2002.

However, one fact is clear; as regards both the annual number payments and annual number of RJIs filed with the Courts, little has changed over the past ten years. What then is the basis of the claims by the medical lobby that there is a malpractice "crisis"?

Further evidence comes from national comparisons of the profitability of New York's medical malpractice insurers and the national average. As seen below, the profitability of New York's insurers compares favorably with the national average.

**MEDICAL MALPRACTICE INSURERS' PROFITABILITY
NEW YORK STATE VERSUS THE NATIONAL AVERAGE 1992 - 1999¹⁸**

	1992	1993	1994	1995	1996	1997	1998	1999	Average
NYS Average	4.0	13.8	14.4	19.9	18.8	20.7	9.7	7.4	13.6
National Average	15.5	15.3	13.7	12.7	12.6	12.6	7.6	5.1	11.9

Clearly, New York's medical malpractice insurers have done well compared to the national average.

There is no question that malpractice premiums in New York State are high in comparison to premiums elsewhere. And the evidence does show an increase in the median value of malpractice payments for 2001, although the ten-year trend of payments is highly variable. To further explore what possible evidence might support organized medicine's claims, we examined the experience of three New York counties, Nassau, Brooklyn and Manhattan. These three counties accounted for nearly half of all of all the malpractice payments made by New York State physicians. The table below shows the variations in median payouts over the past decade:

**PHYSICIANS' MEDICAL MALPRACTICE MEDIAN PAYOUTS FOR THREE COUNTIES
WITH LARGEST NUMBER OF PAYMENTS 1992 - 2001¹⁹**

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Brooklyn	\$90K	\$105K	\$112.5K	\$125K	\$118.75K	\$125K	\$150K	\$137K	\$135K	\$175K
Manhattan	\$75K	\$102.5K	\$105K	\$125K	\$125K	\$150K	\$137.5K	\$110K	\$115K	\$175K
Nassau	\$125K	\$150K	\$172.5K	\$141,608	\$155K	\$158,333	\$175K	\$175K	\$197.5K	\$220K

¹⁸ National Association of Insurance Commissioners, NAIC Report on Profitability by Line by State, released in 2001. The chart compares profitability using the "Return on Net Worth" analysis by NAIC.

¹⁹ National Practitioner Data Bank, information obtained by the Patient Information Alliance. Used with permission.

Because of the high variation exhibited over the ten years, it is too early to predict any trend based on the 2001 experience. While the size of payouts deserves watching, the increases of 2001, when considered in the context of the ten-year trend, simply do not signal we are in or even headed for a "crisis." ²⁰ And what's more, the New York State Insurance Department agrees.

The analysis of this trend data reveals nothing about the possible causes of the 2001 uptick in median payouts. Are New York juries, often accused of being uniquely generous and pro-consumer, becoming even more so? Are the attorneys for the injured patients becoming more skilled at hammering out settlements? Are physicians in New York State more likely to practice substandard care in 2001 than prior years?

Unfortunately, there is little good data to guide policymakers in answering these questions. Other than the National Practitioner Data Bank, for example, most other malpractice information lumps together litigation against both hospitals and physicians. So determining any cause of a trend will be very difficult at best. The only area of almost universal agreement is that far too many patients are injured or killed by medical mistakes. That is why we believe this is the one area where New York State policy-makers should focus their efforts.

The Evidence #2

Not only is there no evidence that New York State is losing physicians, it is in fact gaining them. New York's medical malpractice litigation environment, and high insurance cost appears to have little - or no - influence over the desire of physicians' to practice here.

