

# THE DOCTOR *IS* IN: NEW YORK'S INCREASING NUMBER OF DOCTORS

GOVERNMENT DATA REFUTES MEDICAL  
LOBBY'S CLAIMS



Endorsed by:  
B.E.S.T. F.R.I.E.N.D.S.  
Center for Justice & Democracy  
Center for Medical Consumers  
New York Public Interest Research Group  
New York StateWide Senior Action Council  
Patient Safety Alliance  
Public Citizen  
PULSE of New York

Written by:  
Frank Clemente, Public Citizen  
Blair Horner, NYPIRG  
Arthur Levin MPH, Center for Medical Consumers

October, 2004

To obtain copies of the report, please send \$5 to:  
NYPIRG  
107 Washington Avenue  
Albany, NY 12210  
Attn: "Patient Safety"

Or you can download a PDF version at:

[www.centerjd.org/medmalindex.htm](http://www.centerjd.org/medmalindex.htm)

[www.citizen.org](http://www.citizen.org)

[www.medicalconsumers.org](http://www.medicalconsumers.org)

[www.nypirg.org/health/medical](http://www.nypirg.org/health/medical)

# THE DOCTOR *IS* IN: NEW YORK'S INCREASING NUMBER OF DOCTORS

## TABLE OF CONTENTS

<b>Section</b>	<b>Page</b>
Executive Summary	1
The Number of Doctors in New York State Has Increased Significantly Despite High Malpractice Premiums	4
New York State Ranks Second in the Overall Number of Doctors and Near the Top in "High Risk" Specialties	5
Licensing of New Physicians in New York Has Been Steady	7
The Number of Doctors in Nonmetropolitan New York Has Substantially Increased	8
New York Surpasses California for Growth in Metropolitan and Nonmetropolitan Area Physician Availability	9
Demographic Shifts Are a Significant Factor in the Distribution of New York's Physicians	10
Demographic Shifts Indicate the Need for Obstetricians Has Decreased, Especially in Rural New York State	11
Doctors' Malpractice Payouts Increased at a Rate Consistent with Medical Care Cost Inflation	12
Congressional Watchdog Agency Finds AMA Claim of Malpractice Insurance "Crisis" Unsubstantiated	13
Many Factors Contribute to a Continually Low Supply of Rural Physicians	16
A New York Study Found a Relationship Between Age and Discontinuing Obstetrics Care but not Between Malpractice Premiums and Discontinuing Care	19
A Variety of Factors Have Led to a Nationwide Scarcity of Obstetrics Providers in Rural Areas	21
Why Doctors Practice Where They Do: Quality of Life, Not Caps on Damages	22
Recommendation: Protect Patients	28

# THE DOCTOR *IS* IN: NEW YORK'S INCREASING NUMBER OF DOCTORS

## Index of Charts

<b>Charts</b>	<b>Page</b>
Figure 1: The Increasing Number of Doctors in New York	4
Figure 2: The Number of Physicians, New York vs. California	6
Figure 3: The Number of Physicians Licensed, 1998 through 2003	7
Figure 4: Growth in the Number of Physicians, Metropolitan areas vs. Nonmetropolitan areas in New York State	8
Figure 5: Comparison of New York and California Physician Growth Per 100,000 People in Metropolitan and Nonmetropolitan Areas, 1991 and 2001	9
Figure 6: Population and Economic Change, by New York Region, 1990 – 2000	10
Figure 7: Population Change by Age, 1990 – 2000	11
Figure 8: Actual Medical Malpractice Payouts Compared with Projected Inflation-Adjusted Medical Malpractice Payouts, 1993 and 2003	12
Figure 9: States with the Most Doctors Per Capita	23
Figure 10: States with the Fewest Doctors Per Capita	23

**The Doctor Is In:  
New York's Increasing Number of Doctors  
Government Data Refutes Medical Lobby's Claims  
*Executive Summary***

For three years in a row, New York's medical and insurance lobby has rallied to protest what it calls "skyrocketing" medical malpractice premiums. Available governmental data show that there is no justification for the claims of the American Medical Association (AMA) and Medical Society of the State of New York (MSSNY) that New York is one of a number of states facing a crippling malpractice insurance "crisis." In fact, after ten years of no increase in overall malpractice premiums,<sup>1</sup> in 2003 and 2004 small increases of 8.5% and 7% respectively, were approved by the New York State Insurance Department. Hardly a "crisis."

*Yet, the facts haven't deterred the doomsayers from continuing to cry "crisis."*

The medical lobby's lead group, the Medical Society of the State of New York (MSSNY) has publicly warned, "Skyrocketing liability exposure threatens to limit patient access" to health care. In particular, MSSNY predicted New York's "cost of liability insurance threatens to severely limit the availability of physicians to deliver babies and provide essential pre-natal care."<sup>2</sup> Last year, the American College of Obstetricians/Gynecologists (ACOG) went so far as to issue a flyer with the headline "Help! You may lose your OB/GYN." The flyer urged patients to contact their OB/GYN to get "the addresses and telephone numbers of people who need to hear from you," meaning lawmakers.<sup>3</sup>

These scare tactics continued. As part of a national news conference, the situation in New York was labeled a "medical crisis." The lobbying group stated

"Will your doctor be there when you need him? Can you find a specialist in New York willing to perform your needed surgery? Is there a radiologist willing to read your mammogram? Will the obstetrician who delivered your first child be available to deliver the second? Unfortunately, many New Yorkers are finding out that the answer to these questions is no."<sup>4</sup>

---

<sup>1</sup> "Overall" premiums are the aggregate average premium costs for physicians, not for the premiums paid by specialties.

<sup>2</sup> The Medical Society of the State of New York, 2003 Legislative Program, p. 9.

<sup>3</sup> The American College of Obstetricians and Gynecologists, "Red Alert: Women's Health Care At Risk, The Professional Liability Crisis," undated, obtained by authors in April 2003.