Despite paying the nation's highest medical malpractice premiums for years, New York State has seen a dramatic increase in the number of physicians practicing within its' borders - an increase that far exceeds the national average. When compared to the state of California - a state with a three-decade-old malpractice system that is the model for the reforms supported by the organized medicine - New York has far more physicians per capita, both in the aggregate and by individual specialty. Organized medicine warns that

²⁰ The trends could reflect the medical inflation rate. For example, the medical inflation rate increased by 44 percent during this same period according to *The Report on the August 2002 Economic Indicators* prepared and published for the Joint Economic Committee, U.S. Congress, by the Council of Economic Advisors. (Page 23, "Consumer Prices - All Urban Consumers.") In fact, medical inflation could account for the entire increase in payments made for the period 1998 through 2001 for the three counties as shown in the Table on page 7. (See *Health Affairs*, March/April 2002, footnote #4.)

physicians will flee from states with an unfriendly litigation climate. If that was true wouldn't it be reasonable to expect that California - the national model of "reform" according to the AMA - would have had more physicians per capita than New York? But it does not. New Yorkers should stop worrying that their state's litigation climate and high insurance premiums may cause them to lose their access to health care services.

According to data compiled by the New York State Conference of Blue Cross/Blue Shield plans, here is how New York ranks nationally in physicians per capita compared with California (the number in parentheses after the numeric ranking is the number of physicians per capita):

THE NUMBER OF PHYSICIANS PER CAPITA, NEW YORK STATE V. CALIFORNIA²¹

Category of physicians	New York State's national ranking	California's national ranking
Overall number of physicians	2 (332 per thousand)	16 (215 per thousand)
Surgical specialists	1 (77)	21 (52)
OB/GYNs	3 (39)	17 (27)
General surgeons	1 (22.1)	33 (12.3)
Medical specialists	2 (154)	13 (80)
Orthopedic surgeons	8 (9.9)	19 (8.7)
Plastic surgeons	1 (3.2)	5 (2.8)
Ophthalmologists	1 (9.9)	13 (6.4)
Podiatrists	3 (8.8)	16 (4.6)
Internists	2 (90)	14 (42)
Pediatricians	1 (145)	17 (75)
Primary care physicians	1 (142)	16 (93)
General practice physicians	47 (20)	28 (29)

In addition, national data shows that the number of physicians per capita is increasing *faster* in New York than nationally. Nationwide in 1980, there were 195 doctors per 100,000 population; in New York State there were 280 per 100,000. By 1998, the national physician to population ratio had grown by 43.6% to 280 per 100,000 population; in New York the ratio increased 47.9% to 414 per 100,000.²²

In addition, according to the U.S. Census Bureau, the trends in the number of physicians show that New York has seen an increase in the number of physicians per capita, while California's national ranking in the number of

²¹ New York State Conference of Blue Cross and Blue Shield Plans, "The Facts About Physician Supply," www.nysblues.org.

²² New York State Conference of Blue Cross and Blue Shield Plans, "The Facts About Physician Supply," www.nysblues.org, citing the American Medical Association, "Physician Characteristics and Distribution in the U.S., 2000-2001 Edition, 'nonfederal physicians.'"

physicians per capita has declined relative to the rest of the nation. According to the Census Bureau, between 1990 and 1998, California's ranking in the number of physicians per capita actually declined, while New York's ranking increased.²³ The trend was so stark that the American Medical News ran a headline, "Doctors Fleeing California."²⁴

So, in reality and despite the dire predictions of organized medicine, there has been no exodus of physicians from the state. The strident voice of organized medicine and individual doctors busy railing against the purported burdens of the current legal system aside, New York's admittedly expensive malpractice environment does not appear to deter physicians from practicing here.

The Evidence #3

Few physicians ever pay a malpractice award. But, a large percentage of malpractice payments are made by a small number of doctors. A proactive program to identify and deal with this small group of easily identified, problem physicians, could help reduce malpractice payments and thus help stabilize malpractice insurance premiums. More important, it would save thousands of New Yorkers from being unnecessarily harmed, or even killed, by medical incompetence and negligence.