<sup>4</sup> Doctors for Medical Liability Reform, "There is a Serious Medical Crisis in New York," [www.protectpatientsnow.org/866.html](http://www.protectpatientsnow.org/866.html), 2/10/04.

Such scare tactics are designed to frighten New Yorkers, and their lawmakers, into siding with the medical lobby and its insurance allies. In truth, despite New York having medical malpractice premiums that are higher than the national average, there have *not* been negative impacts on the number of practicing physicians. In fact, New York State has one of the highest per capita number of physicians in the nation. This report is written to arm New Yorkers with the truth so that they can recognize and disregard the fabrications and “spin doctoring” of the medical lobby. This report finds:

- **New York State has the second 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 1995 through 2003 the number of active physicians practicing in New York increased 16.4%. During the period 1990 through 2000, the state’s population grew a mere 5.5%.
- **National data shows that the number of physicians per capita is increasing *faster* in New York than nationally.** According to the New York State Conference of Blue Cross and Blue Shield Plans, between 1980 and 2001 the national physician to population ratio had grown by 46.6% while in New York the ratio increased 47.5%.
- **New York is among the top states for physicians practicing in the “high-risk” specialties of OB/GYN and surgery.** New York has the fourth highest number of OB/GYNs per capita in the country. The per capita number of New York general surgeons is *second* highest in the nation and New York has the *highest* per capita number of surgical specialists.
- **New York State is adding physicians in rural areas at an even faster rate than in metropolitan areas.** Between 1991 and 2001, the number of physicians practicing in nonmetropolitan New York increased by 18.8%, and by 12.3% in metropolitan areas, according to the U.S. Government Accountability Office (GAO), the non-partisan investigative arm of Congress.
- **The number of specialists in nonmetropolitan New York increased at an even faster rate than in metropolitan New York.** Between 1991 and 2001, the number of specialists practicing in nonmetropolitan areas of New York increased by 26.9% compared with 14% in metropolitan areas.
- **Physician shortages that exist in New York’s rural areas are longstanding and correlate to stagnating local economies and decreasing populations in those regions, not to lawsuits or the legal system.** Population growth in all of New York was 5.5% from 1990 to 2000, but *declined* .5% in western and northern New York – areas that

contain the most rural parts of the state. The number of people in New York aged 20-to-34 – the prime child-bearing ages – declined 5.4% throughout the state from 1990 to 2000 but dropped 23.1% in western and northern New York. Moreover, employment growth and wage growth were both much more sluggish in western and northern New York than in the entire state during that period.

- **The total amounts paid on behalf of New York physicians to injured patients for malpractice judgments and settlements have risen at roughly the same rate as inflation throughout the medical services sector from 1993 through 2003.** Medical malpractice payouts and on behalf of New York physicians were \$495.7 million in 1993 and climbed to \$705.7 million by 2003, according to the National Practitioners Data Bank. But over those 11 years, medical care inflation increased about 50%. Based on medical care inflation, the 1993 amount would be \$731.2 million – slightly more than the actual payouts of \$705.7 million.
- **New York State significantly outpaces California, where malpractice insurance rates are lower, in the number of practicing physicians per capita.** The AMA and other liability cap advocates consider California as a model for medical malpractice “reform,” but lower insurance rates aren’t enough to keep doctors in practice there. New York ranks 2<sup>nd</sup> in the overall doctors per 100,000 people, but California only ranks 15<sup>th</sup>. Moreover, the pool of practicing physicians from all specialties, in both metropolitan and nonmetropolitan New York is growing significantly faster than in California.

## The Number of Doctors in New York State Has Increased Significantly Despite High Malpractice Premiums

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 1], according to the Federation of State Medical Boards of the United States. However, the state’s population grew a mere 5.5% from 1990 to 2000.<sup>5</sup>
- The increase of 8,250 physicians licensed in-state during that same period represented a 12.3% increase.
- Moreover, the overall physician to population ratio grew by 47.5% in New York State from 1980 to 2001 compared to 46.6% nationally – according to the New York State Conference of Blue Cross and Blue Shield Plans.<sup>6</sup>

**Figure 1**  
**Doctors Licensed in New York State, 1995 – 2003<sup>7</sup>**

<b>Year</b>	<b>Total licensed doctors</b>	<b>Doctors practicing in-state</b>
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>5</sup> U.S. Census, see: <http://quickfacts.census.gov/qfd/states/36000.html>.

<sup>6</sup> New York State Conference of Blue Cross and Blue Shield Plans, “The Facts About Physician Supply,” [www.nysblues.org](http://www.nysblues.org), citing the American Medical Association, “Physician Characteristics and Distribution in the U.S., 2003-2004 Edition, ‘nonfederal physicians.’”

<sup>7</sup> The Federation of State Medical Boards of the United States, Inc. “Summary of Board Actions,” 1996 through 2004.

## New York State Ranks Second in the Overall Number of Doctors and Near the Top in “High Risk” Specialties

The medical lobby claims that rising malpractice premiums are forcing New York doctors to quit practicing “high-risk” specialties, including obstetrics, general surgery and neurological surgery. They have warned *“Skyrocketing premiums have forced obstetricians to discontinue the obstetrical side of their practices, to retire early, or relocate. This leaves women without access to the critical obstetrical care they need.”*<sup>8</sup> But New York boasts a very high per capita ratio of doctors practicing these “high risk” specialties.

Moreover, a comparison of New York with California, the state offered as a model of medical malpractice “reform,” but which imposes draconian limits on the legal rights of people harmed by medical malpractice, illustrates how little malpractice premiums affect the availability of physicians.