While organized medicine paints a picture of physicians bedeviled by malpractice lawsuits at every turn, in fact very few physicians ever make a medical malpractice payment in their careers. There are over 70,000 physicians licensed to practice in New York State.²⁵ An analysis conducted in March 2000 by the *New York Daily News* found the following:

- Almost 90 percent of New York's physicians did not appear to have made a malpractice payment in the period from 1990 through 1998.
- In contrast, two percent of New York's physicians had made at least three malpractice payments between 1990 and 1998. This small group of apparent problem physicians accounted for over one-third of the total

²³ U.S. Census Bureau, "State Rankings: Doctors Per 100,000 Population," www.census.gov/statab/ranks/ranks05.txt. The Census Bureau had California ranked 8th in 1990 and 12th in 1998. New York State was ranked 3rd in 1990 and 2nd in 1998.

²⁴ *American Medical News*, In Brief, 8/14/00. www.ama-assn.org/sci-pubs/amnews/pick_00/bib0814.htm.

²⁵ New York State Education Department, Office of the Professions, www.op.nysed.gov/medcounts.htm.

number of payments and almost 39 percent of the aggregate dollars paid out!²⁶

- The *Daily News* investigation identified a list of 15 physicians with the most malpractice payments in New York during the 1990s. These “top” 15 were responsible for 412 payments totaling over \$26 million.²⁷

The results of the *Daily News* investigation should not have been a surprise. Most researchers and health officials had long known that a small number of physicians are responsible for a disproportionately large percentage of malpractice payments. New York law requires medical malpractice insurance companies to report payments they made on behalf of insured physicians to the State Health Department’s Office of Professional Medical for its use in disciplining doctors. Shockingly, the *Daily News* also found that despite this mandate, Health Department investigators rarely used the malpractice database to identify and investigate those physicians who had multiple malpractice payments. The Department has since stated that it will start to use the database to identify problem doctors.²⁸

The Evidence #4

Physicians are the unwitting victims of the flawed business decisions of their insurance carriers. Under pricing and the downturn in financial markets - not escalation in the numbers of lawsuits and cost of payments - is behind the problems of the industry.

According to the *International Risk Management Institute* (IRMI), “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 the 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 goes on to say that, “Clearly a business cannot continue operating in that fashion indefinitely. Indeed, this has been the case for such long time writers of professional liability insurance as Frontier, Reliance, and P.I.E. Mutual. These

²⁶ *New York Daily News*, The 15 Most Sued Doctors in New York, 3/5/00.

²⁷ *Ibid.*

²⁸ Buettner, R. and Sherman, W., Targeting the Worst Doctors, *New York Daily News*, 3/17/00, p. 2.

companies, who suffered through several years of weakening performance, have been liquidated or are otherwise inactive.”²⁹

In addition, questionable business moves by the country’s leading medical malpractice insurer, St. Paul Companies, led to almost one billion dollars in losses in 2001. Their new Chief Executive, Jay Fisher, announced in December 2001 that in light of such staggering losses, the company would no longer continue its medical malpractice line of business.³⁰

THE “DEFENSIVE MEDICINE INFLATES COSTS” ARGUMENT

The Medical Lobby’s Claims

Due to skyrocketing malpractice premiums, physicians have to practice medicine “defensively” - ordering unnecessary tests and being overly cautious in treating their patients. Health care costs will skyrocket as a result.

The Evidence

Those who would like not to be held legally responsible for their incompetence have been beating the defensive medicine drum for decades. While it can be difficult to measure the exact amount of influence physician concerns about their liability has on medical practice, it is not impossible. The Office of Technology Assessment has determined that liability concerns have a relatively small effect on practice patterns. And, some so-called “defensive medicine” may be good medicine - averting unnecessary patients’ injuries.

Advocates of limiting patients’ legal rights argue that it is not just insurance premiums that make medical malpractice expensive. They claim that “defensive medicine” - medical practices that are not in the best interest of the patient, but are performed because the providers is concerned about avoiding liability - is driving up health care costs. One problem in assessing this claim is that “defensive medicine” has not been objectively defined or quantified, and all its causes have not been clearly identified.