- New York State had the second highest number of physicians per capita in 2001, whereas California ranked 15<sup>th</sup>. New York had 50% more physicians per capita than California – 328 vs. 218 per 100,000 [See Figure 2].
- The number of New York doctors specializing in obstetrics and gynecology is fourth highest in the nation. New York has 38 OB/GYNs to every 100,000 females. The national average is 28 per 100,000 women. California ranks 18<sup>th</sup> in the nation.
- The number of New York general surgeons is second highest and the number of surgical specialists is the highest in the nation. California is ranked 35<sup>th</sup> when it comes to its ratio of general surgeons and 20<sup>th</sup> when it comes to surgical specialists.

---

<sup>8</sup> American College of Obstetricians and Gynecologists (ACOG) in an *April 22, 2002* News Release.

**Figure 2**  
**Ranking of Physicians Per Capita, New York State Vs. California, 2001<sup>9</sup>**

<b>Category of physicians</b>	<b>New York State's national ranking (2001)</b>	<b>California's national ranking (2001)</b>
Surgical specialists	1 (74 per 100,000)	20 (51)
OB/GYNs	4 (38)	18 (27)
General surgeons	2 (18.8)	35 (10.8)
Medical specialists	2 (155)	12 (85)
Orthopedic surgeons	9 (9.2)	27 (7.7)
Plastic surgeons	1 (3.3)	6 (2.7)
Ophthalmologists	2 (9.3)	14 (6.3)
Podiatrists	1 (10.1)	18 (4.4)
Internists	2 (89)	14 (44)
Pediatricians	2 (147)	18 (78)
Primary care physicians	4 (137)	20 (96)
General practice physicians	47 (20)	30 (29)
<b>Overall number of physicians</b>	<b>2 (328 per 100,000)</b>	<b>15 (218 per 100,000)</b>

<sup>9</sup> New York State Conference of Blue Cross and Blue Shield Plans, "The Facts About Physician Supply," [www.nysblues.org](http://www.nysblues.org), 2001.

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

New York State continues to issue physicians licenses at a steady rate, according to the State Education Department. In fact, the number of new physicians being licensed was higher in 2003 than any previous year, [See Figure 3].

**Figure 3**  
**New York State Physician Licenses Issued, 1998 – 2003<sup>10</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>11</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>12</sup> (Note: First year physicians typically receive huge discounts in malpractice premiums.<sup>13</sup>)

<sup>10</sup> New York State Education Department, Office of the Professions, <http://www.op.nysed.gov/medcounts.htm>.

<sup>11</sup> University at Albany, State University of New York, Center for Health Workforce Studies, [Residency Training Outcomes in New York State, 2002](#).

<sup>12</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>13</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.

## The Number of Doctors in Nonmetropolitan New York Has Substantially Increased

One of the most repeated claims of the medical lobby – and one that has attracted the most attention from the media – is that New York’s higher than the national average malpractice premiums has led to a crisis in access to health care in rural New York. ***It’s not true.*** In fact, New York State is adding physicians in nonmetropolitan areas at a faster rate than in metropolitan areas.<sup>14</sup>

According to the U.S. Government Accountability Office (GAO), which is the non-partisan investigative arm of Congress (previously named the General Accounting Office):

- Growth among all physicians and generalists was 53% and 107% higher, respectively, in *nonmetropolitan* areas of New York as compared to *metropolitan* areas during the last decade. For the period 1991 to 2001, the total number of physicians per 100,000 people grew by 18.8% in nonmetropolitan New York compared with only 12.3% in metropolitan areas. For the same period, the number of generalists per 100,000 nonmetropolitan New Yorkers increased 21.6% compared with an increase of 10.4% in metropolitan New York [See Figure 4].
- The number of *specialists* practicing in New York’s nonmetropolitan areas grew 26.9% between 1991 and 2001, compared with 14% in metropolitan areas.

**Figure 4**  
**Growth in Physicians Per 100,000 People, 1991 and 2001<sup>15</sup>**

	Metropolitan New York		Nonmetropolitan New York	
Physicians per 100,000 (1991)	318	<b>12.3%</b> <b>Increase</b>	121	<b>18.8%</b> <b>Increase</b>
Physicians per 100,000 (2001)	357		149	
Generalists per 100,000 (1991)	115	<b>10.4%</b> <b>Increase</b>	51	<b>21.6%</b> <b>Increase</b>
Generalists per 100,000 (2001)	127		62	
Specialists per 100,000 (1991)	200	<b>14%</b> <b>Increase</b>	67	<b>26.9%</b> <b>Increase</b>
Specialists per 100,000 (2001)	228		85	

<sup>14</sup> According to the U.S. Census Bureau, the term “metropolitan area” contains at least one urban area of 10,000 or more population. Each metropolitan statistical area must have at least one urbanized area of 50,000 or more inhabitants.

See: [www.census.gov/population/www/estimates/aboutmetro.html](http://www.census.gov/population/www/estimates/aboutmetro.html).

<sup>15</sup> General Accounting Office, Physician Workforce: Physician Supply Increased in Metropolitan and Nonmetropolitan Areas But Geographic Disparities Persist, October 2003, p. 25. “Nonmetropolitan areas” are those areas of New York State that are outside of the urban and suburban populations of the state.

## New York Surpasses California for Growth in Metropolitan and Nonmetropolitan Area Physician Availability

Once again, New York State outpaced California for physician growth in metropolitan and nonmetropolitan areas. Clearly, factors other than the cost of medical practice insurance play the principal role in deciding where to set up practice.

According to the GAO, only 17 areas across the nation saw the number of physicians per 100,000 decline between 1991 and 2001. Five of the 17 areas were in California and none were in New York State.<sup>16</sup> The fact that almost a third of the areas where physician supply declined were in California suggests that factors other than tort laws determine where physicians choose to practice.

In fact, according to the GAO, New York State physician growth is considerably higher than in California in both urban and rural areas [See Figure 5].

**Figure 5**  
**Comparison of New York and California Physician Growth Per 100,000 People in Metropolitan and Nonmetropolitan Areas, 1991 and 2001**<sup>17</sup>

	Metropolitan New York		Metropolitan California		Non-metropolitan New York		Non-metropolitan California	
Physicians per 100,000 (1991)	318	<b>12.3% Increase</b>	225	<b>1.7% Increase</b>	121	<b>18.8% Increase</b>	112	<b>15.2% Increase</b>
Physicians per 100,000 (2001)	357		229		149		129	
Generalists per 100,000 (1991)	115	<b>16.4% Increase</b>	78	<b>6.4% Increase</b>	51	<b>21.6% Increase</b>	52	<b>13.5% Increase</b>
Generalists per 100,000 (2001)	127		83		62		59	
Specialists per 100,000 (1991)	200	<b>16% Increase</b>	144	<b>0% Increase</b>	67	<b>26.9% Increase</b>	58	<b>19% Increase</b>
Specialists per 100,000 (2001)	228		143		85		69	

<sup>16</sup> GAO, p. 3

<sup>17</sup> GAO, p. 23 and 25.

## Demographic Shifts Are a Significant Factor in the Distribution of New York's Physicians

While the overall physician growth rate in rural New York is much more robust than in urban New York, some areas of the state continue to be medically underserved – both rural and urban. But there is no evidence that this is due to malpractice lawsuits or insurance rates.

Loss of doctors is much more likely due to declining populations and incomes in rural New York, as compared to the rest of the state. After all, physicians need a steady stream of patients for their practice to survive, and they need patients who have jobs with insurance coverage or else a decent income to pay for services. This is especially true today, as low reimbursement rates from the private sector and government programs have put a crimp in physicians' incomes. Consider these major demographic trends:

- Population growth in all of New York State was 5.5% from 1990 to 2000, but actually declined .5% in western and northern New York – areas that contain the most rural parts of the state [See Figure 6].
- Employment growth in the entire state was 11.2% from 1992 through 2000, but only grew at a 5.9% rate in the most rural parts of the state.
- Differences in wages was even more dramatic – increasing at a 29.4% rate from 1992 to 2000 in all of New York, but only at a 10.4% rate in the areas containing the most rural parts of the state.

**Figure 6**  
**Population and Economic Change, by New York Region, 1990 – 2000<sup>18</sup>**

	2000 Population	% of the state	1990-2000 Pop. Chg. %	1992 – 2000	
				Employment Change %	Total Wage Change %
New York State	18,976,457	100%	5.5%	11.2%	29.4%
New York City	8,008,278	42%	9.4%	12.0%	38.4%
Eastern New York	5,963,029	32%	5.7%	11.7%	21.4%
Western and Northern N.Y.	5,005,150	26%	-0.5%	5.9%	10.4%

<sup>18</sup> Source: U.S. Census Bureau and New York State Labor Department, from the Fiscal Policy Institute, *The State of Working New York 2003*, released in 2004, p. 17. The term “Eastern New York” represents the Capital District, the Hudson Valley and Long Island, the term “Western and Northern New York” represents the remainder of non-New York City, New York.

## Demographic Shifts Indicate the Need for Obstetricians Has Decreased, Especially in Rural New York State

Demographic trends also play a major role in the types of physicians' services that are needed. For example, the need for obstetricians should ebb and flow according to increases or decreases in the number of women of childbearing age. In fact, the areas of the state most identified by the insurance and medical lobby as most lacking in access to obstetricians are precisely those areas that have experienced a dramatic population decline among 20-to-34 year olds.

- New York State's 20-to-34 year old population declined 12% from 1990 to 2000. But in Western and Northern New York, the most rural areas of the state, the drop was 23.1%, or nearly double [See Figure 7].

**Figure 7**  
**Population Change by Age, 1990 – 2000<sup>19</sup>**

Region	1990	2000	% Change
<b>United States</b>			
Total	248,709,873	281,421,906	13.2%
16-64	160,578,562	182,157,374	13.4%
20-34	62,196,244	58,855,725	-5.4%
<b>New York State</b>			
Total	17,990,455	18,976,457	5.5%
16-64	11,826,584	12,348,932	4.4%
20-34	4,547,087	4,001,633	-12.0%
<b>New York City</b>			
Total	7,322,564	8,008,278	9.4%
16-64	4,862,861	5,336,794	9.7%
20-34	1,945,991	1,957,852	0.6%
<b>Eastern New York</b>			
Total	5,639,028	5,963,029	5.7%
16-64	3,741,774	3,821,781	2.1%
20-34	1,364,680	1,092,403	-20.0%
<b>Western and Northern New York</b>			
Total	5,028,863	5,005,150	-0.5%
16-64	3,221,949	3,190,357	-1.0%
20-34	1,236,416	951,378	-23.1%

<sup>19</sup> Fiscal Policy Institute, p. 30.

## Doctors' Malpractice Payouts Increased at a Rate Consistent with Medical Care Cost Inflation

For public policy purposes, an important medical malpractice cost “bellwether” is the amount of aggregate dollars paid out to settle all malpractice claims in a given year. While there has been a significant increase in the total value of malpractice payouts over the past ten years, as the chart below demonstrates, the increase appears to be consistent with the overall level of medical care inflation. Medical care inflation, which has risen less than 5 percent a year over the last decade, is a conservative estimate of increased health costs.

- The amount that New York State physicians paid out for medical malpractice claims remained stable from 1993 through 2003, after adjusting for medical care inflation [See Figure 8].

**Figure 8**  
**Actual Medical Malpractice Payouts Compared with Projected Inflation-Adjusted Medical Malpractice Payouts, 1993 and 2003<sup>20</sup>**

Year	Malpractice Payouts
1993 <i>Actual</i> Physicians' Malpractice Payouts	\$495,721,030
2003 <b>Projected</b> Malpractice Payouts in Adjusted for Medical Care inflation with 1993 as Base	\$731,152,847
2003 <i>Actual</i> Physicians' Malpractice Payouts	\$705,662,293

<sup>20</sup> Physician malpractice payout data from the National Practitioner Data Bank, information obtained by the Patient Information Alliance. Used with permission. For the “projected” category, using the 1993 actual figures as a base, the authors calculated how medical care inflation would have increased the 1993 costs through 2003. Medical care inflation source: Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers 1993 – 2003. Calculations by authors. Totals rounded off to the nearest dollar.