In 1994, the former research arm of Congress, The Office of Technology Assessment (OTA), released its report, *Defensive Medicine and Medical Malpractice*, examining the issue of defensive medicine. The OTA found

²⁹ Kolodkin, Charles, *Medical Malpractice Insurance Trends? Chaos!*, *International Risk Management Institute*. www.irmi.com/expert/articles/kolodkin001.asp.

³⁰ *Wall Street Journal*, *Insurers’ Missteps Helped Provoke Malpractice “Crisis,”* 6/24/02.

- Only “a relatively small proportion of all diagnostic procedures - certainly less than eight percent - is likely to be caused primarily by conscious concern about malpractice liability risk.” The OTA also stressed that the figure actually “overestimates the rate” of “defensive” medicine because it “is based on physicians’ responses to hypothetical clinical scenarios that were designed to be malpractice sensitive.”³¹
- Most physicians who order “aggressive diagnostic procedures ... do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability.”³²
- The effects of so-called tort reforms - primarily caps on damages and amendments to the collateral source rule - on defensive medicine “are likely to be small.”³³
- “Physicians are very conscious of being sued and tend to overestimate the risk.”³⁴
- “It is impossible to accurately measure the overall level and national cost of defensive medicine.”³⁵
- “Health care reform may change financial incentives toward doing fewer rather than more tests and procedure. If that happens, concerns about malpractice may act to check potential tendencies to offer too few services.”³⁶

Given the overwhelming numbers of patients that are needlessly injured or killed by medical mistakes (more on that later), one could argue that clinically appropriate “defensive medicine” could be “just what the doctor ordered” in the effort to reduce medical mistakes.

FIRST DO NO HARM: A LOOK AT THE FACTS

THE INSTITUTE OF MEDICINE’S REPORT AND THE CRISIS IN PATIENT SAFETY

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

³¹ U.S. Congress, Office of Technology Assessment, Defensive Medicine and Medical Malpractice, OTA-H-602 (Washington D.C.: U.S. Government Policy Office, July 1994), p. 1

³² OTA, p.1.

³³ OTA, p.2.

³⁴ OTA, p.2.

³⁵ OTA, p.1.

³⁶ OTA, p.2.

of medical errors in America’s health care system and called for sweeping reforms to bolster patient safety. In its report, the IoM estimated that patient deaths resulting from medical errors was a leading cause of death in America.

LEADING CAUSES OF DEATH IN AMERICA, 1999³⁷

Cause of death	Number of deaths
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

Furthermore, the IoM estimated that \$17 to \$29 billion is added to the nation’s health bill for the cost of additional medical treatment of patients injured by medical mistakes.³⁸ This estimate dwarfs the aggregate of the medical malpractice premiums currently paid by physicians nationwide.

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, 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. Improving patient safety is where policy makers must place their focus.

THE MEDICAL SOCIETY’S REACTION TO PATIENT SAFETY LEGISLATION

Protecting patients from substandard medical care is one policy concern that should have broad agreement as being in everyone’s interest. During two

³⁷ 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.

³⁸ National Academy of Sciences’ Institute of Medicine, To Err is Human: Building A Better Health Care System, November 1999, p. 1.

recent key patient safety initiatives in New York the medical lobby opposed legislation designed to help protect the public from medical negligence.

Physician profiles

In response to the Institute of Medicine report, consumer, senior, patients' rights and employer groups began working in 1999 to get legislation passed that would help improve patient safety in New York State. One initiative was to create a program that would allow New Yorkers easy access to all the available background information on physicians - including education, board specialty, disciplinary record (if any), malpractice payments (if any) as well as any actions affecting hospital privileges or credentials.