## Congressional Watchdog Agency Finds AMA Claim of Malpractice Insurance “Crisis” Unsubstantiated

The AMA and the state Medical Society have claimed that rising malpractice premiums are limiting consumers’ access to health care by driving doctors either out of practice, or out of the state. The non-partisan watchdog, the U.S. Government Accountability Office (GAO) took a look at conditions in five of the AMA’s “crisis” states to determine whether there was evidence to support the claim that rising malpractice premiums affects consumers’ access to health care.

These findings have direct bearing on New York, one of the AMA’s target “crisis” states. In fact, the AMA explicitly asked whether these findings apply to states other than the five under study. The GAO replied this way: “While we did not attempt to generalize our findings beyond these five states, we believe that – because they are among the most visible and often-cited examples of ‘crisis’ states – the experiences of these five states provide important insight into the overall problem.”<sup>21</sup>

The GAO’s findings, published in a August 2003 report, should incite skepticism among New Yorkers about the health industry lobby’s claims that rising premiums are, or could be, limiting their access to health care. We highlight some of their conclusions below:

- **Many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis.** The GAO examined in-depth states on the AMA’s malpractice crisis list: Florida, Mississippi, Nevada, Pennsylvania and West Virginia. The study failed to find convincing evidence that increased malpractice insurance premiums had caused a significant number of physicians to move, retire or reduce high-risk services.

The GAO report said: “In the five states with reported problems ... *we determined that many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to health care.* For example, some reports of physicians relocating to other states, retiring or closing practices were not accurate or involved relatively few physicians.” [emphasis added]<sup>22</sup>

---

<sup>21</sup> GAO, Medical Malpractice: Implications of Rising Premiums on Access to Health Care, GAO-03-836, August 2003, p. 7.

<sup>22</sup> GAO Study, p. 5.

Although the GAO confirmed instances in which “actions taken by physicians [in response to malpractice insurance rates] have reduced access to services ... these were not concentrated in any one geographic area and often occurred in rural locations, where maintaining an adequate number of physicians may have been a long standing problem.”<sup>23</sup> The GAO further reported “the problems we confirmed were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services.”<sup>24</sup>

- **The GAO found no decreases in three specialty services frequently cited by the AMA as being most adversely affected.** After analyzing utilization rates among Medicare beneficiaries in the five states, the GAO found that spinal surgeries actually increased during the so-called “crisis” period. Moreover, the rate of spinal surgeries in the five “crisis” states was higher than the national average. Similarly, the GAO found that utilization rates of mammograms increased during the “crisis” period and were higher in the five states studied than the national average. Utilization of joint revision and repair services (hip, knee and shoulder repairs) in the five states studied was slightly below the national average but had not recently declined.<sup>25</sup>

Regarding three of the specific states covered in its study, the GAO reported:

- **Florida:** In Florida, where doctors successfully lobbied for the passage of a cap on damages, “[r]eports of physician departures ... were anecdotal, not extensive, and in some cases ... inaccurate. For example, state medical society officials told us that Collier and Lee counties lost all of their neurosurgeons due to malpractice concerns; however, we found at least five neurosurgeons currently practicing in each county as of April 2003. ... [O]ver the past two years the number of new medical licenses issued has increased and physicians per capita has remained unchanged.”<sup>26</sup>
- **Nevada:** “In Nevada, 34 OB/GYNs reported leaving, closing practices, or retiring due to malpractice concerns; however, confirmatory surveys conducted by the Nevada State Board of Medical Examiners found nearly one-third of these reports inaccurate ... Random calls [GAO] made to 30 OB/GYN practices in Clark County found that 28 were accepting new patients ... Similarly, of the

---

<sup>23</sup> GAO Study, p. 5.

<sup>24</sup> GAO Study, p. 19.

<sup>25</sup> GAO Study, p. 20.

<sup>26</sup> GAO Study, p. 17.

11 surgeons reported to have moved or discontinued practicing, the board found four were still practicing.”<sup>27</sup>

- **Pennsylvania:** “In Pennsylvania, despite reports of physician departures, the number of physicians per capita in the state has increased slightly during the past six years. The Pennsylvania Medical Society reported that between 2002 and 2003, 24 OB/GYNs left the state due to malpractice concerns; however, the state’s population of women age 18 to 40 fell by 18,000 during the same time period.”<sup>28</sup>

---

<sup>27</sup> GAO Study, p. 18.

<sup>28</sup> GAO Study, p. 18.

## Many Factors Contribute to a Continually Low Supply of Rural Physicians

Leaders of the medical community have raised alarm that due to unlimited malpractice awards, doctors in rural New York are being forced to leave their practices and some specialties are no longer available throughout the state. As demonstrated earlier, government data shows that New York is one of the most physician-rich states in the nation.

But to the extent that doctors practicing certain specialties are not available in some parts of the state, it is not likely that it is caused by a spike in malpractice insurance rates or a result of unlimited non-economic damages. As seen earlier, New York's economic growth has been unevenly distributed with some rural parts of the state stagnating both in terms of wages and population.