Advocates believed that this modest proposal would help consumers to make more intelligent decisions in choosing a physician. A number of other states had already adopted such a program - most notably Massachusetts, where in 1996, the state medical society helped write and pass a profiles bill. Supporters of the law argued that public access to such information was particularly important as employers increasingly turned to managed care schemes to provide health coverage for their employees. In such plans, enrollees are asked to choose a primary care physician from a list with little or no biographical information - not an easy task. Allowing the public easy access to physicians' backgrounds via the internet or by making a phone call to the Health Department, advocates believed was absolutely necessary for informed consumer decision-making.

Several years after passage of the Massachusetts physician profiles program, the president of that state's medical society sang its' praise in a meeting with representatives of the Medical Society of New York (MSSNY), advocates and legislators. The response of MSSNY was "well it may be OK in Massachusetts, but this is New York - we're different, more litigious." In New York the medical lobby, unmoved by Massachusetts's positive experience, mobilized to squash New York's proposed physician profile legislation. Among MSSNY's claims was that the program would significantly reduce the number of malpractice settlements and result in more cases going forward to trial - even though there was no such evidence of such an effect in Massachusetts.³⁹

Despite MSSNY spending hundreds of thousands of dollars in lobbying and campaign contributions, the coalition supporting physician profiles legislation

³⁹ Buettner, R. and Sherman, W., Docs Fight to Hide Lawsuits, *New York Daily News*, 4/17/00, p.9

was able to muster enough support to get the legislature and the Governor to enact the program in 2000.

Regulating office-based surgeries

Increasing numbers and varieties of surgical procedures are being performed outside of hospitals and licensed ambulatory surgery centers, many in physicians' private offices. But, because government has traditionally been prevented from doing anything that "interferes in the private practice of medicine," physicians are not required to report anything about their office-based practice to the state. Shockingly this includes "incidents" in which a patient suffers a serious injury as a result of a surgical procedure and/or whose peri- or post-operative condition requires transfer to a hospital. Advocates for improving patient safety have supported legislation that would require that physicians report such incidents.

It is an absolutely critical public health policy - that as more procedures of increasing complexity, involving longer anesthesia, move into the physician office setting, that there be monitoring of the quality of care in such environments. If licensed facilities required by law to have safety programs and procedures along with highly trained staff must report adverse outcomes - it is irrational that physicians, working in their offices, often without such safety backup in place, are not required to do so.

Despite the compelling public health arguments in favor of such a policy, New York's medical lobby organized a vigorous campaign opposing any such legislation.⁴⁰ In this case their efforts were successful, so today "bad things" that happen in physicians' offices continue to go unreported. Without this information it will be impossible to protect patient safety and improve quality in physician office based surgery.

If physicians are, as they tell us, concerned primarily about the welfare of their patients, then these patient safety initiatives - as well as others called for by the IoM - should be welcomed, not opposed, by them. But, as we have chronicled, such measures are more often than not opposed by MSSNY.

If physicians are so concerned about medical malpractice issues doesn't it make sense for them to support measures designed to reduce the incidence of medical mistakes and improve quality? Disappointingly, the real priority of organized medicine becomes disturbingly transparent - to lower malpractice insurance premium costs to physicians no matter what the human costs. Organized medicine appears to be saying that there are no malpractice victims,

⁴⁰ Medical Society of the State of New York, 2001 Legislative Program.

no epidemic of medical errors - only "greedy" plaintiff's attorneys. And their only solution appears to be abandoning victims who are injured by medical mistakes, rather than working to prevent such mistakes from occurring in the first place.

ORGANIZED MEDICINE'S MODEL FOR "REFORM" - THE CALIFORNIA MEDICAL INJURY COMPENSATION ACT OF 1975 (MICRA)

National "tort reform" legislation (H.R.4600) being advanced by supporters of limits on payments to injured patients is based on a 1975 California law the "Medical Injury Compensation Act (MICRA)." ⁴¹ 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. Worse, proposed federal legislation also adopts the 1975 MICRA cap unadjusted for inflation!] This limitation on recovery has unquestionably kept malpractice insurance premiums paid by California physicians considerably lower than those in New York State. ⁴² Recently, however, premiums in that state have increased by a percentage that exceeds the national average. ⁴³

As mentioned earlier in our report, California - the state that is considered the model for tort reform by the AMA and some in Congress - 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.* In a recent fifty state comparison of per capita personal health spending, New Yorkers spent \$1,112 on physician services while Californians spent \$1,340 or *20 percent more.* 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 costs of physician services. ⁴⁴ 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.

⁴¹ 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? Presented by Donald Palmisano, MD, JD, 6/12/02.

⁴² American Medical Association, Ibid.

⁴³ Center for Justice & Democracy and the Foundation for Taxpayer and Consumer Rights,

⁴⁴ 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.

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 this limit on the legal rights of patients in the public interest?

The question takes on even more urgency given that we know that MICRA-style "reforms" can have devastating consequences for patients. In an upcoming book, the Foundation for Taxpayer and Consumer Rights, tells this story about some horrific consequences of MICRA:

Twelve year old Steven Olsen is blind and brain damaged because, as a jury ruled, he was a victim of medical negligence when he was two years old. He fell on a stick in the woods while hiking. Under his family's HMO plan, the hospital pumped Steven up with steroids and sent him away with a brain tumor, although his parents had asked for a CAT scan because they knew Steven was not well. Steven Olsen came back to the hospital comatose. At trial, medical experts testified that had he received the \$800 CAT scan, which would have detected a growing brain mass, he would have his sight and be healthy today.

The jury awarded \$7.1 million in non-economic damages for Steven's avoidable life of darkness and suffering. However, the jury was not told of a two-decade-old restriction on non-economic damages in the state. The judge was forced to reduce the amount to \$250,000. The jurors only found out about their verdict had been reduced by reading about it in the newspaper. Jury foreman Thomas Kearns expressed his dismay in a letter published in the San Diego Union Tribune:

"We viewed a video of Steven, age 2, shortly before the accident. This beautiful child talked and shrieked with laughter as any other child at play. Later, Steven was brought to the court and we watched as he groped, stumbled and felt his way along the front of the jury box. There was no chatter or happy laughter. Steven is doomed to a life of darkness, loneliness and pain. He is blind, brain damaged and physically retarded. He will never play sports, work, or enjoy normal relationships with his peers. His will be a lifetime of treatment, therapy, prosthesis fitting and supervision around the clock."

Our medical-care system has failed Steve Olsen, through inattention or pressure to avoid costly but necessary tests. Our legislative system has failed Steven, bowing to lobbyists of the powerful American Medical Association (AMA) and the insurance industry, by the Legislature enacting

an ill-conceived and wrongful law. I think the people of California place a higher value on life than this.

In 2001, Steven had 74 doctor visits, 164 physical and speech therapy appointments, and three trips to the emergency room. And his parents say that was a good year because Steven was not hospitalized. Steven's mother Kathy had to leave her job because caring for Steven is a full time job. She has to struggle constantly with the school district for Steven to receive special education classes.⁴⁵

It is painfully obvious that a MICRA-style system will enrich some, but be devastating to those who will receive significantly less compensation for their needless injuries - injuries like Steven's.

THE MEDICAL LIABILITY MUTUAL INSURANCE COMPANY (MLMIC)

Created in the mid-1970s by the Medical Society of the State of New York, MLMIC is the state's largest medical malpractice insurer. MLMIC insures roughly half of the state's 32,000 privately insured physicians. MLMIC also covers some hospitals and dentists.⁴⁶

The company had an extremely successful period financially in the 1990s racking up big surpluses, much of which was returned to policyholders in the form of dividends each year.