For decades, many rural communities have not had the number of medical professionals that most experts consider adequate.<sup>29</sup>

- **Access to medical care has long been a problem throughout rural America.** According to the Council on Graduate Medical Education (COGME), "Geographic maldistribution of health care providers and services [the tendency for physicians to practice in affluent urban and suburban areas] is one of the most persistent characteristics of the American health care system. Even as oversupply of some physician specialties is apparent in many urban health care service areas across the country, many inner-city and rural communities still struggle to attract an adequate number of health professionals to provide high-quality care to local people. This is the central paradox of the American health care system: shortages among surplus."<sup>30</sup>

COGME also notes, "The relative shortage of health professionals in rural areas of the United States is one of the few constants in any description of the United States medical care system."<sup>31</sup>

- **Attracting and retaining rural doctors is currently a problem throughout the country – not just in states that do not limit malpractice awards.**

---

<sup>29</sup> Ricketts, T. *Special People for Special Places*, *The Journal of Rural Health*, Spring 1999, at 210.

<sup>30</sup> Council on Graduate Medical Education, *Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner City Areas*, see: [www.cogme.gov/10.pdf](http://www.cogme.gov/10.pdf), at p. xiii.

<sup>31</sup> COGME at p. 11.

Rural doctors around the country find it difficult to recruit colleagues, and community groups in rural areas have similar troubles in recruiting doctors to work in their communities.<sup>32</sup>

Although nearly 25 percent of the U.S. population resides in rural areas, only about 10 percent of the nation's doctors work in these areas.<sup>33</sup>

- **A number of factors have been cited by doctors and researchers to explain the low supply of rural doctors.**

People who live in rural areas are more likely to be uninsured than those who live in urban areas, meaning that they see a doctor less often or are often a financial liability for doctors who care for them.<sup>34</sup>

The percentage of public health recipients is also greater in rural areas.<sup>35</sup> Low Medicare and Medicaid reimbursement rates can be crippling for these doctors.

Rural doctors have a lower volume of patients, while costs for things like equipment remain the same.<sup>36</sup>

Rural doctors report that they are overworked.<sup>37</sup>

Rural doctors are more likely to report that they receive inadequate assistance and coverage from other health professionals. One study of obstetricians and gynecologists in North Carolina investigated these doctors' perceptions of adequacy of consultation and coverage and found that 13 percent of rural physicians but only 1.5 percent of urban physicians in North Carolina indicated that assistance (opportunities for colleagues to see patients and review charts) in high-risk delivery situations was "inadequate" or "very inadequate." In terms of coverage (opportunities for colleagues to assist in the primary doctor's absence), 16.7 percent of rural physicians and only 2.5 percent of urban physicians indicated that coverage was "inadequate" or "very inadequate."<sup>38</sup>

---

<sup>32</sup> Ricketts at p. 210.

<sup>33</sup> Gamm L., Huchison L., Dabney B., and Dorsey A., eds. (2003). *Rural Healthy People 2010: A Companion Document to Healthy People 2010, Volume 2*, at 17, available at [www.srph.tamushsc.edu/rhp2010/litreview/Volume2.pdf](http://www.srph.tamushsc.edu/rhp2010/litreview/Volume2.pdf).

<sup>34</sup> Gamm L., Huchison L., Dabney B., and Dorsey A., eds. (2003). *Rural Healthy People 2010: A Companion Document to Healthy People 2010, Volume 1*, at 19, available at [www.srph.tamushsc.edu/rhp2010/litreview/Volume1.pdf](http://www.srph.tamushsc.edu/rhp2010/litreview/Volume1.pdf).

<sup>35</sup> Fondren, L. and Ricketts, T. The North Carolina Obstetrics Access and Professional Liability Study: A Rural-Urban Analysis. *The Journal of Rural Health*, Spring 1993, at 135.

<sup>36</sup> Kramer, A. Rural Areas a Hard Sell for Doctors; Practicing Medicine in the Country is Becoming More of a Money-Losing Proposition. *Fewer Hours and Lower Costs Lure Many to Cities.* *Los Angeles Times*, October 12, 2003.

<sup>37</sup> Ricketts at p. 210.

<sup>38</sup> Fondren and Ricketts.

Studies indicate that women are less likely to settle in rural areas than are men. As the percentage of doctors who are women increases, it has been suggested that women' preferences for urban practice may be contributing to the problem of recruiting and retaining rural doctors.<sup>39</sup>

- **Numerous additional factors explain the limited number of rural doctors.** According to the Association of Maternal and Child Health Programs, the health departments in Alaska, Idaho and Washington, cite the following barriers to attracting doctors to rural areas of their states.<sup>40</sup>
  1. “**Burnout** is one reason it is so difficult to retain qualified primary care providers. Physicians note that as the only doctor in a small, isolated community they are on-duty 24-7 and can expect to be asked for medical opinions at the post office, grocery store or a 2:00 a.m. call at home from a worried family member. Taking time off for vacation or professional training means complicated arrangements for a substitute doctor.”
  2. “**Isolation** is a factor in rural practice, not only for the physician but also for their families. Physicians note that while they may find rural practice challenging and engaging, their families may be less enthusiastic. Rural areas offer limited employment opportunities for spouses and limited educational, recreational and social opportunities for children. Physicians are also isolated from colleagues. Rural physicians are not able to enjoy the day-to-day personal contact with peers for consultations, quality assurance and feedback.”
  3. “**Wages** are generally lower for non-urban practitioners. Higher rates of unemployment and poverty, uninsured residents and fewer patients mean rural communities are less able to match the financial incentives and job benefits offered in urban areas.”
  4. “**Community and cultural connections** are important for both physicians and the patients they serve, but are not easily made. Physicians and health care providers are usually recruited from larger urban areas or from out-of-state and usually have limited knowledge of the health needs, culture or history of the people in their care. At the same time the physician is feeling disconnected, community members are reluctant to accept or support a new physician unless they have proven their commitment to the community over time.”
  5. “**The health care infrastructure** – such as a hospital, clinic and laboratory facilities – supports primary health care providers. Physicians are reluctant to locate in a community without a hospital or other supporting facilities.”

---

<sup>39</sup> COGME at p. 17.