MLMIC STATUTORY POLICYHOLDERS' SURPLUS, 1994-2000⁴⁷

Year	1994	1995	1996	1997	1998	1999	2000
Surplus (millions)	\$334	\$496	\$625	\$902	\$1,142	\$1,328	\$1,329

Mirroring the experience of most of the insurance industry, things changed for MLMIC after the beginning of the bear market and a subsequent precipitous drop in the value of investments on Wall Street after the Spring of 2000. As a result of depressed financial markets, MLMIC projected losses of \$92 million in 2001.⁴⁸ The loss was a big part of the rationale behind the Medical Society's campaign to limit patients' legal rights this year.

⁴⁵ Center for Democracy & Justice, 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, presented by Joanne Doroshov, 6/12/02.

⁴⁶ Medical Liability Mutual Insurance Company, 2000 Annual Report, "President's Report."

⁴⁷ MLMIC Annual Report

⁴⁸ Solnik, Claude, Denying hike, state freezes med mal rates, *Long Island Business News*, 7/19/02.

However, there is apparently little evidence of significant new malpractice losses that would require adding to the current value of the statutorily required surplus through premium increases. As a result, the State Insurance Department denied the insurer's request, even commenting that the projected 2001 losses might turn out to be lower than predicted by MLMIC.⁴⁹

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 included the following:⁵⁰

- **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.⁵¹ 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 payments.
- **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

⁴⁹ Ibid.

⁵⁰ Chapter 294 of the laws of 1985.

⁵¹ Further amended by Chapter 266 of the laws of 1986. Excess limit increased by Chapter 1 of the laws of 2002.

award if it “shocks the conscious of the court.” The current standard is that the award “deviates from that which would be reasonable compensation.”⁵²

- **Statute of limitations.** A change in 1975 created the current two and one-half year limit on the amount a time a legal action can be commenced after a medical injury occurred. The statute of limitations has three exemptions: (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.⁵³

These changes appear to have stabilized the medical malpractice situation. As mentioned earlier, over the past decade there have been little changes in malpractice litigation in New York State. Unfortunately, not nearly enough has been accomplished to reduce the needless patients’ injuries and deaths resulting from medical mistakes.

FIRST DO NO HARM SOME “REAL” MEDICAL MALPRACTICE REFORMS

STRENGTHEN PATIENT SAFETY EFFORTS

Policymakers must make protecting patient safety as their number one priority. Common sense proposals called for by the IoM and others should be the first steps taken by reformers and include:

1. **Better reporting of hospitals’ and physicians’ health care quality.** 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 included reports of the experience level of a hospital and its physicians in performing particular surgeries and other treatments.
2. **Create a system of periodic recertification of physicians.** Both the IoM⁵⁴ and the State Health Department⁵⁵ have recommended that

⁵² Chapter 682, of the laws of 1986.

⁵³ Chapter 476, of the laws of 1975.

⁵⁴ National Academy of Sciences’ Institute of Medicine, To Err is Human: Building A Better Health Care System, November 1999, p. 10.

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 almost impossible 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.

3. **Require the State Health Department to review malpractice payments by physicians to identify potential problems.** As mentioned earlier, a small percentage of physicians account for an extremely high percentage of malpractice payments in New York. The overwhelming majority of physicians make no malpractice payments, yet their high premiums help subsidize the losses caused by a few. The State Health Department collects insurer data on the malpractice payments of physicians and has recently pledged to use that data to identify problem doctors. A law should be passed to make that pledge a Departmental requirement.
4. **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.⁵⁶ The force of law should back up this common sense ethical requirement.
5. **Change New York State's medical malpractice statute of limitations.** 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.

Our organizations urge policymakers to focus their priorities on efforts to reduce medical mistakes and reject proposals to weaken the legal rights of injured patients and their families.

⁵⁵ 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.

⁵⁶ American Medical Association, Current Opinions of the Council on Ethical and Judicial Affairs, E-8.12 "Patient Information."

APPENDIX

DATA OBTAINED FROM THE NATIONAL PRACTITIONER DATA BANK