<sup>40</sup> The Association of Maternal Child Health Programs, *From Rural to Remote: Family Health Care in Alaska, Idaho, Oregon and Washington* (March 2004) at 11, available at: [www.amchp.org/aboutamchp/Rural%20Health.pdf](http://www.amchp.org/aboutamchp/Rural%20Health.pdf).

## A New York Study Found a Relationship Between Age and Discontinuing Obstetrics Care but not Between Malpractice Premiums and Discontinuing Care

The medical lobby has repeatedly claimed that “skyrocketing” malpractice premiums would reduce New Yorkers’ access to obstetric care. They have used overheated rhetoric to frankly scare the public. For example, last year the medical lobby claimed “More than 100,000 women in New York could be without their obstetricians July 1<sup>st</sup>. On July 1<sup>st</sup> a proposed insurance rate increase around 20 percent will put many of my colleagues over the edge.”<sup>41</sup> The fact is that the overall malpractice premium increase was 8.5 percent and there was no such loss in access.

Undeterred by the facts, lobbyists for the OB/GYNs continue to twist the truth in order to spin a “crisis.” Most recently they have claimed that in “seven upstate counties where there are no Obstetricians at all and eight other upstate counties where there is only one active Obstetrician in each ...”<sup>42</sup>

This statement is supposed to make the public think that malpractice premiums are the cause of a shortage of OB/GYNs in some upstate counties. But malpractice premiums in the largely rural counties of Livingston, Monroe, Ontario, Seneca, Wayne and Yates have not seen appreciable increases!<sup>43</sup> The areas with the biggest premium increases are downstate, precisely the areas that do not lack OB/GYNs. And, besides, those rural areas of the state that suffer an OB/GYN shortage, generally suffer from a shortage of *all* kinds of physician specialists.

These conclusions are further undercut by the fact that doctors often choose to quit obstetrics as they get older – for lifestyle reasons and not because of high liability premiums.

- **A University of California-San Francisco study of New York doctors found that the main reason doctors cease providing obstetrics care is advancing age.** The UCSF study, of New York State physicians during the mid-1980s insurance crisis, found no association between malpractice premiums and doctors’ decisions to quit.<sup>44</sup> The study did

---

<sup>41</sup> ACOG in a *June 11, 2003* News Release.

<sup>42</sup> ACOG Fact Sheet.

<sup>43</sup> According to tables produced by Medical Liability Mutual Insurance Company, OB/GYNs in region 6 (which contains the above-referenced counties), premiums were \$26,945 in 2000 and \$26,029 in 2003 (despite a 2002 change in coverage that increased the statewide average premium by 5%).

<sup>44</sup> Grumbach, et al. Charges for Obstetric Liability Insurance and Discontinuation of Obstetric Practice in New York, *The Journal of Family Practice*, Vol. 44, No. 1 (Jan. 1997) at 61.

find that the decrease in doctors practicing obstetrics was associated with the *length of time* since receiving a medical license in New York. This relationship “very likely represents the phenomenon of physician retiring from practice or curtailing obstetrics as they age.”<sup>45</sup>

- **Obstetricians frequently cut back their practice as they advance in years.** As doctors become more financially secure, and as the child-bearing years of their patients pass, many obstetricians give up the demands of delivering babies in favor of concentrating on the gynecological needs of their patients. For example, in 2000, 18.7 percent of Georgia’s OB/GYNs were between 40 and 44 years old, but only 11.1 percent of OB/GYNs were 50 –54 years old – a decrease of 40 percent.<sup>46</sup>
- **A North Carolina survey found that the main reasons doctors decreased their obstetric patients were unrelated to fear of lawsuits.** The authors noted that while some providers whose obstetrical patient volume had decreased cited fear of lawsuits as a factor, “... [T]his was not the overwhelming reason for stopping or planning to stop deliveries. The strain and inconvenience of the practice and problems of burnout also were issues.”<sup>47</sup>

---

<sup>45</sup> Grumbach, et al. Charges for Obstetric Liability Insurance and Discontinuation of Obstetric Practice in New York, *The Journal of Family Practice*, Vol. 44, No. 1 (Jan. 1997) at 61.

<sup>46</sup> Georgia Board for Physician Workforce, “Physician Workforce 2000 Report,” August 2001.

<sup>47</sup> Fondren and Ricketts at p. 136.

## A Variety of Factors Have Led to a Nationwide Scarcity of Obstetrics Providers in Rural Areas

The lack of obstetric care in rural areas is a problem throughout the United States. To the extent that certain areas of New York lack doctors who perform deliveries, many factors other than high liability premiums contribute to this scarcity.

- **When premiums decline, rural areas often do not see an increase in the providers willing to provide obstetrical care.** In many states, reducing malpractice rates did not bring obstetrical providers back to rural areas.<sup>48</sup> One study of doctors in North Carolina found that tort limits and a malpractice subsidy “did not seem to be extremely important in their decision-making process over whether to remain in obstetrics or to expand access to their practices.” Instead the authors stated that, “The data suggest that the clinical network supporting rural obstetrics might be more of a key to the problems of access to care in rural areas than tort reform ...”<sup>49</sup>
- **Throughout the country, few obstetricians practice in rural communities.** According to a nationwide study reported by COGME, in 1995 rural counties where the largest towns had fewer than 10,000 people had an average of less than three OB/GYNs.<sup>50</sup>
- **There is a decreased demand for obstetric services in many parts of rural New York.** As seen earlier, in some parts of rural New York, there has been a dramatic decline in the number of adults of childbearing age.

---

<sup>48</sup> Taylor, D., et al. One State's Response to the Malpractice Insurance Crisis: North Carolina's Rural Obstetrical Care Incentive Program, *Public Health Reports*, Vol. 107, No. 5 (Sept-Oct 1992).

<sup>49</sup> Fondren and Ricketts at p.136.

<sup>50</sup> COGME at p. 15.

## Why Doctors Practice Where They Do: Quality of Life, Not Caps on Damages

The AMA and the Medical Society claim that doctors will leave New York and other states with high malpractice premiums to settle in states where damage awards are limited and premiums are more stable. If this were true there would be more doctors in states that already have enacted caps on damages. In reality, the existence of damage caps has no relationship to the number of doctors in each state.<sup>51</sup>

- **Liability laws do not correlate with where doctors locate their practices.** The following figures compare the states with the most per capita number of doctors in 2001 with the states with the fewest per capita number of doctors.<sup>52</sup>

While four of the states with the fewest per capita number had enacted caps on non-economic damages, only three of the states with the highest number of doctors had enacted them. Similarly, while three of the states with the fewest per capita number of physicians had enacted caps on punitive damages, only three of the states with the most number of doctors had capped punitive damages.

According to the U.S. Chamber of Commerce, Iowa, Utah and South Dakota rank 5<sup>th</sup>, 8<sup>th</sup> and 9<sup>th</sup> for having a “reasonable litigation environment.” Yet those states rank 47<sup>th</sup>, 42<sup>nd</sup>, and 44<sup>th</sup> respectively in the per capita number of doctors. Only one of the Chamber’s legal climate top ten, Connecticut, also ranks among the top ten for the capita number of doctors.<sup>53</sup>

- **Doctors choose to reside in states they deem to have a higher quality of life, not because of state liability laws.** Like anyone else, doctors want to live in places where they can earn high incomes, enjoy cultural and leisure activities, and send their children to good schools. Doctors migrate to states on lists of “Best Places to Live”:

40 of the top 100 cities with “strong arts, cultural programs, and higher education” were in the top states with the most per capita number of doctors, while there were none in the ten states with the fewest per capita number of doctors.<sup>54</sup>

<sup>51</sup> This section draws on analyses released by Public Citizen.

<sup>52</sup> U.S. Census Bureau, “Doctors Per 100,000 Resident Population, 2001,” available at: [www.census.gov/statab/ranks/rank18.html](http://www.census.gov/statab/ranks/rank18.html).

<sup>53</sup> Harris Interactive, “States Liability System Ranking Study,” January 2002.

<sup>54</sup> CNN/Money, *Best Places to Live*, (Nov. 24, 2002, <http://money.cnn.com/best/bplive/>).

33 of the top 100 cities rated for plentiful leisure activities were in the ten states with the most per capita number of doctors, while there were none in the ten states with the fewest per capita number of doctors.<sup>55</sup>

48 of the top 100 cities rated for having good schools were in the ten states with the most per capita number of doctors, while there were only seven in the ten states with the fewest per capita number of doctors.<sup>56</sup>

**Figure 9**  
**States with the Most Doctors Per Capita**

		Non economic damage cap?	Punitive damage cap?	Income Rank	Have cities placed in the top 100 for:		
					Arts	Recreation	Schools
MA	1	Yes	No	12	X	X	X
NY	2	No	No	28	X	X	X
MD	3	Yes	No	2	X	X	X
CT	4	No	No	7	X	X	X
RI	5	No	No	18			X
VT	6	No	No	22			X
NJ	7	No	Yes	3	X	X	X
PA	8	No	No	24	X	X	X
HI	9	Yes	No	17			

**Figure 10**  
**States with the Fewest Doctors Per Capita**

		Non economic damage cap?	Punitive damage cap?	Income Rank	Have cities placed in the top 100 for:		
					Arts	Recreation	Schools
ID	50	Yes	No	32			
MS	49	No	No	49			
OK	48	No	Yes	42			
AK	47	Yes	Yes	1			X
IA	46	No	No	30			X
WY	45	No	No	39			X
NV	44	No	Yes	20			
SD	43	Yes	No	45			
AR	42	No	No	50			
UT	41	Yes	No	9			

<sup>55</sup> CNN Money.

<sup>56</sup> *Sperling's Best Places To Live*, (Mar. 30, 2001) [www.bestplaces.net](http://www.bestplaces.net).

## 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>57</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>58</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>59</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.

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

---

<sup>57</sup> Rand Institute for Civil Justice, Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA, 2004, p. xxvi.

<sup>58</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>59</sup> The Foundation for Taxpayer and Consumer Rights, *How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California*, February 2003.

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>60</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 this limit on the legal rights of patients in the public interest?

---

<sup>60</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>61</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>62</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 court.” The current standard is that the award “deviates from that which would be reasonable compensation.”<sup>63</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

<sup>61</sup> Chapter 294 of the laws of 1985.

<sup>62</sup> Further amended by Chapter 266 of the laws of 1986. Excess limit increased by Chapter 1 of the laws of 2002.

<sup>63</sup> Chapter 682, of the laws of 1986.

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>64 65</sup>

These changes appear to be the reason why, as mentioned earlier, over the past decade malpractice litigation has remained fairly stable in New York State. Unfortunately, not nearly enough has been accomplished to reduce needless patients’ injuries and deaths resulting from medical negligence or mistakes.

---

<sup>64</sup> Chapter 476, of the laws of 1975.

<sup>65</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.

## RECOMMENDATION: PROTECT PATIENTS

Policymakers must make protecting patient safety their number one priority.

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 includes 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 Institute of Medicine<sup>66</sup> and the State Health Department<sup>67</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.
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 pledged to use that data to identify problem doctors. However, there is no evidence that the DOH has begun to use this data. 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.<sup>68</sup> The force of law should back up this common sense ethical requirement.
5. **The state should review its programs that help place physicians in underserved areas.** New York currently provides financial assistance to encourage physicians to practice in underserved areas. A review of this program must examine what reforms, or expansions, are needed.

---

<sup>66</sup> National Academy of Sciences' Institute of Medicine, To Err is Human: Building A Better Health Care System, November 1999, p. 10.

<sup>67</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>68</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>69</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>69</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.